Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting
Thursday 31 October 2019

Agenda and papers

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: Thursday, 31 October 2019, 10:00-13:40
Venue: Barnes, Richmond, Sheen Rooms, Queen Mary's Hospital

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	A	Visits to various parts of the site	Board Members	Note	Oral
STAFF VALUES AWARD					
	B	Staff Values Award Presentation - Caroline Van Marle and Hayley Blanchett	Chairman	-	Oral
1.0 OPENING ADMINISTRATION					
10:30	1.1	Welcome and apologies	Chairman	Note	Oral
	1.2	Declarations of interest	All	Assure	Report
	1.3	Minutes of meeting on 26 September 2019	Chairman	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
10:35	1.5	CEO's Report	Chief Executive Officer	Inform	Report
2.0 QUALITY & PERFORMANCE					
10:40	2.1	Quality and Safety Committee Report	Committee Chairman	Assure	Report
		2.1.1 Infection Prevention and Control Audit Annual Report	*Chief Nurse & DIPC*	*Assure*	*Report*
		2.1.2 Learning Disability Services Annual Report			
		2.1.3 Learning from Deaths Quarterly Report	*Chief Medical Officer*	*Assure*	*Report*
11:05	2.2	Integrated Quality & Performance Report	Chief Transformation Officer	Assure	Report
11:20	2.3	Emergency Care Performance Update	Chief Operating Officer	Assure	Report
11:35	2.4	Cardiac Surgery Update	Chief Medical Officer	Assure	Report
11:45	2.5	Transformation Quarterly Report	Chief Transformation Officer	Assure	Report
3.0 WORKFORCE					
11:50	3.1	Workforce & Education Committee Report	Committee Chairman	Assure	Report
12:00	3.2	Healthcare Workers Flu Vaccination	Chief Nurse & DIPC Chief People Officer	Assure	Report
4.0 FINANCE					
12:05	4.1	Finance and Investment Committee Report	Committee Chairman	Assure	Report
12:15	4.2	FIC (Estates) Report	NED Estates Lead	Assure	Report

Time	Item	Subject	Lead	Action	Format
12:25	4.3	**Finance Report (Month 06)**	**Chief Financial Officer**	Update	Report
5.0 GOVERNANCE, STRATEGY & RISK					
12:35	5.1	**Audit Committee Report**	**Committee Chair**	Assure	Report
12:45	5.2	**Research Strategy**	**Chief Medical Officer**	Approval	Report
12:55	5.3	**Corporate Objectives Quarterly Report**	**Head of Strategy**	Assure	Report
13:00	5.4	**St George's Hospital Charity Report**	**Head of Strategy**	Update	Report
13:05	5.5	**Board Assurance Framework Quarterly Report**	**Chief Nurse**	Assure	Report
13:15	5.6	**Horizon Scanning Reports:** ***5.6.1 Policy, Legislative and Regulatory issues – Quarter 2*** ***5.6.2 Regional & Local Updates***	**Chief Corporate Affairs Officer/ Head of Strategy**	Inform	Report
6.0 CLOSING ADMINISTRATION					
13:20	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 PATIENT/STAFF STORY					
13:30	7.1	**Physiotherapist Case Study: Learning from Patients with Complex Rehabilitation Needs**	**Chief Nurse**	-	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".

Thursday, 28 November 2019, 10:00-12:30
Hyde Park Meeting Room

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
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		
Ellis Pullinger	Chief Operating Officer	COO
Harbhajan Brar	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Sally Herne	Quality Improvement Director – NHS Improvement	QID
Ralph Michell	Head of Strategy – deputising for the CSO	HoS
Secretariat		
Tamara Croud	Interim Assistant Trust Secretary	IATS
Apologies		
Suzanne Marsello	Chief Strategy Officer	CSO

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.*

St George's University Hospitals NHS
NHS Foundation Trust

Board Walkabout - Thursday 31st October 2019, 08:30 – 09:45

Meet at the Piano Ground Floor QMH at 08:30

At the time of your visit the wards and departments will be extremely busy. This is one of the busiest times for areas with morning ward rounds, medication and assistance with patient care being completed.

Please ensure that your team is in the Barnes, Richmond and Sheen room for 09:45 to provide verbal feedback on your areas visited. Please nominate one individual to provide a summary of the findings who will be given 3 minutes to complete this.

During your visit to areas this is an opportunity to meet with staff and understand the breadth of services that are provided. You are encouraged to discuss with staff the services they provide and challenges they may face.

In addition to this we would ask that you continue to observe environmental cleanliness and infection control principles and therefore the following points may assist you in this process.

1. **Are staff bare below the elbows in clinical areas and adhering to principles of hand washing?**
2. **Is the ward/department clutter free?**
3. **What impression are you given on entering?**
4. **Is the ward calm and organised? Is the ward odor free?**
5. **Are signs and notice boards clear and well displayed?**
6. **Is any unused equipment clean and labeled as clean and ready for use?**
7. **Are resus trollies, ledges etc free from dust?**
8. **Are there any outstanding urgent estates or maintenance issues?**
9. **What do staff enjoy most about working at St Georges Hospital?**
10. **What do staff feel the barriers are to undertaking their job?**
11. **How do staff feel the board can support them in delivering care to patients or undertaking their job?**
12. **Are there any outstanding urgent estates or maintenance issues?**

These visits are not “inspections” as these will be done using a more formalised approach.

Practicalities

- This is usually conducive to visiting two clinical / non clinical areas but need to be flexible and go to another area if it is not a suitable to visit at that time or visit finishes early.
- When arriving in a clinical area always ask to speak to Nurse in Charge (NIC), if NIC and other staff are busy ask for the Matron or Head of Nursing to be bleeped if they are not already on the ward.
- Board members must be ‘bare below the elbow’, including the removal of any rings with stones.
- All belongings can be left in the Hyde Park room as a member of staff will stay with the belongings while you are out visiting the wards.
- If you need to make notes please do so and let the staff know that you are doing so to feedback to the Board.

The table overleaf sets out group and areas to visit. We will start from the piano on the ground floor at 08:30 and return to Barnes, Richmond and Sheen room for 09:45 to report our observations and findings to the other groups at the start of the Board meeting at 10:00.

Finally – enjoy! Staff really appreciate visits by Board members and welcome the opportunity to speak to us directly.

Groupings- 31st October 2019

NED	Exec / Divisional Chair	Divisional Representation	Area Visiting, 08:30 – 09:45
Gillian Norton, Chair	Avey Bhatia	Catherine Logan, Sister Debbie Hind, ENP	Outpatients MIU
Ann Beasley	Richard Jennings	Louise Paterson, Team Leader Allison Hempstead, Head of Nursing	Bryson Whyte Rehab Unit Mary Seacole Ward
Prof Jenny Higham	Stephen Jones Harbhajan Brar	Sukpal Kaur, Matron Dr Sancho Wong, Neuro Rehab Consultant	Gwynne Holford Ward Wolfson Rehab unit
Stephen Collier	Ellis Pullinger	Sarah Smith, Team Lead	Douglas Bader Rehabilitation Centre
Tim Wright	Jacqueline Totterdell Andrew Grimshaw	Alison Stroud, Day Case Unit Sandra Howard, CNS Derm	Day Case and Endoscopy Dermatology

Meeting Title:	**TRUST BOARD**		
Date:	**31 October 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. Members of the public will also be able to see what declarations our staff, including Board members, has made following the launch of the new Declare system on 01 October.		
Recommendation:	For the Board to note, review and provide any relevant updates.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and improvement capability (well-led) – Effective boards and governance.		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The public rightly expect the highest standards of behaviour in the NHS. Decisions involving the use of NHS funds should not be influenced by outside interests or expectations or private gain.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix A. Register of Board Members' interests		

Appendix A. Register of Board Members' interests

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Gillian Norton	Chairman	Deputy Lieutenant (DL) Greater London Lieutenancy Representative DL for Richmond	October 2016	Present	
Gillian Norton	Chairman	Chairman of Epsom and St Helier Hospitals	October 2019	Present	Remunerated
Gillian Norton	Chairman	Chair of Trustees of Richmond upon Thames Voluntary Fund	September 2019	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	

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	

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	

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)	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	
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

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
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
Timothy Wright	Non-Executive Director	Owner/Director, Isotate Consulting Limited	January 2013	Present	IT advisory and consulting services to private and public sector clients (none of whom are in the healthcare sector)
Timothy Wright	Non-Executive Director	Trustee, St George's Hospital Charity	19 January 2018	Present	

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Executive Board Members					
Jacqueline Totterdell	Chief Executive	Partner, NHS Interim Management and Support	2005	Present	
Jacqueline Totterdell	Chair	Chair of the Clinical Research Network (CRN) South London Partnership Board	2019	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			

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
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	District Councillor Westcott, Mole Valley District Council	2008	Present	Leader of the Opposition

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, Radio Wey	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			

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 26 September 2019, 10:00 – 13:00
Room 2.6, Hunter Wing St George's University of London

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection Prevention & Control	CN
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
Ellis Pullinger	Chief Operating Officer	COO
APOLOGIES		
Tim Wright	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Jacqueline Totterdell	Chief Executive Officer	CEO
Andrew Grimshaw	Chief Finance Officer/Deputy Chief Executive Officer	CFO/DCEO
Dr Richard Jennings	Chief Medical Officer	CMO
Sally Herne	NHSI Improvement Director	NHSI-ID
SECRETARIAT		
Tamara Croud	Interim Assistant Trust Secretary (Minutes)	IATS

Feedback from Board Visits

Renal Dialysis Unit and Court Yard Clinic: Chairman, CSO and COO

The CSO reported that the renal dialysis unit which moved out of the Knightsbridge Wing was now located in the portacabin facilities co-located with transplant services. Although the environment was not ideal, patients were very complimentary and had written to the CEO praising the service. Staff were working hard to ensure that patients had a good experience despite the challenges with the environment. A year ago, the Court Yard Clinic had some significant challenges around temperature control but this has now been dealt with. The Chairman advised that staff in the Dialysis Unit were disappointed at being awarded bronze award following the recent ward accreditation and asked whether this rating was related to the environmental factors which were not in their control, it should be revisited?

Feedback from Board Visits

Coronary Care Unit and Cardiology Nurse Practitioners: Sarah Wilton and CTO

The CTO reported that both visits were very good and in discussions two quality improvement project ideas had been apparent. The first was the development and use of a patient experience video which explained to new patients what to expect when they attended the Coronary Care Unit and the second related to how to schedule cardiac capacity and the use of the cardiology laboratories for inpatients and possibly reduce length of stay. In both areas a material issue raised related to the cleaning contract and whilst staff were completing Datix they did not feel that they are getting feedback on individual areas. The Coronary Care Unit was cluttered with workstations on wheels and the Trust needed to think about how to manage this. On workforce, recruitment remained a challenge but headway was being made and the team wanted to focus on retention and the learning environment. Sarah Wilton advised that there was also a lot of discussion about the closure of the Charles Pumpfrey space and frustration that it is not efficient for patients or staff. The COO agreed to follow-up on the issues related to Charles Pumpfrey but advised that the Trust did have a flexible arrangement for the services especially in relation to elective activity and this is within the gift of the division to address with the current understanding being the only issue related to staffing. In addition, Sarah Wilton reemphasised the cleaning issue and requested that as part of the Trust's review of the award of the cleaning contract the delivery of against key performance indicators be considered. The Chairman noted that the CN would pick up on the issue of cleaning with the CFO/DCEO.

Therapy Outpatients and Hydrotherapy Pool: Stephen Collier and CN

Stephen Collier commended Gemma Stot, Interim Chief Therapist, as the embodiment of the St George's values who had a can-do competent approach which was very effective. Staff demonstrated good practice with the right approach to patients. The calibre of the staff was uniformly strong. The service had extensive service hours five days per week across different therapies and a passion for driving service improvement. The service demonstrated how effectively it managed vacant slots where patients 'did not attend' for appointments which meant it was running at 97% capacity. The service continued to deliver the pathway and has an adaptable approach to its interfaces with South West London Elective Orthopaedic Services (SWLEOC) and Trauma and has a strong focus on delivering care. There needed to be more focus on single point of access where channelling patients through physiotherapist before they see consultants has significantly increased the services case numbers and workload without commensurate increase in resource which has an impact on triaging patients leading to a backlog. Ceasing the Saturday clinic had impacted on the service given increase in demand. The environment was reasonable but there were two issues, firstly the hoist needed to be replaced and the showers in the hydrotherapy pools had been out of order for some time. The COO would pick up the booking issue and report back and the CN would follow-up on the estate issues.

Complaints Team, PALS and Flu Clinic: Ann Beasley and CPO

The CPO reported that the Trust was progressing with the flu vaccination programme and a report would be presented to the Board in October with the aim to hit the 90% target this year. The Complaints and PALS services were very positive, enthusiastic and the teams loved what they were doing. Consideration needed to be given to how best to address issues and complaints that arose over the weekend. A key issue was the IT system which could be erratic but staff acknowledged the responsiveness of the ICT team. The Complaints team commended the CommCell approach that had been adopted in addressing the timeliness of responding to complaints. In August 2019, responses had reached 100% for timeliness for the first time in many years.

Values Award

The Board welcomed Security Officer Errol Skeete, who, with colleagues Donovan Berry, Jit

Gurung, John Teale and Peter Windus, was nominated for a Living Our Values Award by a member of staff for the professional, knowledgeable and vigilant support provided during a particularly serious and stressful incident. The Board thanked the team for their contribution to the Trust and noted that the hospital depends on the professionalism and expertise of its staff. The Chairman presented the award.

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting and noted the apologies as set out above. The Chairman reported that whilst it was unfortunate the Sir Norman Williams was called away to another meeting she wanted to formally acknowledge his contribution to the Trust and the Board given this would be his last Board meeting. Sir Norman Williams would join the private session later in the day but it was important to acknowledge publicly his support to other Non-Executive Directors and Executive colleagues. His significant expertise had been invaluable and whilst the Trust would prefer that he stayed it was understood that this was not possible alongside his new national role as Chair of the Independent Reconfiguration Panel.	
1.2	**Declarations of Interest** The Board noted the register of Board members' interests. The Chairman highlighted that among her declarations was her new role as Chairman of Epsom and St Helier University Hospitals NHS Trust, which had commenced on 1 October 2019. The Chairman observed that she had been appointed to the role by NHS England and NHS Improvement and while she would be Chair in Common of both Trusts she assured the Board that she would continue to be able to fulfil the time commitments required in her role at St George's. Robust arrangements were in place for the management of any specific interests that arose from her appointment to this role.	
1.3	**Minutes of the meetings held on 26 July 2019** The minutes of the meeting held on 26 July 2019 were agreed as an accurate record subject to ensuring that the action related to the CSO and the Chairman discussing what needed to come back to the Board in relation to the outpatients strategy detailed in section 4.3 on page 10 be included in the action log.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log including the actions on which were not yet due.	
1.5	**Chief Executive Officer's Update** The CN presented the Chief Executive Officer's Update in the absence of the CEO and highlighted the following: • The Trust was pleased with the Chairman's appointment as Chairman of	

		Action
	Epsom and St Helier University Hospital NHS Trust alongside her existing role as Chairman of St George's. This would help ensure that both organisations worked more closely together which would have benefits for the patients of both organisations. • The Trust had now returned to Referral-to-Treatment reporting at the Queen Mary's Hospital (QMH) site and iClip, the electronic patient administration system, had been successfully deployed at the site to bring it in line with the Tooting site. The staff in the ICT team had gone to great lengths to ensure the success of the project and should be commended for their work. Linked to this, it was also highlighted that the number of people waiting for treatment over 52 weeks has reduced to six patients. • The Trust was concerned about the ongoing challenges in meeting the Four Hour Operating Standard for the Emergency Department. Performance remained challenged and while the hard work of the teams involved was recognised it was clear that more work needed to be done. To this end, the CEO would be chairing a weekly ED performance group to ensure that overall performance and volatility in performance levels was addressed. • Fiona Ashworth, Divisional Director of Operations (DDO) and Lisa Pickering, Divisional Chair of the Medicines and Cardiovascular Division, were both leaving the Trust in September 2019. The Trust thanked both Fiona and Lisa for their contributions over a number of years and wished them the very best for the future. Mandy Woodley and Jane Evans had been appointed as DDO and Divisional Chair for the Division. • There were a number of significant upcoming events to which the attention of the Board was drawn. The first was the Annual Members' Meeting which would take place that evening. There was also a Health and Wellbeing Week planned for 1 October 2019. The Trust had also won a Nursing Times award for best recruitment experience the previous evening. The CN, on behalf of the CEO, expressed the thanks and appreciation of the executive directors for Sir Norman Williams' support and advice during his term as non-executive director and noted that he would be much missed but nonetheless congratulated him on his new role. Ann Beasley reiterated gratitude and acknowledgment of the work carried out by the ICT and operations teams to implement iClip and return to referral to treatment time reporting at the QMH site. The level of planning and engagement had been a good example of effective project implementation and management.	
1.5.1	**Trust Executive Committee Terms of Reference** The Board received and noted the terms of reference for the Trust Executive Committee. For avoidance of doubt, the Trust Executive Committee was not strictly a committee of the Board as it was not chaired by a non-executive director. Rather, it was an executive management Committee chaired by the Chief Executive to oversee and ensure the effective implementation of Trust strategy, oversee organisational performance, make management decisions on key issues, oversee the effectiveness of operational governance and risk management, and escalate issues to the Board. Given its status, the Board	

		Action
	was not asked to approve the terms of reference but as a matter of good practice these were presented to the Board for information and assurance that there was a robust governance process in place at executive level. In response to a question from Sarah Wilton, it was reported by the CCAO that the Board would be kept abreast of the work of Trust Executive Committee as appropriate through the regular reports that are provided to each Committee as well as through the CEO's report to the Board.	
2.0	**QUALITY AND PERFORMANCE**	
2.1	**Quality and Safety Committee Report** On behalf of Sir Norman Williams, Chair of the Committee, Professor Jenny Higham presented the report of the meetings held on 22 August and 19 September 2019. The Trust should be very proud of the exemplar Learning and Disabilities Services which, despite increased activity, was delivering excellent support to patients with disabilities. The Committee endorsed the extension of the deadline to achieve the outstanding CQC action related to attaining the 85% target for mandatory and statutory training to December 2019 as opposed to end-September 2019. This was in recognition of the fact that there was a national issue with triangulating new nurse and junior doctors prior training records and being able to utilise these to demonstrate completion of basic training such as resuscitation training. For the first time in many years the Trust complaints response target was green and the Committee was reassured that this would remain the case in September and that focus was being given to sustainability, with more experienced staff being brought in to support the team. The Committee had noted the many areas of good performance across the Trust. The Committee also thanked the Sir Norman Williams for his contribution and chairmanship of the Committee, his championship of the quality agenda and respectful yet robust challenge of the issues which had contributed to the improvements in the Committee. The CN advised that the current complaints on-time response rate was 100% for September. The Chairman concurred with the praise of the Learning Disabilities Service noting that the level of care and attention provided by the service had met the highest standards and therefore the Board formally thanked the service. The Board noted the report.	
2.1.1	**Mental Capacity Act and Deprivation of Liberty Standards (Annual Report 18-19)** The CN presented the Mental Capacity Act and Deprivation of Liberty Standards Annual Report for 2018-19 advising that this had been considered in depth by the Quality & Safety Committee in July 2019. She reported the assurance the Committee had received and commended the Trust for attaining the 80% training target. The progress made was the result of an enormous amount of work in this area. The Chairman commented that this represented real progress and the good work done was very evident. The CTO added that it may be useful to complete annual reports against other targets such as treatment escalation plans.	

		Action
	The Board agreed that it would be useful to complete annual reports for certain other performance areas such as treatment escalation plans and that proposals on which areas would benefit from this approach would be presented to the Quality and Safety Committee for consideration.	**CN**
2.2	**Integrated Quality and Performance Report (IQPR)** The CTO gave an overview of the IQPR at Month 5 (August 2019). Day case and elective activity performance continued to improve. Performance was currently 5,035 which was above target and represented an increase on the 4,535 recorded for August. Similarly, the Trust continued to record increases in the number of outpatients receiving first appointments with actual performance being 15,094 which is an increase from the recorded 14,971 in August. The Trust has now managed to change its balanced scorecard rating on cancer to green as result of achieving all cancer performance standards which could be credited to the work of the COO and the operations teams. The Trust and South West London were the national leaders for cancer. Theatre productivity had improved significantly but the Trust needed to manage its activity within the block contracts and ensure it was having the right conversations with local commissioners to ensure it was properly reimbursed for activity. Stephen Collier queried whether theatre utilisation issues was impacted by the turnaround of beds to which the CTO advised that the Trust cancelled very few patients for beds. Non-elective stay was increasing whilst elective length of stay has reduced. Things that have impacted on beds relate to outpatient flow through and the level of booking capacity. Sarah Wilton queried the degree to which the Trust was clear about day cases and how the Trust utilised beds. The CTO advised that the report (page 16) set out the increase in the number of elective and day patients treated by day but it was recognised that the Trust could do more activity in the day surgery unit but the focus was on ensuring that the Trust placed the patients in the most appropriate environment to be treated given that day cases happened across the Trust. The COO advised at the recent Trust Executive Committee performance review meeting focus was given to day surgery performance and the divisions outlined plans to review and improve utilisation with a deadline of October 2019. In addition in relation to patient pathway management the Trust was rolling out Insight, the patient booking system, in partnership with Four Eyes which would further improve theatre utilisation. The COO provided a comprehensive verbal update on the Trust's emergency care performance and the Board noted the following material points: • The Trust was working with the Wandsworth and Merton Clinical Commissioning Groups to complete a review of the Trust's emergency department (ED). This work was completed by the Emergency Care Intensive Support Team (ECIST); • The initial review by ECIST had identified the following key themes: – There were too many patients being streamed through the ED and the Trust needed to use its ambulatory services more effectively to appropriately divert patients who had been referred by a GP to a more relevant area across the Trust for example to ambulatory services. – There was a lack of joined-up working within the ED team and the Trust needed to build dynamics within the team which included clarity on	

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	trigger points in terms of level of business and acuity in the department. – The EDs ward processes and how it discharged patients across the organisation. There was a lack of consistency in how the department applied and utilised the red-to-green processes for assessing and planning for patients to move across the hospital. The Trust needed to re-energise the work and use of this system uniformly. – The Trust needed to significantly refresh its protocols for running the site when the ED had high demand and in escalation status. While there were some examples of good practice the Trust could learn from other trusts in this area. • The ECIST final report would be available mid-October 2019. • Given the performance and challenges with the ED recently the CEO would now chair a weekly meeting and this will be informed by the ECIST feedback to ensure the organisation was realigned. Ann Beasley noted that the Trust had undertaken previous reviews and held discussions about ED performance and queried whether or not any of the ECIST findings were novel or surprising and the extent to which the recommendations would resolve the underlying issues in performance. The COO advised that ECIST had very hands-on expertise about what works well in other organisations across the country. ECIST had flagged that the Trust should be proud of the quality and delivery of the care it was delivering and that there were some things it was doing very well. However, there were challenges with ED leadership and team working which the Trust needed to address in addition to ensuring that all GP referred patients are triaged to the right parts of the hospital and not just into ED. The ECIST work would prompt the Trust in the right direction and would provide tangible actions which could be implemented to drive improvement in the short-term. Stephen Collier queried whether or not the team working and leadership issues related to policies and processes or culture. The COO reported that team working issues related predominately to culture and behaviours. Sarah Wilton reflected that the Trust had previously had other organisations conduct similar reviews and commented that it was therefore difficult to understand, from the verbal update, what was going to be different in terms of having a clear plan on accountability and leadership and a timetable for delivering real change. The Board needed to have sight of the action plan and the timetable in order to ensure it could track and measure success and be assured that the actions were delivering the required improvement. The COO advised the Trust had already put in place the process for streamlining GP referred patients to the appropriate part of the hospital. The Trust was under no illusions about the scale of the task and would focus on this work to ensure actions were implemented and that performance was both improved and sustained. The Chairman noted that the ECIST work had only been completed on 23 September 2019 and therefore appreciated the frank and open discussion with the Board and it was good to note that the CEO would chair the weekly meetings. **The Board agreed that a clear plan would be presented at its next meeting which gave Board the sense there was sufficient grip. The plan would outline the expected percentage improvement that would be gained from streamlining the pathway to ensure that GP referred patients were triaged to other parts of the hospital, a progress report on the actions taken to**	

		Action
	complete the quick wins such as improving the processes for discharging patients and refreshing the protocols for running the site when there was high demand in ED and the plan for addressing the cultural issues. The CN reported that the Trust's friends and family response rates and positive responses for inpatients had increased, while ED remained static. Outpatients' FFT response rates had improved but were still well below the threshold. The Trust would be carrying out focused work in this areas which reflected the new guidance and this would be discussed at the Quality and Safety Committee and how best to triangulate this with PALS and complaints. The CPO reported that funded establishment and agency spend were the material issues of concern in relation to workforce. The Chairman noted that the agency spend was a matter of concern and Stephen Collier noted that in the next two/three months the Cost Improvement Programme calls for the savings to start to be delivered . The materiality of this was stark set in the context of current capacity and demand for services and therefore the Board should not underestimate the challenge in the next three months. It was noted that the CFO/DCEO was very much sighted on this issue and the CPO reported that discussions had already begun with Divisions about the need to focus on operational delivery and the workforce implications with the view that more needed to be done to tighten up controls. The Chairman summarised that, the discussion had given the Board limited assurance. The planned increase in assumed CIP delivery is going to be challenging for the Trust and therefore the Board would need to monitor performance carefully. The Board noted the report.	**COO**
2.3	**Cardiac Surgery Update** In the absence of the CMO, the CTO presented an update on the steps being taken to improve the cardiac surgery service and outlined the key points of the report. The Trust continued to work with partners to develop the networked model for delivering cardiac services across South London. This work was being clinically-led. Ann Beasley flagged that there had been a change in the scoring of the risks related to the service and asked for clarity on the rationale for the movement in the scores. The CN explained that the movement in the risks were not well articulated in the report and reassured the Board that there was a risk register in place for the service which was managed robustly in line with the Trust's risk management policy. The CTO also reported that the Trust had reconciled its cardiac surgery risk register and ratings with the NHS England and NHS Improvement assessment of risks in this area. The CCAO suggested that at the appropriate time the Board should revisit progress against the action plan from the Bewick Report to ensure that the actions were being progressed and/or closed as appropriate. The last time the Board had reviewed this was in December 2018 and it may be appropriate for this to come back in a future report before the end of the calendar year. **The Board agreed that the next iteration of the cardiac surgery report would include more information on the risks and movement in risks score and that a future report on cardiac surgery would be presented to the Board before the end of 2019 which would review the actions from the**	

		Action
	Bewick Review.	**CMO**
2.4	**Quality improvement Academy Quarter 2 Update** The CTO reported that there continued to be lots of quality improvement (QI) work taking place across the Trust. As previously agreed the Trust was developing a dashboard to track QI projects and performance. Lots of the QI work in the divisions linked with the 'get it right the first time' (GIRFT) initiative and the Trust was also progressing projects as part of the Heath Improvement Network (HIN) and leading better use of technology and pathway management. The CTO added that the Trust had recently won an HIN award for the most innovative trust. The Chairman noted the Board's congratulations on winning the HIN award and expressed appreciation to all the teams involved. The CSO noted that QI was a key enabler to delivering the clinical strategy and QI would be a focus in scoping the strategic priorities next year. Ann Beasley noted the good working being done but queried plans to send ten key leaders to learn more about the potential of QI in Orlando Health given the financial position of the Trust and asked whether such training could be offered closer to home at lower cost. **The Improvement Methodology Director (IMD), Martin Haynes, commented that the proposed visit to Orlando Health would be supported by the Charity and that Orlando Health was one of the leaders in QI. However he would revisit the proposal to consider whether there were any closer alternatives**. Sarah Wilton enquired as to the speed and scope for training and developing staff to deliver the QI methodology which would empower them to begin to make changes in the 'St George's Way' and requested the new dashboard for tracking QI projects include measures of tangible impact and evidence of change. The Chairman echoed the latter point noting that the dashboard should track the difference made to patients and that QI became a more strategic driver of change. The IMD commented that staff were being trained in QI and that three new QI leads had been deployed across the divisions to support staff to drive QI projects. In addition, he confirmed that the new dashboard would include tangible data on impact and evidence of change. The Board noted the report	**CTO**
3.0	**Workforce**	
3.1	**Workforce & Education Committee Report & Terms of Reference** Stephen Collier, Chair of the Committee, presented the report of the meeting held on 8 August 2019. The Committee's focus had shifted to assurance in line with its terms of reference and the membership of the Committee had also changed. These changes were connected with the establishment of a new People Management Group (PMG) which would focus on the operational side of workforce issues and report to the Committee through Trust Executive Committee. This would ensure that the Workforce and Education Committee operated as an effective assurance Committee of the Board and that it would avoid getting drawn into operational and management issues. The	

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	Committee considered the key strategic risks related to workforce and agreed that the risk on Diversity and Inclusion be increased to reflect the lack of progress on the project. Conversely, there had been real improvement on recruitment and there was a planned focused on retention. As a result, the Committee decided it was appropriate to propose reducing the risk score on recruitment and retention given the sustained performance. The Committee had approved the Freedom to Speak Up Policy and the submission to Health Education England on revalidation. The workforce metrics reflected steady progress and, when benchmarked with other trusts, the Trust performed well with the exception of sickness and appraisal rates. However, the Trust had plans in place to address these areas. Workforce spend was a key area of focus for the Committee at present. The Committee had proposed minor changes to its recently approved terms of reference to reflect the establishment of the PMG and to provide that going forward the Corporate Affairs team would provide secretariat support to the Committee, and he asked the Board to approve these amendments. The CPO flagged that the proposals to reduce the recruitment and retention risk from 16 to 12 in line with the Committee's discussion had been considered at the Risk Management Executive which had not been assured by the rationale for such a change and as result the risk currently remained scored at the previous level. The CN reported that while there had been real progress on recruitment, the Risk Management Executive were not assured that the risk could be reduced given that each division had high-rated risks related to junior doctors rota and therefore asked the CPO to comeback with further proposals. The Chairman noted that the Board needed to discuss where the responsibility lay for deciding the scores for a Board Assurance Framework risk (strategic risks). This discussion would take place in October when the Board considered the BAF Q2 papers. The Chairman also reflected that thought should also be given to the sequencing of management of meetings so that the Board Committees were considering the final proposals that had been fully discussed and explored by the Executive as it was unsatisfactory that an Executive forum should overrule the BAF risk score of a strategic risk which had been considered by a Board Committee or the Board itself. The Chairman asked for assurance that there were programmes of work ongoing to address the sickness and appraisal performance and the CPO advised that there were robust plans in place. Stephen Collier advised that Committee would keep these plans under close review. The Board noted the report and approved the revised terms of reference.	
3.2	**Staff Engagement Plan 2019-21** The CPO presented the Staff Engagement Plan for 2019-21 which had been discussed and endorsed by the Workforce and Education Committee (WEC) at its meeting in August 2019. The focus of the plan was getting the basics of engagement right, with six key strands of work which included: • Listening, responding to and engaging our staff; • Developing outstanding leaders and effective teams; • Taking a zero tolerance approach to bullying and harassment; • Working to deliver our Diversity and Inclusion Strategy; • Empowering our staff to make real change; and • Refreshing and living our Trust Values. The plan had been redrafted and enhanced following discussion at the	

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	private Board meeting in June 2019. Progress on delivery would be monitored at WEC and the Board would receive quarterly reports on progress. The CN commented that the plan was much improved from the version considered by the board in June and enquired about the senior responsible officer (SRO) for the programme of work. It was noted that the CPO would be the SRO for the project and senior leaders in the workforce team would be responsible for driving key strands of the programme. Sarah Wilton enquired whether or not WEC would receive a detailed plan with timelines for delivery. The CPO advised that the plan was deliberately high level but reports on progress across each of the workstreams would be considered at WEC so that the Committee could provide effective assurance to the Board on progress. Sarah Wilton suggested it would be useful for WEC to receive a baseline report in October 2019. Stephen Collier advised that the plan was the important basic building block which could be developed further in the workforce strategy. The CTO noted that each workstream should include measureable outcome metrics which could easily be tracked in order to identify impact. The Board noted and approved the staff engagement plan and the governance framework for monitoring performance and delivery.	
3.3	**A Framework of Quality Assurance for ROs and Revalidation – Annual Report** The Board received and discussed the Framework for Quality Assurance for Responsible Officers and: • Accepted the standardised annual report, which followed an annual audit submitted to NHS England and NHS Improvement in June 2019, covering the period from 1 April 2018 to 31 March 2019; • Approved the "Statement of Compliance" confirming that St George's University Hospitals NHS Foundation Trust was compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013); and • Authorised the CEO to sign the statement of compliance for return to NHSE&I by the end of September 2019, on behalf of the Board.	
4.0	**FINANCE**	
4.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meetings held on 22 August and 19 September 2019. The Committee noted that the Trust's financial performance was broadly on plan with focused discussions about the risks related to a block contract and whether or not the Trust or the commissioner held the majority of the risk. Discussions in relation to this were underway with the Clinical Commissioning Groups. The Trust's emergency department was challenged as discussed earlier in the meeting, but there was a lot of good performance across the Trust, for example in relation to the cancer standards. The Trust's financial performance at Month 6 would be the critical juncture for forecasting financial performance to year-end. In Month 7 there would be a step change in the expected returns from CIPs and it was	

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	important that the Trust was sufficiently focused on driving these programmes of work to deliver the required savings targets. Ann Beasley also commented that it should be noted that the Trust had not made progress on closing the £3m CIP gap previously identified and executive leads were focused on putting in place necessary mitigations for any gaps in the CIPs. The Committee had also conducted a review of the five year financial plan and had approved the full business case on for the refurbishment of the cardiac catheter laboratories and had recommended this to the Board. The Board noted the report.	
4.2	**Finance and Investment Committee (Estates) Report (FIC(E))** Ann Beasley, Chair of the Committee, provided an update on the meetings held on 22 August and 19 September 2019. The Trust had made significant progress on estate matters in recent months. There was greater transparency about the nature and scope of the estates challenges and the Committee had reviewed all relevant Authorised Engineer reports. The Trust was starting to develop systematic plans to address the key issues that had been identified. The recent Authorised Engineer report on water safety provided the Trust with an improved assurance rating. More focus was being given to the infrastructure. The Committee had also considered the issues around the new Mitie contract and discussed how the Trust had planned for implementation issues. The Trust was now moving past those early difficulties and Mitie's management team had stepped up. However, the Trust also needed to review the lessons learnt from this. The Committee would now focus on other health and safety issues such as fire safety. The Chairman commented that there had been a marked improvement in the level of focus and quality of the reporting to the Board, which now had a more thorough understanding of the scale and scope of the issues. Progress had been made but there remained much to do. The Board noted the report.	
4.3	**Month 5 Finance Report** The Board noted the Month 5 financial report and the DFP reported that there was a lot of focus on forecasting with divisions and the Trust had begun discussions with commissioners about winter planning and Quality Innovation, Productivity and Prevention plans. The Board noted the report.	
5.0	**Governance**	
5.1	**Audit Committee Report** Sarah Wilton, Chair of the Committee, provided an update on the meetings held on 1 August 2019. Good progress was being made against the internal audit programme for 2019/20 but the Committee was concerned about the delays in certain audits which, the Committee was told, would come to the next Committee meeting in October. Mindful of this, and its earlier request that the internal audit plan be reviewed at the mid-year point, the Committee also asked that the Trust Executive Committee consider the internal audit	

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	programme with the view to ensuring it was fit for purpose and addressed any key risks. The Committee reviewed and endorsed the Freedom to Speak Up (FTSU) Policy and was reassured by the level of work completed. However, it was concerned about the delay in the internal audit of Diversity and Inclusion. The CPO advised that additional resources had been brought in to lead the work on Diversity and Inclusion and therefore the internal audit could now be progressed. The Committee was assured by the progress made with ensuring Trust-wide policies were being gripped and reviewed and commended the CCAO's team for the progress made in this area. The Committee reviewed the Clinical Audit Plan and, while reassured by the programme of work, noted that this was something that required close scrutiny and monitoring by the Quality and Safety Committee. The CN advised that, with the CMO, additional support was being provided to the Clinical Audit team to ensure that their processes were robust. The Chairman reflected that it was good to see the FTSU posters around the Trust and that progress was being made in this important area. The Board noted the report.	
5.1.1	**Use of Trust Seal 2018-09** The Board received and noted the report on the use of the Trust's Seal in 2018-19 and the first quarter of 2019/20.	
5.1.2	**Standing Orders, Reservation and Delegation of Powers, and Standing Financial Instructions (SOs, RDP, and SFIs)** The Board reviewed the proposed amendments to the revised Standing Orders, Reservation and Delegation of Powers, and Standing Financial Instructions, agreed the proposed changes and noted the plans for communicating the updated SOs, RDP and SFIs across the organisation. The Board's approval was subject to the CCAO and CFO/DCEO considering whether or not there were any further changes required to the Standing Financial Instructions and Scheme of Delegation in relation to the role of the Director of Estates and Facilities (DEF) following the independent review of estates governance. Should further changes in relation to the DEF's role be required, time permitting these would be presented to the Audit Committee in October 2019, to which the Board delegated authority for approval, but otherwise the changes would be presented to the Board upon completion of the review of the SFIs and RDP against the estates governance review.	**CCAO/ CFO/DCEO**
6.0	**CLOSING ADMINISTRATION**	
6.1	**Questions from the public** The Chairman invited questions from the public. In response to a comment from Hazel Ingram, Patient Participation and Engagement Representative, the CN reported that the introduction of generic emails for Radiology results responded to issues highlighted from a thematic analysis of serious incidents. The Trust would also introduce a programme of audit to ensure that this system with the other actions from the review was having the required impact.	

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	The Board also noted that Mr Richard Watts had asked that the following be raised at the meeting following an incident with his patient transport: • Change the transport company; • Train staff about what was acceptable behaviour and treatment of patients especially vulnerable patients protected by the Equalities Act 2010 and Safeguarding and Vulnerable Groups Act 2006; and • Put a system in place to ensure that the issues that had happened did not happen again to any patients. The CN reported Mr Watts had raised a complaint and the matters was being addressed as part of the Trust's complaints processes and therefore it would not be appropriate to comment until that process was completed. The Trust was in regular contact with Mr Watts about his complaint.	
6.2	**Any other risks or issues identified** There were no other risks or issues identified.	
6.3	**Any Other Business** The CCAO advised that the new Trust branding would be rolled out from 30 September 2019 with the result that the papers for the next Board meeting would start to look and feel different.	
6.4	**Reflections on the meeting** The Chairman invited the CTO to offer reflections on the meeting. The CTO commented that Board was one of the ways that the Trust identified areas for operational and governance improvement and prioritising these was still a challenge for the Trust. It was good to see the discussions linked to the Board Assurance Framework and the conversations had informally led to prioritisation. There had been lots of humour in amongst some challenging discussions with a 'can do attitude'. The Board needed to reflect on whether it was being tough enough so that there was not a sense of repetition of key matters. Stephen Collier commented that it was important that the Board continued to be appraised of and understand the level scrutiny and discussions that happened at the Board Committee level which would enable the Board to focus on the key strategic discussions at its meetings. The Chairman concurred, noting that there was a fine line to tread in balancing scrutiny and assurance by the Board and taking full account of the challenge and assurance taken by the Board Committees. The DFO noted that the Board was tackling some significant issues and it could see that there was a joined-up approach to the discussions linking to workforce, performance and finances. The Chairman reflected that the Trust was focussing its discussion on the key areas of risk as set out in the Board Assurance Framework.	
7.0	**PATIENT & STAFF STORIES**	
7.1	**Patient Stories: Paediatric Patient Journey** The Board welcomed Mrs Susannah Stevenson who provided an overview of the care and support she received at the Trust when her four year old son got ill with a suspected perforated appendix and was transferred to the Trust's Tooting site from Ashford and St Peters NHS Foundation Trust. Rachel	

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	Bolland, Specialist Senior Paediatric Nurse (SSPN), and Terrence Joe, Head of Patient Experience & Partnership (HPEP), also attended the meeting. Mrs Stevenson's relayed her experience noting the issues which occurred when her son was transferred to the Trust: • As a result of an administration the patient was left of the list for the agreed ultrasound which did not come to light or addressed until Ms Stevenson and her husband proactively followed-up with the imaging department and the nurses; • The wrong amount of antibiotics was given to the patient because the weight was estimated which only came to light when Mrs Stevenson flagged this with clinical staff; • Many attempts were made at cannulating the patient, in the hands and feet, without success. These attempts were made by junior doctors and only with the intervention of the parents was this escalated to a senior clinician; • The discharge process appeared rushed and in part linked to bed availability and it did not always appear that the interests of the patient were at the heart of the timing of the decision to transfer the patient back to Ashford and St Peter's. Mrs Stevenson reported that the above incidents caused significant distress and upset to not only the patient but also to her and her husband and queried why these issues had arisen and why it was left to her and her husband to champion the cause of their son. Accordingly, she asked the Trust to consider the following four points: • When a patient moves from being a surgical case to a non-surgical case and as a shared-care pathway the issues with communication needed to be addressed to ensure that there was clarity and the patient was not caused any undue stress and the agreed care plan was enacted; • Where a patient needed cannulation if junior staff were not successful there should be upward escalation rather than multiple attempts by other junior staff ; • Where the case caused acute distress a follow-up should be made shortly afterwards to discuss the next steps and to provide emotional support, including to the parents and the child; and • Where a child was involved, parents should not be the ones having to wave the flag due to the feeling that their child was being overlooked. Mrs Stevenson noted her gratitude to the Trust for the diagnosis which led to her son getting better. She had not wanted to make a complaint but instead wanted to raise these issues so that the Trust could improve its services and avoid repeating the experiences her family had endured. The Chairman thanked Ms Stevenson for sharing her story and apologised on behalf of the Trust for the experience. The SSPN apologised on behalf of the service and as the new patient engagement lead for paediatrics she would be progressing these issues and said she would like to arrange a meeting with Mrs Stevenson to share her experience with the General Manager and the team. She would take her messages back to the governance meetings and the wider multi-disciplinary meeting. There was normally good communication between teams and every child should be under a general paediatrician if they are under a surgeon and the Trust needed to ensure that this communication happened at all times, including at the weekend because a lot of the issues that arose happened at the	

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	weekend. There should have been PLACE support and this would be investigated. The Trust would also look at how it managed the repatriation of the patients back to the referring Trust to ensure that it was not distressful. This would be shared at the ward meetings to ensure that nurses thought about their communication. For the first time, the Trust had a full complement of paediatric nursing and some of the issues that occurred should not now resurface. This would also be fed back to the bed managers responsible for arranging transport to ensure they embraced the learning and drove improvement. The HPEP noted that it was important that the Board heard this story which had a powerful impact and the Trust could use Mrs Stevenson's experience to share learning across the organisation not just in paediatrics. The CN noted that one of the key themes was the absence of nursing and compassion and the Trust would make it a priority to address this with the team. The chasing Mrs Stevenson had to do regarding the ultrasounds was unacceptable and the Trust would ensure that this was not a systemic issue. Another key point from the story was the issue of shared care models which was a fundamental part of paediatrics and the Trust was working on this actively because a lot of the children are under multiple specialities and the important of having a lead is key to the model of shared care. There was a lot of feedback from which the Trust needed to learn. Sarah Wilton asked why the Trust's specialist venous access team were not brought it to help with the cannulation of the patient. The SSPN advised that the crux of the issue may have related to the provision 7-day working where some services were not always as fully provided at the weekends. Nonetheless, there were nurse practitioners at the weekend who should have been able to assist. The CN noted that it was not acceptable that this was not escalated and repeated attempts for cannulation was clearly very distressing for the child and his parents. The Chairman reiterated the thanks of the Board and noted its commitment to addressing this issues raised by the story. **It was agreed that the Board would receive a follow-up report on actions taken in relation to the patient story.**	**CN**
Date of next meeting: Thursday, 31 October 2019 at Queen Mary's Hospital		

Trust Board Action Log Part 1 - October 2019

Action Ref	Section	Action	Due	Lead	Commentary	Status
TB27.06.19/01	**Integrated Quality and Performance Report (IQPR) (Month 02)**	It was agreed that the CMO and CPO would look into reviewing quality of appraisals and report to the Workforce and Engagement Committee.	19/12/2019	CMO & CoP	**Not yet due.**	**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~~ 28/11/2019	CMO	**Item deferred on request of CMO to November 2019.**	**OPEN**
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~~ 28/11/2019	CMO	**Item deferred on request of CMO to November 2019.**	**OPEN**
TB25.07.19/01	**Board Assurance Framework (Quarter 1(19-20) Review)**	The Workforce & Education Committee (WEC) would review the workforce and organisational risks to ensure they adequately articulated the key elements of risks and were appropriately rated giving consideration to the wider BAF and other interdependent risks; and Further work would be carried out to increase the rating for strategic risk 5 and the CN and Chairman would work on the description of strategic risk 6 with the view of increasing the risk rating to 12.	31/10/2019	WEC/CN/Chairman	**See Agenda Item 5.5**	**PROPOSED FOR CLOSURE**
TB25.07.19/02	**Outpatient Strategy**	The CSO and the Chairman to meet and discuss what needed to come back to the Board in relation to the outpatients strategy.	31/10/2019	Chairman/CSO	The Chairman and CSO met and agreed a way forward.	**PROPOSED FOR CLOSURE**
TB26.09.19/01	**Patient Stories: Paediatric Patient Journey**	It was agreed that the Board would receive a follow-up report on actions taken in relation to the patient story on Paediatric Patient Journey.	28/11/2019	CN		**NOT DUE**
TB26.09.19/02a	**Cardiac Surgery Update**	The Board agreed that the next iteration of the cardiac surgery report would include more information on the risks and movement in risks score.	31/10/2019	CMO	**See Agenda Item 2.4**	**PROPOSED FOR CLOSURE**
TB26.09.19/02b	**Cardiac Surgery Update**	The Board agreed that a future report on cardiac surgery would be presented to the Board before the end of 2019 which would review the actions from the Bewick Review.	19/12/2019	CMO	**Not yet due.**	**NOT DUE**
TB26.09.19/03	**IQPR M5/ Emergency Department Update**	The Board agreed that a clear plan would be presented at its next meeting which gave Board the sense there was sufficient grip. The plan would outline the expected percentage improvement that would be gained from streamlining the pathway to ensure that GP referred patients were triaged to other parts of the hospital, a progress report on the actions taken to complete the quick wins such as improving the processes for discharging patients and refreshing the protocols for running the site when there was high demand in ED and the plan for addressing the cultural issues.	31/10/2019	COO	**See Agenda Item 2.3. The Board may wish to consider whether this action should be closed following the discussion of this agenda item.**	**OPEN**
TB26.09.19/04	Mental Capacity Act and Deprivation of Liberty Standards (Annual Report 18-19) **- Developing Annual Reports for other performance areas**	The Board agreed that it would be useful to complete annual reports for certain other performance areas such as treatment escalation plans and that proposals on which areas would benefit from this approach would be presented to the Quality and Safety Committee for consideration.	26/03/2020	CN/CTO		**NOT DUE**
TB26.09.19/05	**Quality improvement Academy Quarter 2 Update**	The Improvement Methodology Director (IMD), Martin Haynes, commented that the proposed visit to Orlando Health would be supported by the Charity and that Orlando Health was one of the leaders in QI. However he would revisit the proposal to consider whether there were any closer alternatives.	31/10/2019	CTO	**Verbal Update to be provided by the CTO at the meeting.**	**OPEN**

Meeting Title:	Trust Board		
Date:	31 October 2018	**Agenda No.**	1.5
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

Chief Executive's report to the Trust Board – October 2019
Trust Board, 31 October 2019

1.0 Developments in our external environment

1.1 It already feels like we are well and truly into winter, and the past few weeks have seen further developments at a local and national level.

1.2 The debate around Brexit continues and, whilst I am confident we have contingency plans in place to ensure services won't be affected, whatever happens, the ongoing uncertainty Brexit creates is a concern, for both staff and patients.

1.3 Since our last Trust Board meeting, we have seen significant announcements at a regional, strategic level. NHS England and NHS Improvement published its Vision for London earlier this month, with a strong focus on public health; and the same goes for the Wandsworth Health and Care Plan, also unveiled in October.

1.4 I am supportive of the visions set out in both plans, but (as always) the true test will be how effectively the aims and ambitions they set out can be delivered; not least because they require organisations to work in different ways to how they have in the past, as those familiar with the NHS Long Term Plan will not be surprised by. This method of thinking is already beginning to happen across our system.

1.5 I am certain that all acute providers want to play a bigger role in the lives of the populations they serve, and not only when they are under our direct care; although we need to be realistic, as the pressures and demands of treating thousands of patients day in, day out in our hospitals should not be under-estimated.

1.6 Finally, we have made positive starts to both our NHS staff survey and flu campaigns, both of which are agendas being pushed hard at a national level. We have delivered year on year improvements in our staff survey response rates, and our annual flu campaigns are regularly used by other Trusts as a model of best practice to follow. However, we mustn't be complacent, as there is a long way to go.

2.0 Delivering on our vision and strategy

2.1 Work continues at pace to deliver our new clinical strategy, although this is dependent to a large extent on a number of supporting strategies - including, for example, our new research strategy, presented to Trust Board in October.

2.2 My focus at present, however, is on making sure we are getting the basics right, and delivering high quality services for local people. Our performance in this regard is variable; waiting times for diagnostics, cancer care and planned operations are continuing to improve, but emergency care remains a concern, both for the Trust Board and our regulators.

2.3 We welcomed the Emergency Care Intensive Support Team earlier this month, and our emergency care improvement plans - to be discussed in detail today - need to take effect, and quickly, with the worst of winter almost certainly yet to come.

2.4 We also need to see more progress with our deficit reduction plans. I have been clear with the organisation that for us to realise the ambitions in our clinical strategy, we need to first get back on a secure financial footing; a big part of which is delivering the savings plans we agreed at the end of 2018/19.

2.5 We have detailed cost improvement plans, with additional controls in place (e.g. on agency staffing) - but if we are to deliver a deficit of £3 million by year end, we need to move at a faster pace than we have thus far this year.

3.0 Our staff

3.1 This month, we have held a number of events as part of our diversity and inclusion agenda. We held a fantastic event to mark Black History Month, with staff new and old sharing their experiences, including the battles some have faced in progressing their careers.

3.2 We also held a Diwali celebration event at St George's last Friday, which was well attended by staff with a wide range of beliefs, from diverse backgrounds. The event was a perfect example of why St George's is so special; and why we mustn't take the diversity of our staff for granted. In fact, it is something we have to protect, nurture and support.

3.3 October is also Freedom to Speak Up month. We are working hard to raise the profile of Karyn, our Freedom to Speak Up Guardian, and her network of freedom to speak up champions. However, I have been at pains to stress that managers and team leaders have an equally important role to play - and they need to help us create a culture where staff feel able to raise concerns, including about unsafe practice if they witness it.

3.4 As Prerana Issar, Chief People Officer for NHS England/NHS Improvement said at a conference earlier this month; we need to make it easier for staff to speak up, but there is no point people speaking up, if no-one is listening.

3.5 On a more positive note, we were delighted to welcome Professors Mike Richards and Andrew Goddard to St George's this week in separate visits. Mike was the NHS' first cancer director, and a former CQC chief inspector of hospitals; whilst Andrew is President of the Royal College of Physicians.

3.6 Both Mike and Andrew spent time with our teams and left with a very positive impression of the work our staff are doing to improve patient care, including in new and innovative ways.

4.0 Updates from the Trust Executive Committee

4.1 With the establishment of a new structure and approach to Trust Executive Committee (TEC) meetings, I wanted the Board to have sight of how the new TEC is going and to give the Board a summary of the key decisions and discussions held by the Executive team. We now have an established rhythm to TEC which is linked to our new accountability framework. All reports presented to the Board are, of course, first scrutinised and discussed by TEC to make sure what we present to the Board is robust and has had appropriate challenge and input. But the new TEC also involves regular reporting of each directorate to ensure greater focus on delivery of organisational priorities, monthly in-depth performance reviews with the clinical divisions, and focused time spent on key transformational programmes of work.

4.2 Since the Board's last meeting, we have held four TEC meetings and I wanted to highlight some key discussions and decisions beyond those matters which are on the Board's agenda for this meeting:

- Establishment of Financial Recovery Group: Given the importance of delivering on our agreed control total, we have agreed to establish a new Financial Recovery Group reporting to TEC, which will meet weekly and ensure there is appropriate oversight and challenge on the delivery of our financial plans for 2019/20;

- Renal South London Operational Delivery Network: We approved the proposed Renal South London Operational Delivery Network Memorandum, which sets out the basis on which St George's will work in partnership with Epsom St Helier, Guy's and St Thomas', King's and with the NHS England and NHS Improvement London Regional team in driving up the quality and efficiency of services for renal patients;

- EPRR Policy: We approved an updated Emergency Preparedness, Resilience and Response Policy which ensures we have appropriate and fully up-to-date plans in place to respond to major incidents and business continuity disruptions;

- Performance Reviews: We held an in-depth performance review with the Medicines and Cardiovascular Division (MedCard) and with the Surgery, Cancer, Neurosciences and Theatres Division (SCNT). For MedCard, the key challenges were emergency department performance, site operations and delivery of CIPs. For SCNT, the key challenges were day surgery productivity, medical pay, and CIP delivery; and

- Programme board updates: We also held our regular programme board discussions on our key programmes of work. This has now got into a good rhythm and there is greater consistency in reporting. CIP delivery, medical staffing and unplanned care were the areas were ranked as red in terms of programme delivery. In terms of unplanned care, actions needed to successfully deliver the four hour operating standard will now be taken forward

through a group chaired by me which will meet weekly and will give sustained focus to improving our emergency performance.

Jacqueline Totterdell
Chief Executive
25 October 2019

Meeting Title:	**Trust Board**		
Date:	**Thursday, 24 October 2019**	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	**Tim Wright, Chairman of the Quality and Safety Committee**		
Report Author:	**Tim Wright, 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 meetings in October 2019.		
Recommendation:	The Board is asked to note this report.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Quality and Safety Committee Report

Matters for the Board's attention

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

1. Deep Dive

The deep dive was the third in the series of Thematic Serious Incident Analyses conducted by the Trust. These reviews were identified and agreed in conjunction with commissioners looking at themes, root causes or contributory factors in completed serious incident investigations.

This review focused on serious incidents in the Cardiology Clinical Academic Group during 2017-18 and the Committee discussed the material emergent themes arising from the analysis including communications within the Cardiology service and with other teams across the Trust.

The Committee noted the depth of the analysis and it was demonstrable that the team understood what the key issues were and the actions which are required to address the key themes to prevent recurrence of the related serious incidents. The team have a number of material actions underway such as increasing daily ward rounds, developing standard operating procedures and sourcing new resources and notably have rolled out the 'human factors' programme within the cardiac catheter laboratories in order to improve communication and quality. Given many of the actions are at the early stages and ongoing, the Committee could not easily ascertain the level of impact of the learning and has therefore requested a further report which provides evidence that the appropriate actions have been implemented and the lessons learnt.

The Committee also noted the *Make A difference Alert* from GPs and was reassured that in parallel with the thematic reviews there is an additional review of quality alerts and a robust system is in place to support learning.

2. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality performance at month 6 and noted that the Trust achieved all seven Cancer standards in August. The Committee were pleased to hear that the Trust had recorded no MRSA cases for the last 12 months and noted that the Trust currently screens everyone for MRSA. This procedure is outside NICE guidance which states that Trust's should risk assess which patients should be screened. The Trust is reviewing its practice in light of the NICE guidelines to access the best approach locally and to support justification for any deviation.

The Committee reviewed the maternity dashboard and noted that the performance for the percentage of women booked by 12 weeks and 6 days fell below the upper control limit. The Committee were reassured that the dip in performance was related to room availability and that this issue was being addressed.

The Committee noted the importance of increasing the number of VTE assessments undertaken and were reassured that the use of iClip will improve data capture and that the targeted work in Maternity and the Clinical Decision Unit (CDU) will further improve performance. In relation to the echocardiogram performance trends the Committee heard that performance issues related to capacity constraints, staff sickness and vacancies and asked that the Finance & Investment Committee (Core) receives an activity report. The Trust Emergency Department Friends and Family Test performance whilst on par with other London trusts needs to be improved. The Committee agreed to conduct a further review in this area to ensure there are no adverse trends.

3. Exception Report: Care Quality Commission Outstanding Actions

The Committee noted that the Care Quality Commission (CQC) action related to achieving mandatory training targets remained below target as a result of not being able to achieve 85% on resuscitation training. The Committee were assured that the Trust has sufficient resources to deliver the required training. The key factor to meeting the December 2019 deadline will be managing the 'did not attends' (DNAs) and a robust process of daily scrutiny and engagement with divisions is underway and a daily CommCell will be established to manage attendance at training sessions.

The Committee revisited the issue of doctors on rotation bringing their resuscitation certificates with them when commencing employment with the Trust. This would alleviate the issues with retraining these members of staff so shortly after they had completed their medical training. The CN agreed to follow this up with the Medical Education Department.

4. Nurse Staffing Report (Planned vs Actual)

The Committee considered the nurse staffing reports and noted the overall fill rate for September of 94.1%. These fill rates were within the normal limits with any exceptions effectively managed to ensure there were no safety issues.

5. Cardiac Surgery Update

The Committee considered the monthly Cardiac Surgery Updates which is discussed later on the Board agenda.

6. Gosport Action Plan

The Committee considered the report which responds to the Department of Health and Social Care review into Gosport War Memorial Hospital where the avoidable deaths of 450 patients were identified as a result of excessive use of palliative medicines. The review sets out three key areas for trusts to consider:

- Listening to patients, families and staff
- Ensuring care is safe
- Identifying and addressing problems in care

The Committee were assured by the actions developed by the Trust under each area which include, for example, promoting the culture of raising concerns and freedom to speak up, introducing electronic prescribing, enhancing the governance and reporting framework and aligning care standards with the Care Quality Commission's Key Lines of Enquiry. The Committee was assured by the level of work completed to date and agreed that it would next consider progress against the individual actions in six months.

7. Report from Patient Safety & Quality Group (PSQG)

The Committee received a summary report from the PSQG meeting held in September 2019. The Committee noted that although the Trust had reduced the number of patient falls there was an increase in the number of those rated moderate. This is being closely monitored by the Trust. Another area of concern is the Trust's compliance with the completion of lying and standing blood pressure checks and whilst the Trust is not an outlier when benchmarked nationally it has put in place local action plans which are being monitored as part of the matron checks. The Committee were pleased to note in the report that compliance with duty of candour targets had improved substantively following local actions put in place by the MedCard division which brought the divisions compliance to 100% completed in 20 days as at 16 October 2019 compared with 58% in September.

8. Learning from Deaths Quarterly Report

The Committee considered the quarter two report from the Mortality Monitoring Committee on Learning from Deaths. The Trust is on track with the implementation of the Learning from Deaths Framework and the Medical Examiner system. Dr Nigel Kennea has been appointed to the role of Medical Examiner and the office will be located next to the bereavement office. The Committee heard that the Trust's Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HMSR) mortality rates are banded better than expected and the Trust is enhancing its reporting around learning disability patients' deaths. The Committee discussed the report and that the Trust had no deaths with an avoidability of death judgement score which was classified as either one (definitely avoidable), two (strong evidence of avoidability), or three (probably avoidable) within the last two quarters. The Committee debated these findings and were assured that the methodology used for classification was both consistent and robust.

9. Human Tissue Act (HTA) Designated Individual Report

The Committee received an update on the Trust's progress against implementing the recommendations from the HTA inspection of the Trust's Mortuary in December 2018. The Committee was reassured that the Trust will address the five outstanding minor issues by 31 October and continue to meet the licencing requirements of the HTA.

10. Referral to Treatment (RTT)

The Committee considered the quarter two update on RTT performance. The Trust is performing well against the RTT trajectory with September data including Queen Mary's Hospital following the roll out of iClip at QMH in mid-September.

11. Strategy

11.1. Quality Strategy Development

The Committee noted that the development of the Quality Strategy is on track with the Board to receive an update at its Seminar on 26 November 2019**.**

11.2. Research Strategy

The Committee received the draft Research Strategy which outlines how the Trust proposes to maximise its research footprint and secure funding from the National Institute of Health Research. The Committee noted that the draft strategy has already been the topic of a Board Workshop and propose that the Board approves the strategy minded that funding arrangements would be subject to the Trust's normal business and governance processes.

12. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Registers which focused on the four strategic risks which fall within its remit. The Committee endorsed the proposal to split the risk related to learning from incidents and complaints to reflect the different positions. In light of the challenges in the Trust's emergency department the Committee again discussed the corporate risks pertaining to patient safety and experience and the Trust's reputation which fall under strategic risk SR3. Whilst the Committee felt the current rating was appropriate it noted that ED performance required scrutiny which already takes place at Finance and Investment Committee. The Committee agreed that in relation to strategic risks SR1, SR2, SR3 and SR16 it was content with the partial assurance rating given to these risks.

13. Recommendation

The Board is asked to note the contents of this report and the matters raised for its attention and in the following reports which were discussed by the Committee at its September and October Meetings:

- Learning Disability Services – September 2019
- Infection Prevention and Control Annual Report – September 2019
- Learning from Deaths Quarter 2 Report – October 2019

Tim Wright
Committee Chair
24 October 2019

Meeting Title:	Trust Board	
Date:	31 October 2019	**Agenda No: 2.1.1**
Report Title:	Infection Prevention & Control Annual Report	
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director Infection Prevention & Control	
Report Author:	David Shakespeare, Head of Infection Control	
Freedom of Information Act (FOIA) Status:	Unrestricted	
Presented for:	Approval	
Executive Summary:	This report provides detail of the arrangements in place within the Trust for Infection Prevention and Control; in addition it presents a summary of activity pertaining to Infection Prevention & Control during 2018-19 and sets out key priorities for 2019-20. The Trust Board is asked to note the content of the report and the key performance measures and incidents relating to infections prevention and control for 2018-19. • 31 cases of Trust assigned *Clostridium difficile* against a trajectory of no more than 30 cases. However, the Trust recorded no causative lapses in care in relation to these cases. • Trust recorded just one Trust assigned Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia (blood stream infection) compared to 4 during the previous year 2017-18. • A case of Legionnaires Disease was reported at the Trust during March 2019. However, an investigation in conjunction with Public Health England concluded that while the case was probably healthcare associated, it could not be established which healthcare establishment that the affected patient had visited, was the most likely source of the infection. However, this case has prompted a substantial programme of work to provide assurance of water safety at the Trust. • A failure of a ventilation system occurred in December 2018, and whilst no harm was caused to any patients this has resulted in improvements in governance of ventilation systems across the Trust. • Influenza cases were reduced in comparison to the previous financial year, which is in line with the national picture. The Emergency Department implemented point of care testing which allowed early identification and management of flu positive patients. • The Trust vaccination rate for flu was 86.5% which was the highest in London and sixth highest in England. • 30% reduction in *E.coli* bacteraemia • Continued reductions in MRSA acquisitions • The Trust compliance with Infections Prevention and Control Mandatory Training at year end was 88% for IPC *clinical* and for *non-clinical* 93% against a Trust target of 85%. In addition to continuing measures to meet national targets for infections the IPC team will in 2019/20	

	• Consider a programme of targeted screening for MRSA colonisation in line with national guidance • Improve the root cause analysis investigation of MSSA bacteraemia in line with that in place for C.Diff • Introduce Surgical Site Surveillance of spinal surgery procedures and strengthen the process of root cause analysis for SSI identified • Work collaboratively within the Trust and with other local organisations to reduce the rate of *E. coli* bacteraemia, through work such as the catheter pathway in the APC. • Review and strengthen screening for CPE and *Candida auris*		
Recommendation:	The Board is asked to note the report and key priorities for 2019-20.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures required to minimise risk from Healthcare Associated Infection.		
CQC Theme:	Safe, Effective, Responsive, Well Led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	Healthcare Associated Infections leading to increased morbidity and mortality at the Trust.		
Legal/Regulatory:	The Health and Social Care Act (2008): The Hygiene Code		
Resources:	N/A		
Previously Considered by:	Infection Control Committee members Quality & Safety Committee	**Date**	July 2019 August 2019
Equality Impact Assessment:	N/A		
Appendices:	N/A		

St George's University Hospitals
NHS Foundation Trust

Annual Report
Infection Prevention and Control
2018 – 2019

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Executive summary

The purpose of this report is to provide the Board with information on Trust performance and provide assurance that suitable processes are being employed to prevent and control infections at St George's University Hospitals NHS Foundation Trust.

During 2018-19 the Trust recorded just one Trust assigned Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia (blood stream infection) compared to 4 during the previous year 2017-18.

There were 31 cases of Trust assigned *Clostridium difficile* infection against an NHS Improvement set target of no more than 30 cases. However, the Trust recorded no causative lapses in care in relation to these cases. This does however; represent an increase on the 16 cases reported during 2017-18, which was the lowest on record for the Trust.

There were 27 Trust assigned cases of Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia during 2018-19 compared to 28 during 2017-18.

Influenza cases were reduced during the 2018-19 winter season in comparison to the previous year, reflecting the national position. The use of point of care testing in the Emergency Department has continued to help the Trust identify cases of flu at the earliest possible point on the patient's journey and has facilitated the use of infection prevention measures and isolation at an early stage to avoid spread to other patients.

A huge achievement has been the uptake of staff influenza vaccination, which at 86.5% is the highest in London and the sixth highest in England.

Norovirus activity was similar to previous years and resulted in closures of bays and some wards to prevent further transmission.

There continue to be low levels of colonisation and infection with multi-drug resistant bacteria. Numbers of bacteraemia with glycopeptide-resistant enterococci continued to remain low in comparison with similar Trusts in London. There remains a strong antimicrobial stewardship programme at St George's which continues to support the prevention of antimicrobial resistance.

A case of Legionnaires Disease was reported at the Trust during March 2019. However, an investigation in conjunction with Public Health England concluded that while the case was probably healthcare associated, it could not be established which healthcare establishment that the affected patient had visited, was the most likely source of the infection. However, this case has prompted a substantial programme of work to provide assurance of water safety at the Trust.

During December 2018 a failure of a ventilation system, while no harm was caused to any patients, has led to improvements in the arrangements for the governance of ventilation systems at the Trust.

A note of thanks to all our staff who take seriously that prevention of infection at the Trust is everyone's business. We continue look forward to further strengthening infection prevention and control at the Trust during 2019-20.

1. Infection Control Team and reporting arrangements

Head of Infection Prevention & Control	1.0 wte
Infection Control Doctor/ Consultant Microbiologist	4 PA's
Lead Nurse-Infection Prevention & Control	0.5 wte
Clinical Nurse Specialists- Infection Prevention & Control	3.0 wte
Infection Prevention & Control Nurse	4.0 wte
Infection Prevention & Control Support Worker	1.0 wte
PA to infection Prevention & Control	1.0 wte

The *Trust Board* recognises and agrees their collective responsibility for minimising the risks of healthcare associated infection and agrees and supports the means by which these risks are controlled. The responsibility for Infection Prevention and Control (IPC) lies with the Director of Infection Prevention & Control (DIPC) who is the *Chief Nurse*. The Chief Nurse is supported by a Deputy Chief Nurse, a Consultant Microbiologist as the Infection Control Doctor and a Head of Infection Control. The Chief Nurse & DIPC reports directly to the Chief Executive and the Board and chairs the Trust Infection Prevention & Control Committee (IPCC).

The *Infection Control Doctor* is a Consultant Microbiologist and provides expert microbiological and infection prevention advice and provides support for the wider Infection Prevention and Control Team (IPCT).

The *Deputy Chief Nurse* provides leadership for the patient safety agenda in the Trust of which IPC is a key element. The Deputy Chief Nurse is also the Deputy Director of Infection Prevention & Control and where required chairs meetings for any outbreaks of infection or infection control related incidents on behalf of the DIPC and provides support and leadership for the Infection Prevention Nurse Team.

The *Head of Infection Control* is a senior nurse who provides leadership for the IPCT. The Head of Infection Control reports professionally to the Deputy Chief Nurse / Deputy DIPC and works closely with the Infection Control Doctor and other Consultant Microbiologists to ensure the agreed annual infection prevention plan is implemented and that an appropriate response is maintained to any infection prevention incident arising.

The *IPCC* is the main forum for governance and monitoring of action around IPC practice at the Trust. The membership of the IPCC includes representation from all Divisions at the Trust, plus an infection prevention representative from the local Clinical Support Unit and a representative from Public Health England. The IPCC is chaired by Chief Nurse / DIPC. The committee meets bi-monthly. Quarterly reports from the IPCC are received in the Patient Safety & Quality Group and the Quality & Safety Committee, which is a subcommittee of the Board.

The *Infection Prevention & Control Team* (IPCT) provides expert knowledge and day to day management of IPC related issues. The IPCT liaise regularly with clinicians and managers across the Trust. They are supported by *IPC Link practitioners* based in clinical areas for whom study events are held quarterly.

Members of the IPCT also attend and participate in (but are not limited to) the following groups / committees:

Infection Prevention & Control Committee	Antimicrobial Stewardship Group
Strategic Water Safety Group	Ventilation Safety Group
Operational Water Safety Group	Decontamination Group
Waste Project Group	Winter preparedness Groups
Occupational Health Groups	Building planning meetings
Matrons Environmental Action Team	Cleaning review meetings

2. Compliance with the Hygiene Code

The Trust is required to demonstrate compliance with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (The Hygiene Code). The Trust declares compliance with all ten criteria of the Hygiene Code (listed below) during 2018-19.

Criterion one: Systems to manage and monitor the prevention & control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them
Criterion two: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion three: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
Criterion four: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion
Criterion five: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
Criterion six: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
Criterion seven: Provide or secure adequate isolation facilities
Criterion eight: Secure adequate access to laboratory support as appropriate
Criterion nine: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections
Criterion ten: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

3. Summary of Infection Prevention and Control performance

Trusts are required to participate in six mandatory reporting schemes;

I. MRSA bacteraemia
II. MSSA bacteraemia
III. *Clostridium difficile* infection
IV. Glycopeptide-resistant enterococcal bacteraemia
V. *Escherichia coli*, Klebsiella and *Pseudomonas aeruginosa* bacteraemia
VI. Surgical Site Infection Surveillance

MRSA, MSSA and *E. coli* Bloodstream Infections (BSI) and laboratory detected *Clostridium difficile* toxins are reported monthly via the Public Health England Health Care Associated Infection (HCAIs) data capture system.

3.1 MRSA Bacteraemia

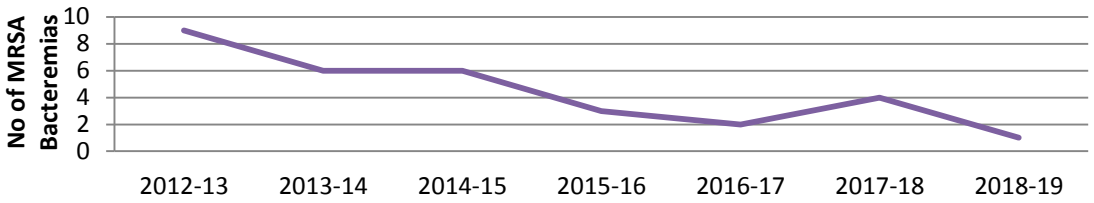
All MRSA bacteraemias are initially apportioned to the organisation based on the timing of the positive blood culture The MRSA bacteraemia then undergoes a post infection review (PIR) process.

There has been one episode of Trust-apportioned MRSA bacteraemia during the financial year 2018-19. PIR confirms no causative lapses in care were identified.

It is acknowledged that this case was a hospital acquisition though the exact source of transmission could not be established. The case amounts to a rate of 0.3 per 100,000 bed days.

It is noteworthy that the last Trust assigned-episode before this was June 2017, more than 14 months previously. Figure 1 shows the decline in reported Trust assigned MRSA bacteraemia since 2012-13.

Figure 1: MRSA bacteraemia St George's University Hospitals NHS Foundation Trust (SGH) 2012-2019



3.2 MSSA Bacteraemia

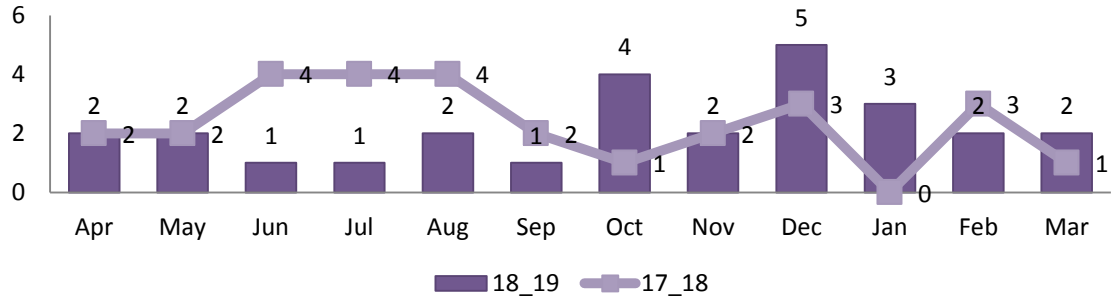
There were 76 episodes in 2017-18 of which 27 were apportioned to the Trust. (See Figure 2). This compares to 28 during 2017-18, 31 during 2016-17 and 36 during 2015-16.

St George's undertakes an RCA similar to the MRSA PIR in these cases. The key themes are:

- Care of intravascular devices
- Wound care

There are no national thresholds for MSSA bacteraemia at present. The rate of Trust-apportioned episodes for St George's for 2018-19 was 8.31 per 100,000 bed days. Rates at other London teaching Trusts ranged from 5.02 to 11.98 with St George's having the fourth lowest rate.

Figure 2: MSSA bacteraemia SGUH 2017-19



3.3 *Clostridium difficile*

Clostridium difficile infection (CDI) is a major cause of antibiotic-associated diarrhoea Figure 3 below shows CDI Trust assigned 2012-19 against NHS Improvement set targets.

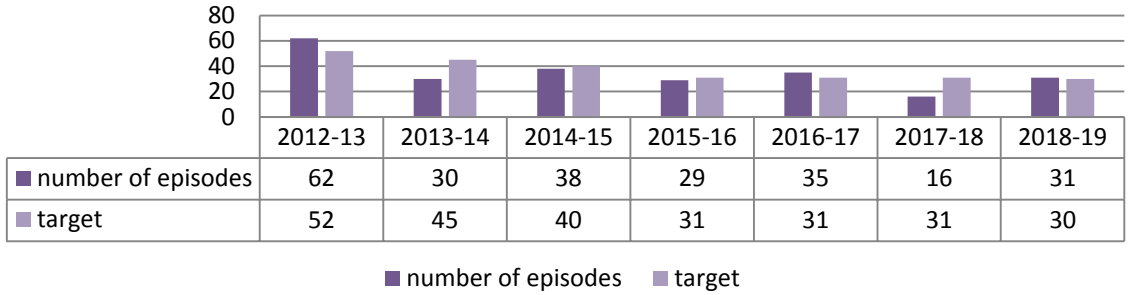
In **2018-19** St. George's had 31 episodes of Trust-apportioned infection with an NHS England set target/threshold of 30 cases.

As per CDI standard operating procedure (SOP), episodes that were Trust-apportioned underwent RCA and all isolates of *C difficile* were sent for ribotyping to look for any evidence of cross-infection.

Wards where the CDI was acquired were also commenced on a Period of Increased Audit and Surveillance (PISA) to ensure that there were high standards of patient care, hand hygiene and environmental and equipment cleanliness. These standards must be maintained for a minimum of 3 weeks before the ward can come off PISA.

Most of the cases were attributed to the administration of appropriate antibiotics to patients with infections which were not preventable and life threatening if not treated with antibiotics. Reviews indicated that antibiotic prescribing was appropriate and in line with microbiological and clinical advice. The ribotyping did not indicate cross infection of any cases (see below for analysis of CDI Cases 2018-19).

Figure 3: *Clostridium difficile* at St George's University Hospitals Foundation Trust 2012-13 to 2018-19



	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
number of episodes	62	30	38	29	35	16	31
target	52	45	40	31	31	31	30

3.3.1 Analysis of CDI Cases 2018-19

Analysis of the 31 cases showed that there were no lapses in care and no instances of cross infection from one patient to another.

Two cases were community acquired but counted as Trust apportioned cases due to the timing of specimens. Two cases were relapses but were Trust assigned because specimens were taken >28 days since the last positive test.

3.3.2 Period of Increased Incidence (PII)

A PII is defined as two or more cases of *Clostridium difficile* infection within a 28-day period that are linked by place and time. There were two PIIs during 2018-19.

Lessons learnt from the review of root cause analysis findings, MDT discussion and PISA findings identified gaps in care, though no lapses. These include the following for the 31 cases:

- 15 instances where there were concerns about a lack of medical review prior to sending a specimen, or the medical review not documented
- Six instances where there was a lack of isolation on recognition of symptoms. This was usually due to a lack of available side-rooms; which in turn was

sometimes the ward side-rooms being in use for other reasons e.g. other infections or for end of life care

- Four instances where sub-optimal cleaning of the equipment or medical devices was observed e.g. dirty fans, dusty equipment, high dust in bed space

3.3.3 Changes to CDI reporting algorithm for financial year 2019/20 are:

- Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks.

NHS Improvement (NHSI) has published the annual target for these categories which is no more than **48 cases** for 2019-20.

3.4 Gram-negative bacteraemia

All Trusts have been required to report cases of *E. coli* bacteraemia using similar mechanisms as for MRSA and MSSA bacteraemia.

3.4.1 E. coli

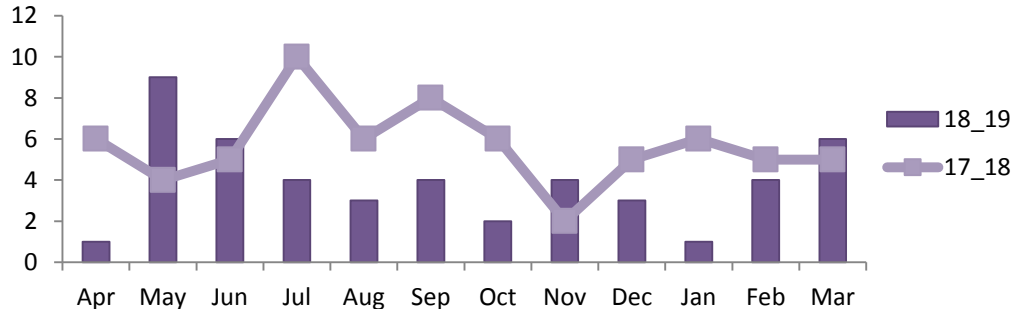
E. coli bacteria are frequently found in the intestines of humans and animals and can survive in the environment. There are many different types of *E. coli*, which can cause a range of infections including urinary tract infection, cystitis and intestinal infection. When primary *E. coli* infection spreads to the blood it is known as *E. coli* blood stream infection (BSI) or bacteraemia.

Typically, community acquired *E. coli* bacteraemia results from abdominal, biliary or urinary tract sepsis. Hospital acquired cases of *E. coli* bacteraemia can also be associated with urinary catheter infections.

The Trust participates in an NHSI collaborative to help reduce catheter related urinary tract infection across the health economy in South West London. A selection of staff from across the Trust also took part in a PDSA cycle using quality improvement methodology to identify and implement improvements in care.

For 2018-19 the Trust reported a total of 232 *E. coli* bacteraemia of which 47 were Trust assigned (See Figure 4). This compares to 2017-18 when there were 242 reported cases of which 68 were Trust assigned representing a 30% reduction.

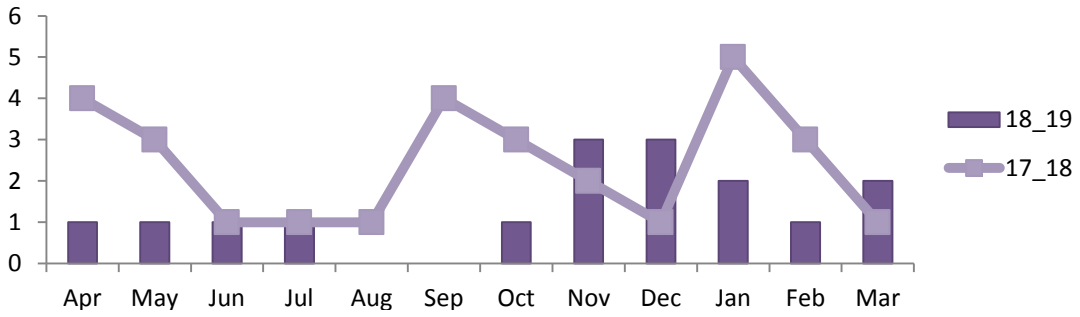
Figure 4: Trust assigned *E coli* bacteraemia 2018-19 showing 2017-18 figures



3.4.2 *Pseudomonas aeruginosa*

There were 16 cases of Trust assigned *Pseudomonas aeruginosa* bacteraemia during 2018-19, a significant reduction on the 27 cases reported during 2017-18 (Figure 5).

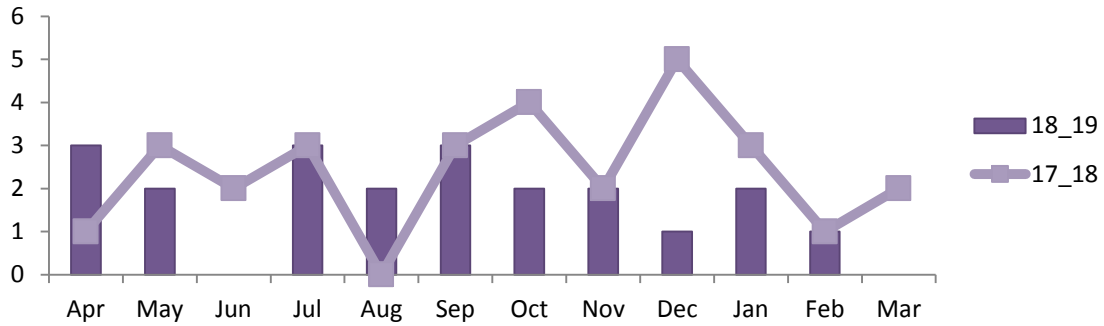
Figure 5: Trust assigned *P. aeruginosa* bacteraemia 2018-19 showing 2017-18 figures



3.4.3 *Klebsiella*

A similar notable reduction was reported for *Klebsiella* bacteraemia with 21 cases reported during 2018-19 compared with 29 cases during 2017-18 (Figure 6).

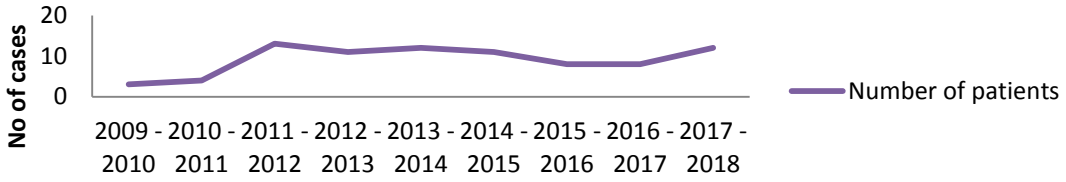
Figure 6: Trust assigned *Klebsiella* bacteraemia 2018-19 showing 2017-18 figures



3.4.4 Glycopeptide resistant enterococcal bacteraemia (GRE)

St George's figures are illustrated below (Figure 7). There are no national thresholds. St George's has always had very low levels (more than 75% lower than some Trusts) and this trend has continued.

Figure 7: GRE bacteraemia 2009-10 to 2017-18



3.4.5 Carbapenamase producing *Enterobacteriaceae and C*arbapenem-resistant organisms (CPE/CRE)

These are multiply-resistant Gram-negative bacteria. No episodes of hospital-acquired infection with CPE were identified in 2018-19. Several patients with CPEs were treated in the hospital. These patients acquired their infections elsewhere.

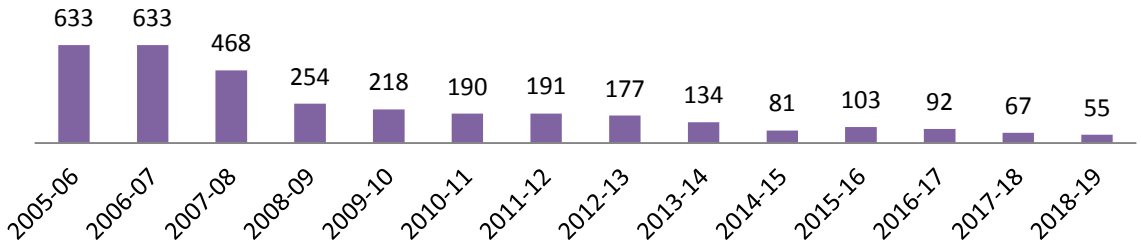
The Trust reports episodes to the voluntary PHE operated CPE database as well as submitting antibiotic resistance data to the PHE. In 2019-2020 the Trust will review and expand the screening and surveillance programme.

3.5 MRSA acquisitions

The Infection Prevention and Control (IPC) team record all new MRSA acquisitions in the Trust as part of alert organism surveillance i.e. MRSA grown from clinical samples other than blood cultures, including screening swabs.

The acquisitions are shown 2005-19 in Figure 8. In 2018-2019 there were two identified clusters of MRSA acquisitions within two ward areas.

Figure 8: MRSA acquisitions 2005-06 to 2018-19



Currently all patients admitted to St George's and Queen Mary's Hospital are screened for MRSA in accordance with previous NHS requirements mandated in 2010.

In 2014 new advice was published indicating that MRSA screening could be reduced to "high-risk" patients only. The Trust Infection Control Committee has agreed a trial switch to screening higher risk patients only and this trial will commence during October 2019-20.

4. Surgical Site Infection (SSI) Surveillance

The aim of the national surveillance program is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice.

The SSIS programme provides an infrastructure for hospitals to collect data on 17 surgical categories spanning general surgery, cardiothoracic, neurosurgery, gynaecology, vascular, gastroenterology, and orthopaedics. Any infections that are reported using the SSISS data base are investigated by the relevant MDT team, surveillance nurses, ward manager and IPCT to identify any issues / practices for improvement.

Results of the mandatory period are then submitted to Public Health England (PHE). During 2018-19 the Trust has participated in SSIS in reduction of long bone fracture and in coronary artery bypass graft surgery.

4.1 Reduction of long bone fracture

The surgical site infection rate for reduction of long bone fracture was 1% for the calendar year 2018, inclusive of all 4 periods, which correlates to the national mean of 1% (for inpatients and patients readmitted with infection). This consists of 603 procedures of which 6 infections were identified in inpatients or patients readmitted. The national mean rate of infection published from cumulative data for

2014 to 2018 is also 1%. The Trust will continue to monitor, review and reconcile infection rate trends for all four quarters during 2019-20.

The data obtained from 2017 (Table 1) is given for comparative reasons against 2018 (Table 2); when the rate of SSI for this category was 0.9%. It should be emphasised that the number of operations reviewed as part of this surveillance program is almost three times the number of cases for each quarter for the year 2018, respectively - making the result more meaningful in terms of achievements being made with regard to IPC in the Division of Surgery. The SSI rate during 2016 was 1.3%.

Table 1: Long bone fracture SSI data 2017 as published by PHE

2017 Trends in rates of SSI by surveillance period at St George's University Hospital							
Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	52	0	0.0%	0	0.0%	0	0.0%
2017 Q2	63	1	1.6%	0	0.0%	1	1.6%
2017 Q3	54	1	1.9%	0	0.0%	1	1.9%
2017 Q4	56	0	0.0%	0	0.0%	0	0.0%
***All SSI = Inpatient & readmission, post-discharge confirmed and patient reported This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q1 Jan-Mar 2017, Q2 Apr-Jun 2017, Q3 Jul-Sep 2017, Q4 Oct-Dec 2017).**							

Table 2: Long bone fracture SSI data 2018 as published by PHE

2018 Trends in rates of SSI by surveillance period at St George's University Hospital							
Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2018 Q1	152	2	1.3%	1	0.7%	4	2.6%
2018 Q2	134	0	0.0%	3	2.2%	3	2.2%
2018 Q3	154	2	1.3%	5	3.2%	8	5.2%
2018 Q4	163	2	1.2%	1	0.6%	3	1.8%
***All SSI = Inpatient & readmission, post-discharge confirmed and patient reported This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q1 Jan-Mar 2018, Q2 Apr-Jun 2018, Q3 Jul-Sep 2018, Q4 Oct-Dec 2018).**							

(Source: Public Health England SSIS Service, Summary Report May 2019)

4.2 Coronary Artery Bypass Grafts (CABG)

The cardio-thoracic surgery team in conjunction with the infection prevention and control team undertook SSI surveillance of all CABG surgery. After the introduction of multiple measures following the high rates reported in the 2013-14 annual report the infection rate reduced significantly. The overall rate dropped from 9% in 2013-14 to 6% in 2014-15 and 3.6% in 2015-2016.

The surgical site infection rate at St George's for CABG was 2.8% for the calendar year 2018 for inpatients and patients readmitted. This consists of 540 procedures of which 15 infections were identified in inpatients or patients readmitted. This is below the national mean of 3.1%. Data for 2017 (Table 3) and 2018 (Table 4) as published by PHE are shown. The rate for 2017 calendar year was 1.6%.

Table 3: 2017 CABG SSI data as published by PHE

2017 Trends in rates of SSI by surveillance period at St George's University Hospital							
Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	182	3	1.6%	0	0.0%	3	1.6%
2017 Q2	180	5	2.8%	0	0.0%	5	2.8%
2017 Q3	164	3	1.8%	1	0.6%	4	2.4%
2017 Q4	158	0	0.0%	0	0.0%	0	0.0%
***All SSI = Inpatient & readmission, post-discharge confirmed and patient reported This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q1 Jan-Mar 2017, Q2 Apr-Jun 2017, Q3 Jul-Sep 2017, Q4 Oct-Dec 2017).**							

Table 4: 2018 CABG SSI data as published by PHE

2018 Trends in rates of SSI by surveillance period at St George's University Hospital							
Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2018 Q1	165	4	2.4%	1	0.6%	6	3.6%
2018 Q2	163	6	3.7%	1	0.6%	7	4.3%
2018 Q3	110	4	3.6%	0	0.0%	4	3.6%
2018 Q4	102	1	1.0%	2	2.0%	3	2.9%
***All SSI = Inpatient & readmission, post-discharge confirmed and patient reported This table refers to data collected over the selected periods for which data has been submitted and reconciled (Q1 Jan-Mar 2018, Q2 Apr-Jun 2018, Q3 Jul-Sep 2018, Q4 Oct-Dec 2018).**							

(Source: Public Health England SSIS Service, Summary Report May 2019)

4.3 Spinal surgery

Spinal infection surveillance at SGH is a new surveillance introduced from April 2019.

5. Other Outbreaks and Incidents

5.1 Legionnaires' Disease

A postive legionella urine antigen test was confirmed by Public Health England in March 2019.

The incubation period for Legionnaires' disease is 2-10 days. The case was investigated as possible hospital acquired however this was not directly attributed to St George's and the patient had been resident in other healthcare establishments during the incubation period.

Following the investigation, there is in place an extensive action plan with regard to improving governance of water safety at the Trust and this continues to be monitored at the Operational and Strategic Water Safety Groups and the Infection Control Committee and Estates Management Board.

5.2 Water Safety

The monitoring and preventative measures of *Legionella* and *Pseudomonas* in taps and showers continue. A system of filtering outlets has been carried out in both St James wing and Lanesborough wing to filter outlets and water outlet testing is in place.

The Operational Water Management Group (OWSG) has led on mitigation and management of this issue with support from IPCT. The OWSG meets on a monthly

basis and is led by the Head of Estates with representatives from Microbiology, Infection Control and contractor services in attendance. There is also a Strategic Water Safety Group chaired by the Chief Nurse / DIPC.

5.3 *Candida auris (C. auris)* outbreak

Candida auris is a fungus that is frequently resistant to many antifungal drugs making treatment challenging.

During December 2018 the index patient was in a six-bedded bay on a vascular ward and had multiple culture-positive specimens. All bay contacts were screened. One bay contact (case two) had two negative *C. auris* screens during hospital admission and was subsequently transferred to another hospital where a third *C. auris* screen was positive; four weeks after contact with the index case. Case three was a ward contact of the index case. They were not captured as part of a ward screening programme as discharged prior to commencement. A sample was culture positive for *C. auris* (in a different hospital); seven weeks after admission to the outbreak ward. The fourth case had previously been admitted to the same bay as the index case but at a different time. A post-operative wound swab and a central line tip cultured *C. auris*. All four cases were full-time residents in England and had no history of foreign travel or hospitalisation abroad. No case had previous admissions to hospitals with known *C. auris* infected or colonised patients.

Contact tracing of patients admitted to the affected vascular ward and Cardiothoracic Intensive Care (CT-ITU), where the index case, case three and four all had post-operative admissions, identified 167 patients for screening. Contact was made with nursing homes and other NHS Trusts (n=9), regarding 50 discharged patients to arrange screening. An extensive environmental screening programme was initiated; 203 environmental swabs were processed from the vascular ward, CT-ITU, diabetic foot clinic and the operating theatre that all four had attended; no positive screens were identified. Staff screening was not performed. Enhanced cleaning of vascular ward, CT-ITU, the operating theatre and diabetic foot clinic was performed, with daily hypochlorite cleaning in the CT-ITU cubicles and hydrogen peroxide vapour in the side room on the vascular ward.

The outbreak was closed February 2019. No further cases have been detected.

5.4 *Salmonella Typhimurium*

Salmonella Typhimurium is an organism that causes symptoms of Gastroenteritis predominantly diarrhoea. It is carried in the gut and is spread via the faecal oral route. It can cause outbreaks or isolated cases of gastroenteritis. Any organisms cultured in the laboratory at St George's are sent to PHE for confirmation of identification and for whole genome sequencing (WGS), which is a tool used to identify outbreaks.

In March 2019 PHE contacted the Trust to notify of four patients diagnosed with *Salmonella Typhimurium.*

Following investigation the Trust and PHE concludes that food contamination has not been the cause of this outbreak. The likely source is environmental contamination via a non-hospital source.

5.5 Ventilation system failure

A patient with extensively drug resistant tuberculosis (XDR-TB) was admitted to the Trust during 2018. Due to the infection risk, the patient was placed in a negative

pressure room. As the affected ward was originally commissioned to have both infectious patients and immunosuppressed patients, it has remained possible to switch some side rooms to positive or negative pressure. It was highlighted that the affected room had probably been at positive pressure where negative was indicated.

A Serious Incident (SI) was declared and investigated. The incident was reported to Public Health England (PHE) and (as per RIDDOR) to the Health and Safety Executive (HSE). The HSE issued an improvement notice and required actions are currently being worked on.

5.6 Influenza infections and outbreaks

Cases of influenza have been reported but at lower levels that the previous year. The Trust has a standard response once influenza is suspected involving the isolation of patients were possible and staff utilising personal protective equipment and face shield masks to prevent the spread of infection to others. Point of Care Testing has been available in A&E as in the previous winter which helps identify patients with influenza virus at the earliest possible point in their patient journey at the Trust so that precautions can be taken to protect other patients.

On Marnham ward an outbreak of influenza was detected with cases first identified in January (2019). A total of 9 cases were confirmed, all were H1N1. The Ward was completely re-opened on 30/01/19.

Other sporadic cases of influenza have been detected across the Trust and are managed by isolating in a side room where possible and assessment of other patients when in an open bay with prophylaxis is offered to at risk patients.

Between October 2018 and March 2019 there were 618 reported cases of flu in the Trust. (This does not include staff members)

Influenza A/ H1N1 was the predominant strain throughout the season. There were 7 cases of Influenza B and 4 patients with both Influenza A and B.

5.7 Staff Influenza vaccination

The Trust's staff influenza vaccination campaign successfully led to an uptake of 86.5% by patient facing staff, ranking as the highest uptake of hospitals in London and the 6th highest in England (Table 5).

Table 5 shows update among a range of patient facing staff groups

Staff Group	Total flu jab
All Doctors	79.4%
Qualified Nurses + Health Visitors	88.4%
Midwives	47.5%
Clinical – Allied Health Professionals	83.7%
Support to Clinical + Admin	92.6%
Patient Facing Students	100%
Total Patient facing staff	86.5%

5.8 Norovirus infections and outbreaks

Sporadic activity has been seen and managed by the Infection Prevention & Control Team. Outbreak meetings were held in respect to Marnham ward following

symptomatic patients and leading to ward closure. There were 9 confirmed positive cases and 2 staff with symptoms.

An outbreak was also declared on Benjamin Weir ward where a total of four cases were positive and eight staff were affected. Other locations have seen sporadic cases of Norovirus in Kent Ward, Belgrave, Caroline Ward, William Drummond and General ICU.

6 Infection Control compliance and audit

6.1 Hand Hygiene

Effective hand hygiene remains the single most important action staff can take to prevent the spread of infection. St George's has placed hand hygiene and monitoring of compliance with hand hygiene technique as a key ongoing priority for infection prevention.

In order to ascertain compliance, each clinical area undertakes a monthly audit via the 'Saving Lives' programme. The audit includes a check on hand hygiene compliance for a range of members of the multi-disciplinary team including Nurses, Doctors, Physiotherapists and Occupational Therapists. The audit scores reflect the units' compliance and allows them to demonstrate any areas of concern.

Issues of compliance are dealt with by the wards and Divisions themselves. However, for continued non-compliance an escalation process is in place ultimately leading to the Medical Director or Chief Nurse / Director of Infection Prevention & Control.

In 2018-2019 a total of 42,263 observations were recorded. The total compliance Trust wide was 98% (Figure 9).

Hand hygiene audit results are displayed within Saving Lives scorecard and discussed at Care Group and Divisional meetings and in Divisional reports to the IPCC. Compliance by Division is shown in Figure 10.

Figure 9: Hand hygiene compliance Trust wide 2018-19

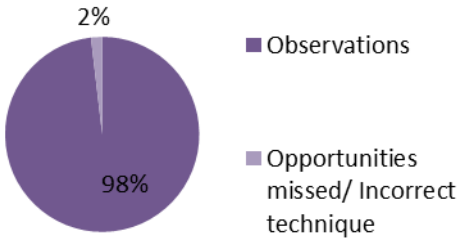
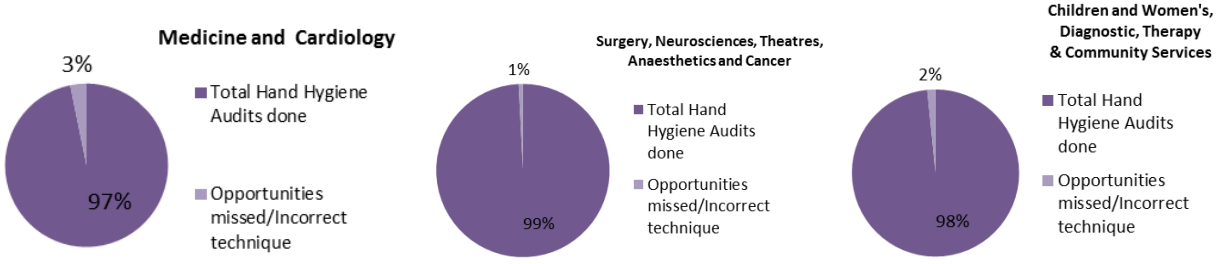


Figure 10: Hand hygiene compliance by Division



6.2 Bare below the elbow (BBE)

The Trust continues to monitor compliance with the Department of Health (DH) initiative 'Bare below the elbow' with all staff working in clinical areas. Compliance is monitored during hand hygiene audits, with results discussed at the IPCC. Staff are advised to locally resolve any non-compliance with colleagues and additional escalation to the DIPC, Clinical Director and/ or the Chief Medical Officer where BBE continues to be a challenge.

6.3 Hospital Acquired Infection (HACI) Audit

Audit data collated by the IPC team for all HCAI and non-HCAI CDI cases indicated that the CDI protocol/policy is not always followed. Examples of non-compliance include medical review within 2 hours and isolation. However Q4 2018-19 there was an improvement in compliance. Actions to ensure CDI remains within trajectory during 2019-20 form part of the IPC annual work plan.

6.4 Period of Increased Surveillance and Audit (PISA)

Since May 2017 the IPC team have been undertaking a process of focussed surveillance and audits for wards with episodes of healthcare-associated infections (HCAI). All wards where patients acquire *Clostridium difficile*, MRSA blood stream infection (BSI) or have a suspected MRSA outbreak undergo a period of increased surveillance and audit (PISA). These tools allow observation of the management of patients with the infection and others with suspected infections including documentation of medical reviews, hand hygiene, Personal Protective Equipment (PPE), screening and isolation. General ward cleaning, hand hygiene, decontamination of patient equipment, management of clean linen and venous access devices (for MRSA) are also all audited during the PISA process.
The ward must achieve 95% or above to pass and must pass 3 consecutive weeks to be successful and to come off PISA. The Antimicrobial Stewardship (AMS) team review antimicrobial prescriptions for all patients on the ward. The ward must achieve 95% on one occasion to come off the AMS component of the PISA.

From 2018-19, 25 wards were on PISA for hospital acquired *Clostridium difficile*. It took an average of 8 weeks to come off the process and the longest time being 13 weeks. Recurring themes were poor adherence to the WHO 5 moments for hand hygiene and incorrect hand hygiene technique by multidisciplinary teams, as well as sub-optimal equipment decontamination. During 2017-18 there were 13 wards on the PISA programme. This is reflective of the lower number of *C.difficile* infections during 2017-18, when 16 cases were reported.

6.5 Saving Lives Audits

The Saving Lives Programme is a set of 'Care Bundles' or High Impact Interventions (HII) that are an evidence based approach relating to key clinical procedures or care processes, these were updated in 2017.

The Infection Control Link Practitioners continue to carry out monthly audits from the 'Saving Lives' programme. This includes auditing hand hygiene, peripheral line insertion and care, urinary catheter insertion and care and isolation practices.

Saving Lives audits are completed on the Trust's quality management reporting system (RaTE). This data is accessible by ward and Division to enable monitoring of compliance and the data is accessible via the Trust intranet for all staff.

Performance is reported to the IPCC and clinical areas that perform poorly are required to produce an action plan to address any failings within a stipulated timeframe.

6.6 Estates and Facilities

The Estates and Facilities (E&F) team in conjunction with the nursing and Infection Prevention & Control Team (IPCT) undertook to audit and assure the Trust of its obligation to provide a safe care environment.

In 2018-19 the E&F team were part of the audit teams for the ward accreditation programme, *C. difficile* route cause analysis reviews, back to the floor, and quality inspections which formed part of the assurance and preparations for the formal CQC visits.

These included audits across the community sites, and Queen Mary's Hospital and actions were then taken to rectify any concerns when noted.

6.7 Cleanliness in Hospitals

Cleaning in hospitals is governed by the National Specifications for Cleanliness in Hospitals (2007) and the NHS Cleaning Manual (2009). Each site has a target score taking into account all the different risk categorisation and cleaning frequencies.

The Trust actual average score for 2018-19 was 97%

6.8 Ward and Department Accreditation Audits

The IPC nurses continue to participate in the ward accreditation audits, led by Corporate Nursing and review infection control practices and adherence to policy.

7. Venous Access Service

7.1 The Venous Access Service is committed to high standards of infection prevention and control in relation to the insertion and on-going care and management of vascular access devices.

The team undertake weekly surveillance on the management of long term vascular access devices and monitors any variation in weekly dressing compliance. If there is evidence of non-compliance then this is addressed at the time with the bedside nurse and the nurse in charge. In addition this measurement of compliance has now been added to the question set for ward accreditation along with observation of any peripheral cannulas.

7.2 The Venous Access Team has been working with the iClip (Patient management system) Team to develop a way of capturing positive blood culture results and cross referencing those with records of central venous access device insertion. There is a framework now in place and it is hoped that this will give a baseline of numbers of catheter related blood stream infections (CRBSIs) and a platform for implementing measures to reduce these rates.

8. IPC Mandatory and Statutory Training (MAST), Training and Education

8.1 IPC MAST Compliance

All wards and departments are encouraged to ensure that their compliance with MAST on-line training was greater than 85%. This proved to be a challenge but significant progress has been made. At present, the compliance rate for IPC *clinical* on-line MAST is 88% (n=5028) and for *non-clinical* 93% (n=2610) compared to 17/18 when compliance was 86% and 94% respectively.

Medical and Dental clinical staff were the least compliant group with 76% but showed an improvement from 67% in 17/18.

8.2 Education

Education, training and promotion work continued to promote hand hygiene and infection control compliance throughout the year and e-learning is mandatory on induction.

8.3 IPC Nurse Teaching

The IPC nurses delivered training across the organisation throughout the year. These included Trust, Nurse and HCA induction, annual updates, link staff training and additional bespoke training.

Hand hygiene training was delivered to all staff attending induction utilising the Glow and Tell machine which identifies poor hand hygiene using a fluorescent cream and by use of the Surewash® machines.

8.4 Additional Events and sessions

The annual World Health Organisation Hand Hygiene Day (in May 2018) and Infection Prevention and Control Week (October 2018) were observed at both St George's and Queen Mary's Hospitals. These involved the IPC nurses providing mobile hand hygiene training and stands for staff and visitors as well as carrying out lectures. IPC company representatives were invited to attend and participated on the stands

9. Antimicrobial Stewardship

The Trust continued to implement recommendations of NICE guideline [NG15]: Antimicrobial stewardship: systems and processes for effective antimicrobial medicines use. (National Institute of Health and Care Excellence, 2015)
The Antimicrobial Stewardship Group focussed work on antimicrobial stewardship, guideline review, use of alternative antibiotic agents and doses and reduction in duration of therapy. This group also measured compliance with CQUIN related activity.

9.1 Summary of CQUIN achievements

We have achieved CQUIN parts 2C and 2D part 1 and 2. We have not achieved CQUIN 2D part 3 but are in line with the national teaching hospital average (Table 6).

Table 6: 2018/19 Combined Antimicrobial Stewardship and Sepsis CQUIN. (Microbiology and Pharmacy are responsible for 2C and 2D parts of the 2018/19 CQUIN) Key: Black = CQUIN target; Green = achieved CQUIN target; Red = CQUIN target not achieved

	CQUIN description	Cost incentive	Q1	Q2	Q3	Q4	National data Q1-2
2c	Number of antibiotic prescriptions reviewed between 24 to 72 hours of initiation in patients diagnosed with sepsis that meet the criteria (i.e. by an appropriate clinician PLUS one of the seven documented outcomes PLUS an IV to oral switch assessment)	140k	>25% 83%	>50% 90%	>75% 87%	>90% 95%	86.1%
2d1	Total antibiotic consumption (DDDs per 1,000 admissions) not to increase from 2017/18* (count= 768, 423, value= 5913.6) England 4900, London 6593 2017/18)	46.67k	<192105.8 174591	<192105.8 173531	<192105.8 185282	<192105.8 178769	
2d2	Carbapenem consumption (DDDs per 1,000 admissions) not to increase from 2017/18* (count=12254, value= 94.3) England 98.7, London 114.3 2017/18	46.67k	3064 2833.5	3064 3562.5	3064 3912.25	3064 1906	
2d3	Proportion of 1st or 2nd choice antibiotics for common infections to increase by 3% from baseline 2016 calendar year (or >55%)	46.67k	>53.84% 43.38%	>53.84% 43.78%	>53.8% 45.09%	>53.84% 46.07%	46.6-47%

9.2 Antimicrobial Audits

Monthly audits were conducted manually Trust wide to measure review of antibiotic prescriptions within 72 hours of initiation (Table 7).

Table 7: Antimicrobial Stewardship audit undertaken quarterly

	No of pts audited	No of Rxs	Allergies Recorded	Indication on DRUG CHART	Stop/Review date on DRUG CHART	Indication in NOTES	Review within 48hours	Appropriate USE	Appropriate CULTURES
Children & Women, Diagnostics, Therapeutics and Critical Care	47	58	100%	78%	78%	93%	100%	94%	78%
Medicine & Cardiovascular	114	156	100%	89%	78%	88%	95%	90%	73%
Surgery, Theatres, Neurosciences & Cancer	71	88	100%	76%	70%	74%	84%	90%	51%
Total	232	302	100%	81%	75%	85%	93%	92%	67%

9.3 Institutional antibiogram

Antibiotic resistance patterns suggest that empirical antibiotic selection is appropriate and there is scope for replacement of carbapenems with other agents from the empirical guidelines without compromising safety of patients.

9.4 AMR CQUIN targets for 19/20:

Two targets involving antibacterial prescribing. A pharmacist will be required to collect data as has been the case for this year.

9.5 CCG1a-

Aim for 90% of antibiotic prescriptions for older people (65+) meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.

9.6 CCG1b- to be Co-Lead by microbiology and lower GI surgeons

Aim for 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.

10. Support from Public Health and Commissioners

The IPC team continues to work closely and receive support from the consultants and scientists based at the South London Health Protection Unit. A member of that team will usually be part of any outbreak/incident investigation team and the help and advice received at those times is invaluable.

The IPC team are also grateful for the advice and support received from Zama Ntusi Clinical Specialist Infection, Prevention and Control Advisor at the local Clinical Support Unit.

11. Priorities for 2019-20

A number of actions are to be incorporated into the annual plan for 2019-2020. These include:

- Meet targets set by Department of Health by remaining below the *Clostridium difficile* target of no more than 48 cases
- Continue to aim for zero cases of MRSA bacteraemia
- Introduce a programme of targeted screening for MRSA colonisation
- Improve the root cause analysis investigation of MSSA bacteraemia
- Strengthen the approach to managing *C.difficile* infections by improving communication with medical staff regarding patient review when diarrhoea is reported
- Introduce Surgical Site Surveillance of spinal surgery procedures and strengthen the process of root cause analysis for SSI identified
- Continue to ensure that optimal infection control practices are in place, and to manage infection incidents and outbreaks efficiently in order to keep our patients as safe as possible while maximising capacity at the Trust
- Work collaboratively within the Trust and with other local organisations to reduce the rate of *E. coli* bacteraemia
- Sustain high rates of compliance with hand hygiene and ‘Bare Below Elbow’.
- Review and strengthen screening for CPE and *Candida auris*

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13. Glossary of terms

Bacteraemia / BSI	The presence of bacteria in the blood / blood stream infection
C *difficile*	A bacterium that is one of the most common causes of infection of the colon. It can sometimes produce a toxin leading to colitis
Colonisation	Germs in or on the body but which not make the person unwell
CPE	Carbapenemase producing Enterobacteriaceae are Gram-negative bacteria that are resistant to the carbapenem class of antibiotics, considered the drugs of last resort for such infections
E. coli	*Escherichia coli* form part of the normal intestinal microflora in humans with some strains having the ability to cause disease. These can include food poisoning e.g. E. coli 0157 or infections of the urinary tract and bacteraemia
GRE	Glycopeptide resistant enterococci are bacteria resistant to the glycopeptide antibitics (vancomycin and teicoplanin) and are sometimes known as Vancomycin Resistant Enterococci (VRE)
Gram staining	A common technique used to differentiate two large groups of bacteria based on their different cell wall constituents. The Gram stain procedure distinguishes between Gram positive and Gram negative groups by colouring these cells differently, thus affecting treatment options
HCAI	Healthcare Associated Infection: Any infection that develops as a result of receiving healthcare treatment
Influenza	A respiratory illness associated with infection with the influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints
MDT	Multi-disciplinary Team: A meeting of a range of specialists who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions
MSSA	Meticillin sensitive *Staphylococcus aureus*: a bacteria that commonly lives on the skin or inside the nose without causing problems, but which is capable of causing infections e.g. in a wound or blood stream
MRSA	Meticillin resistant *Staphylococcus aureus*: strains of *Staphylococcus aureus* which is resistant to a number of antibiotics
RCA	Root cause analysis: A process for identifying “root causes” of problems or events leading to an approach for responding to them
SGH	St George’s Hospital (St George’s University Hospitals NHS Foundation Trust)
NHSI	NHS Improvement – an NHS body that oversees Trust driving quality improvement
PDSA	Plan-Do-Study-Act – a model of quality improvement trialling a small scale change before implementing more widely

Meeting Title:	Trust Board		
Date:	31 October 2019	**Agenda No**	**2.1.2**
Report Title:	Learning Disability Services Annual Report		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Padraic Costello, CNS Learning Disability Aisling Cotter Liaison Nurse Learning Disability		
Presented for:	Assurance		
Executive Summary:	The report provides an overview of the work of the Learning Disability Liaison Nursing Team (LDLNT) in association with patient experiences for adults with a learning disability accessing St George's Hospital site. The objectives of this service are: • To enable patients with a learning disability to access high quality care and treatment through navigation of services provided by SGUHFT • To work in partnership with the other professionals and agencies to ensure that the patient remains safe along the pathway of care from the point of admission to discharge • To facilitate discussion and guidance around best interest decision making in accordance with the Mental Capacity Act (2005) • To coordinate and implement reasonable adjustments where appropriate as required in accordance with the Equality Act (2010). A total of 1,186 referrals were received by SGUHFT LD Liaison Nurses for the period of April 2018 to March 2019. This represents an increase of 9.2% on the previous year. There is strong evidence to suggest that people with learning disabilities and their carers continue to benefit greatly from the intervention of the LDLNT. The Learning Disability Patient Partnership Engagement Group (LDPPEG) meets every 3 months. The LDPPEG is member-led and membership is cross sectional. It includes people with a learning disability, family members, paid carers, learning disability liaison nurses, representatives from local community support groups and other health professionals.		
Recommendation:	The Trust Board are asked to receive this report.		
Supports			
Trust Strategic Objective:	• Treat the patient – treat the person • Right care, right place, right time		
CQC Theme:	Safe/Caring		
Single Oversight Framework Theme:			
Implications			
Risk:	The report highlights the need to address the new Learning Disability Improvement Standards • respecting and protecting rights • inclusion and engagement		

	• workforce • learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both		
Legal/Regulatory:	The Annual Report references the Trust's legal and regulatory duties in this area.		
Resources:	The Annual Report references the currently available resources.		
Equality Impact Assessment:	The report makes reference to the Equality Act 2010		
Previously Considered by:	Patient Quality and Safety Group Quality & Safety Committee	**Date**	21/8/2019 19/09/19
Appendices:	None		

St George's University Hospitals NHS
NHS Foundation Trust

Report of the Learning Disability Liaison Nursing Team (LDLNT)

Year Ending 2019

Aisling Cotter, Learning Disability Liaison Nurse

Padraic Costello, Clinical Nurse Specialist, Learning Disabilities

Supporting adults with a learning disability, their families and carers to access St George's Hospital.

Introduction:

The purpose of this summary is to highlight an overview of the work of the Learning Disability Liaison Nursing Team (LDLNT) in association with patient experiences for adults with a learning disability accessing St George's Hospital site.

SGUHFT continues to operate an enhanced learning disability nursing service which provides support to people with learning disabilities and their carers to access St George's Hospital. Wandsworth Clinical Commissioning Group are the commissioners of this service which sits under the umbrella of Adult Safeguarding and is provided by 2 registered learning disability nurses, a Band 7 Clinical Nurse Specialist and a Band 6 Liaison Nurse. The core aim of the service is to ensure that adults with a learning disability have access to supplementary support, if required.

The objectives of this service are:

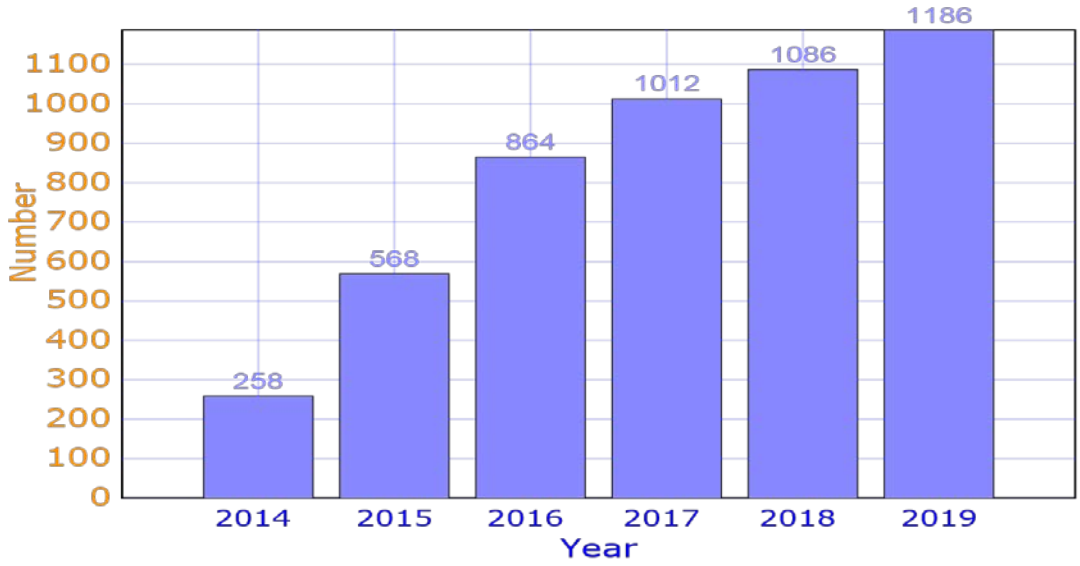
- To enable patients with a learning disability to access high quality care and treatment through navigation of services provided by SGUHFT
- To work in partnership with the other professionals and agencies to ensure that the patient remains safe along the pathway of care from the point of admission to discharge
- To facilitate discussion and guidance around best interest decision making in accordance with the Mental Capacity Act (2005)
- To coordinate and implement reasonable adjustments where appropriate as required in accordance with the Equality Act (2010).

The service operates between 8am and 5 pm Monday – Friday. Referrals can be made by any source to the team via email, telephone, and bleep or in general correspondence.

Referrals:

A total of 1,186 referrals were received by SGUHFT LD Liaison Nurses for the period of April 2018 to March 2019. This represents an increase of 9.2% on the previous year. The majority of referrals were received from nursing and medical staff working at SGUHFT. Referrals were also received from health and social care colleagues in community settings and parent/carers, in advance of elective interventions and treatments. Hospital admissions accounted for 21% of all referrals received. An increase in the number of general referrals (44.5%) was seen; relating to pathway planning, addressing informal concerns, responding to queries related to the patient's experience, implementing reasonable adjustments and facilitating best interest discussions. Outpatient appointment related matters accounted for 22.5% of referrals received. 12% of referrals were terminated following fact finding, the majority of which resulted in onward referral to another service.

Trajectory of referral rates to the LDLNT



The majority of referrals received were from the boroughs of Wandsworth (39.9%) and Merton (19.1%). Increases in referrals were seen over the past year for those ordinarily resident in Wandsworth and Kingston whilst a reduction was noted in the number of referrals received from Merton compared to the previous year.

There was no percentage increase in the total of inpatients seen by the LDLNT compared to the previous year. The reasons for admission to hospital were varied but comprised predominately of care and treatment for aspiration pneumonia, generalised infection, epilepsy related events, falls and strokes.

Referrals based on patient's borough or area of residence

Wandsworth	39.9%
Merton	19.1%
Croydon	6.1%
Surrey	6.0%
Kingston	6.0%
Lambeth	5.9%
Sutton	3.9%
Other	13.1%

Patient journeys through SGUHFT:

The LD nurses at SGUHFT are contactable via telephone and bleep. Their contact numbers are widely published within hospital and community settings. Once notified, the LD nurses will meet the patient with a learning disability and review past and recent history whilst also exploring any requirements for reasonable adjustments.

Examples of reasonable adjustments put in to practice over the past year have included arranging for a family member to be able to stay overnight with a patient sometimes for up to 2 weeks; working in partnership with multiple teams to ensure that a patient with an extreme phobia of surgical scrubs could access the scanning areas without seeing a professional dressed in same, liaising with various departments and teams to ensure that multiple investigations/interventions could be undertaken under one episode of general anaesthetic reducing the need for additional admissions to hospital; rearranging appointment times to make access to the hospital easier and facilitating pre-planned visits to departments and wards particular for patients with known anxieties related to hospital admissions.

Patient Story:

A 22 year old woman with a learning disability, autism and Tuberous Sclerosis was suspected of having kidney AMLs. She is known to have a longstanding phobia of hospitals and in particular of surgical gowns. Best interest decision making discussions involving her parents, community and hospital professionals resulted in plans to admit the patient to hospital for scanning and embolisation of the AMLs. The patient's mother was especially concerned about the potential distress her daughter would experience, particularly as she had not been to St George's Hospital before. A request was made for the patient's Hospital Passport so that further information could be obtained regarding the patient's strengths, needs, baselines, routines and risk factors. This was uploaded to EPR for immediate access to those meeting the patient for the first time. The LDLN exchanged multiple emails with the Consultant Anaesthetist, Consultant Interventional Radiologist and the Tuberous Sclerosis Consultant to plan the least restrictive way for the patient to access the required treatment. In excess of 25 staff in Radiology Department were asked in advance to avoid wearing surgical scrubs at the time of the patient's planned arrival time to the department. Extra time was allowed to negotiate pre anaesthetic medication. No invasive monitoring occurred in the initial stages and an arrangement was made for the patient to remain in her regular clothing whilst being sedated. As the GP had unable to obtain any blood samples and in particular to test for anti convulsant drug levels, it was agreed that the patient would have these done once she was under GA. The patient came to the department as planned. The LDLN had an iPad loaded with music from the patient's favourite artist. This was played as the patient was led with her parents to the waiting area next to the Interventional Radiology Suite. No other patients were allowed access to this area as noise was known to be a stressor for the patient. The patient encountered no staff with surgical scrubs en route to the waiting area. She was distracted to have IM Ketamine as previously agreed in best interest discussions and after 15 minutes of careful observation, the patient was transferred safely on to a trolley to undergo the required interventions. The patients mother was allowed in to the Recovery Room when the patient was about to be woken so she had a familiar face to see on arousal. The patient's favourite music still playing in the background when she awoke. The patient recovered well and safely to return home with a good outcome.

Our further developing relationships with Out Patient Departments have continued to produce increasing evidence of the fast tracking of people with learning disabilities when it is known that a delay in the waiting room area may cause distress for the patient or others.

This year, patients with learning disabilities have availed of fast tracking experiences in the following Out Patient Departments; Urology Clinic, Colo Rectal Clinic, X Ray Department, MRI Scanning and CT Scanning Departments, Phlebotomy, Fracture Clinic, Neurology Clinic, Gastro Clinic, Cardio Clinic, Audiology Department, Chest Clinic and Gynae Clinic.

The safety of patient journeys through St George's Hospital have been further complimented over the last year when the LDLNT has linked with the Pre Op Care Centre, discharge planning coordinators, IMCAs, carers, and Social Services departments. Best interest decision making/MDT meetings facilitated by the LDLNT have also ensured that the patient's episode of care is planned, delivered and concluded as safely as possible at a pace manageable for the patient.

Listening to our patients, carers and other professionals

At SGUHFT, there is strong evidence to suggest that people with learning disabilities and their carers continue to benefit greatly from the intervention of the LDLNT. This is supported by the number of expressions of gratitude received via email and general correspondence. Informal feedback received from wards and department staff also confirms that the hospital experience for patients with learning disabilities is enhanced with support from the LDLNs. The LDLNT was keen to gather more substantiated evidence about how other's perceive it's service and to get a deeper understanding of patient experiences for people with learning disabilities accessing St George's Hospital. As a result, an electronic survey was disseminated to 80 community professionals and carers in March 2019. A 55% response rate was received. Some of the key findings are highlighted below.

Statement	Strongly Agree/Agree
Admissions to St George's Hospital for people with a learning disability result in better outcomes when the LDLNT is involved	95%
Today health professionals at St George's Hospital have a better understanding of the needs of people with a learning disability compared to 5 years ago	84%
The patient experience at St George's Hospital for adults with a learning disability is always excellent	86%
Attending outpatient appointments is less stressful when the LDLNT is involved	92%
I would feel less confident accessing St George's Hospital if the LDLNT service was withdrawn	92%
I feel supported in my contacts with the LDLNT	95%
Members of the LDLNT are always approachable	95%

Qualitative data was also retrieved and a sample of extracts included the following statements:

''This is an essential service that has an outstanding reputation and is far ahead of any other hospital in South West London. Families and service users talk about an extremely positive, supportive experience from highly skilled professional nurses'

'The involvement of the team definitely made a great difference in how departments responded to our cared for person'

'I cannot thank the Learning Disability Liaison Nursing Team enough for the help and support that they gave my daughter and I when we were in St Georges for three weeks. They were always coming into the ward to see how we were and directed questions to my daughter clearly and involved her in any decision making. They are also a great help when we come for outpatient appointments. I wish all hospitals had such a professional team as this'

'Now that the LD liaison team has been established for several years, the care pathway from start to finish is excellent. The two nurses are absolutely dedicated and often go beyond the call of duty. Given that there are still (despite the findings of Mencap's Death By Indifference) thousands of unnecessary deaths every year, this service is absolutely vital'

'Excellent service and so essential'

'Having access to help from the LD liaison nurses helps both the patient with a learning disability but also reduces the stress for their family carers. Many adults with a learning disability find hospital visits very daunting, and they try to make them easier by fixing suitable appointment times, explaining problems to staff etc. It's really good to see the impact of the training done by the LD liaison nurses and the way they have spread the word'

'I cannot express easily the depth of positive impact that the LD liaison team has on our experiences at St. Georges. I have management responsibility to five local support services and registered homes; we have considerable use of services at St. Georges, and the support we have received has genuinely been, simply, fantastic. The advocacy aspect of their work on behalf of the people we support, particularly around accessing appropriate responses from the specialists in the hospital has, I believe, genuinely saved one life of someone we support, and has helped greater understanding of people with learning disabilities and their needs with their health care colleagues. Also the way that they provide information to us as the support providers enable us to support the individuals and their families far better than previously'

'Excellent service is provided by the Learning Disability Liaison Nurses at St George's Hospital. The work they do is invaluable. It would be great if the hospital could employ more nurses to fulfil this role. Thank you'

Raising Awareness

Over 270 professionals availed of a learning disability awareness training session provided by the LDLNT over the past year. Attendees have included Preceptorship Nurses, HCAs on the Foundations of Psychological Care course, junior doctors, commissioners, and ward and clinic staff. Evidence from evaluation of the sessions indicates new learning which participants were intending to introduce to their future practice. The key themes of new learning were reported to be a greater understanding of the distinction between learning disability and learning difficulty, the usefulness of the Hospital Passport, a greater awareness of the reasonable adjustments to be incorporated in to the patients care and using alternative communication strategies with patients who have a learning disability. This new learning can only add to the quality and safety of the patient experience in hospital.

Patient Representation and Partnerships

The LDLNT is represented at number local fora aimed at developing pathways of health promotion for people who have a learning disability, in partnership with other agencies. Examples include the Wandsworth Health Action Group (WHAG) chaired by the commissioners of the LDLNT. The Learning Disability Patient Partnership Engagement Group (LDPPEG) also meets every 3 months. The LDPPEG is member-led and membership is cross sectional. It includes people with a learning disability, family members, paid carers, learning disability liaison nurses, representatives from local community support groups and other health professionals. It seeks to represent the whole community and to be accessible, inclusive and openly run. Aside from having those with the lived experience of patient care at St George's, the group is comprised of some key and influential community professionals including Beverley Dawkins OBE whose report Death By Indifference (2007) was the first national study to examine premature deaths of people with a learning disability in the UK.

Complaints, Concerns and Compliments

One formal complaint was raised about the care of an individual at St George's Hospital over the past year. This centred on a patient who was an outlier on a ward. The patient who has autism and a learning disability fasted from midnight until 5pm when her mother then queried why her daughter did not have a Scan under GA as planned. The patient's mother was informed by the treating team that the scan would occur on the following day. The patient was offered food and again became NBM from midnight. When there was again no update by 3pm on the following day, a staff nurse contacted our team. We had not been aware of the patient's admission before this contact. The LDLNT contacted the CNS in the relevant department and an immediate plan was devised for the patient's care. The complaint was justified as the patient had no understanding of the reason for fasting, her mother who stayed overnight with her tried tirelessly to occupy her, no reference was made by ward staff to the patient's Hospital Passport and there was no contact from the treating team until the concern was raised with the LDLNT. Once a plan was agreed with the incorporation of reasonable adjustments, the patient went on to have the procedure.

Whilst only one formal complaint was received, the LDLNT has facilitated a number of informal complaints and concerns, mainly around attitudes to care. These have usually been resolved at an early stage by the intervention of the LDLNT and in consultation with the person raising the concern and the relevant ward or department. Some examples include

The sister of a man with a learning disability raised concern the patient did not have a name band applied until 20 hours after his admission to the ward. Her concern centred on the patient being unable to verbalise his needs in addition to having refractory epilepsy which could necessitate rescue medication at short notice.

A lady with a learning disability for whom English was not her first language was anxious about remaining in hospital. Her niece asked if she could stay overnight with the patient but was informed by the nurse in charge that this constituted a health and safety risk. No effort was taken by the nurse to consider the request as a reasonable adjustment under the Equality Act.

The mother of a patient raised concern about her daughter with a learning disability who was sedated with Midazolam following a seizure. The patient recovered and was keen to leave the department. A doctor then approached the patient and asked her to sign a self-discharge form. This was totally inappropriate as the patient lacked capacity to make that decision and no best interest discussion took place with her parents who were also in attendance.

Most feedback received through correspondence has highlighted positive patient experiences for people with a learning disability and their carers. Extracts include

'Words will never be enough to thank you for your kindness and support these last nine weeks. We never could have imagined the path that would be travelled but as you have accompanied us, it has provided strength and confidence even at the lowest moments. We will never forget you'

'Thank you so much for all you have done for M and myself. You have made our stay much easier to cope with. You are one of the most caring, kindest people I have met. We will never forget you'.

'Just a quick note to say thank you very much for all your help when L and I were at St George's. I can't tell you how much a bed and food were appreciated. Thank you also for your understanding towards L needs. St George's are lucky to have you both'

There have been no Serious Untoward Incidents involving the care and treatment of a patient with a learning disability at St George's over the past 5 years. The national report 'Treat Me Well' (Mencap 2018) highlights how an estimated 1,200 adults per year with a learning disability die avoidably due to poorly met health needs but there have been no such deaths attributed to St George's over the past 5 years. A total of 9 people with a learning disability died in St George's Hospital in the last year compared to 20 in the previous year. One death was referred to The Coroner's Office who recommended no further action. All deaths of people with a learning disability in England continue to be reported to the national LeDeR programme and any death of a person with a learning disability occurring at St George's is notified to LeDeR by the LDLNT

Developments over the past year;

The LDLNT now presents awareness sessions at the monthly Trust's Nurse Preceptorship Programme and the Foundation of Psychological Care for HCAs. This enables nursing staff to have access to additional information designed to ensure that people with a learning disability continue to receive high quality care and treatment

The BBC as part of their coverage of the 70th anniversary of the NHS liaised with LDLNT to discuss changing attitudes to disability in the programme 'Medicine Matron and Me'.

The team was able to support a local lady with learning disability to appear on the programme and to describe her recent experiences of using hospital services.

The LDLNT has acquired a number of occupational resources which are available to people with a learning disability staying in hospital. These include sensory objects, an IPad, adult colouring books, table top games, dominoes etc.

Nurses from the team spoke at local meetings and conferences to include the Merton and Wandsworth CCG Patient Engagement Group, the Adults First Conference, the LeDeR Family Workshop and a Healthwatch Assembly event.

A joint piece of work commenced involving the Nutrition and LD Clinical Nurse Specialists to formulate accessible information for people with a learning disability requiring parenteral feeding. It is envisaged that discussions with other departments will lead to a series of accessible information leaflets in the future.

The LDLNT and Share Community, a local voluntary organisation supporting adults with a learning disability liaised to jointly devise a health access programme designed to educate people with learning disabilities around appropriate use of the Emergency Department at St George's.

Future Plans

The LDLNT is mindful of the low number of formal complaints received on behalf of patients with a learning disability. It is likely that this may be a testament to the high level of quality care they receive but the LDLNT hopes to devise an accessible format of the Complaints Procedure to ensure that patients with a learning disability have easier access to report any concerns or shortcomings related to their care and treatment.

Many patients with a learning disability would have difficulty in completing the Trust's standard patient satisfaction survey. For this reason, the LDLNT will strive to produce an easy read survey for patients to complete at the point of discharge.

A number of adults with a learning disability find great difficulty in accessing scans without a General Anaesthetic. In the past, when a patient requires a General Anaesthetic for such intervention, considerable time has been spent engaging multiple services to enable a safe pathway. The amount of time spent planning such interventions could be greatly reduced by the availability of an adapted GA pathway. The LDLNT has had initial exploratory discussions with CT Scanning and Anaesthetics Department with a view to involving representation from Bed Management, Theatres and Recovery in a collaborative approach to overcome the current challenges.

All NHS Trusts are required to meet the new Learning Disability Improvement Standards. This is a large piece of work which will involve the LDLNT liaising with numerous departments at St George's.

The four standards concern:

- respecting and protecting rights
- inclusion and engagement
- workforce
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

The standards are intended to help organisations measure quality of service and ensure consistency across the NHS in how they approach and treat people with learning disabilities, autism or both. The standards are prominent in the learning disability ambitions in the NHS Long Term Plan and are included in the NHS standard contract 2019/20. The standards are expected to apply to all NHS-funded care by 2023/24. The final standard is not applicable to the Trust but the remainder will require significant interdepartmental and strategic involvement to ensure compliance. An action plan based on these standards and the findings of the national audit is being developed and will be presented to PSQG in November 2019.

Padraic Costello
Clinical Nurse Specialist
Learning Disability Liaison Nursing Team
15th July 2019

Meeting Title:	**Trust Board**		
Date:	31 October 2019	**Agenda No**	2.1.3
Report Title:	Learning From Deaths Quarter 2 2019/20		
Lead Director:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Kate Hutt, Head of ME Office & Mortality Review Service Dr Nigel Kennea, Consultant Neonatologist		
Presented for:	Assurance		
Executive Summary:	The paper provides an overview of the work of the MMC and data for Q2 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:	• To be updated on Learning from Deaths activity and to support next steps in this process, most urgent of which is recruitment to position of Trust Lead. • To be updated on the project to introduce the Medical Examiner system from April 2019 and support a process of implementation from November 2019. • To note improvements in our processes for the scrutiny of deaths in patients with learning disabilities. • To take assurance that the Trust has robust processes for reviewing deaths and from learning any lessons that arise from them. • For divisional teams to use this report to take learning back to their services.		
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 identifies 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 may require 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. There is a potential risk that the without a Trust Lead for Learning from Deaths that the response to concerns raised by the ME service will not be effectively managed.		
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	**Date**	16/10/19

MORTALITY MONITORING COMMITTEE UPDATE
QUARTER 2 2019/20

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Quality & Safety Committee with an update on the work of the Mortality Monitoring Committee (MMC), focussing on information and learning identified through independent case record review of deaths for Q2 2019/20. An update on the delivery of requirements of the Learning from Deaths framework and the introduction of the Medical Examiner (ME) service is also detailed.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK AND NATIONAL STRATEGY

2.1 Learning from Deaths – Ongoing Development

The Trust has advertised the position of Trust Clinical Lead for Mortality and Learning from Deaths. The interviews are expected to be held on 12 November 2019. This role is central to effective Trust mortality processes, both centrally and at a specialty level. This role is an essential link to the Medical Examiner service.

In September the independent clinical governance review, focussing on the Trust's mortality and morbidity and multi-disciplinary team meetings, was presented to the MMC by the Chief Medical Officer. A number of recommendations were made and an action plan has been formulated. This will be brought back to MMC in October for discussion of the role for the committee in supporting the delivery of actions, for example contributing to updating the Learning from Deaths policy. Additionally revision of the Terms of Reference and strengthening the role of the committee in its aim to support clinical teams with their local M&M governance processes will be priorities.

2.2 Medical Examiner Service – Implementation

Dr Nigel Kennea, formerly Associate Medical Director (Mortality), has been appointed as Lead Medical Examiner and a start date will be agreed shortly. A location from which to operate the service has been identified and plans are progressing to ensure that the service can commence in November. It is intended that the national recommendation to implement the system in a phased way that minimises risk will be followed. An immediate priority will be the recruitment of additional MEs and exploration of how best to meet the requirement for Medical Examiner Officers (MEOs).

To support local implementation of this new service the Lead ME and Lead MEO have continued to liaise with a number of key stakeholders, including the Coroner and the newly appointed Regional Medical Examiner. This is ongoing and will include the Registration Service. A programme of peer visits has also been agreed. The first visit to the national pilot site of Sheffield Teaching Hospitals was very informative and useful for establishing a network of support and learning.

The administrative burden involved in this work is considerable and the project team are exploring IT systems that will support the efficient delivery of the service. Currently the Mortuary Team and Bereavement Services are working on a business case to procure an IT management system (Eden), and this has the potential to link with the ME office. This would support reliable and efficient processes in all stages of care for the deceased and the bereaved.

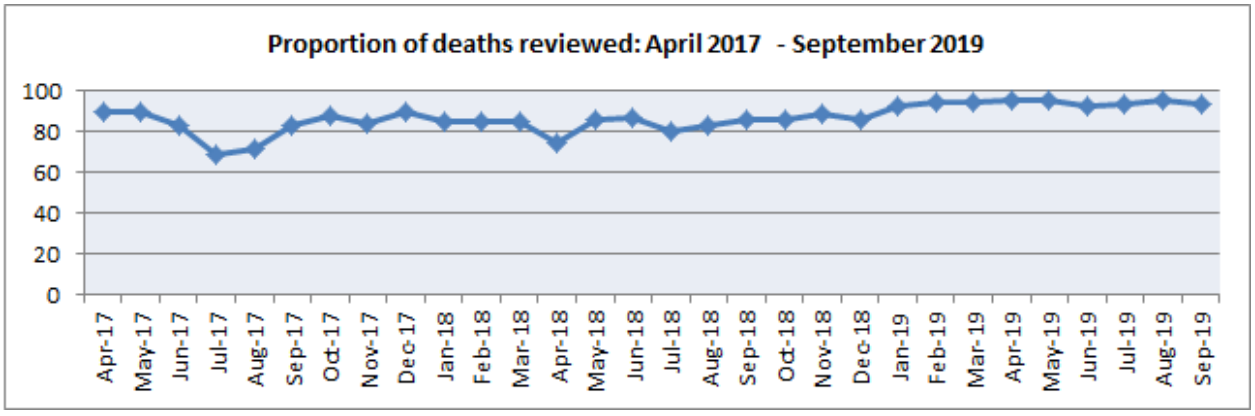
3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 As an interim measure, the previous Chair of the Mortality Monitoring Committee has continued to support mortality review processes. 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, which we have amended to reflect the local reviews of learning disability deaths, is shown in Appendix 1

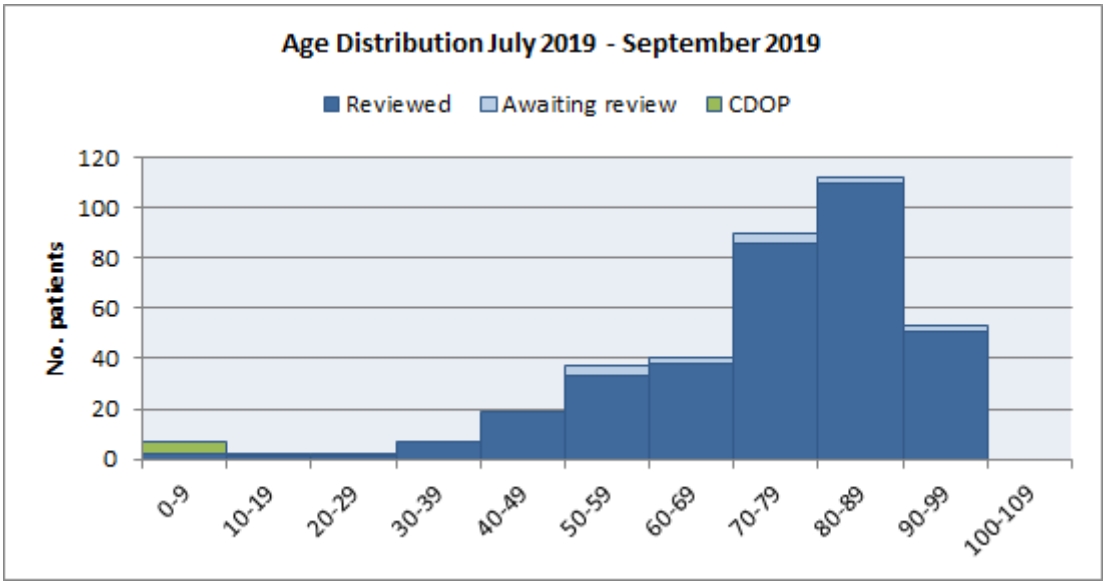
Section 4.1 provides an overview of local scrutiny of deaths in patients with learning disabilities that have occurred during this report period.

3.2 Overview of July to September 2019

Between July and September 2019 there were 370 deaths, of which members of the MMC have reviewed 349. This represents 94.3% 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.

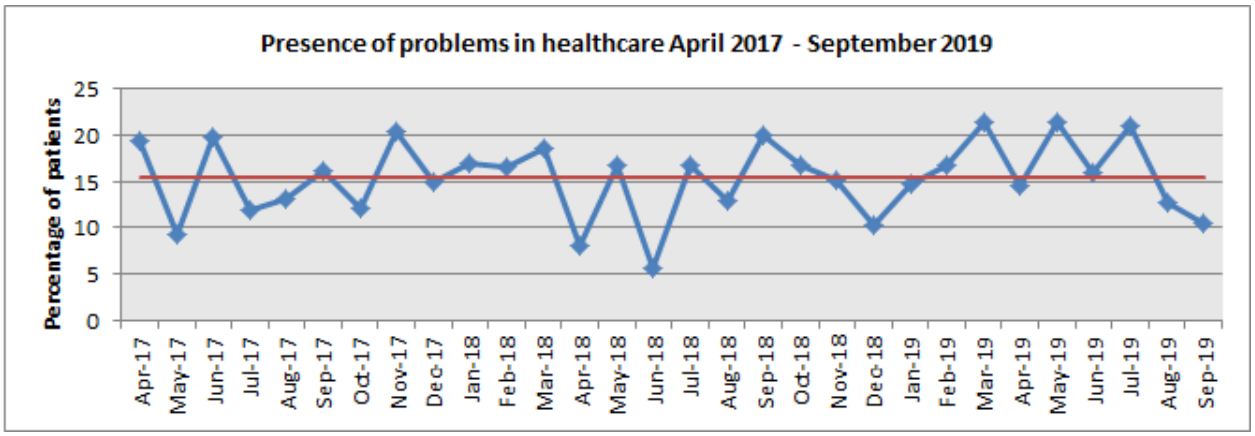


The age profile of deceased patients remains consistent, with the highest proportion of deaths in the 80-89 age group.

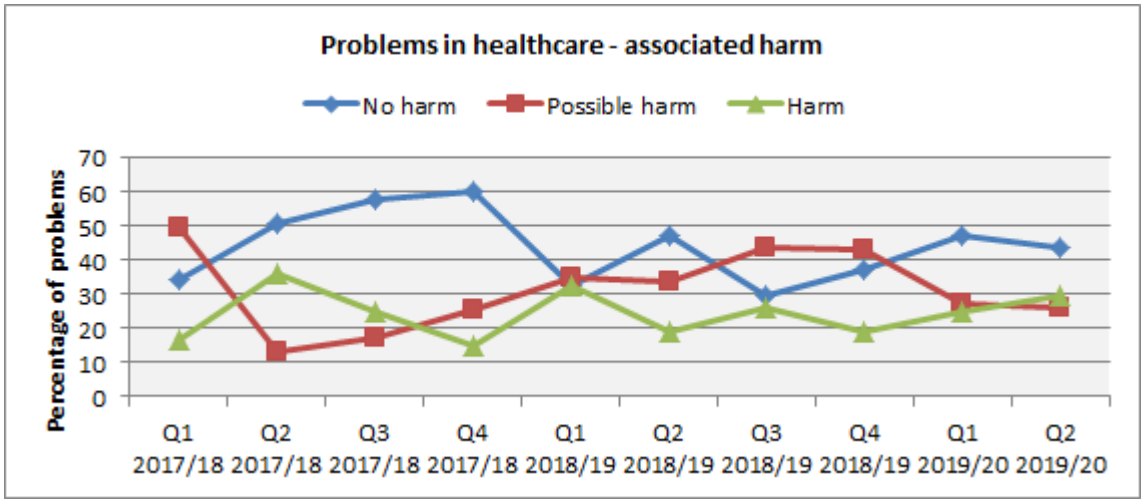


The structured judgement review methodology requires reviewers to identify problems in healthcare and to assess whether or not these have caused harm. The RCP define a number of problems in healthcare, as detailed in the tables below. Locally we have added 'Communication' to these categories. This quarter, one or more problems in healthcare were identified in 14.9% of the deaths reviewed, which is lower than the rate observed in the last two quarters. Looking at the monthly data shows fluctuation around the mean of 15.5%.

Problems in healthcare Q2 2019/20				
	Jul	**Aug**	**Sep**	**Total**
No	94	117	86	**297**
Yes	25	17	10	**52**
% with problems	21.0	12.7	10.4	**14.9**



The problems identified include recognised complications of treatment and not all are judged to have led to harm. The chart below shows that most problems are not judged to have led to harm. This quarter the observed problems did not lead to harm in 43.9% of cases, possibly led to harm in 26.3% and did cause harm in 29.8%.



This quarter the most common problem in healthcare identified by reviewers was those related to communication with 21.0% reported being in this category. It should be noted that the number of problems differs from the number of deaths where a problem is observed. This is because a patient may have encountered more than one problem.

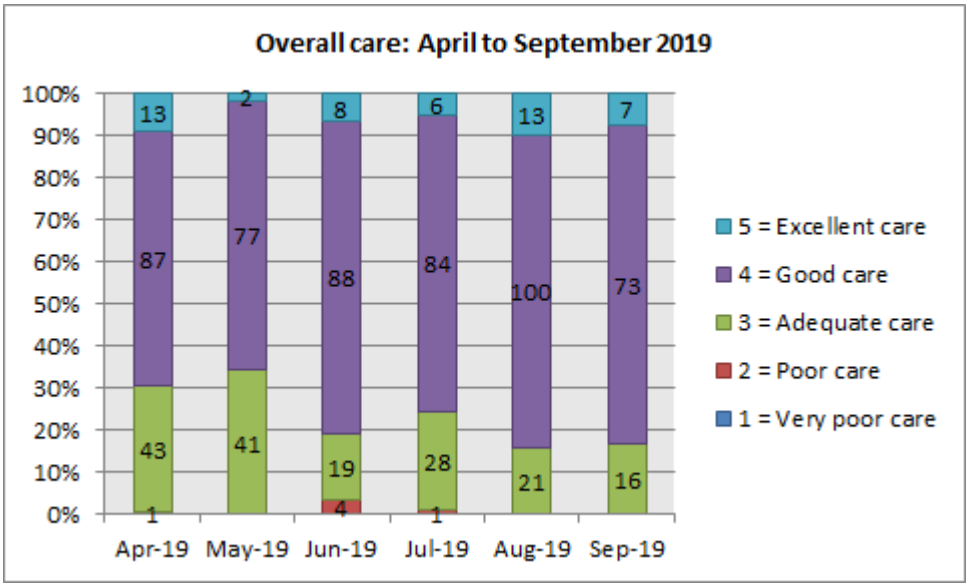
Problems in healthcare: Q2 2019/20	No harm	Probably harm	Harm	Total
Assessment, investigation or diagnosis	0	0	0	**0**
Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)	2	1	0	**3**
Related to treatment and management plan	1	4	5	**10**
Infection control	5	0	2	**7**
Operation/invasive procedure	1	2	7	**10**
Clinical monitoring	1	1	1	**3**
Resuscitation following a cardiac or respiratory arrest	2	1	1	**4**
Communication	8	3	1	**12**
Other	5	3	0	**8**
TOTAL	**25**	**15**	**17**	**57**

A judgement regarding avoidability of death is made for all reviews. As in previous periods, the large majority (98.0%) of deaths this quarter were assessed as definitely not avoidable. No deaths were judged to be more than likely avoidable.

Avoidability of death judgement score: Q2 2019/20	Jul	Aug	Sep	Total
6 = Definitely not avoidable	116	134	92	**342**
5 = Slight evidence of avoidability	2	0	3	**5**
4 = Possibly avoidable but not very likely (less than 50:50)	1	0	1	**2**
3 = Probably avoidable (more than 50:50)	0	0	0	**0**
2 = Strong evidence of avoidability	0	0	0	**0**
1 = Definitely avoidable	0	0	0	**0**
TOTAL	119	134	96	**349**

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 7.4% of care rated as excellent, 73.6% as good and 18.6% as adequate. Poor case was observed in 1 case and there were no cases of very poor care.



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 and our liaison with these colleagues continues to strengthen. This quarter the CCG has requested five local mortality reviews which we were able to share with them immediately. In addition we now have an agreement in place that redacted copies of the completed LeDeR reviews will be shared with the Trust, in order that we can identify learning and best practice. It is positive to note that to date none of our LD deaths have been judged as avoidable; however, both the LD team and the MMC are committed to continually reviewing care for this vulnerable group of patients and to make improvements where necessary. Visibility of the completed reviews will most certainly support this.

The mortality review team continue to carry out timely 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 18 months there were 19 deaths, with reviews completed for each. No avoidability was identified.

This quarter there have been 7 LD deaths, with each reviewed within two working days. No problems in healthcare were identified and the deaths were judged to be definitely not avoidable. Overall care was judged to be good in three cases and excellent in four.

LD DEATHS Avoidability of death judgement score	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20
TOTAL DEATHS	1	3	3	2	3	7
LOCAL REVIEWS COMPLETED	1	3	3	2	3	7
6 = Definitely not avoidable	1	3	3	2	3	7
5 = Slight evidence of avoidability	0	0	0	0	0	0
4 = Possibly avoidable but not very likely (< 50:50)	0	0	0	0	0	0
3 = Probably avoidable (> 50:50)	0	0	0	0	0	0
2 = Strong evidence of avoidability	0	0	0	0	0	0
1 = Definitely avoidable	0	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 prepared a brief summary of the key findings and recommendations and presented this to the MMC in September. The main findings reiterate the picture of care and treatment previously described in the national reports that led to establishment of the LeDeR programme. The committee did not identify any national recommendations that require action locally; however, was very supportive of efforts to enhance learning through the review of completed LeDeR reviews. It was agreed that a regular report containing information and guidance to support improvement will be presented to MMC.

4.2 Identification of Learning

This quarter there have been a number of cases escalated for further review, including 15 cases referred to the service for M&M review and reflection. Of these, five have been referred to draw attention to good practice observed by the reviewer. This tends to centre on good documentation of effective patient and family communication, decision making and communication between teams and high quality end of life care. Feedback of this nature has been very well received by colleagues.

In some cases the requests from the review team are simply to seek a specialist opinion and clarification. Issues that have been highlighted for local consideration include management of end of life care, the early consideration of treatment escalation plans and frequency of consultant review. Potential learning in relation to the discussion and documentation of DNACPR decisions have been identified in a small number of cases. Reflections from clinical teams and for discussion at local M&Ms have included the need to improve transfer of information between teams and to ensure that documentation of decisions is not deferred.

In one instance there was communication issues observed related to a patient transferred from QMH to St George's. Although these issues were not felt to have affected the outcome for the patient it was noted that the imminent deployment of iClip to QMH would improve information sharing and reduce the risk of similar communication difficulties in the future.

Liaison with specialist teams continues to bring benefits. This quarter it has been agreed that mortality reviews for all VTEs in the Trust will be considered by the Hospital Thrombosis Group, in particular to consider whether they might influence any current clinical guidelines and practice.

Close collaboration between the mortality review team and other governance teams continues. In addition to a number of cases highlighted to the risk team for consideration of

local investigation there were two cases where the risk team facilitated the sharing of information with other hospitals that were involved in the final episode of care. In a number of cases independent reviews have been shared with risk to inform ongoing incident investigations. This quarter there have also been four cases that have been scrutinised as part of the ongoing cardiac surgery governance processes.

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 reviews 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 completed their retrospective mortality review sessions at the end of July. Publication of the panel's report is expected in the autumn.

6.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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

The SHMI for June 2018 to May 2019 was published on 10th October 2019. For the Trust overall our mortality is categorised as lower than expected at 0.81. We are one of 13 trusts nationwide in this category. The SHMI for St George' site is 0.82 (lower than expected). For Queen Mary's the SHMI value has been suppressed for the purposes of disclosure control.

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	0.58	Lower than expected
Secondary malignancies	0.76	Lower than expected
Pneumonia (excluding TB/STD)	0.74	Lower than expected
Urinary tract infections	0.61	Lower than expected
Gastrointestinal haemorrhage	0.63	Lower than expected
Septicaemia (except in labour), shock	1.00	As expected
Fluid and electrolyte disorders	0.68	As expected
Acute myocardial infarction	1.25	As expected
Acute bronchitis	0.78	As expected
Fracture of neck of femur (hip)	0.86	As expected

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

HSMR analysis: June 2018 – May 2019	Score	Banding
HSMR (all admission methods)	82.3	Better than expected
HSMR: Weekday emergency admissions	80.1	Better than expected
HSMR: Weekend emergency admissions	86.7	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 April 2018 to March 2019. There were no new signals to consider; however, patient level data was examined for each of the groups; a summary of which is include in the table below. Information from available 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 group were satisfied with the understanding of each signal and did not identify any further areas for investigation by MMC at this time.

Diagnosis/Procedure Group	Summary information
Coma, stupor and brain damage	29 deaths Apr18 to Mar19 (16.5 expected). 25 deaths have been reviewed by one of more of MMC review team, CTICU and Trauma. No concerns or avoidability noted. At least 13 suffered out of hospital cardiac arrest.
Crushing injury or internal injury	12 deaths Apr18 to Mar19 (4.5 expected). 10 deaths have been reviewed by one of more of MMC review team, CTICU and Trauma. 9 noted no concerns or avoidability. As previously reported to MMC, 1 case from June 18 was categorised as 4 (possibly avoidable but not very likely) – DW107234 (related to NG tube).
Other perinatal conditions	29 cases in last 12 months, against 12.3 expected.
Diagnostic spinal puncture	13 deaths Apr18 to Mar19 (4.9 expected). 11 different diagnosis groups. 11/13 reviewed by one of more of MMC review team, CTICU and Trauma. 2 cases were rated as a 5 (slight evidence of avoidability); the remaining cases as 6, no concerns or expected.
Other eye disorders	1 death. This has been independently reviewed and no avoidability found.
Excision of larynx or pharynx	1 death. This has been independently reviewed and no avoidability found. Also reviewed as death following elective admission and submitted to MMC - unexpected and unavoidable.
Residual codes unclassified	This signal is only seen at the highest level of specificity. This confirms our understanding of this as a timing issue, as analysis is based on the second extract for discharges up to and including March 2019, which reflects a final position.
Short gestation, low birth weight, fetal growth retardation	10 deaths Apr18 to Mar19 (5.3 expected). Anomaly appears to be December where 3 cases were observed. None in January or February and 1 case in March.

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

NHS — **St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - September 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
100	138	93	132	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
363	403	342	382	0	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
766	1541	724	1337	3	10

Time Series: Start date 2017-18 Q1 — End date 2019-20 Q2

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	0	0.0%	This Month	1	1.1%	This Month	3	3.2%	This Month	89	95.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	0.6%	This Quarter (QTD)	5	1.5%	This Quarter (QTD)	335	98.0%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.1%	This Year (YTD)	2	0.3%	This Year (YTD)	4	0.6%	This Year (YTD)	15	2.1%	This Year (YTD)	702	97.0%

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
3	2	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	3	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
10	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
3	2	3	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	3	7	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
10	9	10	9	0	0

Time Series: Start date 2017-18 Q1 — End date 2019-20 Q2

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	31 October 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, Kaye Glover		
Presented for:	Information and assurance about Quality and Performance for Month 6		
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. Cancer performance continues to be compliant against all seven standards. 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 where performance dropped to 82.3% in the month of September which was below our trajectory of 92%. Quality Improvement metrics will be added in Q3 and Q4. Reporting on Mental Capacity Act Knowledge is now being reported. Please note that the report is under development working to incorporate NHSI recommendations.		
Recommendation:	The Board is requested to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient, Treat the Person Right Care, Right Place, Right Time		
CQC Theme:	Safe Caring Responsive Effective Well Led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:	The trust remains in Quality Special Measures based on the assessment of the Regulator NHS Improvement		
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Previously Considered by:	Finance and Investment Committee Quality and Safety Committee	**Date**	24/10/19 24/10/19
Equality Impact Assessment:			
Appendices:			

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 30 October 2019
Reporting Period – September 2019

James Friend
Chief Transformation Officer

24 October 2019

Our Outcomes

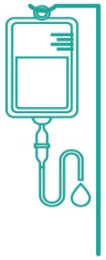
How Are We Doing?

September 2019

Daycase and Elective Surgery operations

Actual: 4,719

Target: 5,282



AMU bed occupancy at 12 Noon

Actual: 95% Target: 85%

Four Hour Emergency Standard

Actual: 82.3%

Target: 95%

Whole Trust Inpatient Friends and Family Test

Actual 96.6%

Target 95%

Outpatient First Attendence

Actual 15,976

Target 17,565

August 2019

Referral to Treatment Standard - Incomplete pathways

Actual: 85%

Target: 92%

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment (A)	
OUR **PEOPLE** PERSPECTIVE	Workforce			Agency Use		

Key

Current Month

(A) Previous Month

Executive Summary – September 2019

Our Finance and Productivity Perspective

- Outpatient Activity at Trust level, although below the mean for the last two months, remained within their normal process limits and showed no sign of special cause variation.
- The Trust is continuing to see increase Elective activity (5% higher than the same period last year), delivering more elective procedures per day whilst continuing to reduce patients length of stay. Although behind SLA plan for month six this is expected to increase through data catch up.
- Non-elective activity for the month of September is 3.63% below plan and compared to the same period last year we have seen a decrease of 3.39%.

Our Patient Perspective

- Reduction in number of Datix incidents, but performance remains above the upper control limits.
- Complaints continues to meet all of its compliance targets.
- After a significant deterioration in VTE performance due to a change in National guidance, performance for the last three months has seen an improvement.

Our Process Perspective

- Performance against the Four Hour Operating Standard in September was 82.3% and performance dropped below the lower control limit showing a special cause variation.
- The Trust achieved all seven Cancer standards in the August. The Trust remained compliant against the 14 day standard achieving above 93% in all tumour groups with the exception of Upper Gastroenterology.
- In August, the Trust has submitted performance below trajectory for the first month since returning to reporting in January 2019. Due to QMH migrating CliniCom PAS to Cerner Millennium from 14 September 2019, the Trust closed August month end three days earlier than usual. This contributed towards the increase in PTL size.
- In September the Trust performance remained compliant against the six week diagnostic standard, and performance remained under the lower process control limit, with a total of 75 patients waiting greater than six weeks and a performance of 0.92%.
- 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 September, 97.8% of patients were re-booked within 28 days.

Our People Perspective

- Mandatory and Statutory Training figures for September were recorded at 89.9% with a mean of 86.2%, a reduction on last month's performance. This is primarily due to junior doctor rotation.
- The Trust's Total Funded Establishment and Trust Vacancy rate are both slightly above the lower control limits with both seeing a steady increase over the past four months. Work has started to understand and control this.
- The Trust's total pay for September was £44.70m. This is £0.05m adverse to a plan of £44.65m.

Balance Scorecard

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment A	
OUR **PEOPLE** PERSPECTIVE	Workforce			Agency Use		

Our Finance & Productivity Perspective

Activity against our Plan

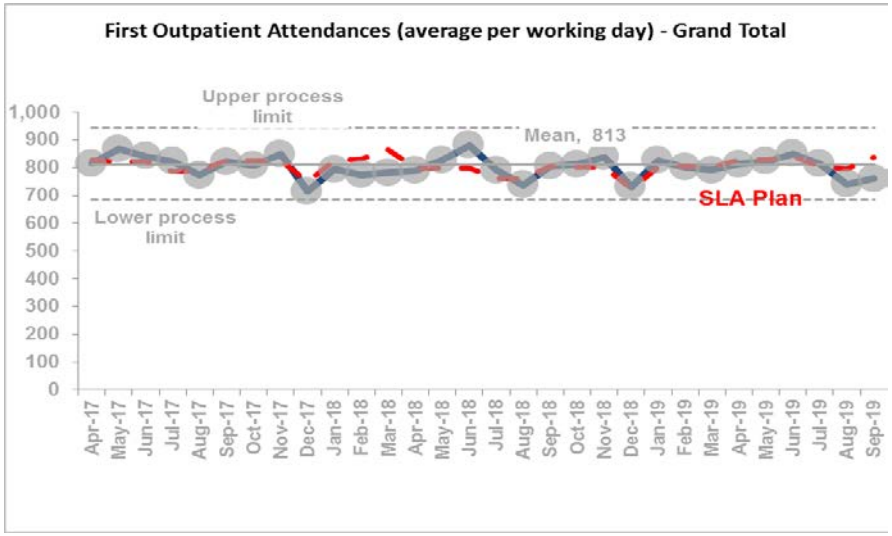
		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Sep-18	Sep-19	Variance	Plan Sep-19	Variance	YTD 18/19	YTD 19/20	Variance	Plan YTD	Variance
ED	ED Attendances	13,787	13,940	1.11%	13,912	0.20%	83,759	85,392	1.95%	84,859	0.63%
Inpatient	Non Elective	3,899	3,767	-3.39%	3,909	-3.63%	23,692	23,690	-0.01%	23,758	-0.29%
	Elective & Daycase	4,630	4,719	1.92%	5,282	-10.66%	28,681	30,078	4.87%	30,554	-1.56%
Outpatient	OP Attendances	54,834	52,551	-4.16%	58,147	-9.62%	331,116	330,210	-0.27%	342,909	-3.70%

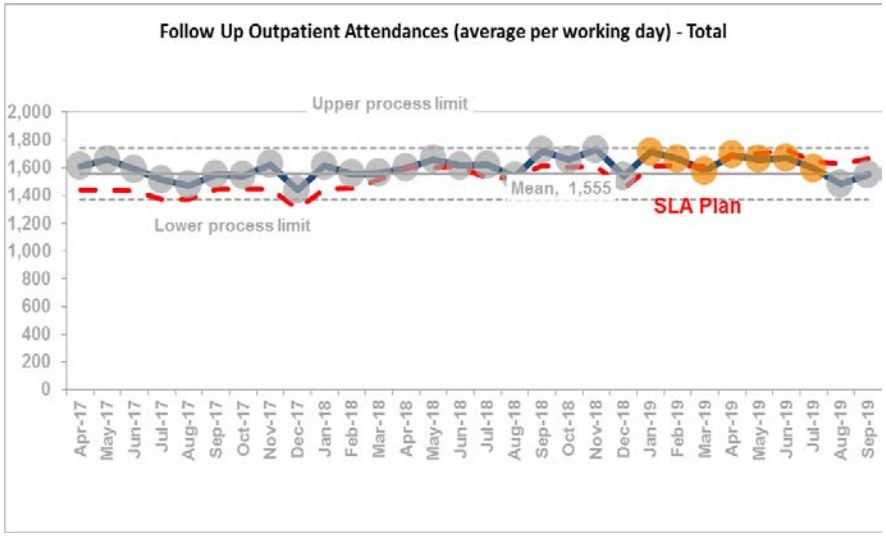
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

Note: Figures quoted are as at 08/10/2019, and do not include an estimate for activity not yet recorded (eg. un-cashed clinics). The expected performance vs. plan by Point of Delivery (POD) post catch up is:

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

Outpatient Productivity





What the information tells us

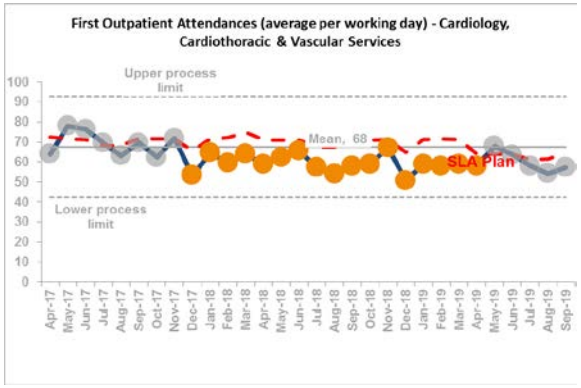
- Outpatient first and follow-up activity remains within the upper and lower control limits at Trust level. We do expect activity for the month of September to increase when cashing up is completed.
- Renal & Oncology continue to have outpatient first activity consistently above their mean, whereas Women's Services have fallen below their mean (likely to increase through data catch up). General Surgery have seen a third consecutive month below the mean with all other services showing common cause variation.
- At Trust level follow-up activity has remained within its process limits with a dip below the mean in August and September.
- Cardiothoracic Surgery outpatient follow-up activity has had several months with their follow-up activities below the mean indicating a special cause variation, with Surgery activity also showing to be on a downward trend.
- Renal and Oncology, Neurosciences, Specialty Medicine and Women's Services outpatient follow-up activity remain above their mean with Children's and Trauma & Orthopaedics showing only common cause variation. Women's services appear to have a greater opportunity for data catch up.

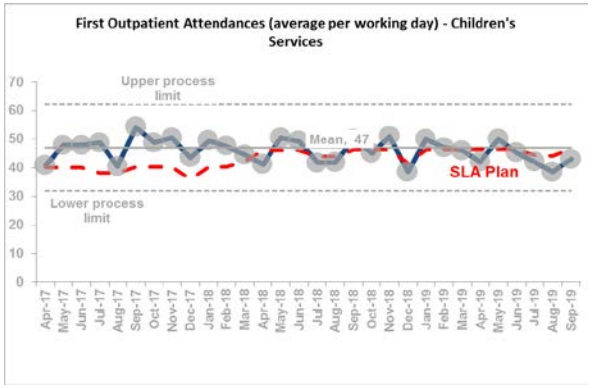
Actions and Quality Improvement Projects

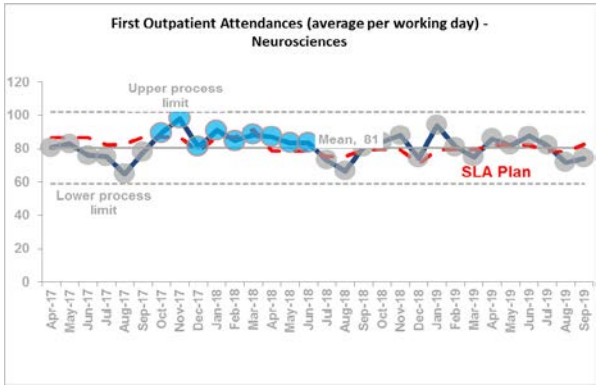
- Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.
- Women's services are meeting weekly to ensure that referrals are being triaged and appointments booked in a timely manner,
- Model Hospital data is being reviewed to identify opportunities.
- The Trust is working in partnership with other hospitals across South West London to redesign six specific outpatient pathways.

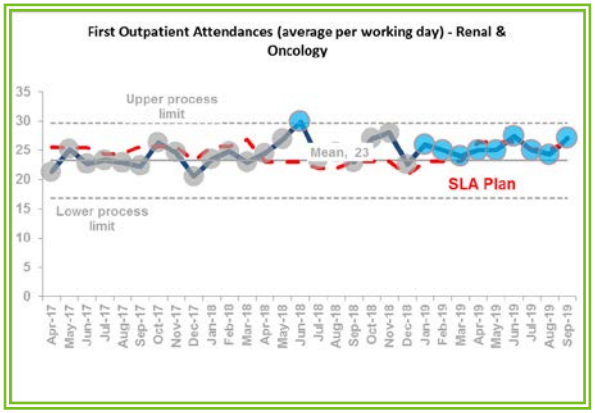
Number of First Outpatient attendances per Working Day

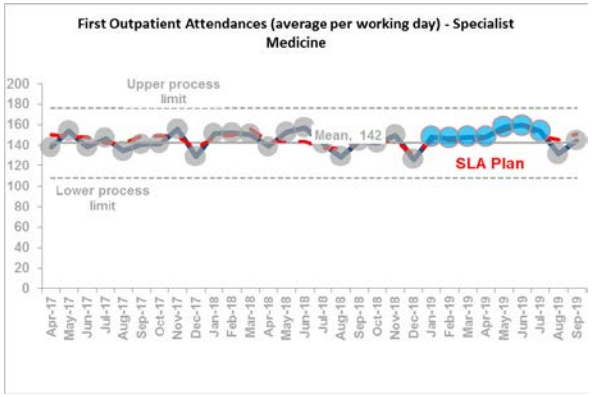
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

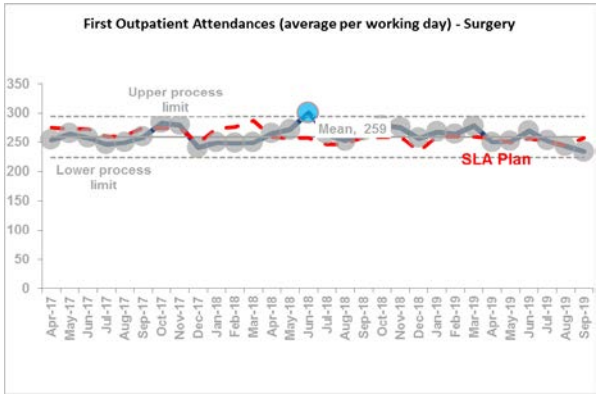


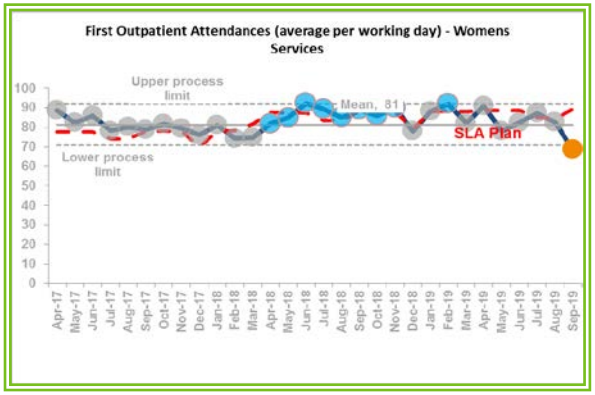


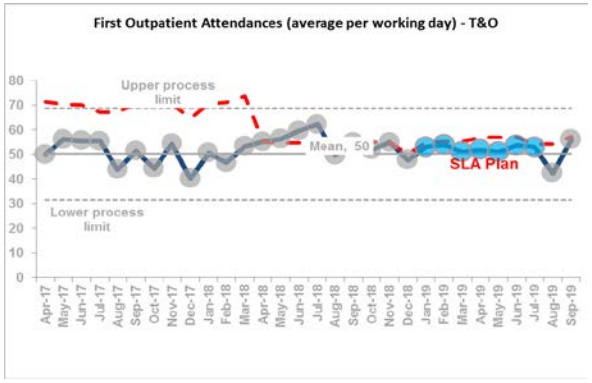






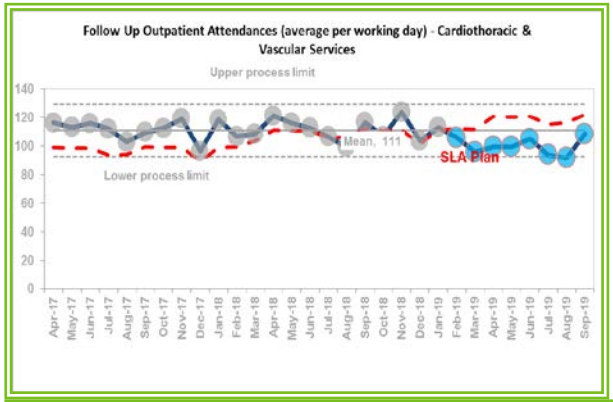


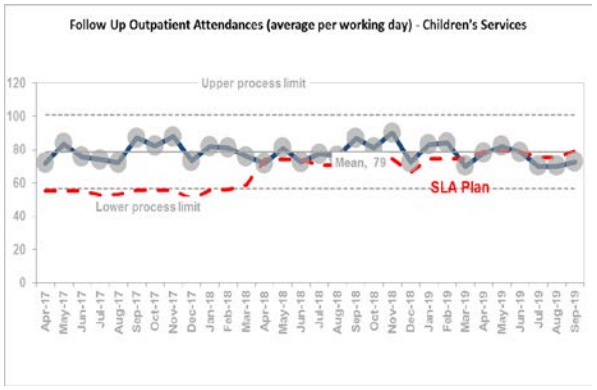


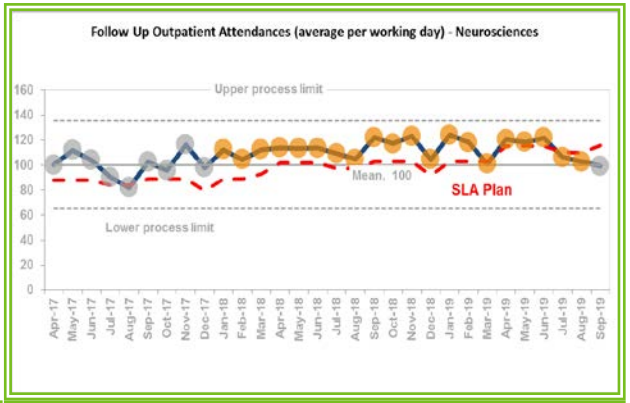


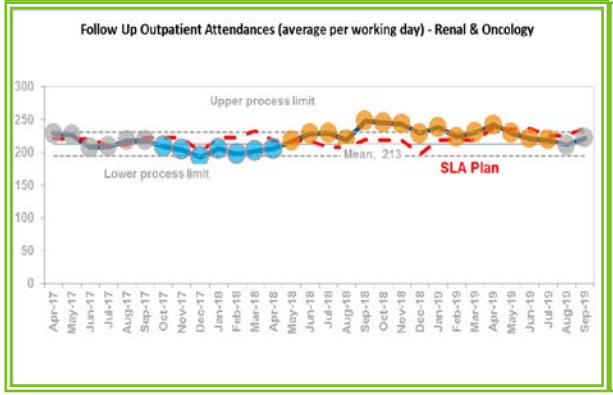
Number of Follow Up Outpatient attendances per Working Day

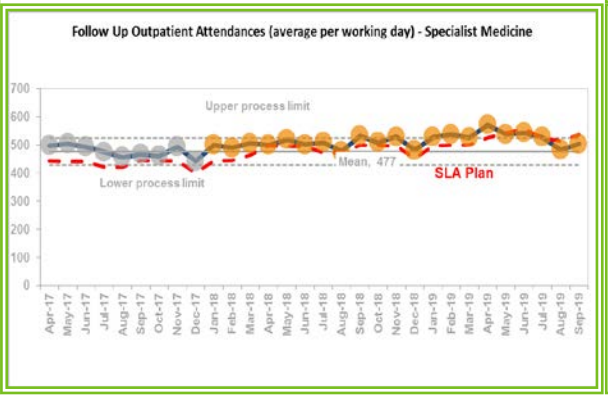
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

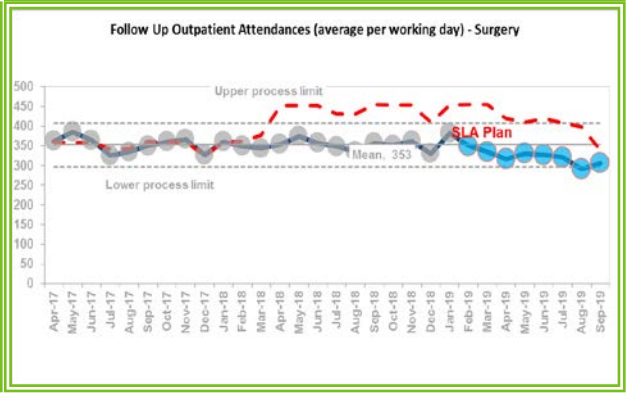


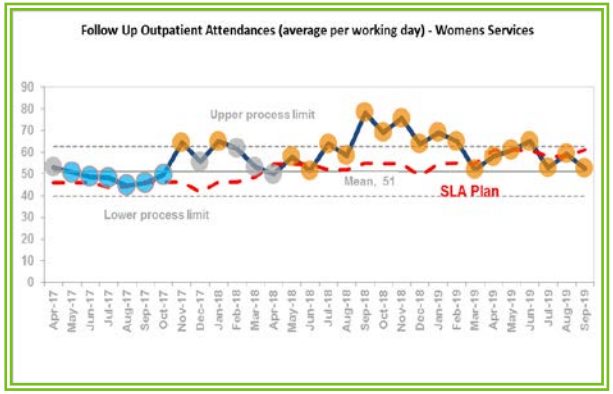


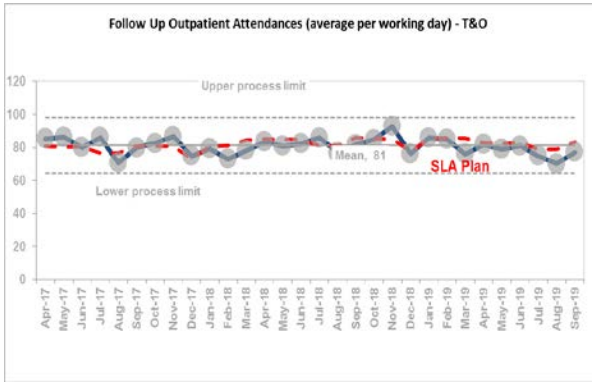




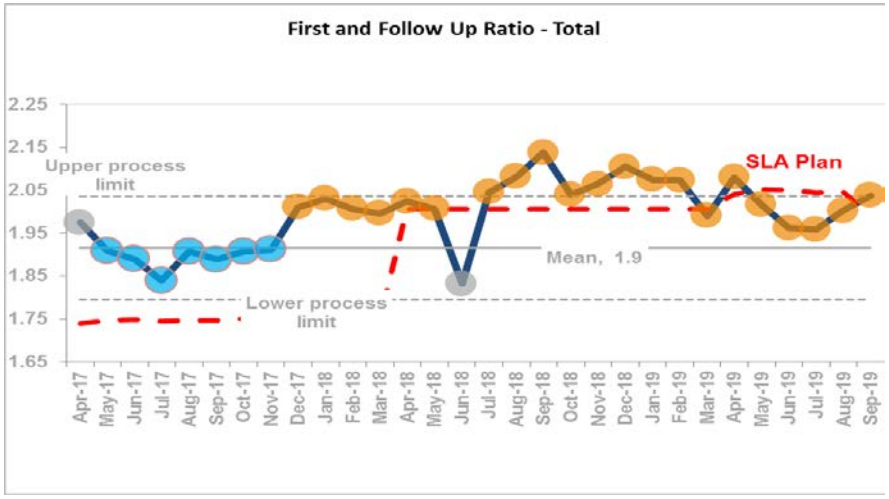


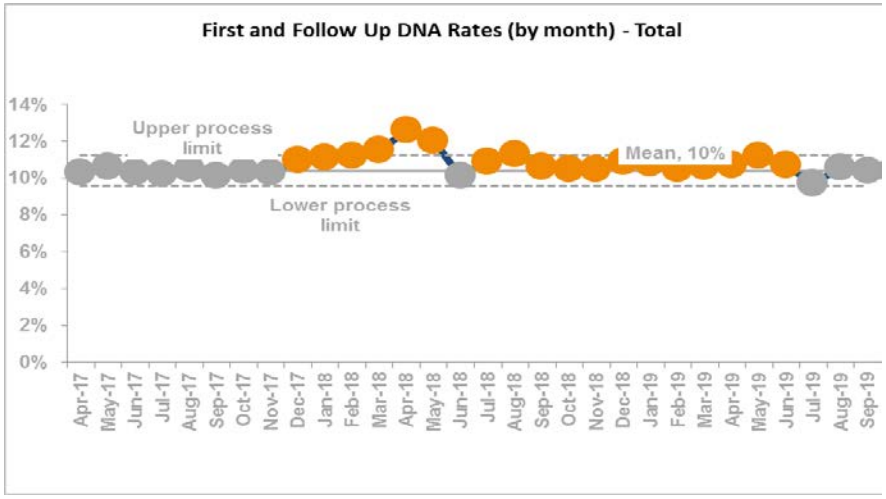






Outpatient Productivity





What the information tells us

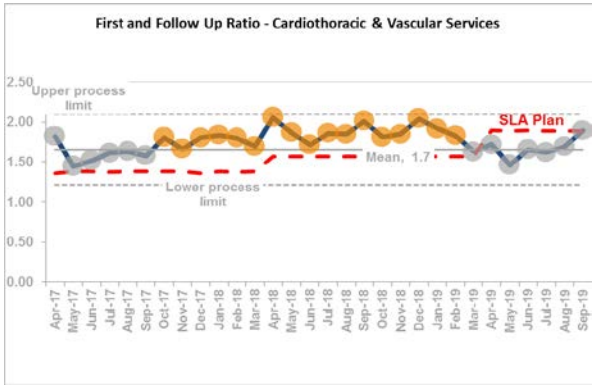
- The Trusts first to follow-up ratio continues to be above the mean showing special cause variation for the month of September.
- Surgery continues to have first and follow-up ratios consistently below their mean for at least the past eight months which reflects the recent reduction in follow-up activity. Whereas Neurosciences and Specialty Medicine continue to see the ratio above the mean reflecting the increase in follow-up activity.
- The Trust DNA rate is within its process limits and shows common cause variation.
- Women's services and Renal & Oncology DNA rates have consistently been below its means whereas Neurosciences and Other (Acute Medicine, Therapies and Diagnostics) have all been consistently above their means for over a year.
- Cardiothoracic and Vascular services have reported their lowest ever DNA rate at 8.3% and are below the lower control limit.

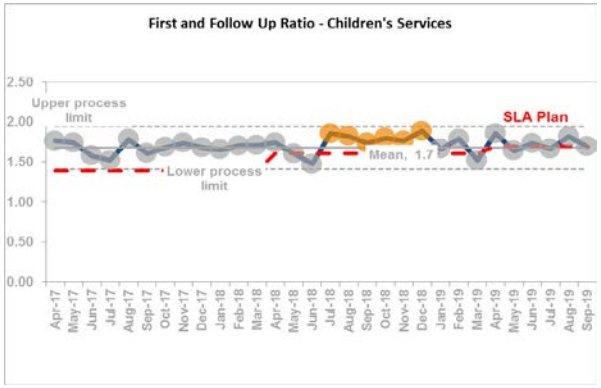
Actions and Quality Improvement Projects

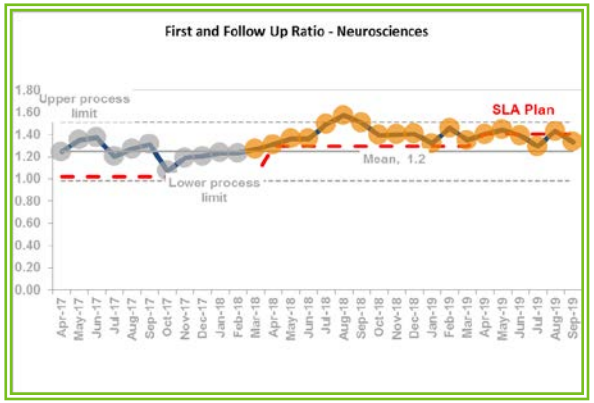
- Divisions are currently scoping opportunities to implement virtual follow-up appointments and open access to support reducing follow-up attendances and improve first to follow-up ratios across the services. Virtual clinics have are now established in Neurosciences.
- Additional appointment types have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

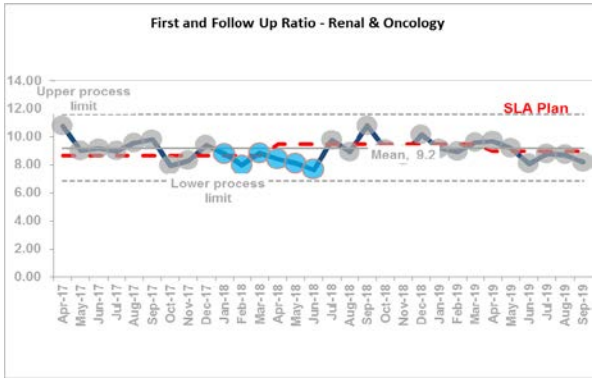
New to Follow Up Ratios

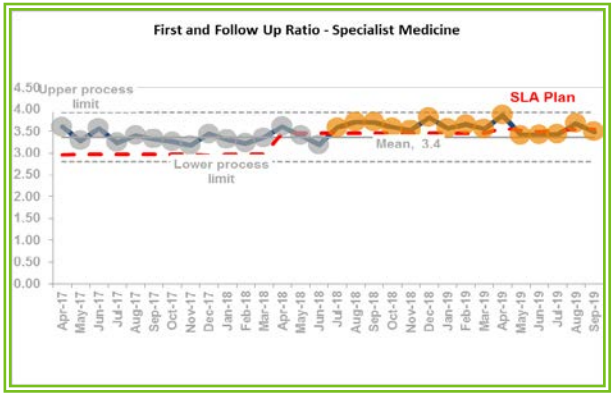
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

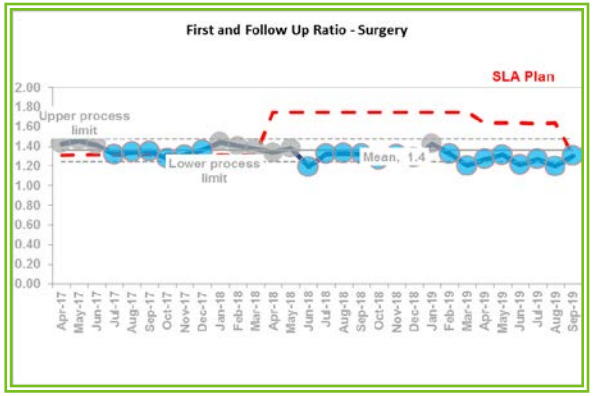


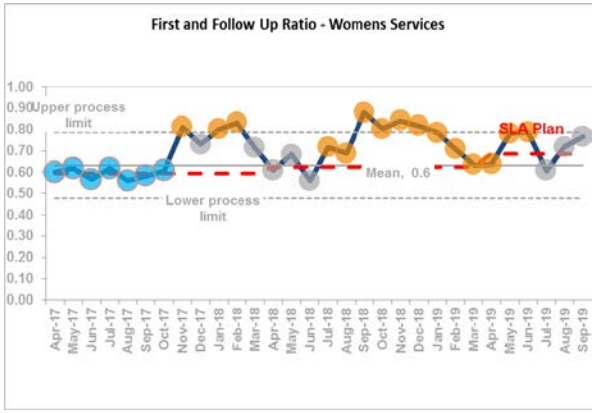


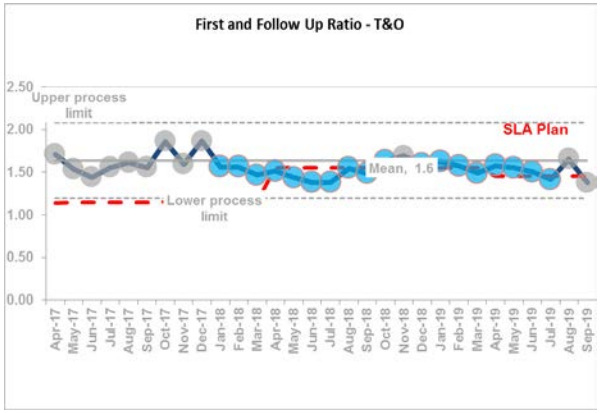








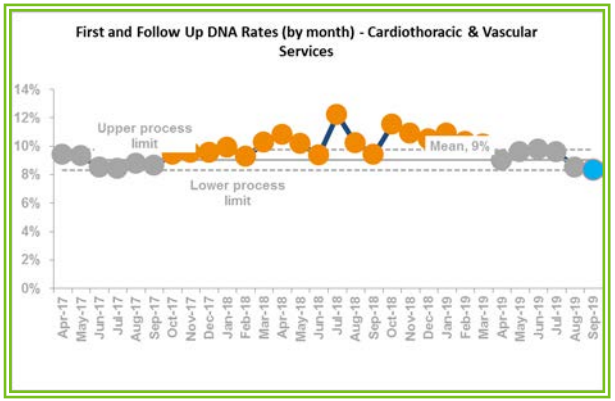


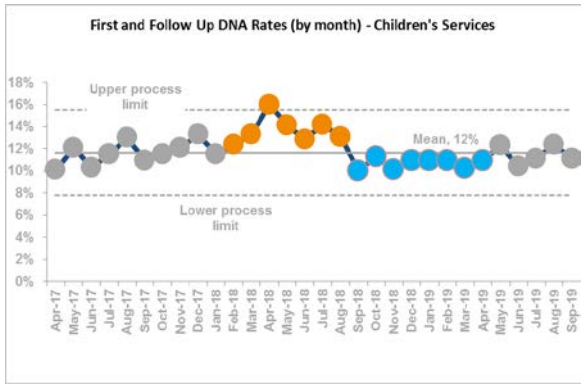


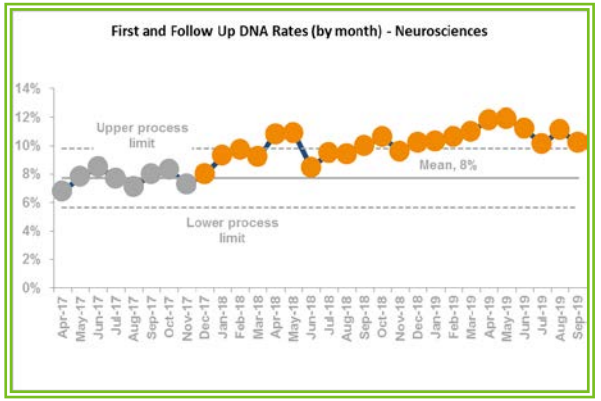
Our Finance & Productivity Perspective

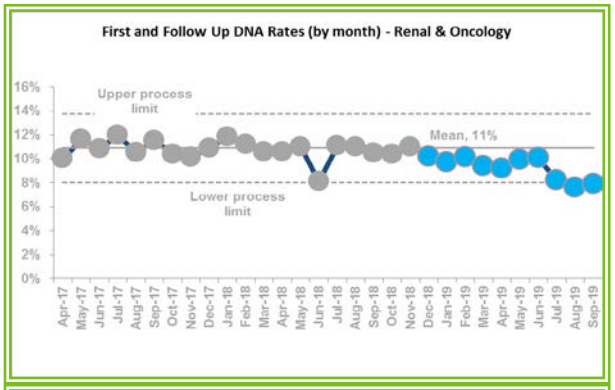
Number of Patients that do not attend

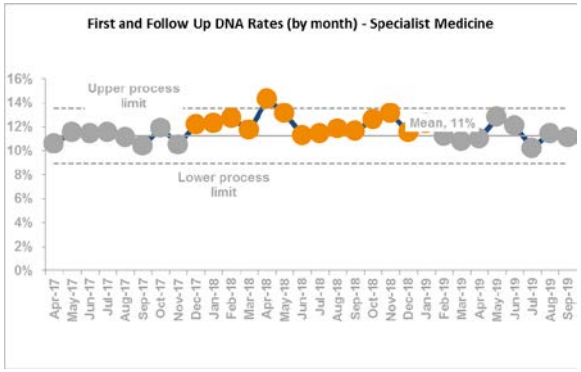
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

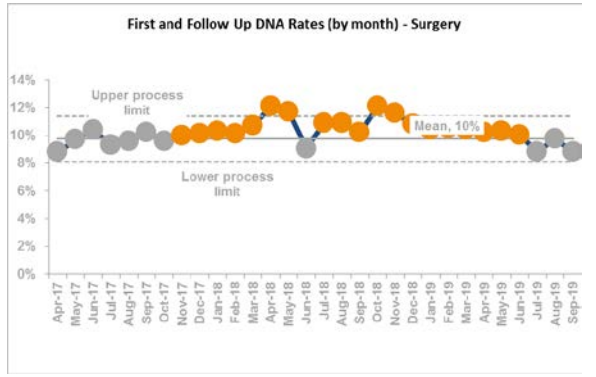


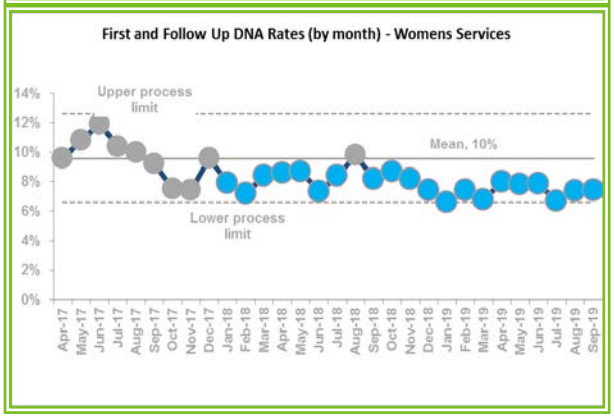


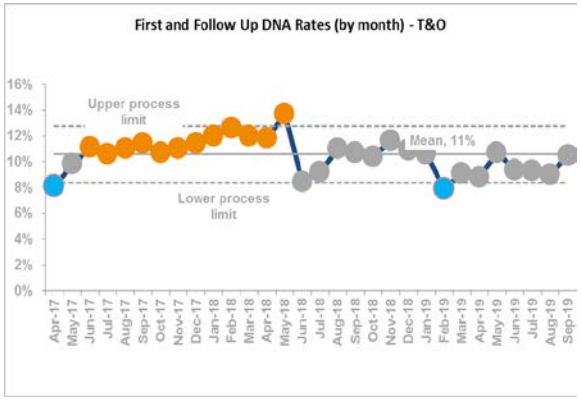


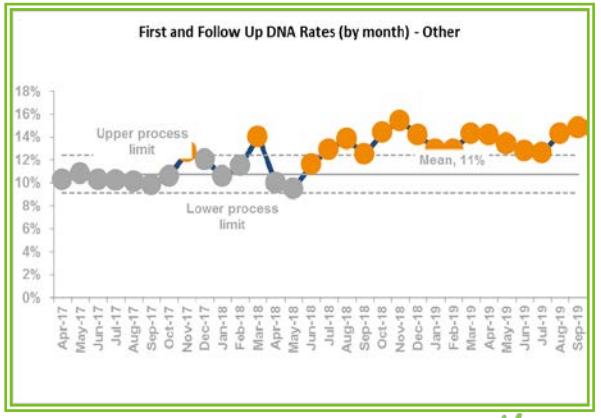






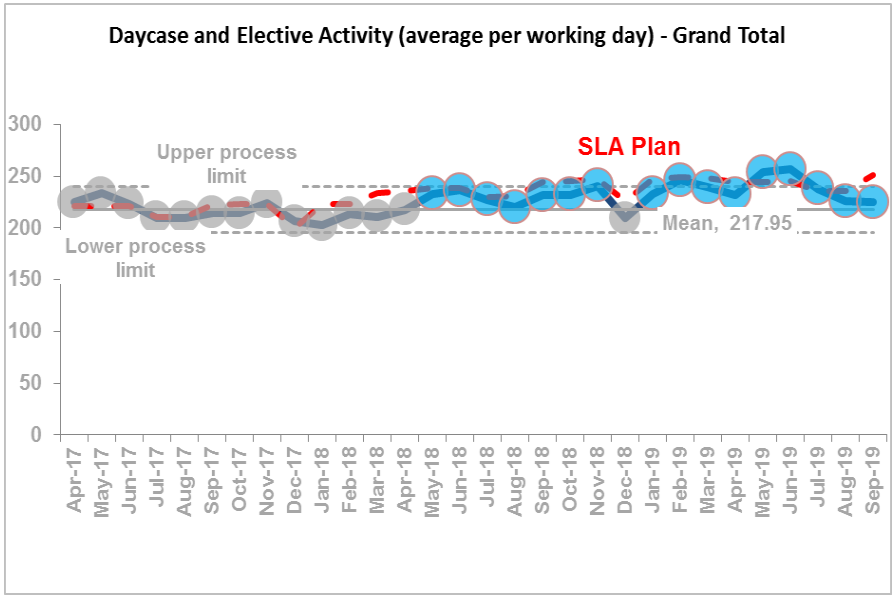


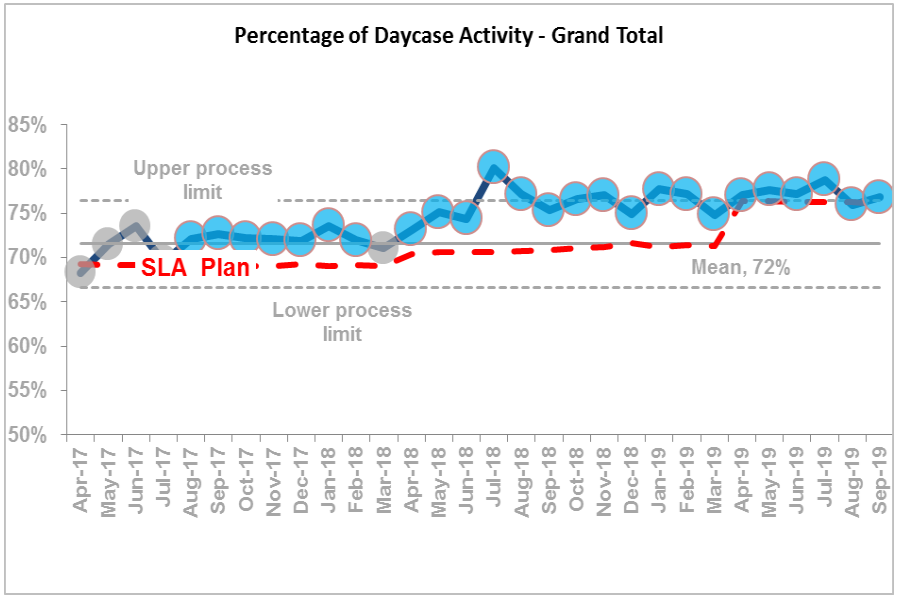




Number of Elective and Daycase Patients treated per Working Day

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





What the information tells us

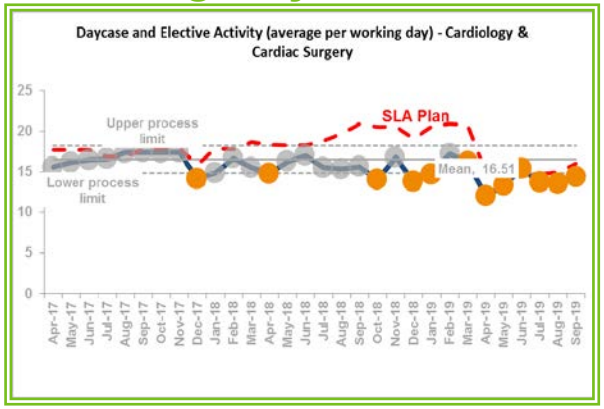
- Activity data for elective treatments remain above the mean and year to date activity is on target with SLA plan. Although the month of September is showing below the plan line there will be an element of data catch up and the activity numbers are likely to increase once coding is complete.
- Neurology, Urology and Plastic Surgery are all performing above their means.
- Cardiology & Cardiac Surgery, General Surgery specialties are showing special cause variation as these specialties are below their lower process limits. Trauma and Orthopaedics have shown variability in recent months and have been below the lower confidence limit for the past three months.
- Ear Nose and Throat have been consistently below their mean for the past eight months
- All of the other specialties are within their expected process limits.
- The percentage of daycase activity is currently above the mean line at Trust level with a number of specialties above their target line. Both Oncology and Plastic Surgery are above the upper control limit. General Surgery have returned to within normal limits.

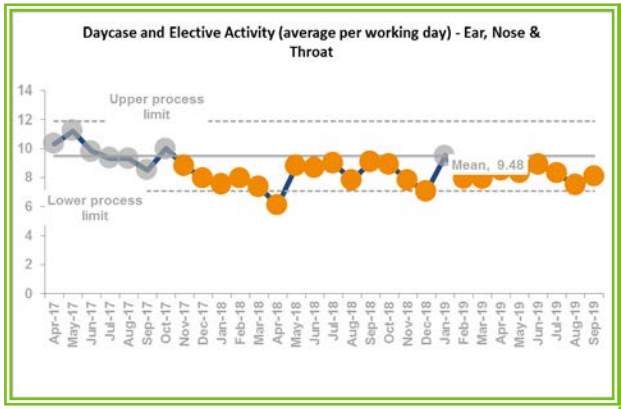
Actions and Quality Improvement Projects

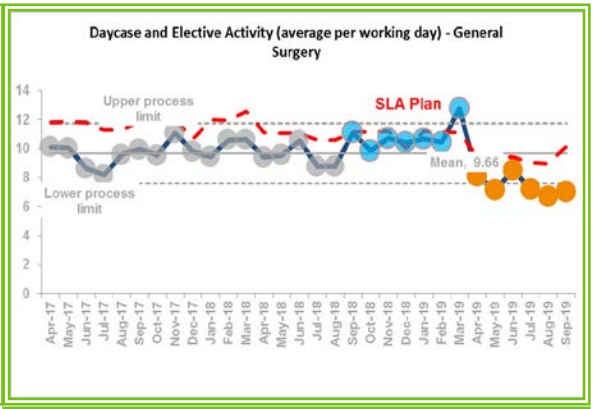
- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions. This is linked to a weekly task and finish group.
- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases and utilisation.
- SNTC Division finance has completed service specific one pagers in conjunction to identify actions required to support SLA achievement.

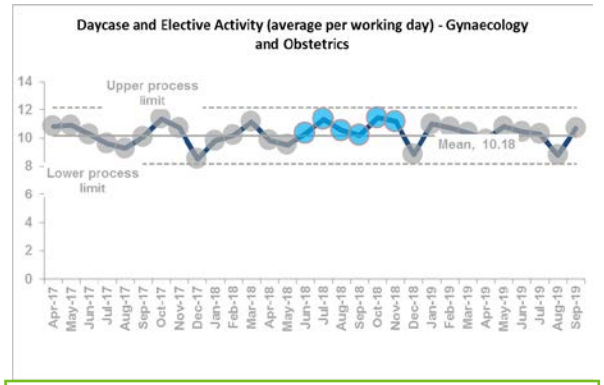
Number of Elective and Daycase Patients treated per Working Day

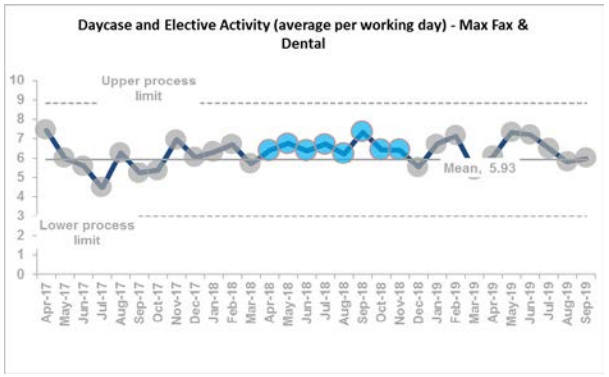
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

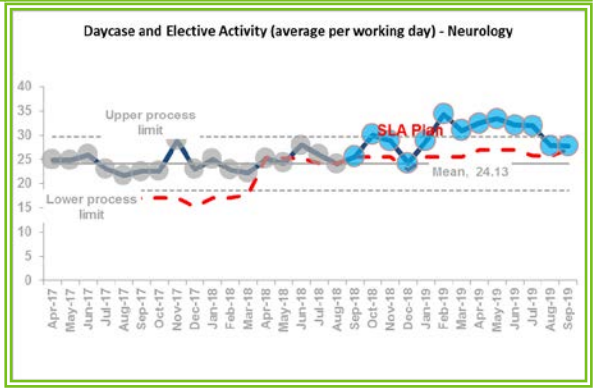


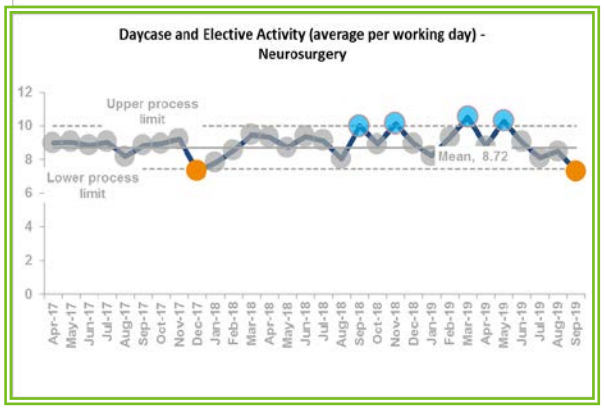


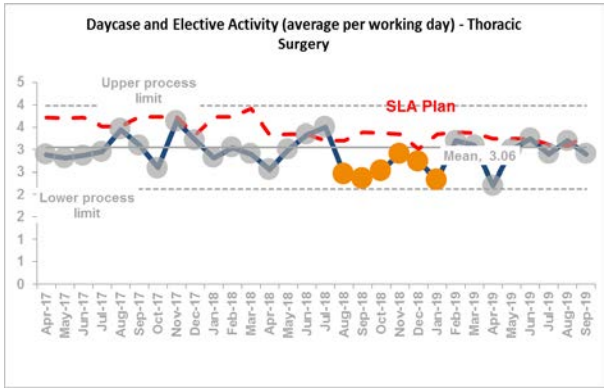


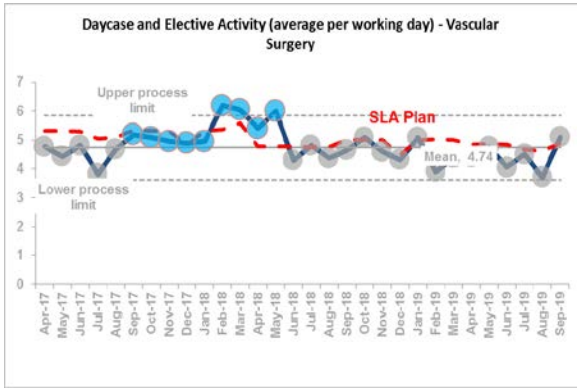








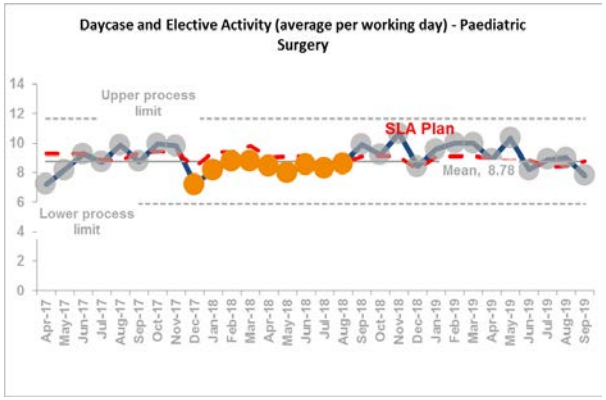


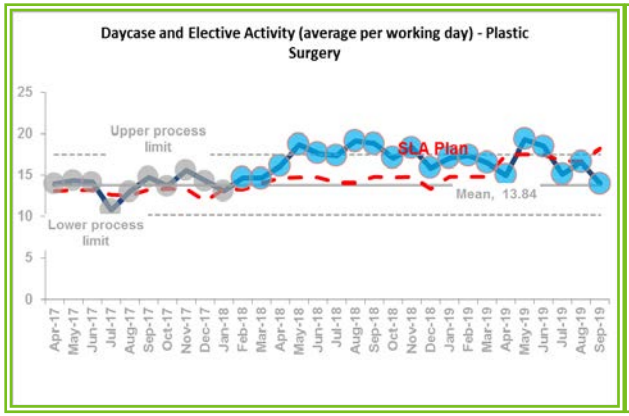


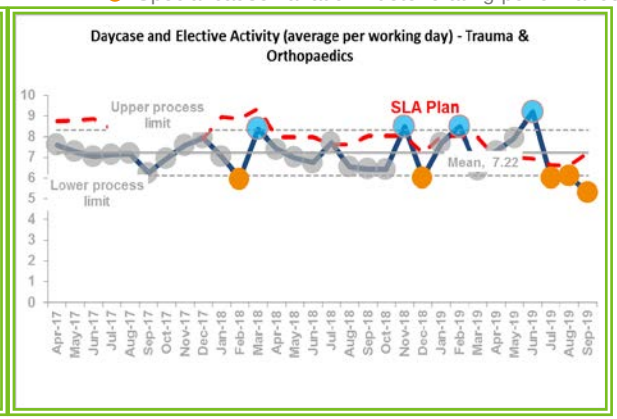
Our Finance & Productivity Perspective

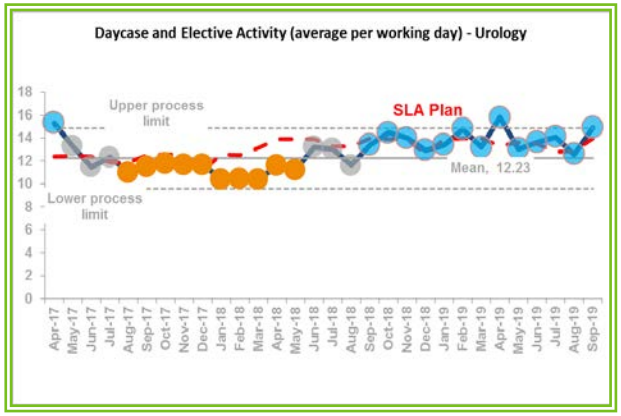
Number of Elective and Daycase Patients treated per Working Day

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





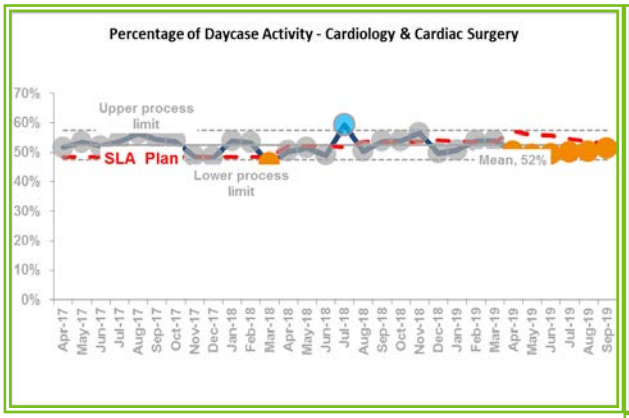


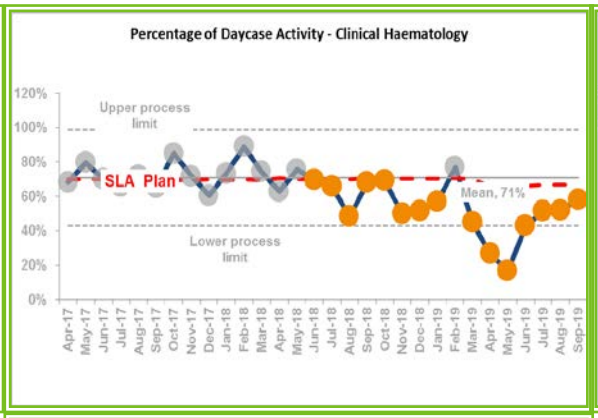


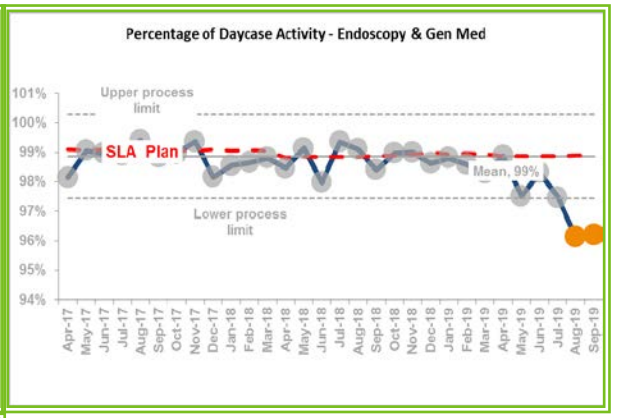
Our Finance & Productivity Perspective

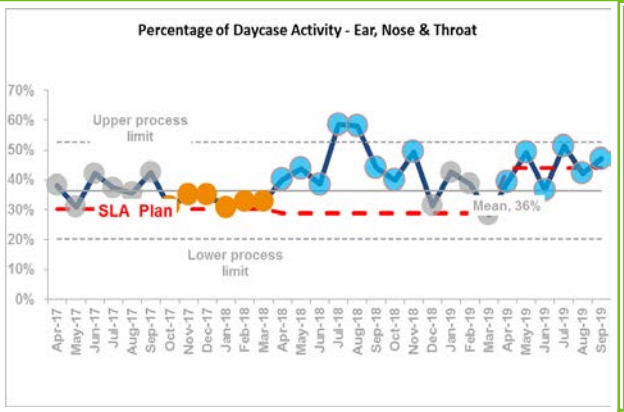
Percentage of daycase activity

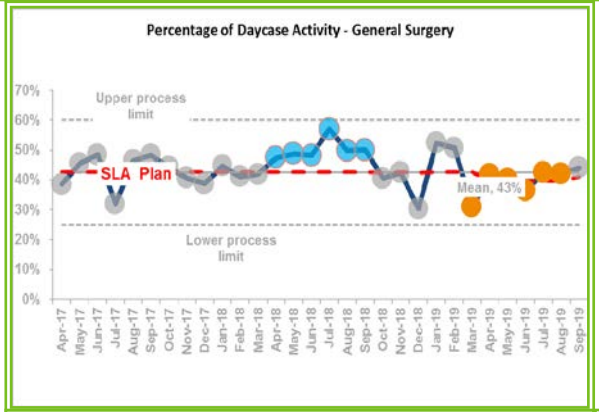
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

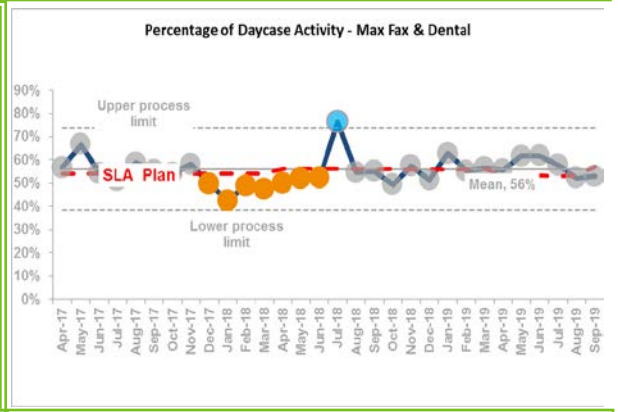


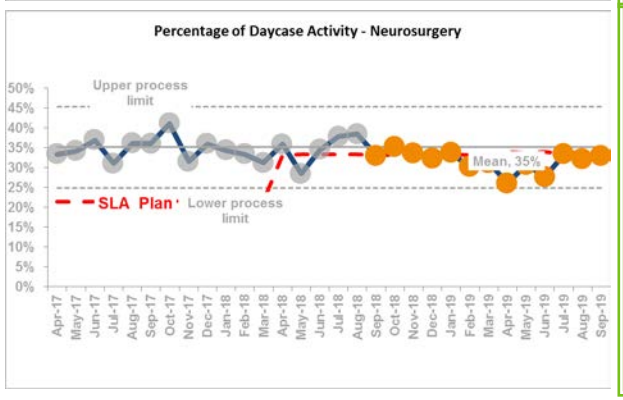


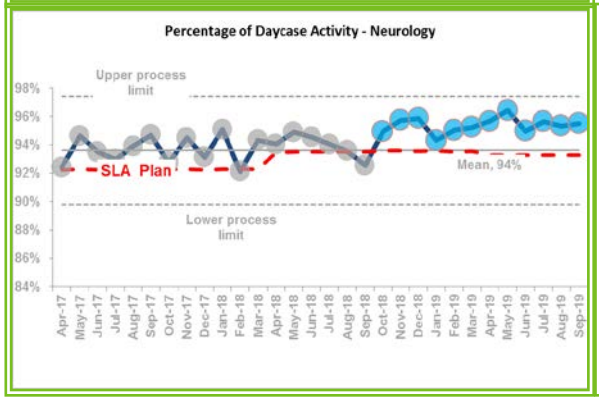


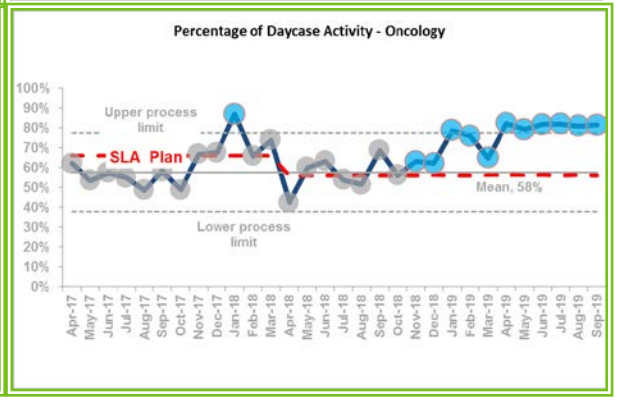






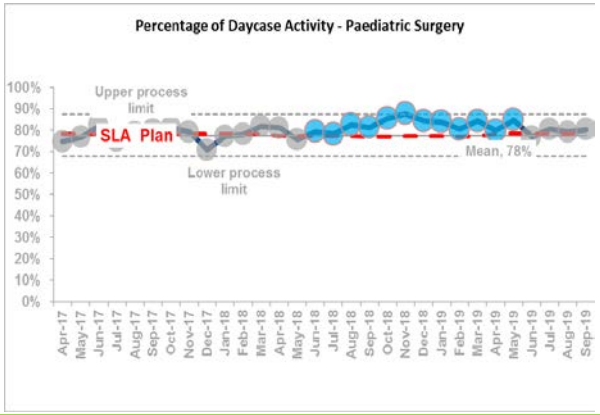


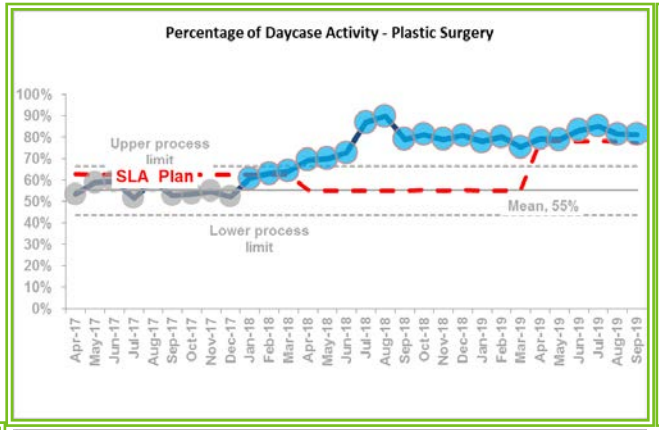


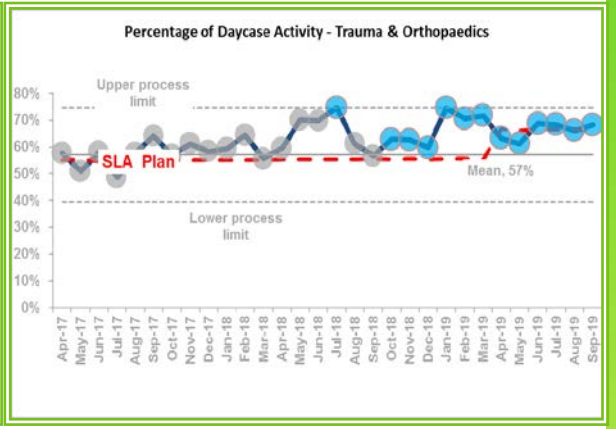


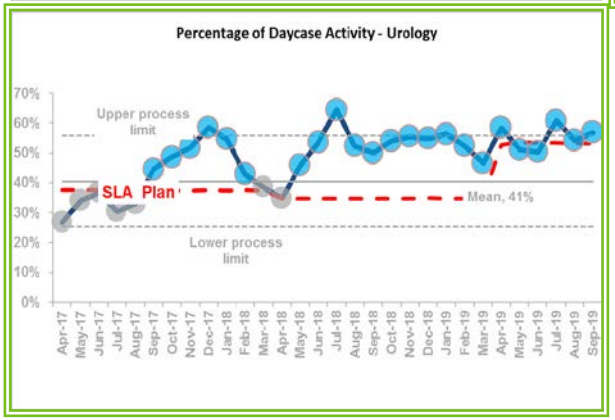
Percentage of daycase activity

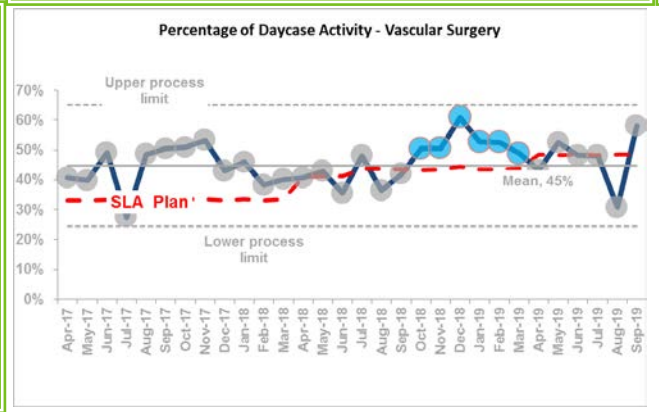
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



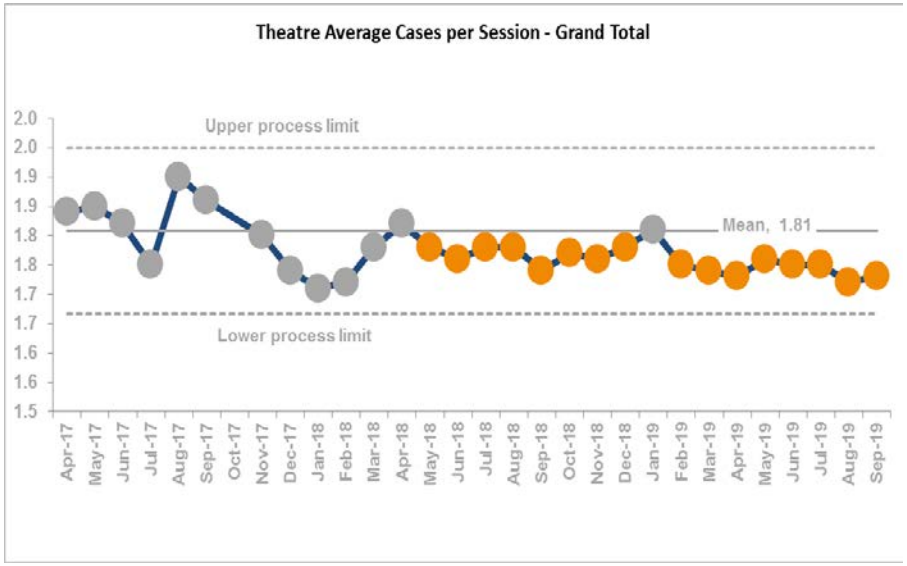


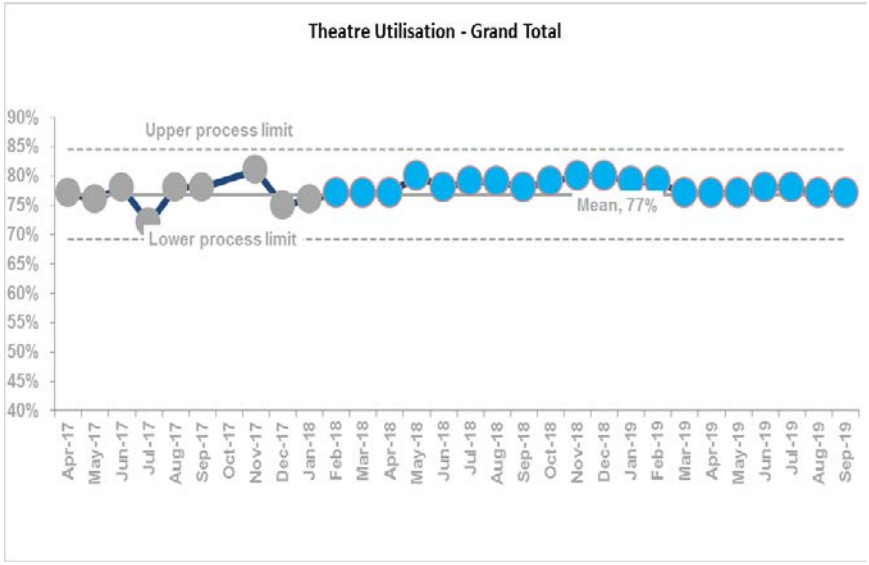






Theatre Productivity





What the information tells us

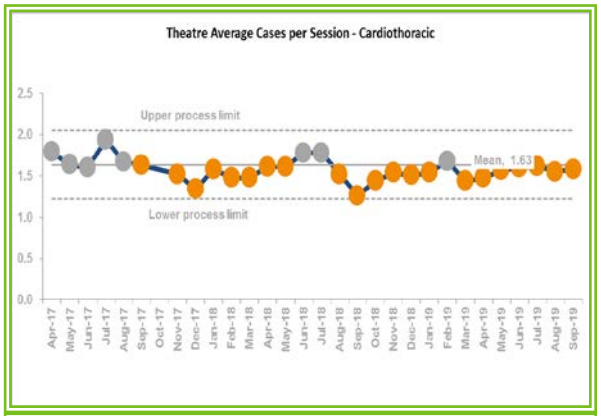
- The Trust's Cases per Session remains within its normal process limits however for the past eight months, it has been consistently below its mean and below the same period last year.
- Ear, Nose & Throat have continued to increased throughput in the month of September staying above the mean, with Vascular Surgery also seeing an increase in the number of cases per session for the past four months but remaining within the control limits. Paediatric Surgery have seen a significant increase in the number of cases per session in September and are above the upper control limit.
- Neurosurgery and General Surgery has fallen below its lower control since the beginning of this calendar year showing special cause variation. 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. Ear, Nose and Throat Services return to performance above the upper control limit.

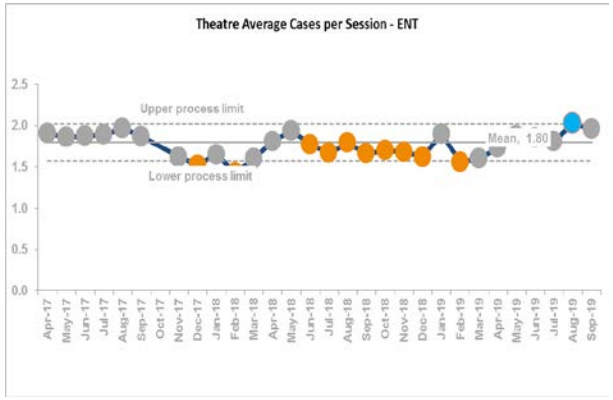
Actions and Quality Improvement Projects

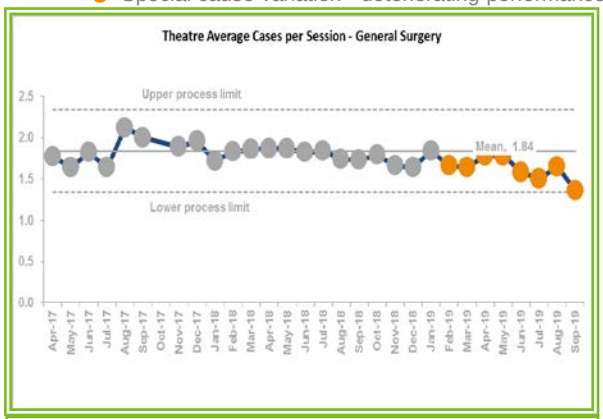
- The Theatre Improvement Programme has been re-launched reviewing at the entire admissions pathway, with a focus on patient and staff experience. The change management process is being led by staff in theatres and booking teams.
- The POA Steering Group is in place and looking to centralise IP and DSU areas into one area to make it an easy as possible for our patients to be assessed for surgery, and make the best use of our resources
- A new scheduling tool called 'INSIGHT will be launched 28 October, the tool will provide consultant specific data, to support with better list compilation to ensure we are efficiently using theatre resource along with the ability to schedule lists at 95-105%.
- Trend analysis of Hospital-Led cancellations, Late starts, Overruns and Underruns to identify of common themes.

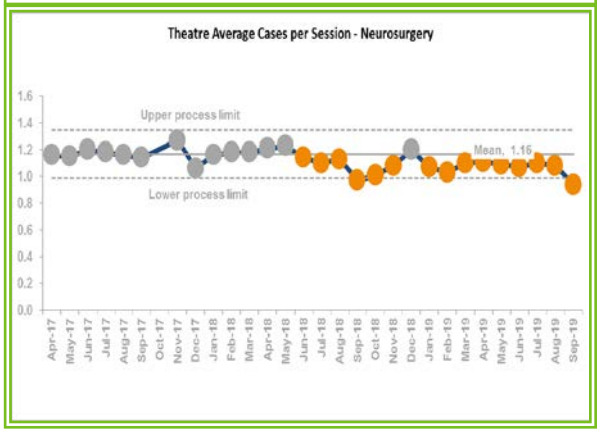
Theatre productivity – Cases per Session

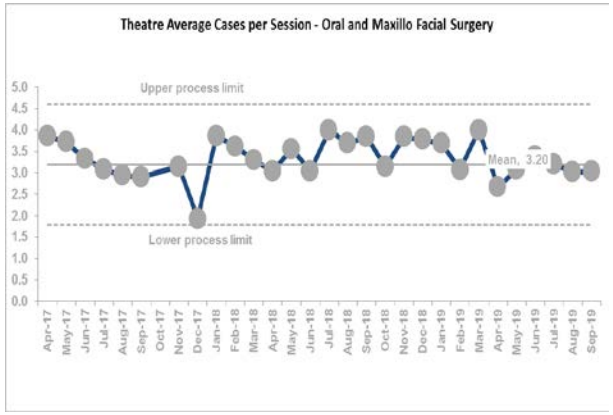
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

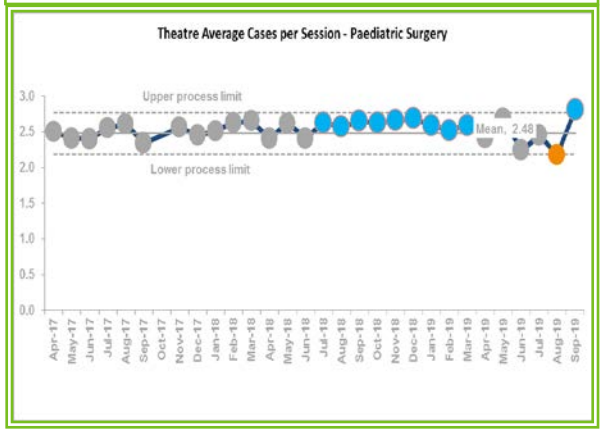


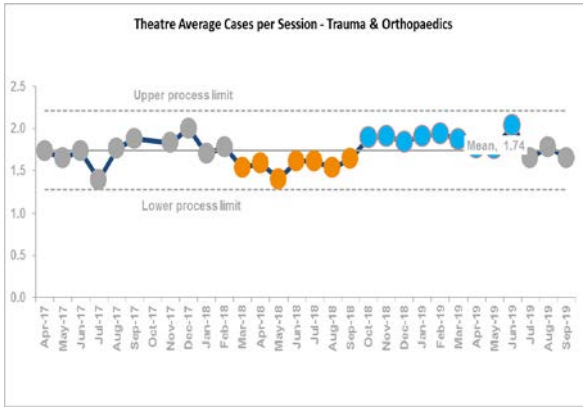


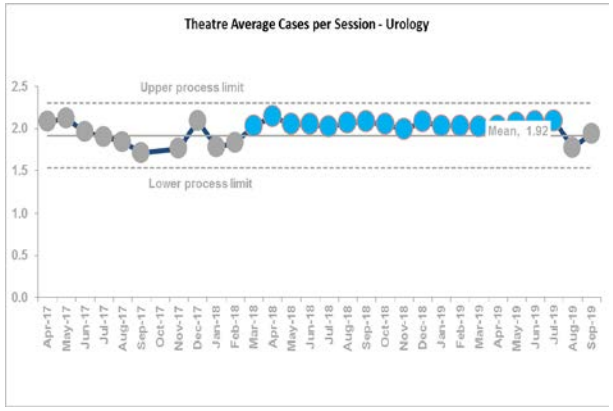


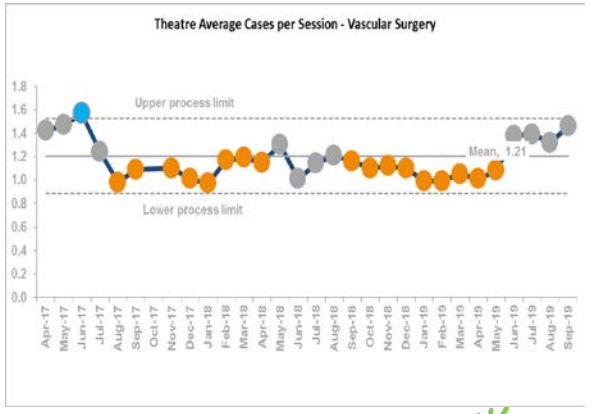






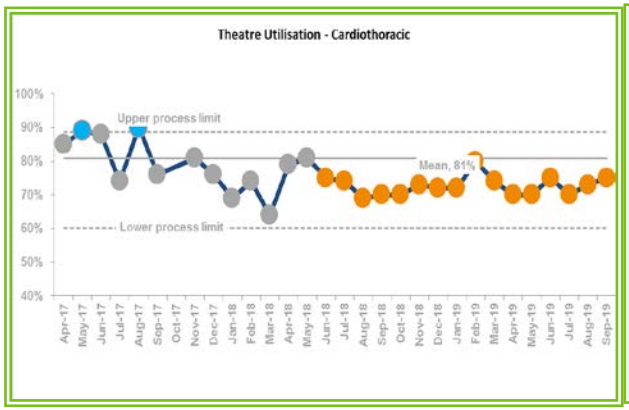


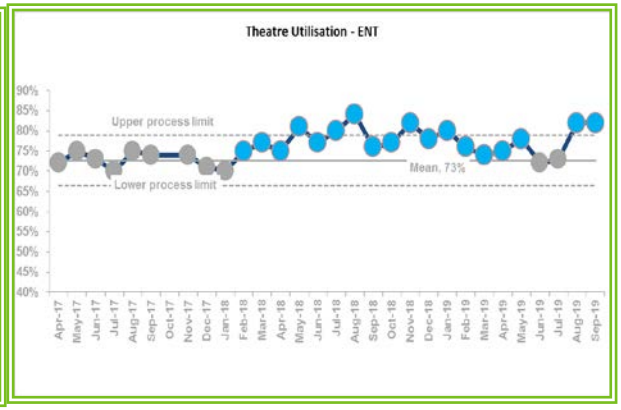


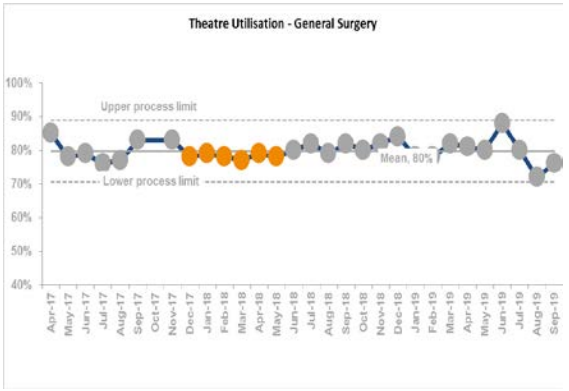


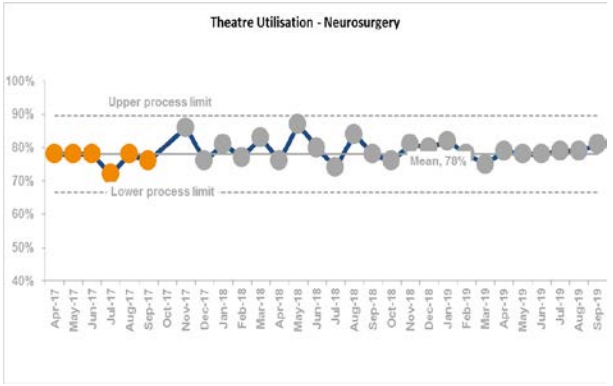
Theatre productivity – Utilisation

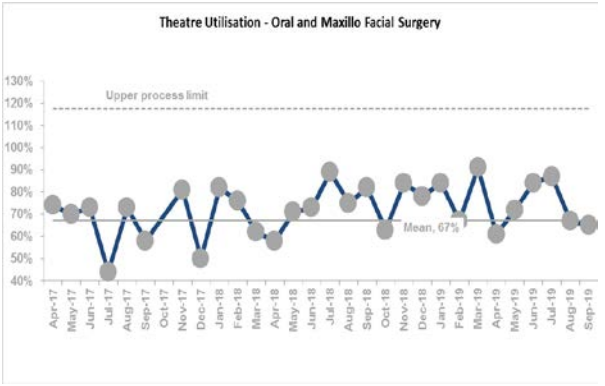
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

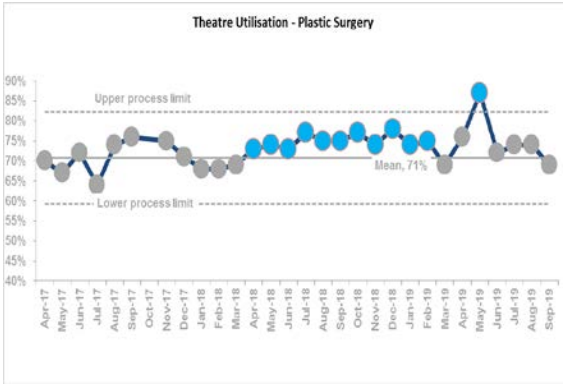


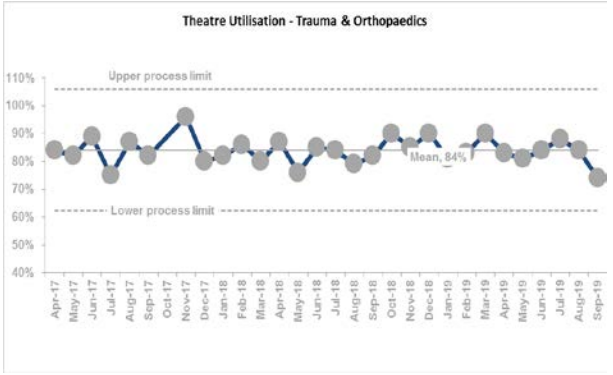


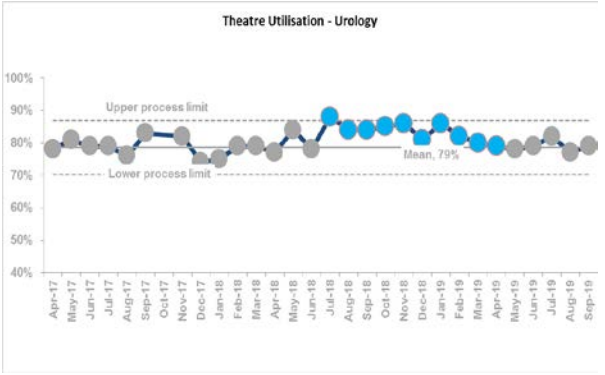


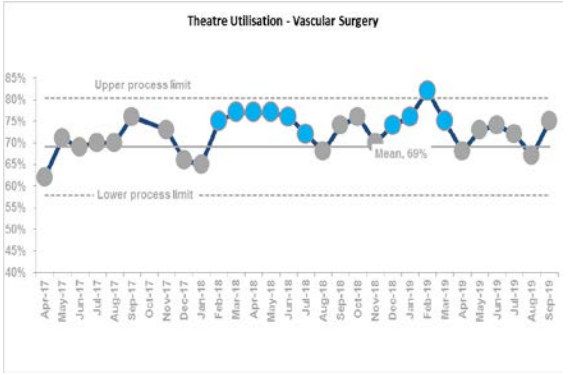




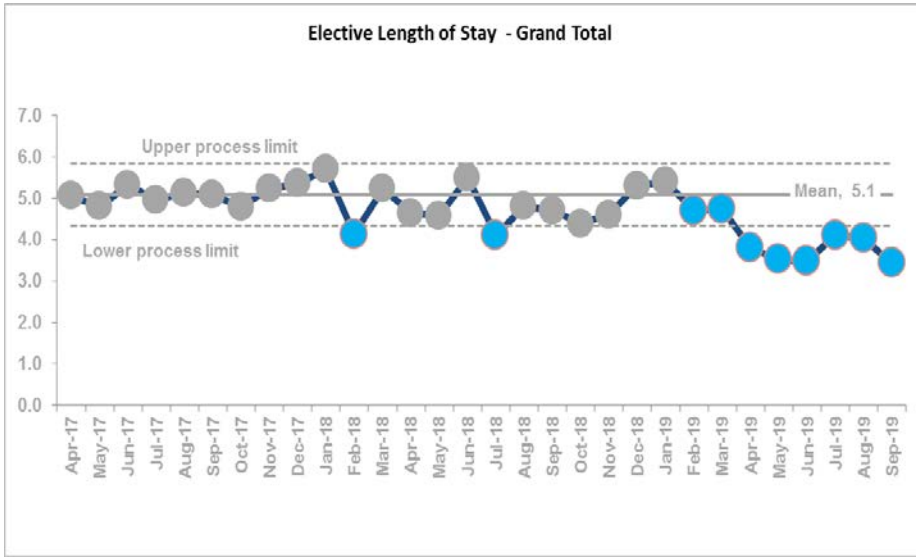


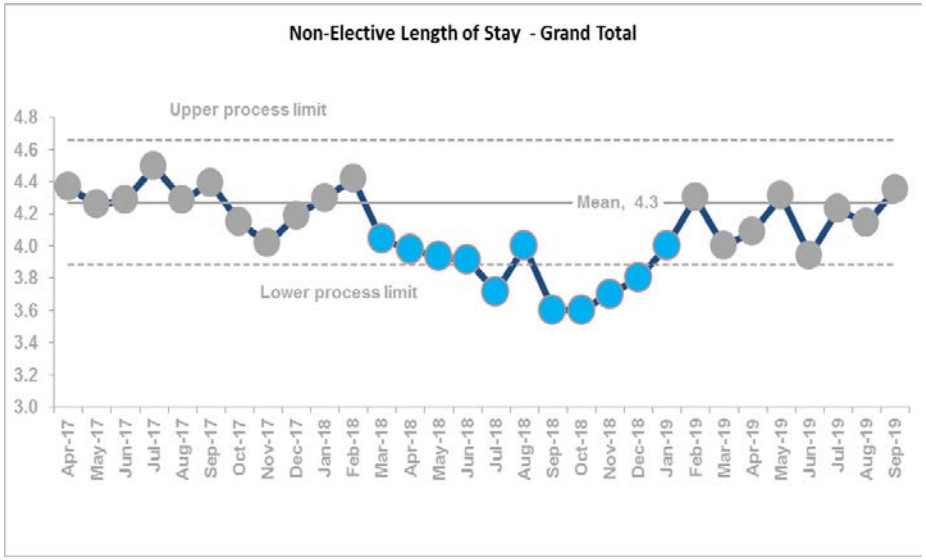






Length of Stay





What the information tells us

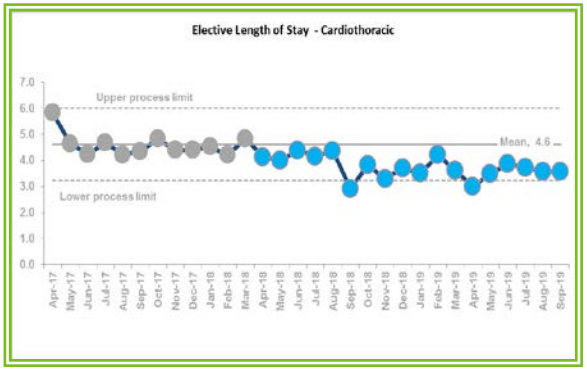
- The Trust's Elective overall elective length of stay is below its lower limit since February this year and has been consistently below its mean for the past six months showing a sustainable improvement.
- Cardiothoracic Length of Stay remains consistently below its mean
- Surgery and Trauma have reduced their length of stay month on month consistently over several months and is at its lower process limit.
- The Trust's Non-Elective length of stay is within the expected process limits.
- Acute Medicine's Non-Elective length of stay has increased above the upper control limit showing special cause variation.
- Specialist Medicine Non-Elective length of stay remains within its process limits, however it is still showing a length of stay above the mean.
- Cardiothoracic Non-Elective length of stay remain within expected control limits however showing significant variability compared to the same period last year.
- All other directorates' variation are due to common cause

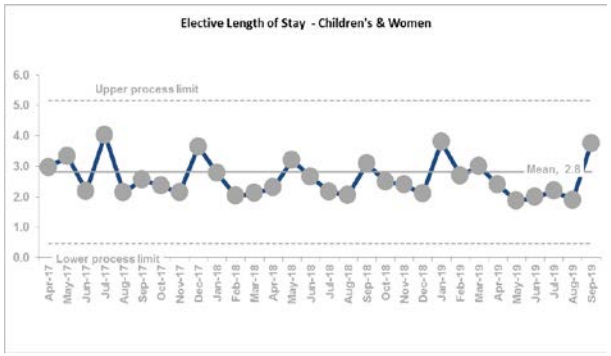
Actions and Quality Improvement Projects

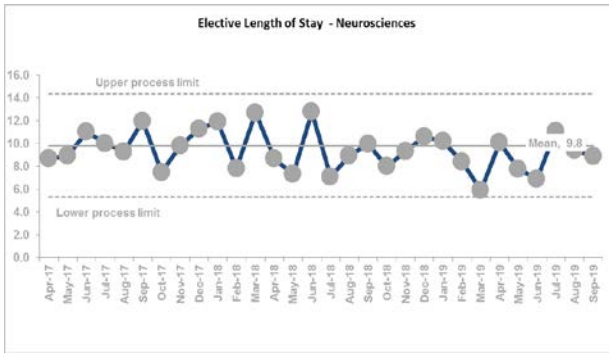
- The Emergency Department and Inpatient Clinical teams have identified a range of patient experience, quality and productivity opportunities to evolve the processes embedded within iClip and this needs to be the immediate priority.
- Support Ward teams to deliver SAFER consistently.
- A return to a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

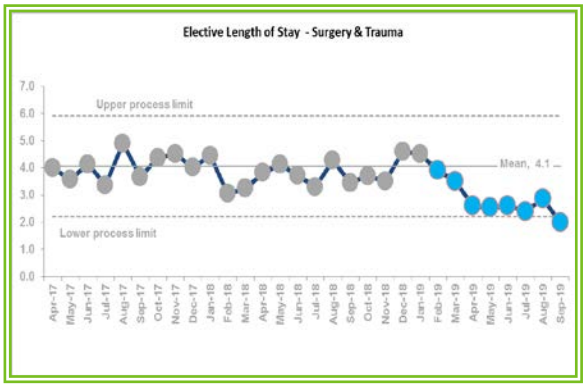
Elective Length of Stay (excluding daycase)

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



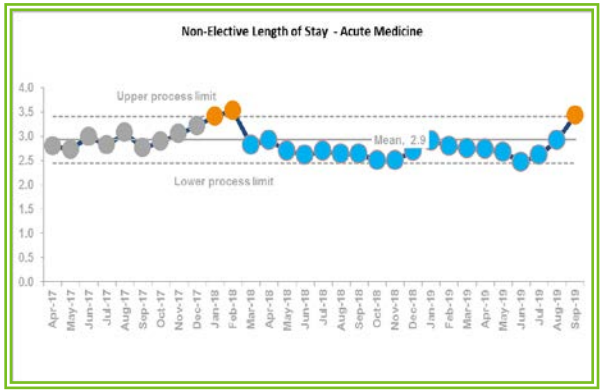


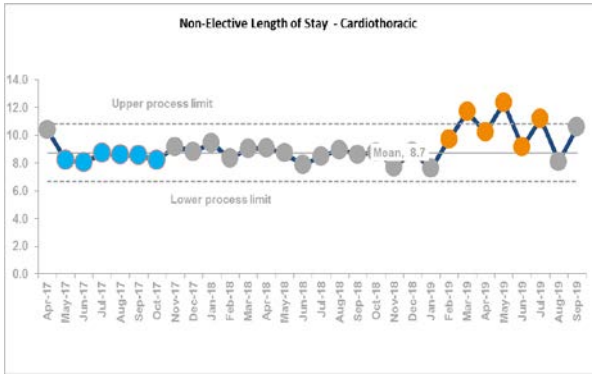


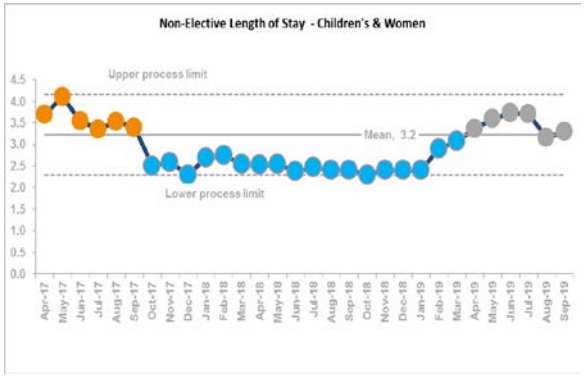


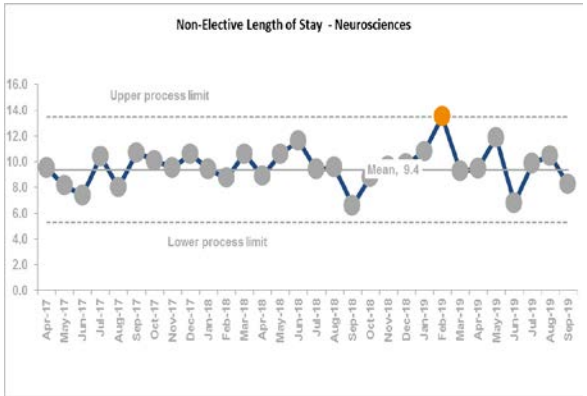
Non Elective Length of Stay

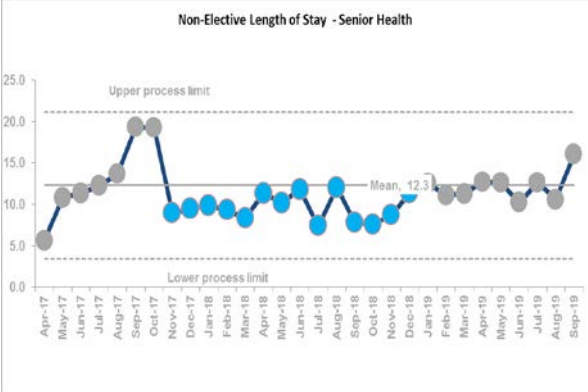
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

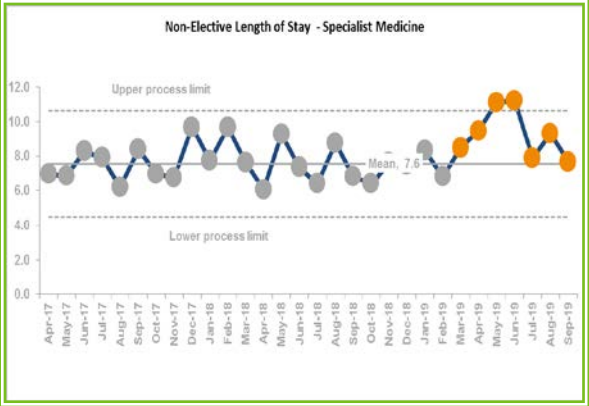


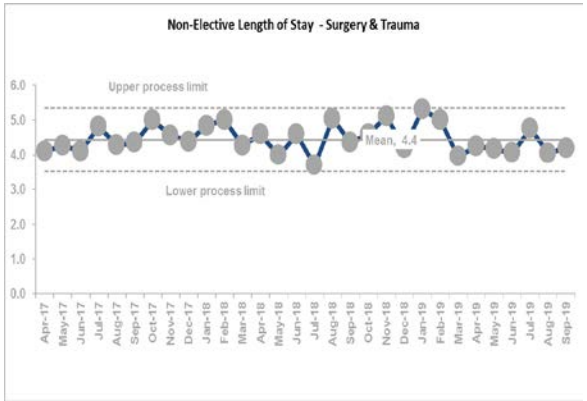


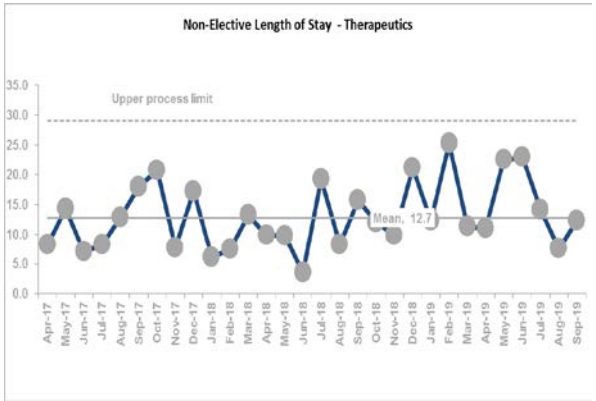










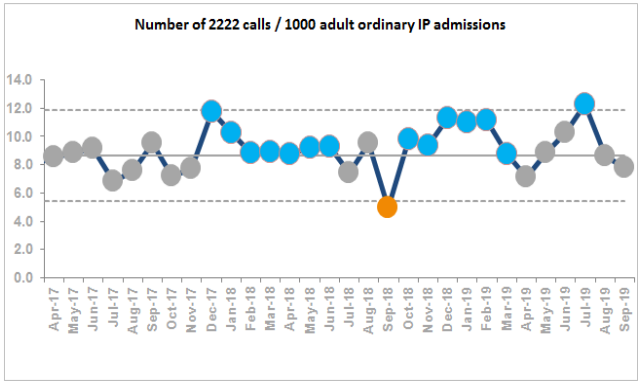


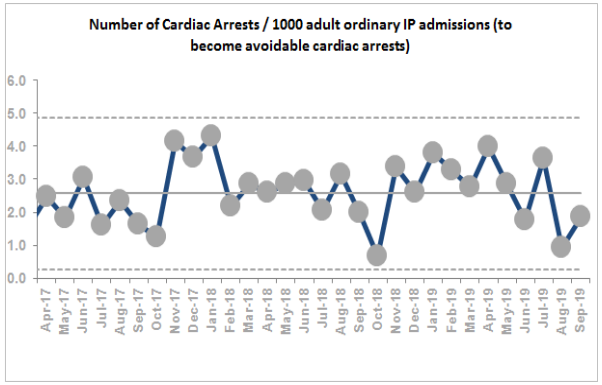
Balance Scorecard

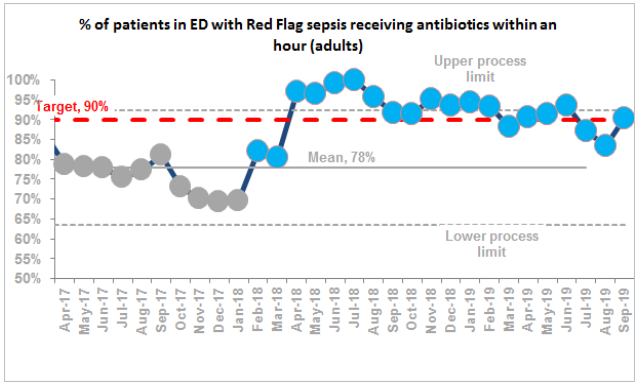
OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment A	
OUR **PEOPLE** PERSPECTIVE	Workforce			Agency Use		

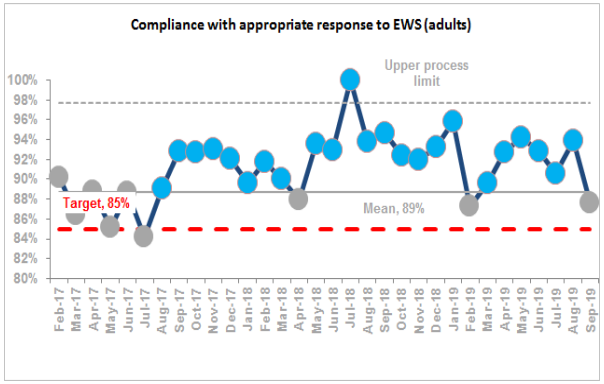
Our Patient Perspective

Quality Priorities – Treatment Escalation Plan









What the information tells us

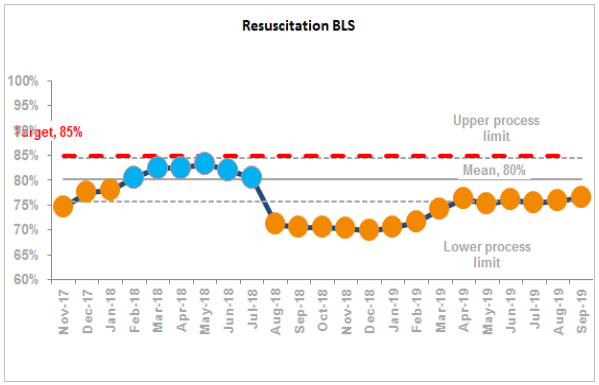
- The rate of 2222 calls and number of Cardiac Arrests remains within control limits
- The Trust has recovered its position of treating at least 90% of adult patients in ED with Red Flag Sepsis receiving antibiotics within an hour
- Compliance with appropriate response to EWS saw a dip in performance however still within target

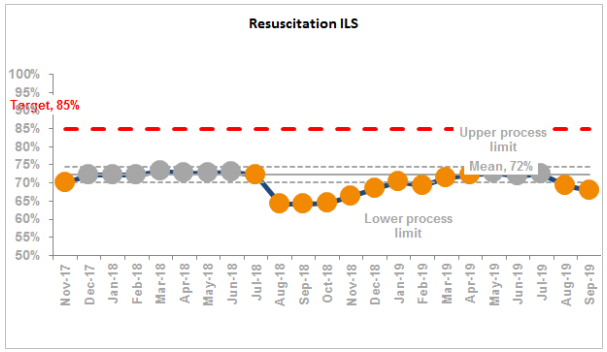
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

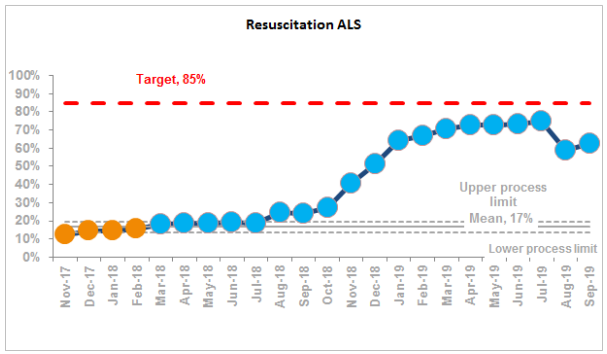
Actions and Quality Improvement Projects

- The emergency department (ED) team are continuing to work with the FLOW programme to decongest ED in order to sustain sepsis performance
- Information Technology (IT) is working towards Treatment Escalation Plans 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.

Quality Priorities – Deteriorating Patients







What the information tells us

- Additional training capacity for ILS and BLS (Intermediate and Basic Life Support) in place.
- ALS (Advanced Life Support) training performance is also benefitting from additional training capacity as outlined above
- Performance has held despite junior doctor turnover and nurse recruitment drive.

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

Actions and Quality Improvement Projects

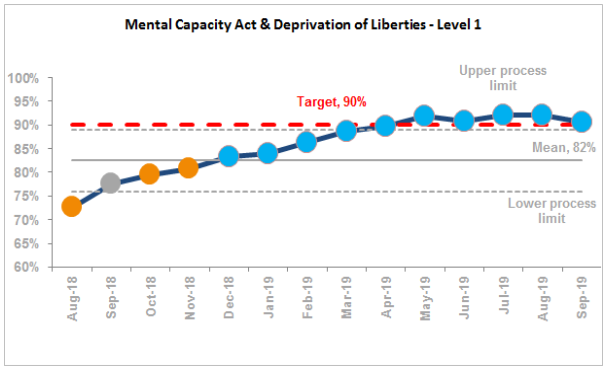
Deteriorating Patients

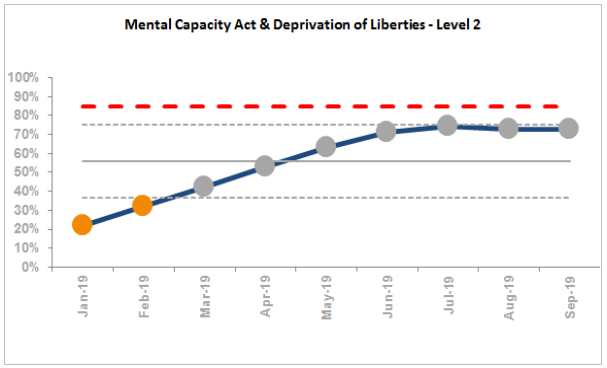
- Improved divisional engagement with Deteriorating Adults Group from nursing with responsibility for driving improvements across the Trust
- Developing management level and monthly audit data with IT for NEWS2 in iCLIP in readiness for electronic audit facility anticipated by end of Q3
- Critical Care Outreach team recruitment commenced with a view to service starting from Q3
- Revised trajectories for delivery under development

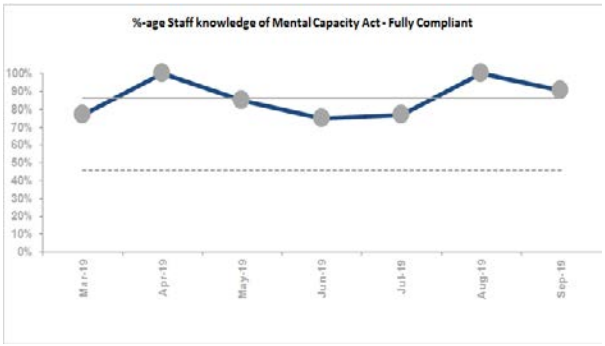
Resuscitation

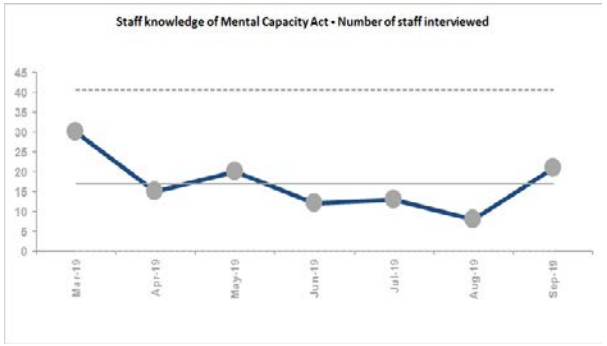
- Additional champions recruited to deliver training
- eILS (electronic ILS which is a blended approach of online and face to face training) has been introduced; a half day course which reduces DNA rate and creates capacity for additional BLS sessions
- Consultant only BLS session - blended approach to learning; video, then face-to-face session, 30 minutes duration.

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









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 sustained performance
- New metrics taken from the ward accreditation system shows the number of staff interviewed and their level of knowledge. Of the 20 staff interviewed in September over 90% could fully answer the question on MCA/DoLs.

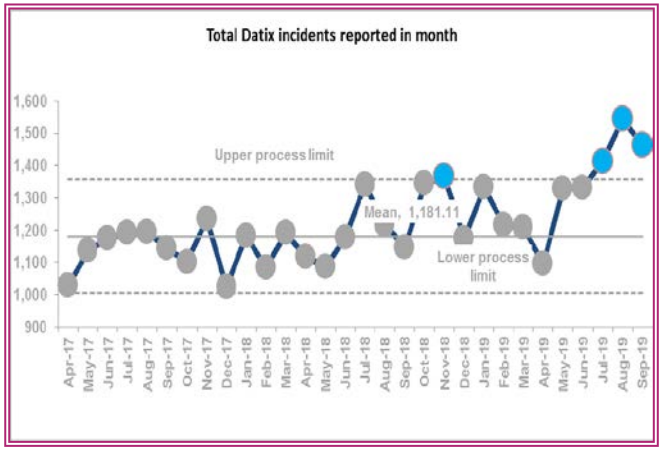
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

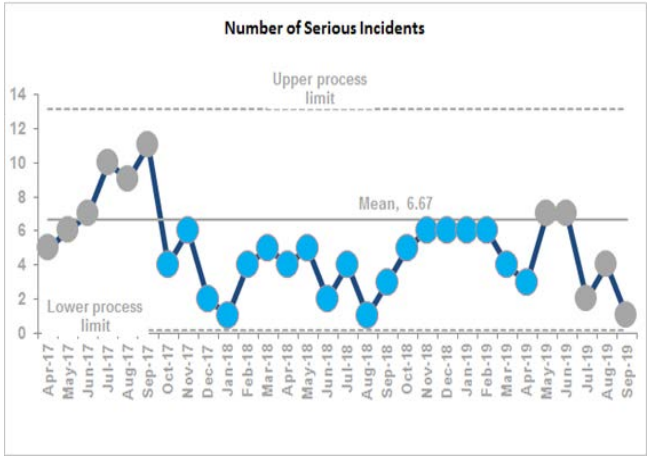
Actions and Quality Improvement Projects

- The Trust, along with SW London sector, has developed a draft standardised audit tool which is now under consultation. Taking a sector approach will enable to Trust to benchmark practice with similar Trusts and create a community of practice
- Electronic templates in iClip for documentation of MCA and Best Interests decisions are being reviewed for testing in Q3

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
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%	92.0%	100.0%	97.0%	data two months in arrears	
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	47%	64%	66%	78%	67%	62%	Compliance timeframe changed from 10 working days to 20 working days						





What the information tells us

- There continues to be no breaches of the 60 day time scale for SI investigations
- Improved performance maintained with performance above the upper process limits.

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

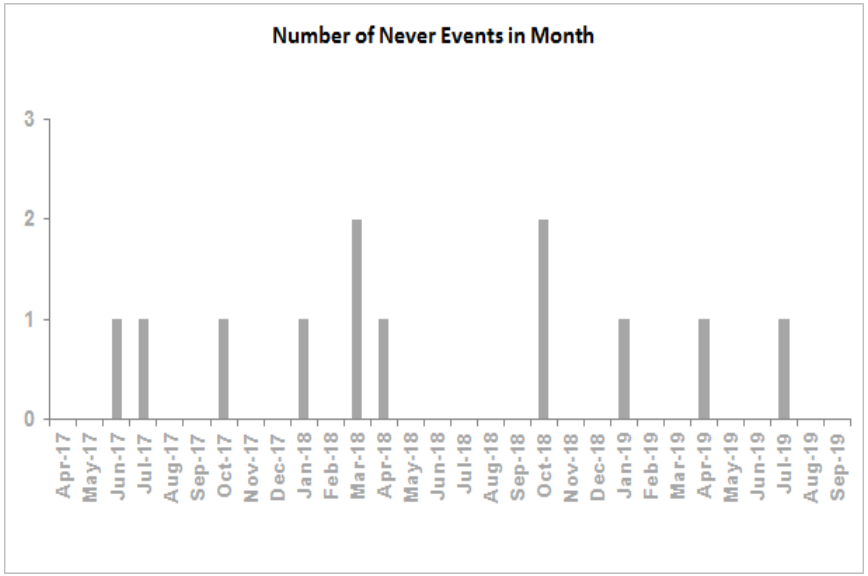
Actions and Quality Improvement Projects

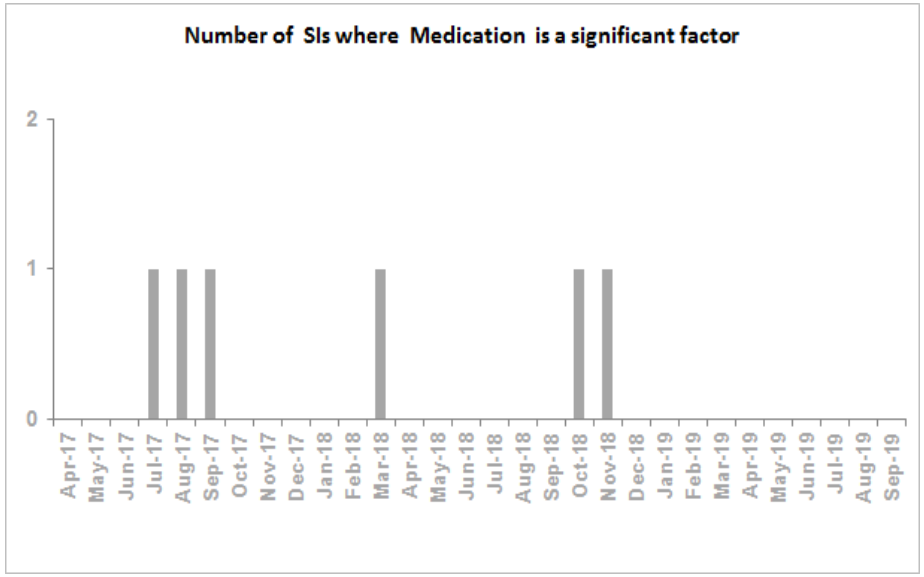
- Incidents – The number of Datix incidents will be reported by severity and per 1000 bed days from Q3 which will allow for benchmarking against other Trusts and tracking of the harm profile.

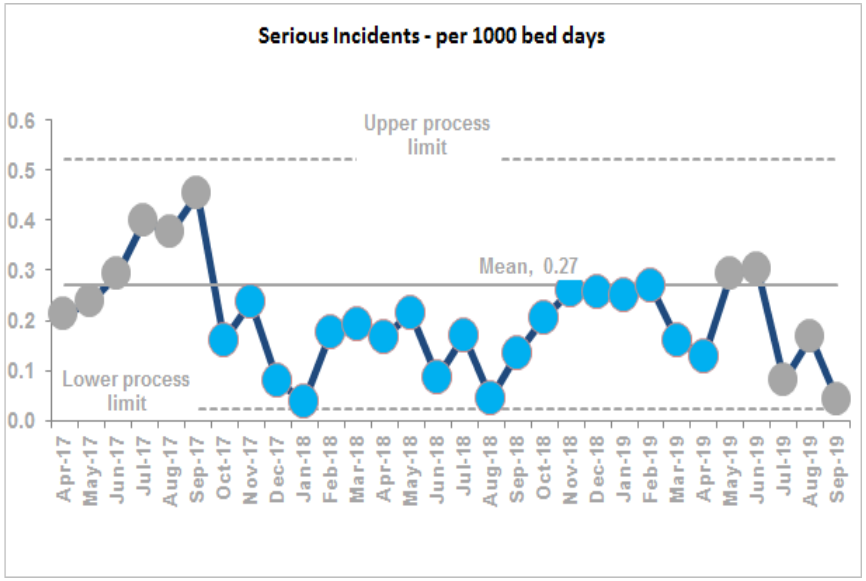
Our Patient Perspective

Quality Priorities – Learning from Incidents

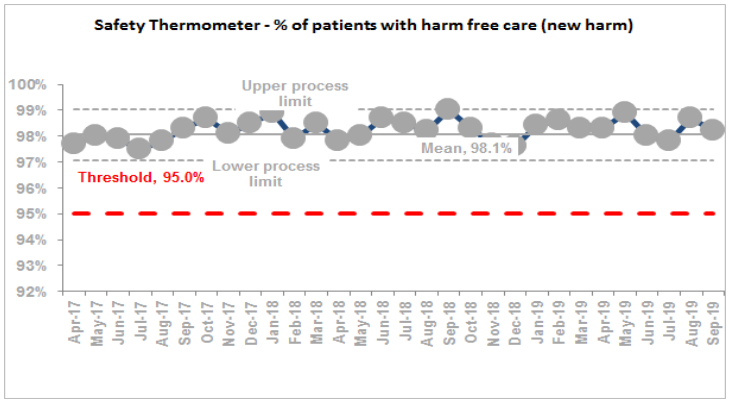
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

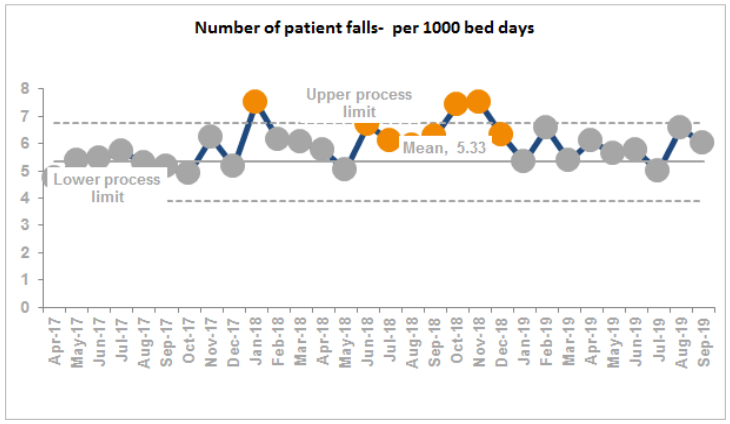


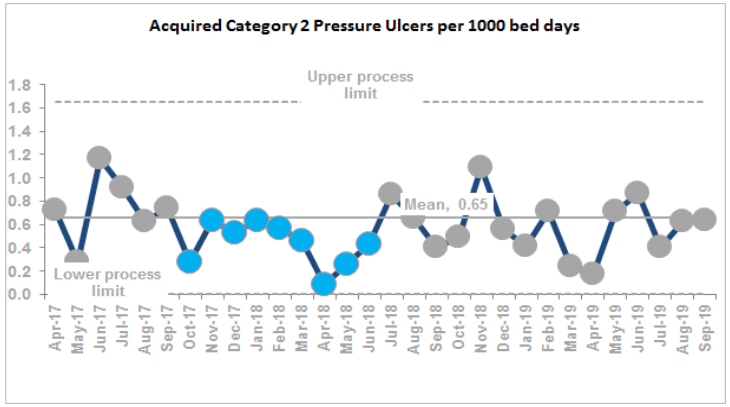




Patient Safety







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

What the information tells us

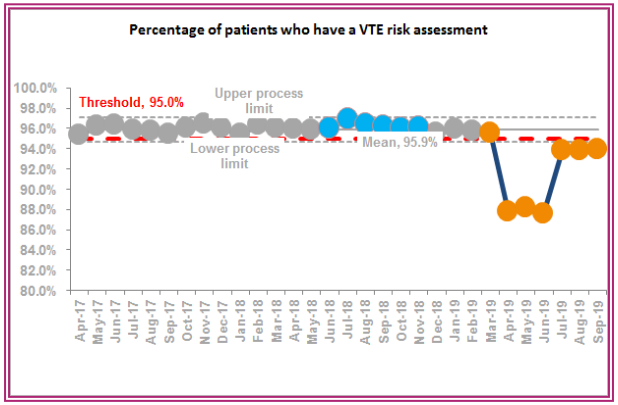
- There has been a step change in the percentage of patients with VTE assessments. This is due to a change in guidance and now includes areas such as maternity and CDU.
- All other metrics show variation due to common cause.

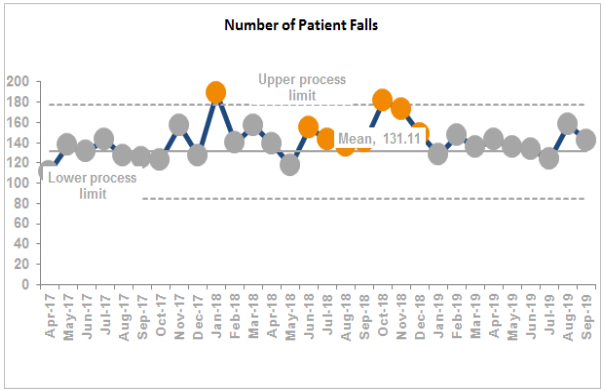
Actions and Quality Improvement Projects

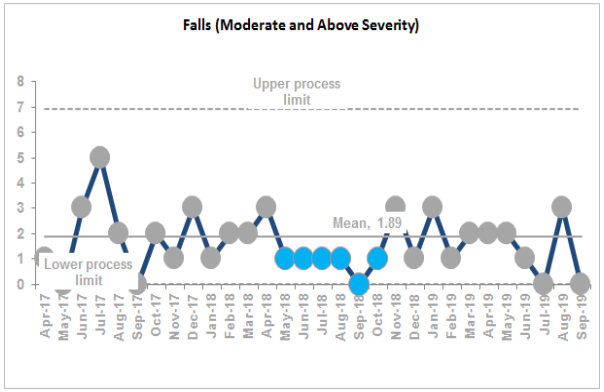
- The ward accreditation programme is fully embedded and there are no inpatient areas which require improvement
- The Trust is working to deliver the Falls CQUIN, specifically focussing on lying and standing for patients over 65 in line with NICE guidance.

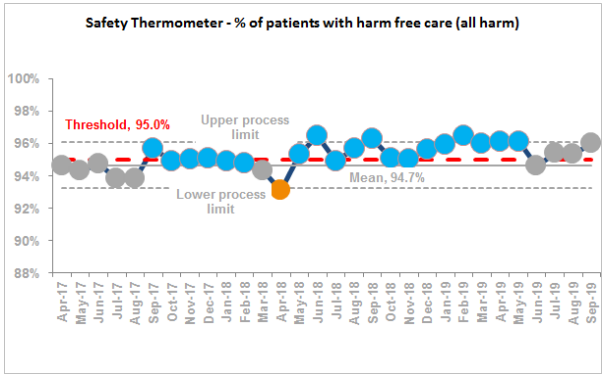
Patient Safety

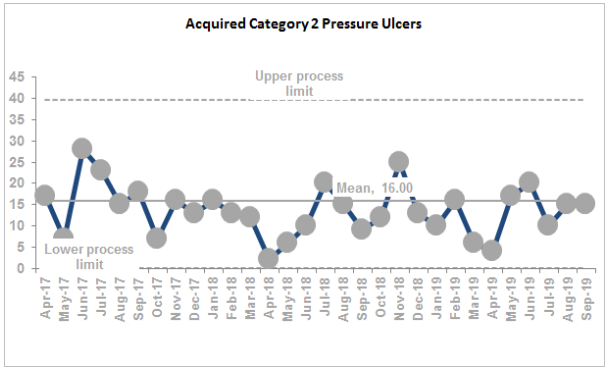
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

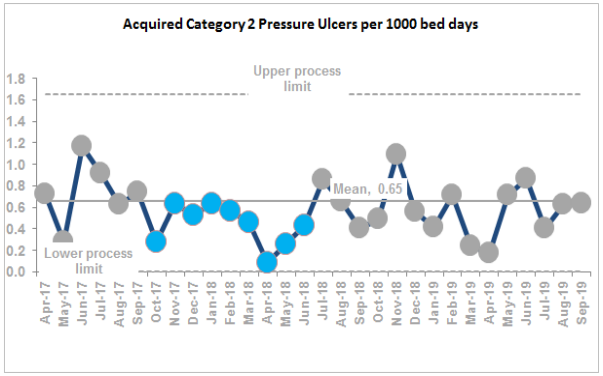


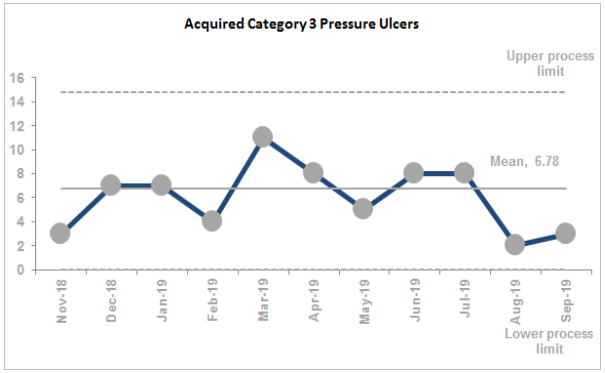


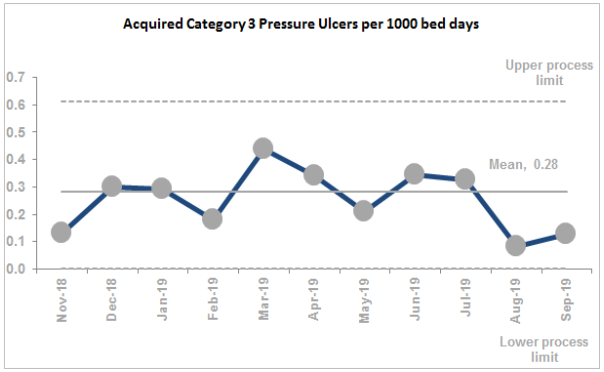












Our Patient Perspective

Infection Control

Indicator Description	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD Actual
MRSA Incidences (in month)	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Cdiff Hospital acquired infections	48	2	3	2	3	2	1	3	4	4	3	4	4	6	28
Cdiff Community Associated infections									0	0	2	0	1	0	
MSSA	25	1	4	2	5	3	2	2	4	6	1	0	3	2	16
E-Coli	60	4	2	4	3	1	4	6	4	7	5	7	7	8	38

What the information tells us

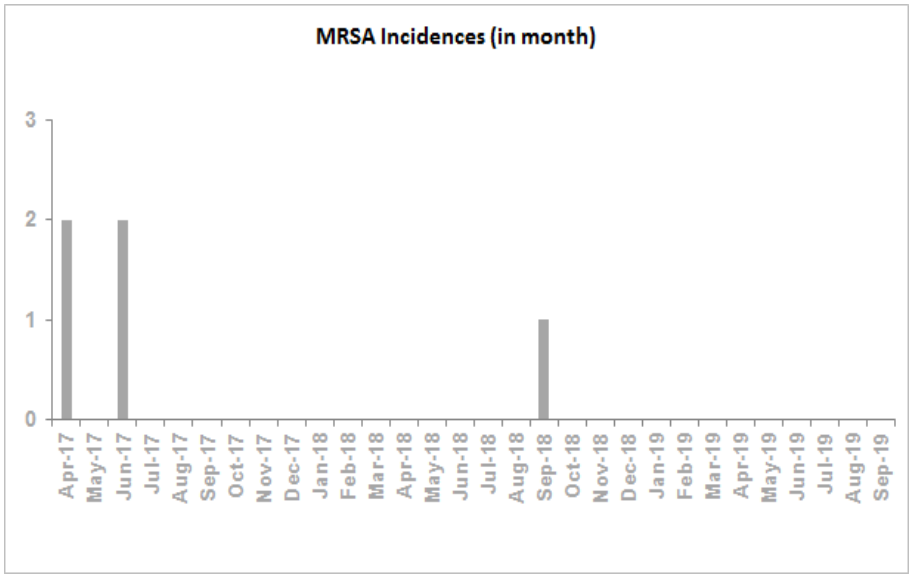
- The Trust MRSA position remains at zero year to date.
- This month saw the highest number of Cdiff incidents since April 19 and for the previous year. All incidents were Hospital Acquired. The Cdiff YTD position is 28 with 25 Hospital Acquired infections and 3 Community Associated infections. This will be monitored closely.
- The number of Ecoli cases reported remains within the control limits. There was 1 case of cross infection which was managed appropriately under infection control outbreak measures
- E-Coli rates show common variation, however the number of incidents have been steadily increasing in the last three quarters.
- MSSA infection rates show common cause variation.

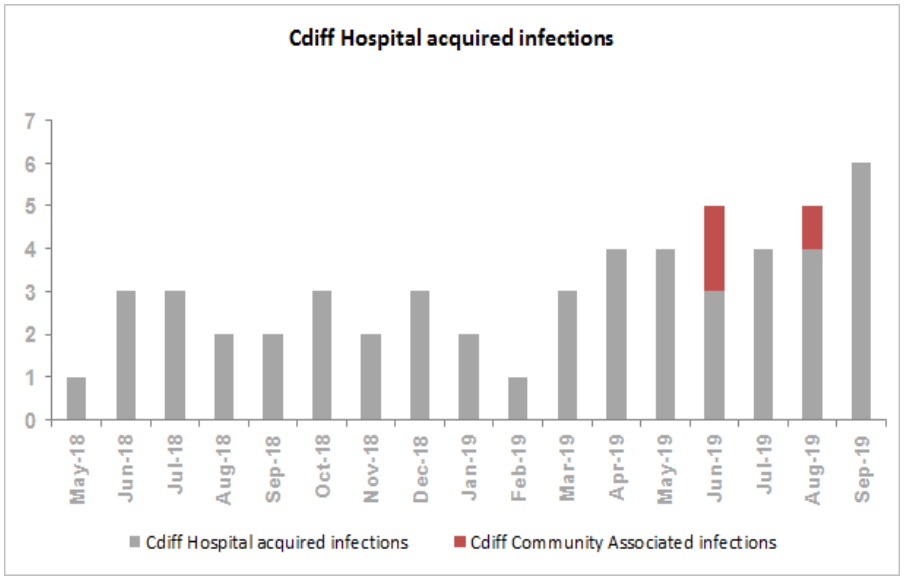
Actions and Quality Improvement Projects

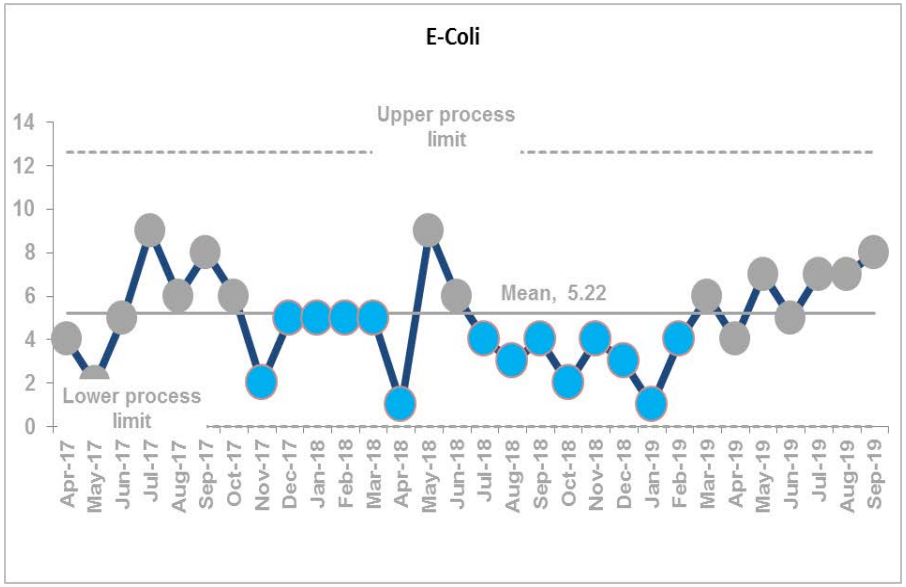
- All Cdiff cases have undergone a Root Cause Analysis (RCA)
- All MSSA cases are now to undertake a RCA to establish any causes and opportunities for learning and change in practice, and is reported through the infection control committee
- A project group has been established across SWL STP to reduce the number of E-Coli infections. The first area of priority is catheter associated infections, however St Georges numbers are lower than peers in SWL.

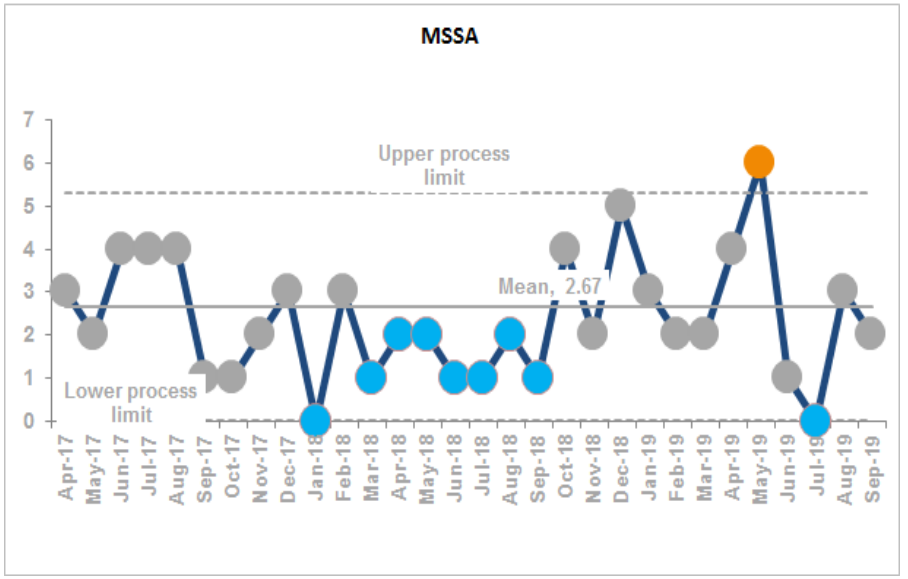
Infection Control

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









Our Patient Perspective

Mortality and Readmissions

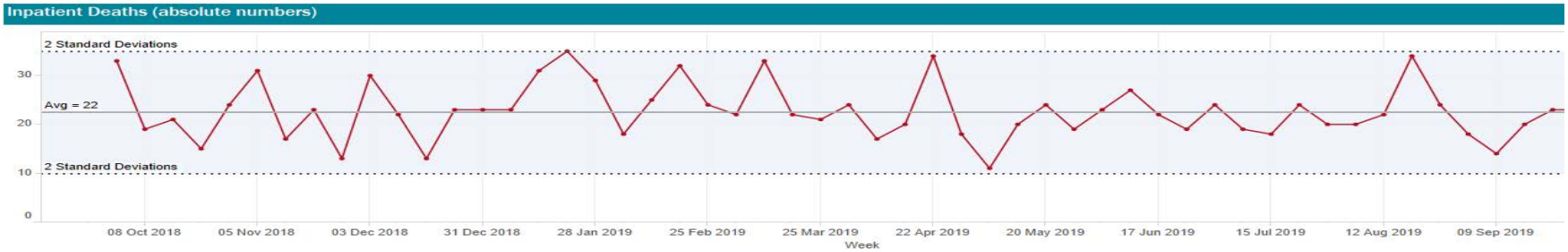
Indicator Description	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Jun 2018 to May 2019
Hospital Standardised Mortality Ratio (HSMR)	86.7	79.5	69.8	80.3	73.0	64.2	76.9	74.5	77.6	78.1	79.4	79.4	91.9	82.3
Hospital Standardised Mortality Ratio Weekend Emergency	78.2	97.6	79.5	72.2	62.7	82.4	113.3	79.1	74.6	85.2	82.9	82.9	91.3	86.7
Hospital Standardised Mortality Ratio Weekday Emergency	87.1	82.5	67.6	78.1	68.4	60.1	64.9	78.2	79.4	74.1	76.3	76.3	91.5	80.1

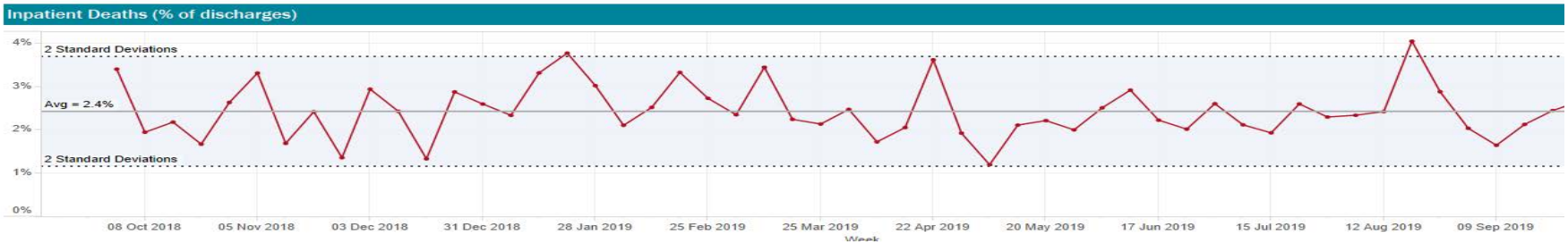
Indicator Description	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Summary Hospital Mortality Indicator (SHMI)	0.82	0.82	0.82	0.82	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.81	0.81
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	8.20%	8.20%	7.00%	8.90%	8.30%	7.60%	8.20%	7.20%	8.20%	7.90%	8.00%	7.00%	8.30%

Please note SHMI data is based on a rolling 12 month period (published Aug 2019). No update from Dr Foster at time of report publication. HSMR data reflective of period June 2018 – May 2019 based on a monthly published position (published Aug 2019).

What the information tells us

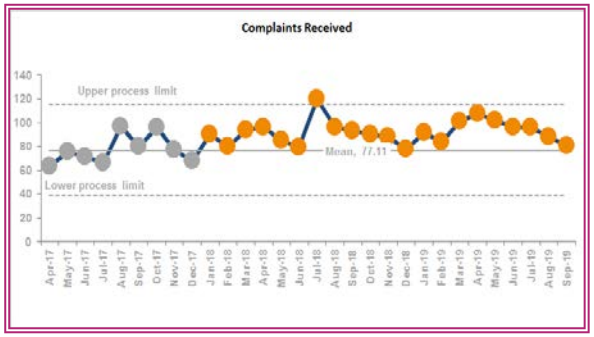
Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns and deaths as a percentage of discharges has increased above standard variation. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over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

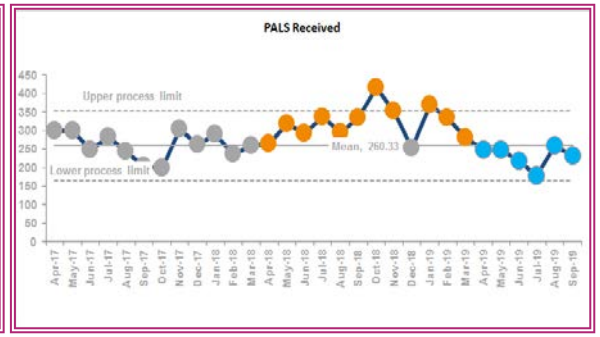


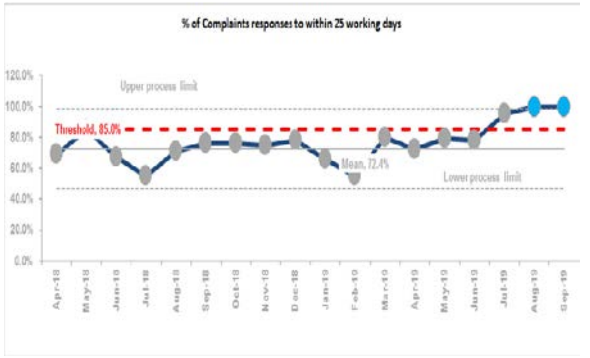


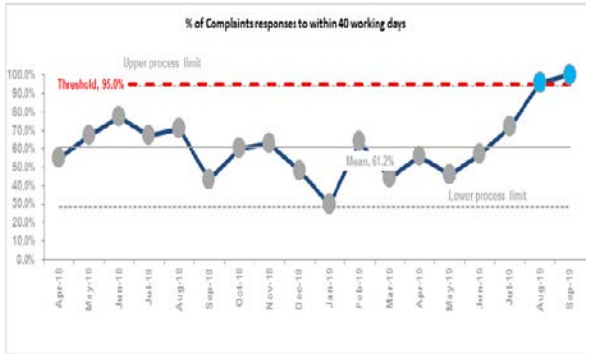
Complaints

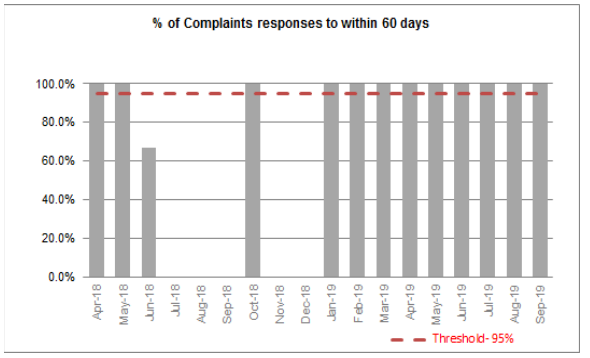
Indicator Description	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
% of Complaints responses to within 25 working days	85%	76%	76%	75%	78%	66%	55%	80%	72%	79%	78%	95%	100%	100%
% of Complaints responses to within 40 working days	95%	43%	60%	63%	48%	30%	64%	44%	56%	46%	57%	72%	96%	100%
% of Complaints responses to within 60 working days	95%	None Due	100%	None Due	None Due	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0		0	0	0	0	0	0	1	0	0	0	0	0











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

What the information tells us

- The number of complaints received is consistently above the 2017/18 average
- Response compliance for 25 working day complaints has reached 100%
- Response compliance for 40 working day has reached 100%
- Response compliance for 60 working day complaints continues to deliver against the performance target

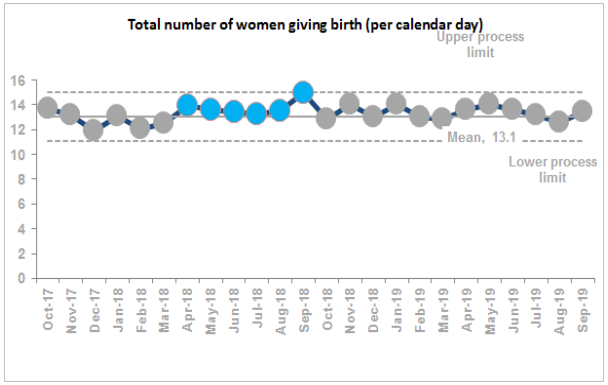
Actions and Quality Improvement Projects

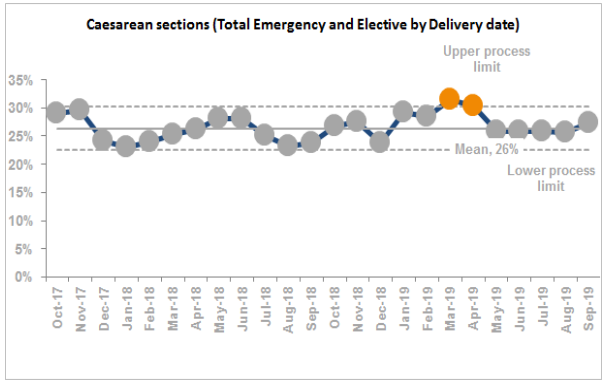
The daily complaints comcell led by the Chief Nurse continues.

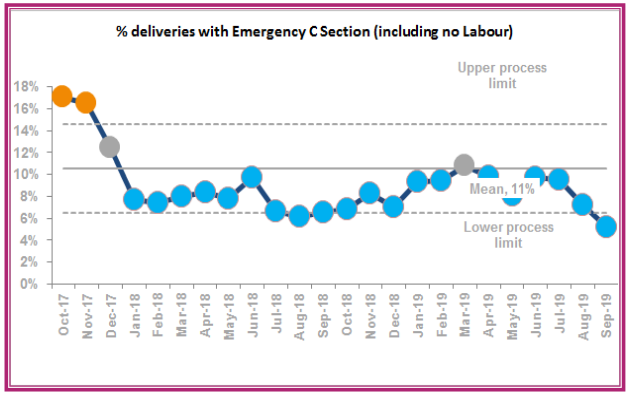
The change in process has had a positive impact on complaints performance with measures showing a continued improvement

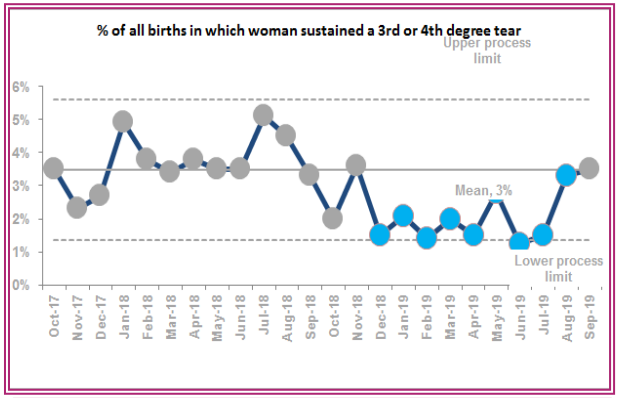
Maternity

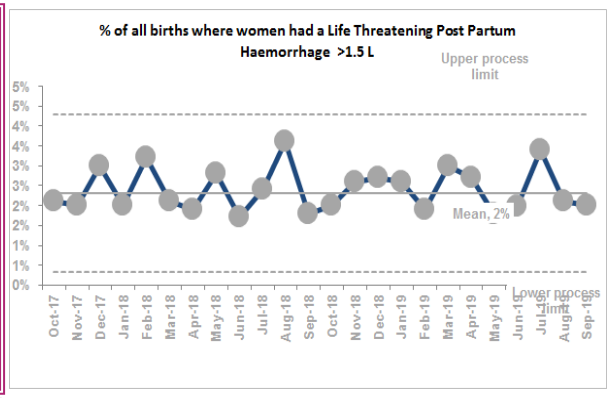
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

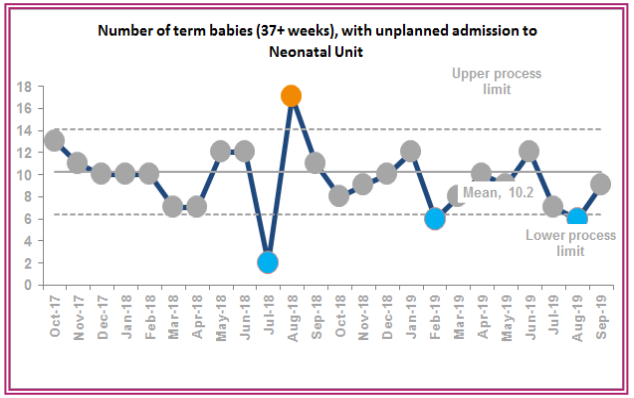


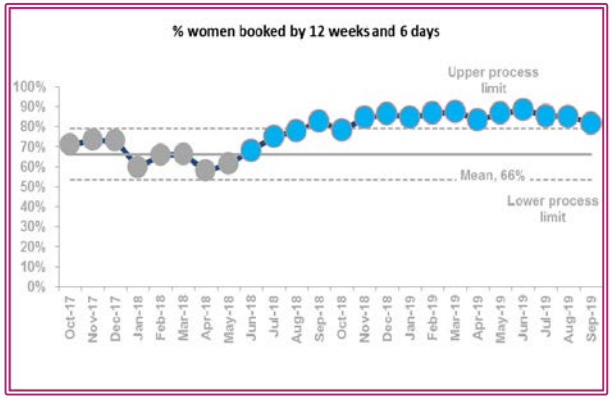












Our Patient Perspective

Maternity

Definitions	Format	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Total number of women giving birth (per calendar day)	Number	14 per day	15	13	14	13	14	13	13	14	14	14	13	13	13
Caesarean sections (Total Emergency and Elective by Delivery date)	%	<28%	23.8%	26.8%	27.5%	23.7%	29.2%	28.5%	31.4%	30.4%	25.9%	25.9%	25.9%	25.6%	27.4%
% deliveries with Emergency C Section (including no Labour)	%	<8%	6.5%	6.8%	8.3%	7.0%	9.3%	9.4%	10.8%	9.8%	8.1%	9.7%	9.5%	7.2%	5.2%
% Time Carmen Suite closed	%	0%			0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%	6.7%	0.0%	4.8%	1.7%
% of all births in which woman sustained a 3rd or 4th degree tear	%	<5%	3.3%	2.0%	3.6%	1.5%	2.1%	1.4%	2.0%	1.5%	2.8%	1.2%	1.5%	3.3%	3.5%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	%	<4%	1.8%	2.0%	2.6%	2.7%	2.6%	1.9%	3.0%	2.7%	1.8%	2.0%	3.4%	2.1%	2.0%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit	Number		11	8	9	10	12	6	8	10	9	12	7	6	9
Supernumerary Midwife in Labour Ward	%	>95%		95.2%	98.3%	100.0%	98.4%	96.4%	95.2%	96.7%	98.4%	98.3%	100.0%	96.8%	96.7%
% women booked by 12 weeks and 6 days	%	90%	82.6%	78.0%	84.4%	86.2%	84.7%	86.6%	87.3%	83.3%	86.6%	88.4%	85.3%	84.9%	81.5%

What the information tells us

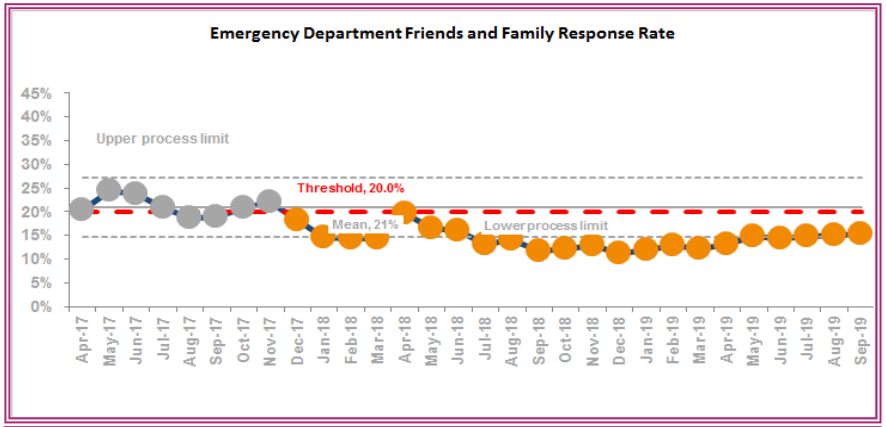
- The number of babies with unplanned admissions to the neonatal unit is within the control limit
- The number of births remains below target and is within process control limits. A renewed focus has been given to booking women soon after their referral, to keep numbers up
- The emergency caesarean rate is below target and the overall caesarean rate remained stable as do the other morbidity measures of Post Partum Haemorrhage (PPH) and tear.
- The percentage of women booked by 12 week and 6 days fell below the upper control limit, with performance the lowest seen in ten months.

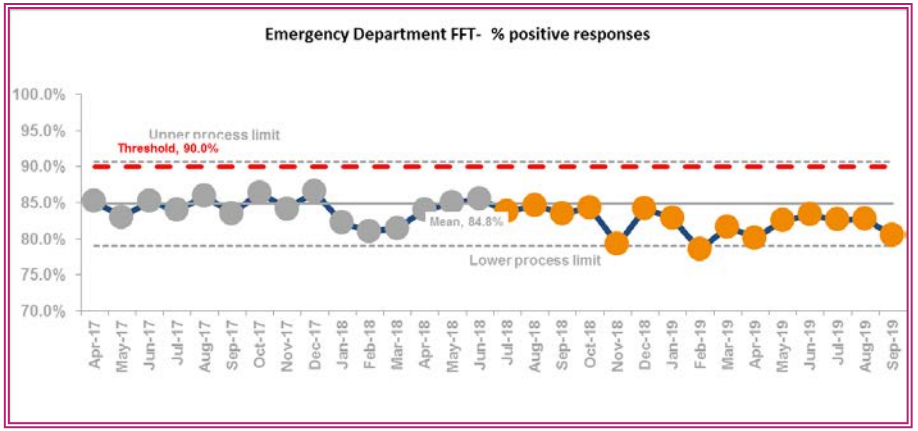
Actions and Quality Improvement Projects

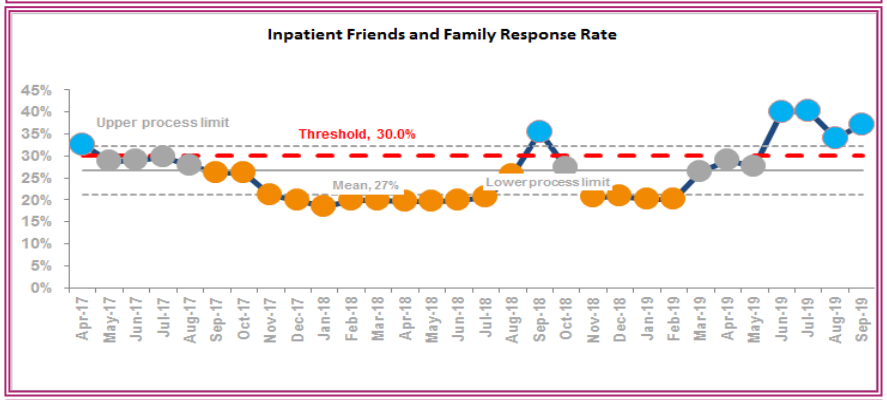
- The MatNeo safety project looking at reducing term admissions to Neonatal Unit is making progress, with team training in September with maternity and neonatal staff
- The room used for bookings was decommissioned which negatively impacted on the number of bookings made. Additional clinics have been set up to address this while a permanent room is identified. A new antenatal clinic template has also been agreed which should lead to improvements in booking times.
- A review of closures in the Carmen Suite is being undertaken to try and identify any underlying patterns.

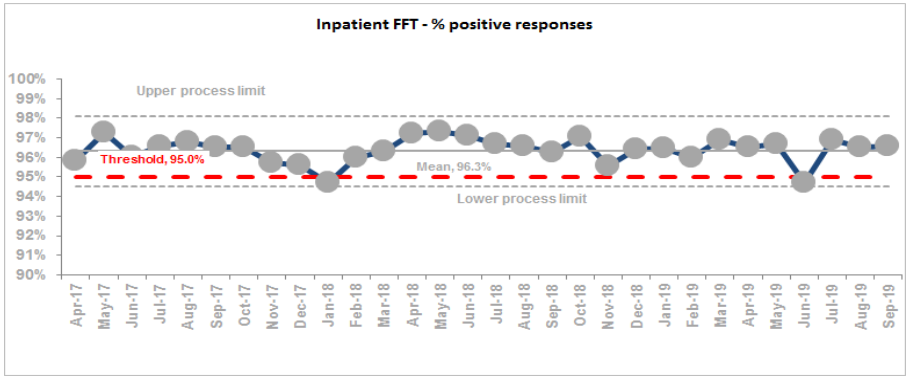
Friends and Family Test

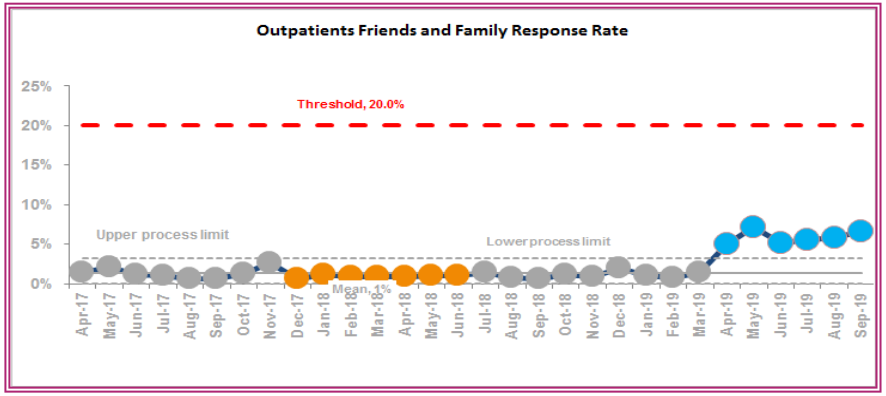
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

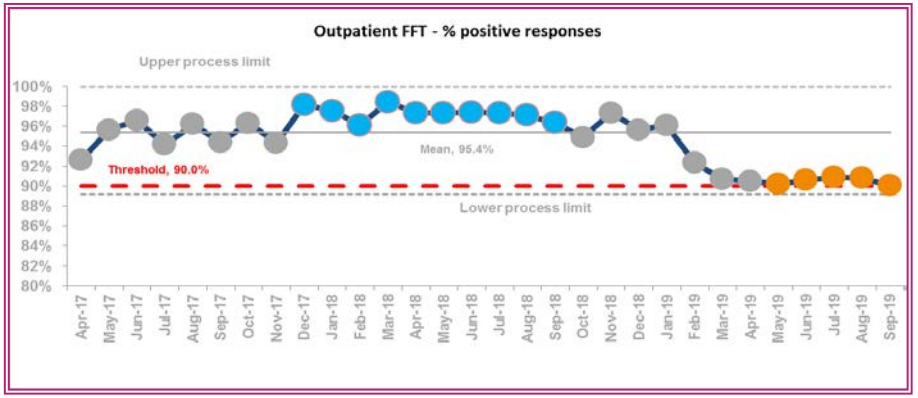






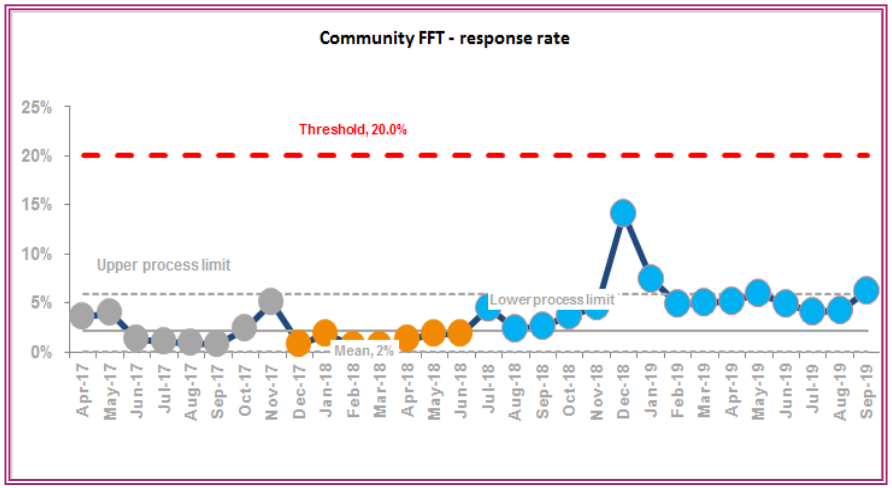


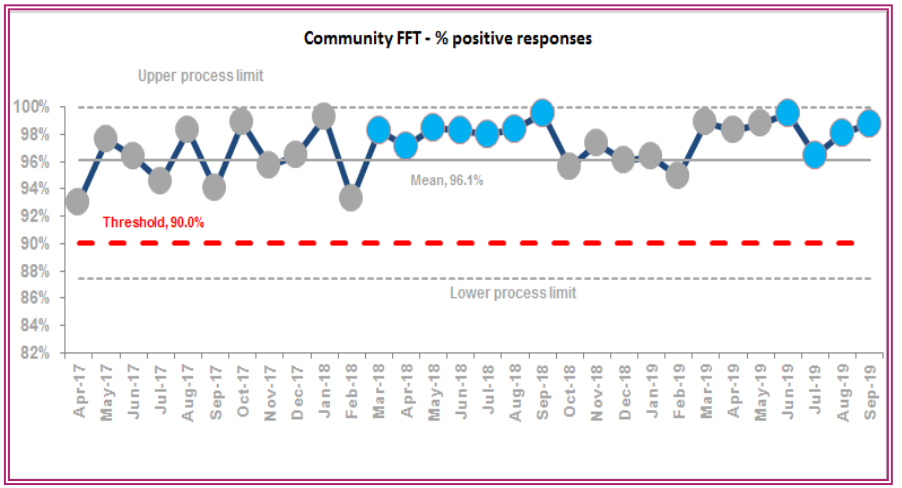


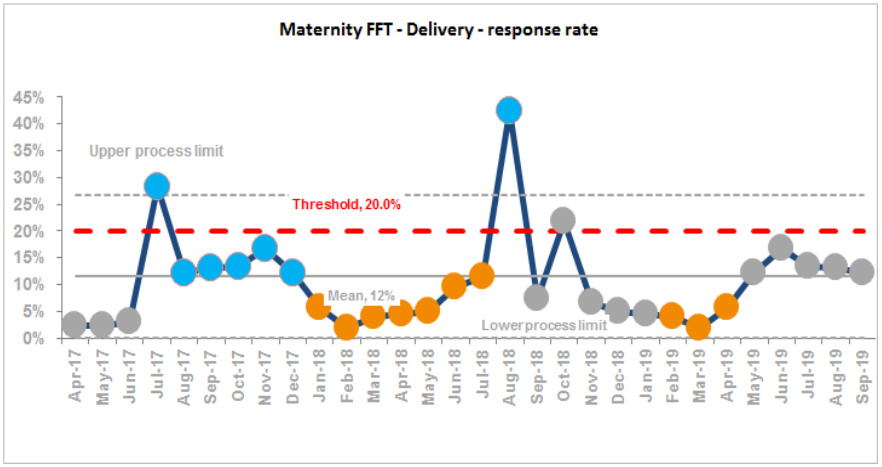


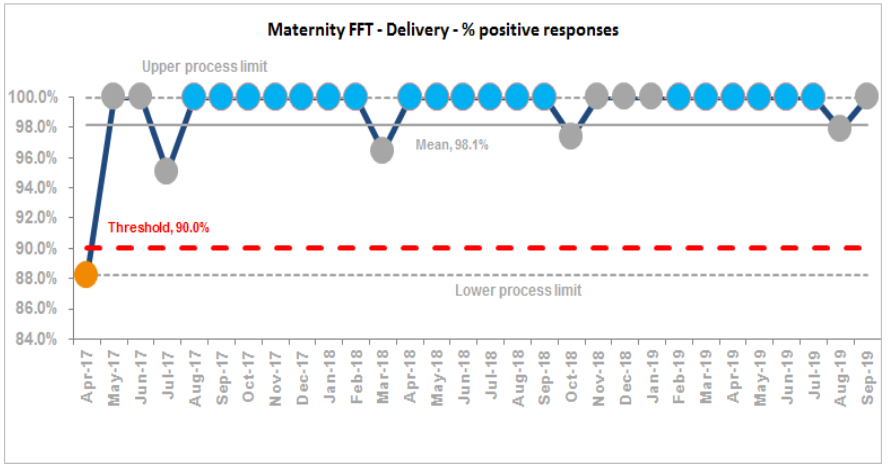
Friends and Family Test

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









Our Patient Perspective

Friends & Family Survey

Indicator Description	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Emergency Department FFT - % positive responses	90%	83.5%	84.2%	79.2%	84.2%	82.8%	78.5%	81.6%	80.1%	82.5%	83.3%	82.6%	82.7%	80.5%
Inpatient FFT - % positive responses	95%	96.3%	97.0%	95.5%	96.4%	96.5%	96.0%	96.9%	96.5%	96.7%	94.7%	96.9%	96.5%	96.6%
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%						100.0%	90.0%	85.7%	100.0%		100.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%
Maternity FFT - Postnatal Ward - % positive responses	90%	98.7%	100.0%	100.0%	90.9%	95.6%	95.7%	91.7%	96.4%	94.6%	98.0%	100.0%	98.3%	95.2%
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%			100.0%		100.0%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%
Community FFT - % positive responses	90%	99.5%	95.6%	97.4%	96.1%	96.3%	94.9%	98.9%	98.3%	98.8%	99.5%	96.4%	98.1%	98.8%
Outpatient FFT - % positive responses	90%	96.3%	94.9%	97.3%	95.6%	96.1%	92.3%	90.7%	90.5%	90.2%	90.6%	90.9%	90.8%	90.1%
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0

What the information tells us

- The emergency department Friends and Family Test (FFT) – In the month of September 80.5% of patients attending the emergency department would recommend the service to family and friends. The response rate has remained at 15% in the month of September, below our target of 20%
- We continue to deliver above target against our outpatient recommend rate with September performance of 90.1%. However the response rate remains below the Trust target, whilst it is recognised this has improved to consistently above 5%
- Maternity and Community FFT are above local thresholds in September and work continues to ensure patient responses improves. The London average response rate for community is 4.4% and England is 3.9%.

Actions and Quality Improvement Projects

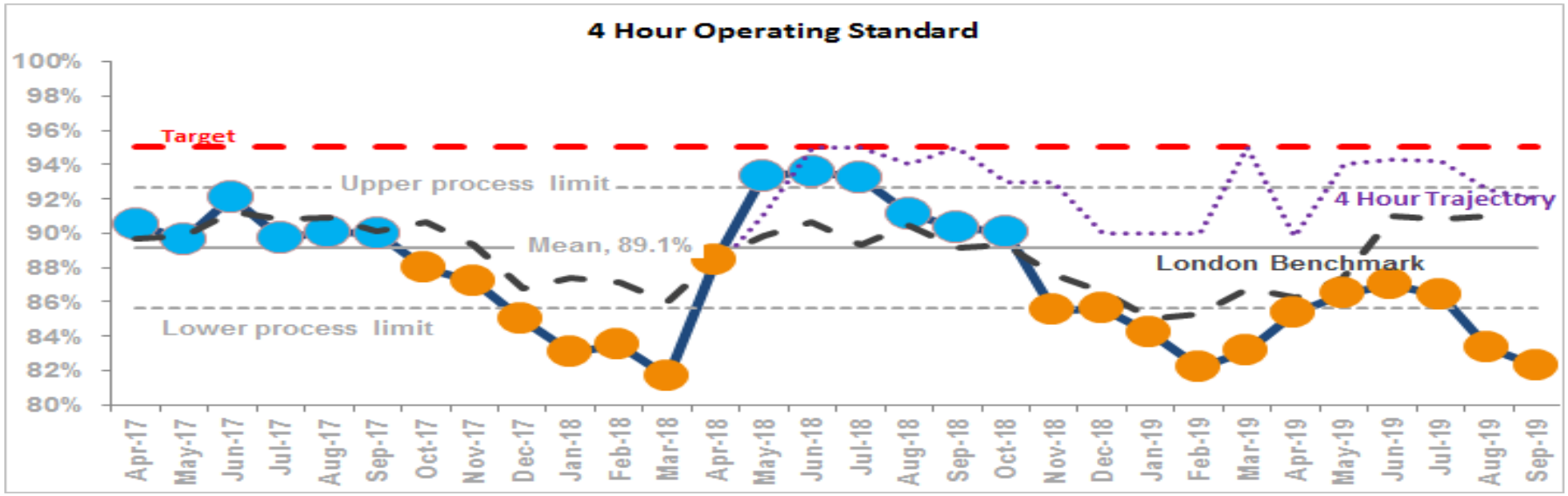
- Patients can now access the FFT on our website. In addition to the monthly reports of performance to ward areas a weekly report to matrons/ward managers is now in place. This gives the number of discharges versus the number of FFT responses completed and clearly identifies areas that need to improve. Text messaging the FFT after appointment has started in a number of outpatient clinics
- Review of London trusts that consistently achieve high response rates for ED and Maternity to be shared with services so that they can review practice
- Changes to the FFT data capture and requirements are awaiting nationally for implementation by the end of the year .

Balance Scorecard

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment (A)	
OUR **PEOPLE** PERSPECTIVE	Workforce			Agency Use		

Our Process Perspective

Emergency Flow



What the information tells us:

- The number of patients either discharged, admitted or transferred within four hours of arrival has seen a decrease from 83.3% in August to 82.3% in September, with performance continuing to be below the lower control limits.
- Performance is currently below the monthly improvement trajectory of 92% for September in order to achieve a year end position of 90%.
- Although attendance remain within the upper and lower control limits, compared to the same period last year are 0.7% higher and continue to be higher than the attendance plan and shows variability on a daily basis.
- Both admitted and non-admitted performance continues to be below its lower process limit.
- The AMU occupancy at midday is above the targeted 85% remaining above the mean.
- The general and acute bed occupancy remains has decreased slightly compared to the previous month however stay above the mean.
- The number of patients staying in a hospital bed greater than 7,14 and 21 days remains above the mean for a third consecutive month.
- Ambulance handover times have seen a slight reduction in performance in August with 30 minute performance continuing to fall below the lower control limit and for the first time has fallen below the London average.

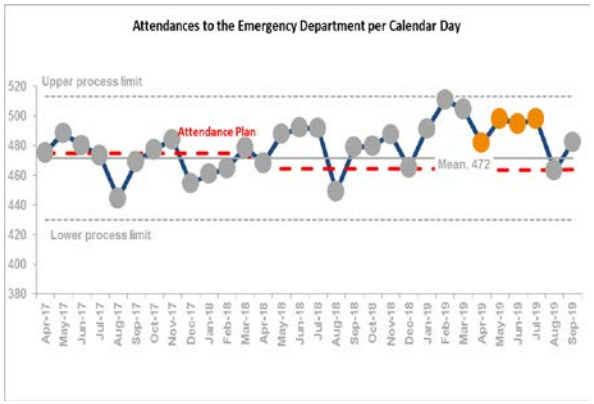
Actions and Quality Improvement Projects

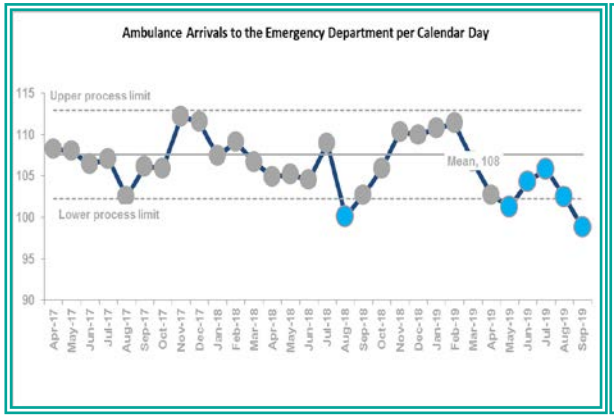
Specifically, in the last month we have undertaken the following to improve the emergency department (ED) Flow:

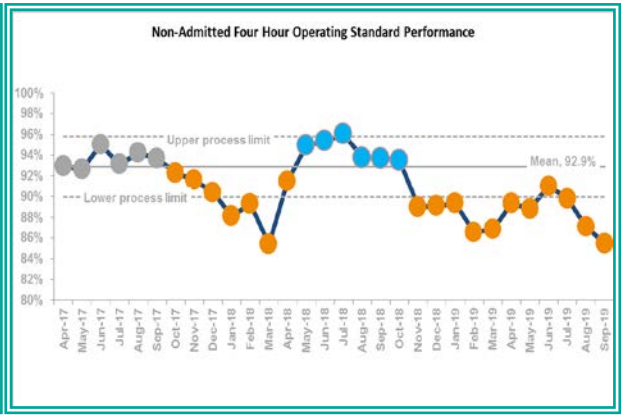
1. Weekly Emergency Care Delivery Board chaired by the Chief Executive with work streams on:
   Inter professional standards; recruitment and retention; leadership, cultural change, care and compassion; Flow (access / discharge / site operations); Emergency Care processes (all Divisions); mental health (ED); UCC waits and direct access; IT
2. External review undertaken by Emergency Care Intensive Support Team (ECIST). Initial feedback received and written report due end of October 2019
3. Establish Long Length of Stay reviews for specialist areas
4. Continue to embed SAFER on every ward
5. New Surgical Matron in place to focus on flow from ED, Nye Bevan and the Surgical wards.

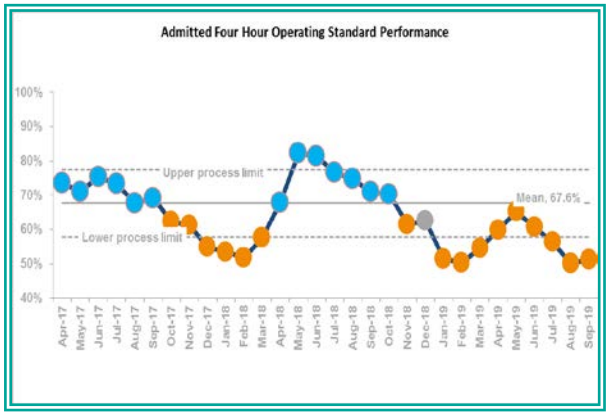
Emergency Flow

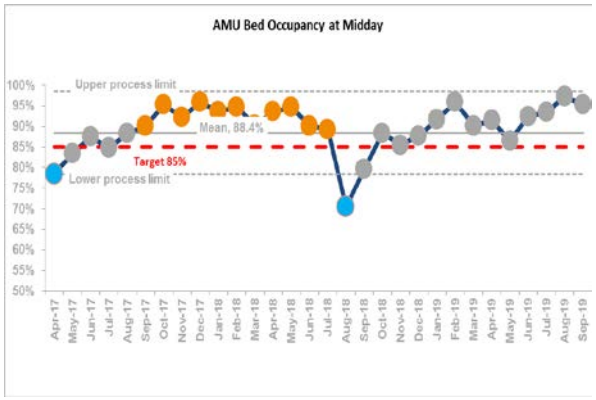
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

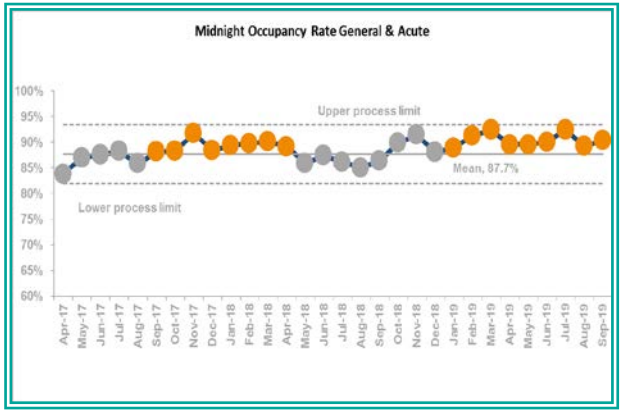


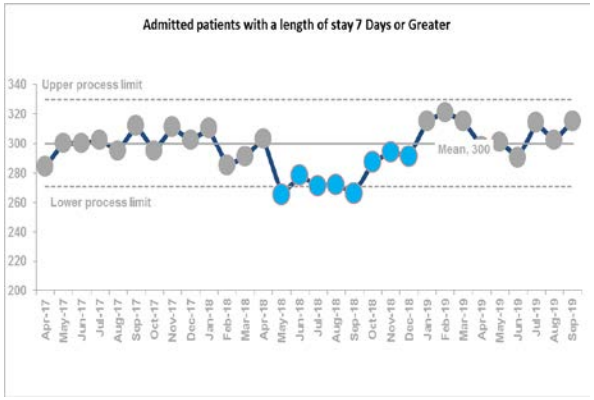


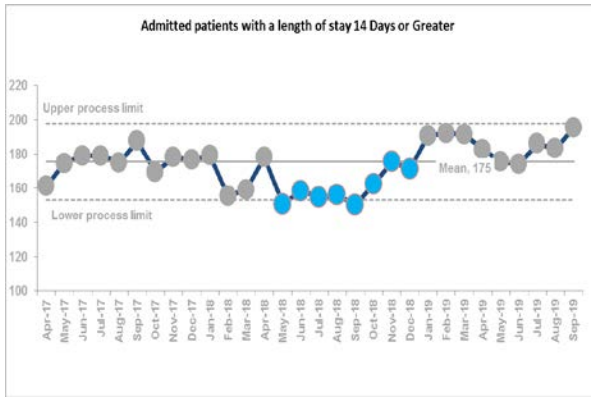


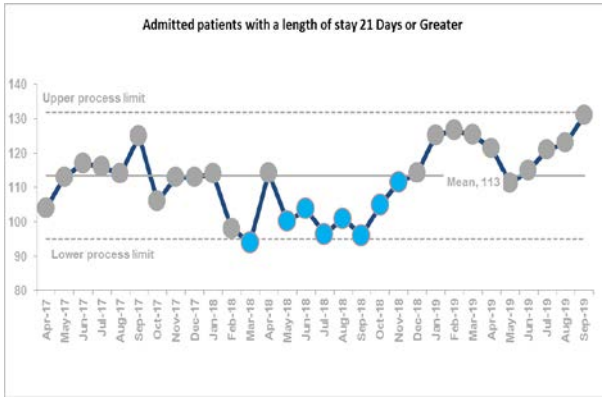






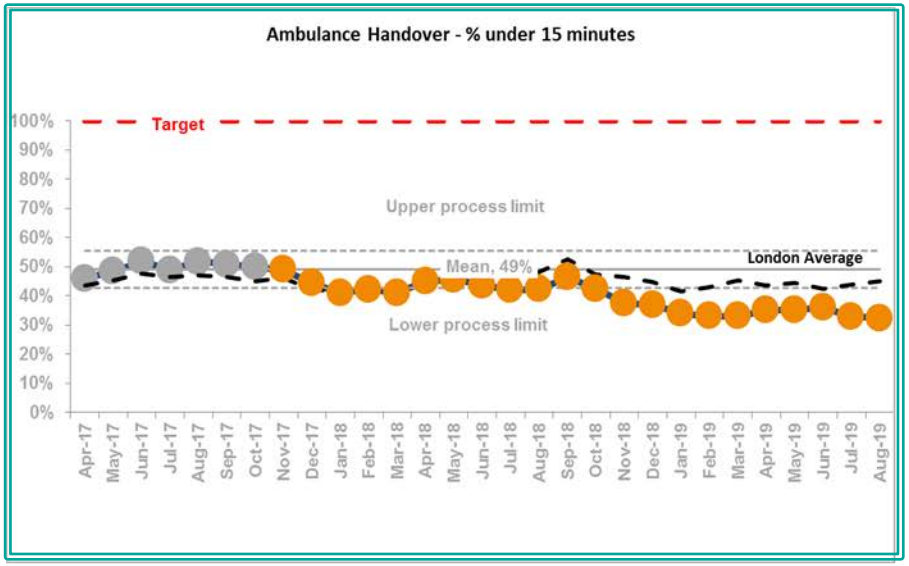


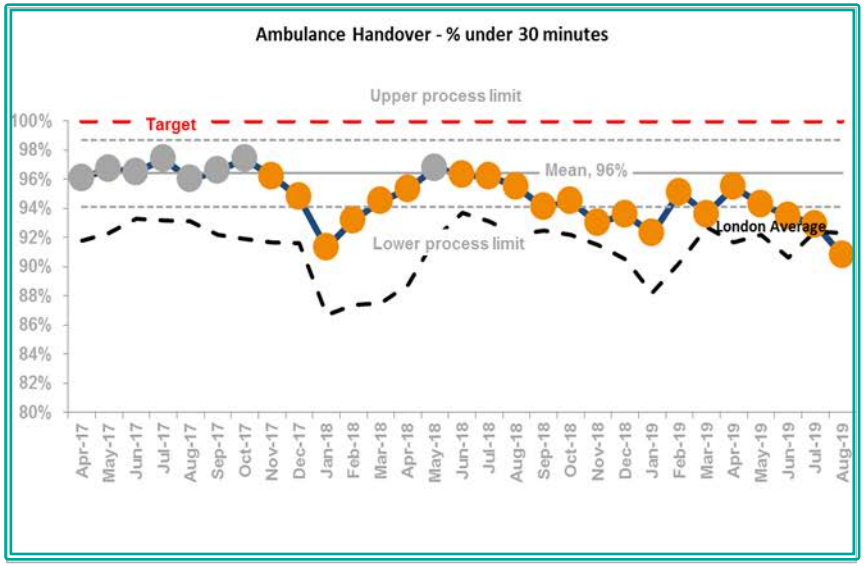


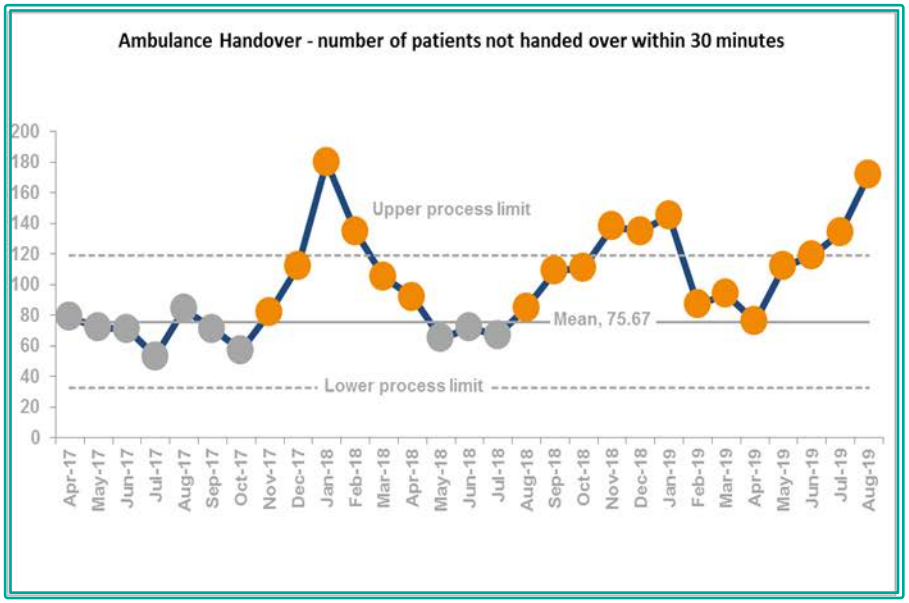


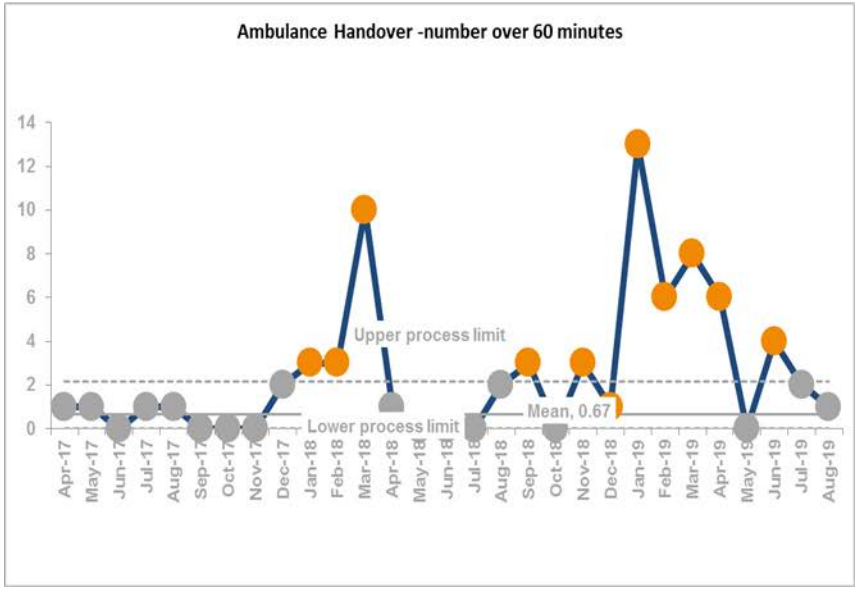
Emergency Flow

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

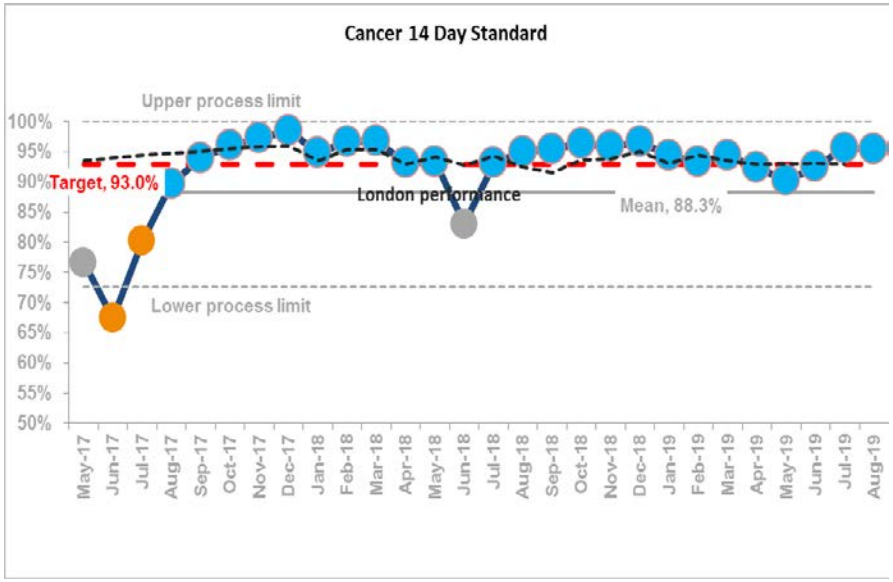


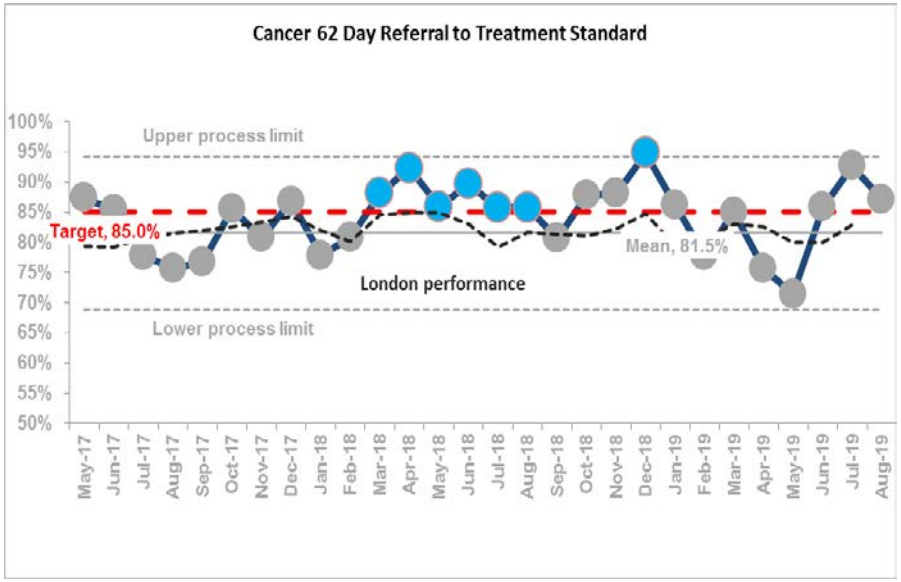






Cancer





What the information tells us

- The Trust has achieved all seven cancer standards for the month of August, remaining compliant against the 14 Day Standard and 62 Day Standard.
- Within the 14 Day Standard, all tumour groups achieved above the 93% national target with the exception of Upper GI, overall Trust performance remains within the upper and lower control limits.
- The number of patients awaiting treatment greater than 62 days from referral has continued above the mean with a performance of 87.1% in the month of August 2019 against the target of 85%.
- As shown by the wide upper and lower process limits, Cancer 62 day screening performance has been varied in past months, however has maintained compliance reporting 100% in the month of August with performance showing above the mean for the forth consecutive month.

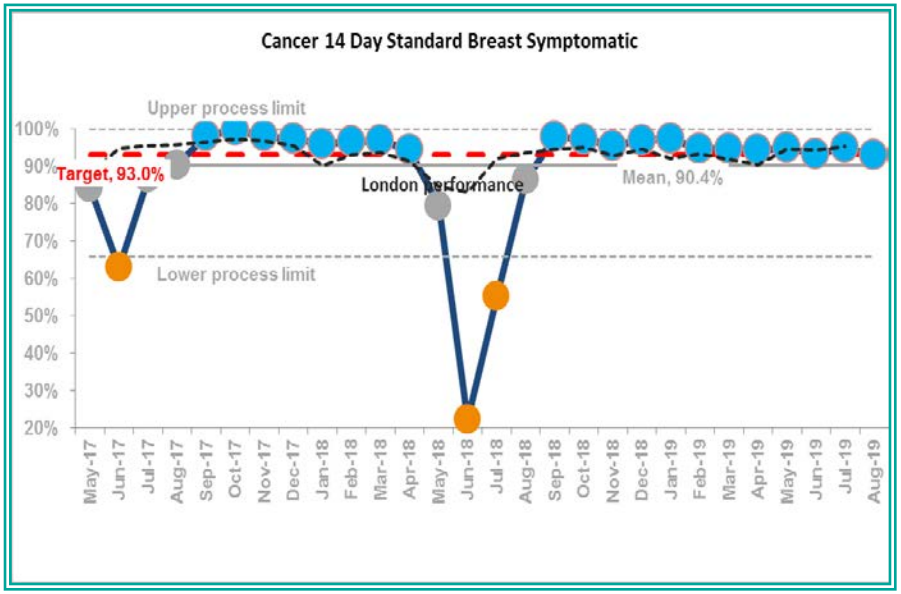
Actions and Quality Improvement Projects

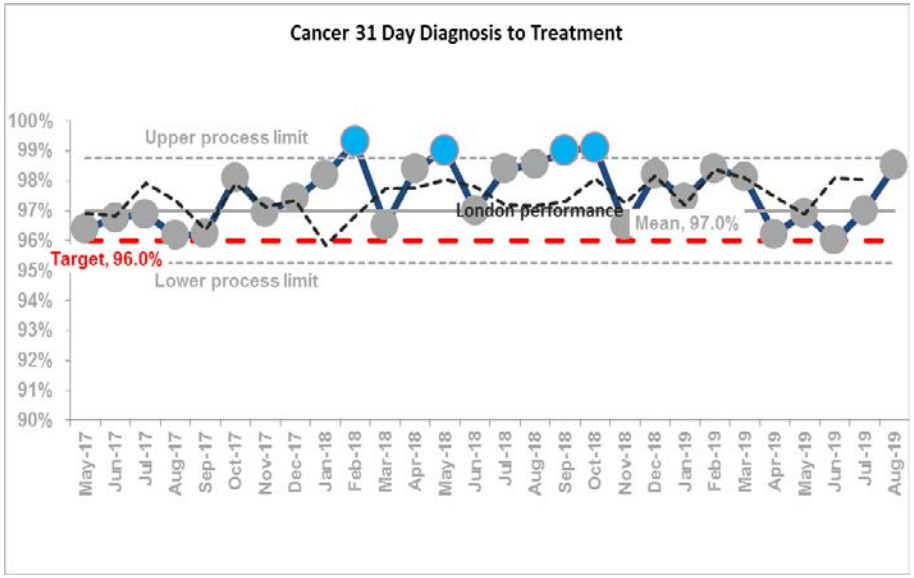
The recovery action plan has three key parts in it:

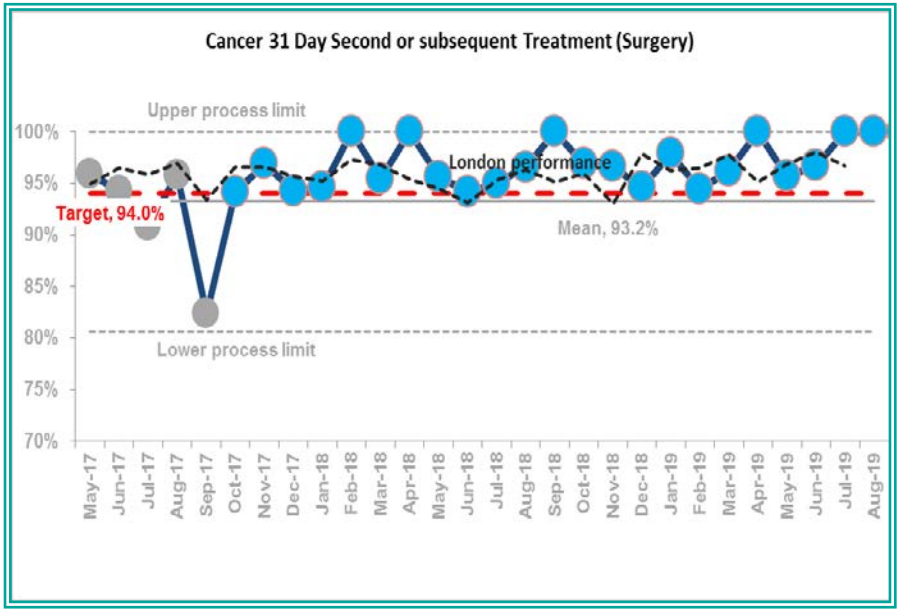
- TWR Clinic polling on ERS set at 12 days with robust management of ASI list has seen reduction in numbers. Further work needs to be done at service level to ensure the right capacity is in place to meet the demand of new polling ranges. Plans for services to review further demand and capacity planning to meet this requirement.
- Continued 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 additional Straight to test capacity identified in Lower GI Service with plans to increase total slots by September 2019. For Gynaecology, short term capacity planning six weeks in advance (both clinic and diagnostic capacity) is the focus. Gynaecology has introduced robust breach management via a weekly huddle and senior management engagement.
- 62 day focus has been on closer integration between Cancer and theatre teams to ensure that all opportunities to treat patients are maximised- including cancer theatres huddle and 642 attendance. Additional walk in slots for pre-assessment identified and slots ring fenced for services. Training & Development of internal and external staff as well as good service engagement.

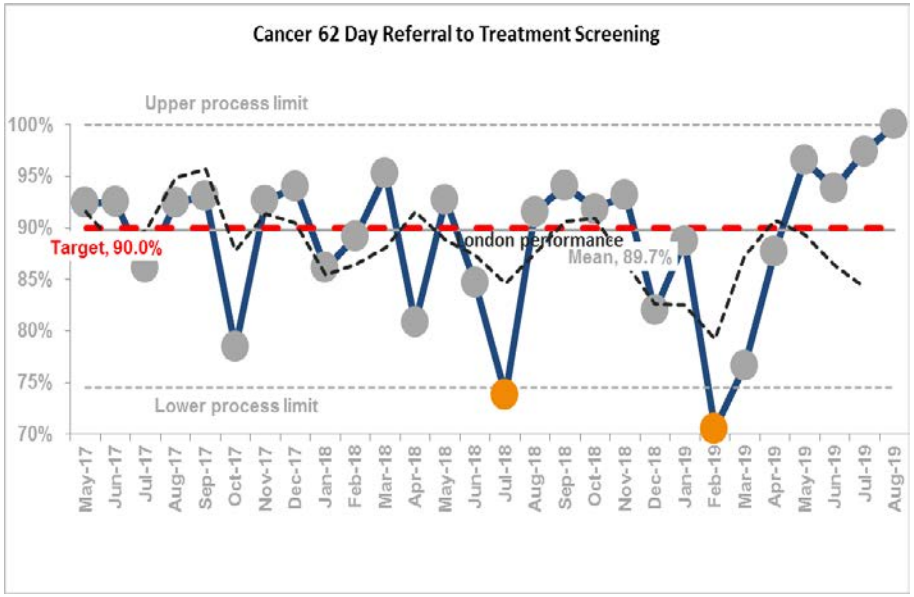
Cancer

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









Our Process Perspective

Cancer

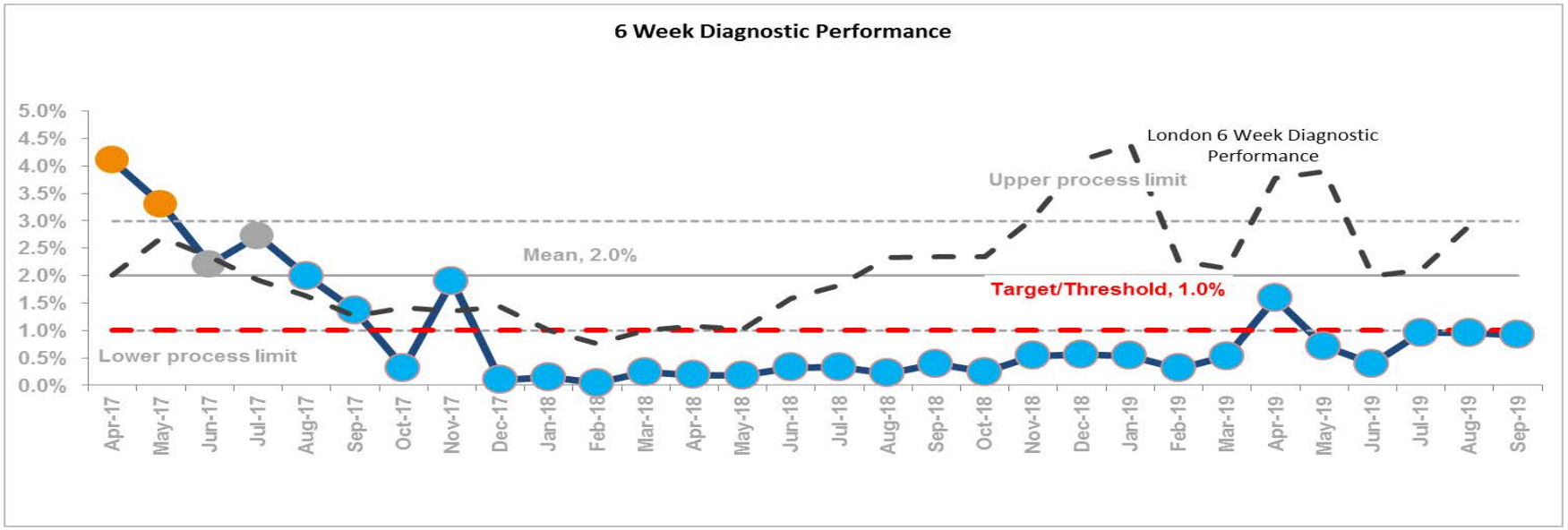
14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	No of Patients
Brain	93%	100.0%	-	100.0%	-	100.0%	100.0%	100.0%	-	100.0%	-	100.0%	-	100.0%	1
Breast	93%	97.5%	94.5%	99.4%	97.4%	98.8%	97.4%	98.6%	97.9%	99.5%	96.3%	96.9%	95.4%	94.9%	237
Children's	93%	-	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	2
Gynaecology	93%	90.8%	81.9%	87.8%	87.5%	95.9%	69.5%	65.3%	80.0%	75.0%	59.3%	78.0%	95.5%	97.2%	108
Haematology	93%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	22
Head & Neck	93%	95.6%	99.3%	99.8%	98.1%	96.0%	98.5%	100.0%	99.3%	98.0%	97.8%	100.0%	98.9%	96.4%	169
Lower Gastrointestinal	93%	98.9%	94.3%	98.1%	95.8%	94.5%	97.2%	92.1%	94.5%	85.6%	91.1%	87.9%	93.7%	93.1%	276
Lung	93%	94.7%	95.2%	100.0%	100.0%	100.0%	93.3%	100.0%	96.9%	100.0%	95.6%	96.8%	95.7%	100.0%	35
Skin	93%	92.9%	97.4%	96.6%	97.4%	97.6%	97.1%	95.9%	97.6%	96.9%	95.5%	94.8%	96.0%	98.0%	358
Upper Gastrointestinal	93%	93.9%	96.7%	98.8%	95.4%	94.1%	91.8%	90.9%	83.5%	87.9%	70.2%	90.9%	95.1%	88.9%	99
Urology	93%	93.1%	96.8%	92.4%	93.4%	96.6%	94.5%	94.2%	92.2%	90.1%	95.4%	92.1%	93.8%	93.0%	114

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	No of Patients
Brain	85%	-	-	-	100.0%	100.0%	-	-	-	-	-	-	-	-	0
Breast	85%	78.9%	100.0%	100.0%	100.0%	100.0%	100.0%	82.4%	90.9%	83.3%	80.0%	87.5%	73.3%	88.6%	17.5
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	100.0%	0.5
Gynaecology	85%	100.0%	80.0%	90.0%	100.0%	83.3%	88.9%	50.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	5
Haematology	85%	88.9%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	30.0%	33.3%	77.8%	100.0%	100.0%	4
Head & Neck	85%	81.8%	80.0%	100.0%	86.7%	87.5%	46.2%	85.7%	80.0%	77.8%	40.0%	28.6%	80.0%	80.0%	10
Lower Gastrointestinal	85%	83.3%	66.7%	88.9%	100.0%	100.0%	100.0%	81.8%	66.7%	41.7%	100.0%	69.2%	83.3%	63.6%	5.5
Lung	85%	66.7%	28.6%	50.0%	70.0%	72.7%	80.0%	75.0%	70.0%	71.4%	100.0%	100.0%	91.7%	89.5%	9.5
Skin	85%	100.0%	84.6%	92.3%	100.0%	100.0%	92.3%	100.0%	89.7%	100.0%	75.8%	95.7%	100.0%	100.0%	9.5
Upper Gastrointestinal	85%	78.9%	50.0%	54.5%	100.0%	100.0%	0.0%	50.0%	60.0%	100.0%	20.0%	75.0%	100.0%	53.8%	5.5
Urology	85%	88.2%	92.9%	88.9%	77.8%	95.0%	89.5%	71.1%	88.9%	83.0%	75.8%	93.9%	100.0%	94.4%	18
Other	85%	100.0%	-	100.0%	100.0%	-	0.0%	-	100.0%	-	-	100.0%	-	-	0

Diagnostics



What the information tells us

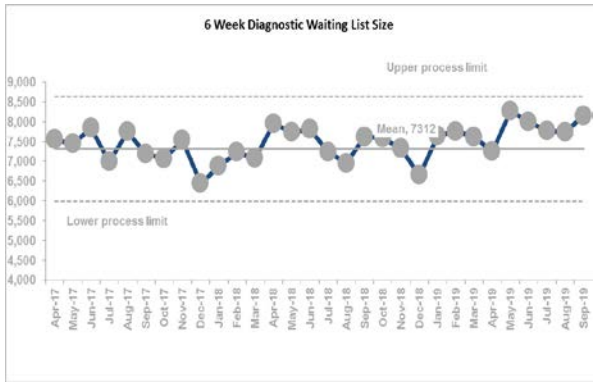
- In September the Trust performance remained compliant against the six week diagnostic standard, and performance remained under the lower process control limit, with a total of 75 patients waiting greater than six weeks and a performance of 0.92%.
- The number of patients on the Trusts diagnostic waiting list remains within the upper and lower control limits.
- Compliance has not been achieved within four modalities, with Echocardiography being the most challenged and performing above the upper control limit, however below London average performance.
- Although Sleep Studies and Flexi Sigmoidoscopy remain within the lower and upper control limits performance has risen and is above national target.
- Gastroscopy although non-compliant have decreased the number of patients waiting greater than six weeks for the third consecutive month.

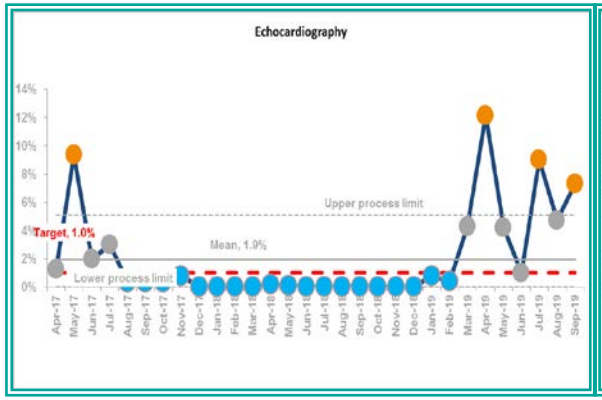
Actions and Quality Improvement Projects

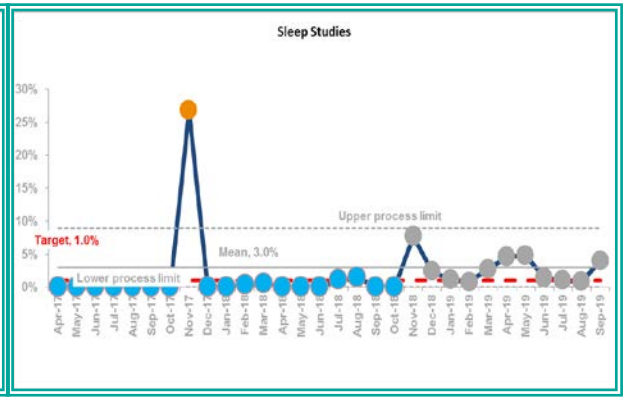
Recovery plan for Echocardiography will be submitted by the end of October for long term impact and sustainability for the service. In the short term tighter booking processes will be managed on a daily basis and additional lists created to reduce the number of patients waiting.

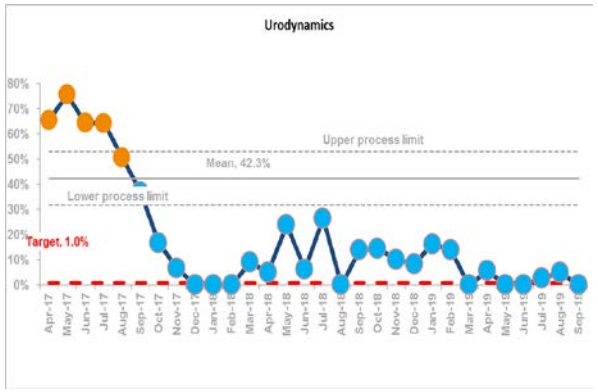
Diagnostics

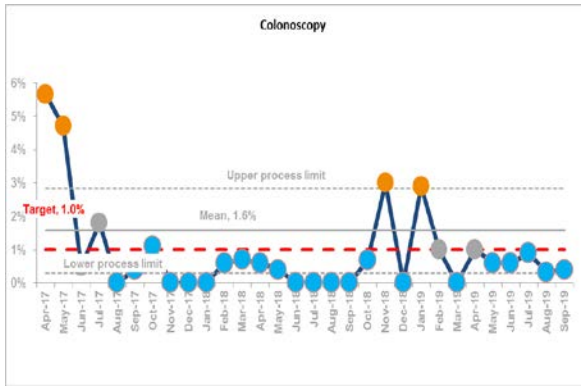
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

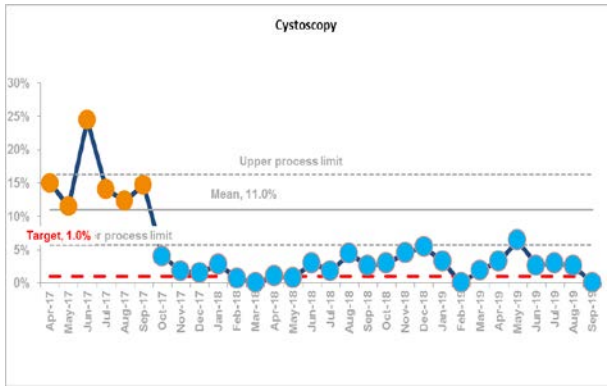


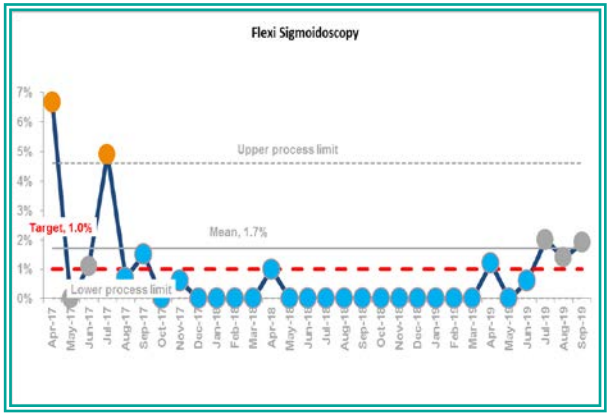


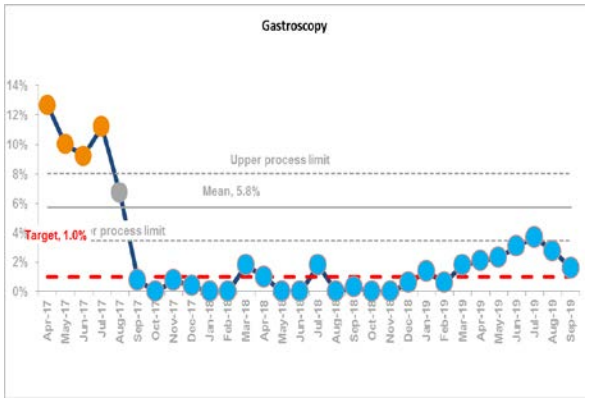


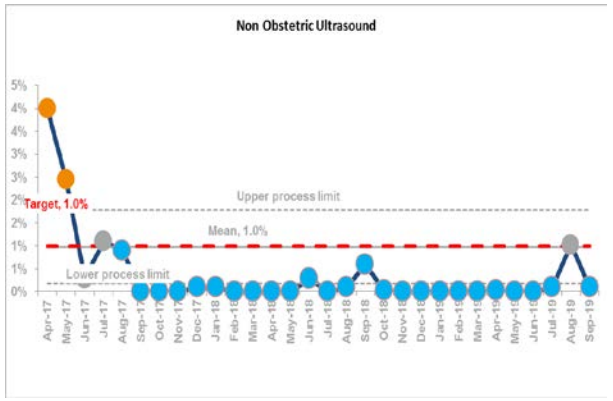






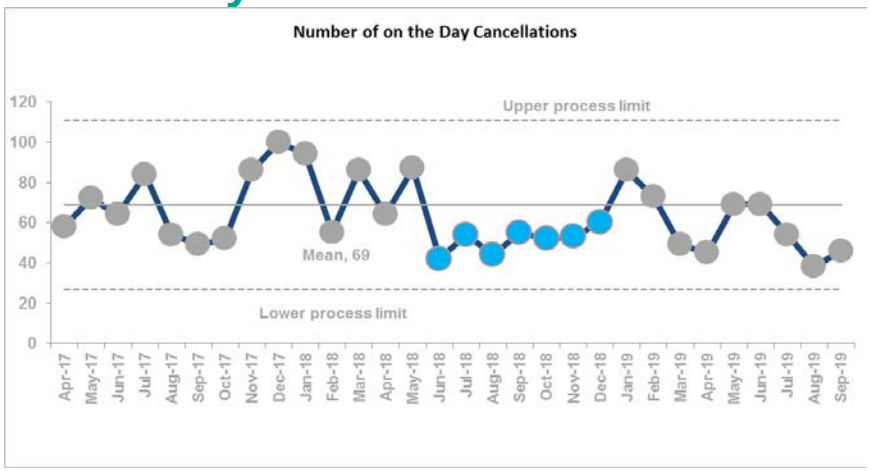


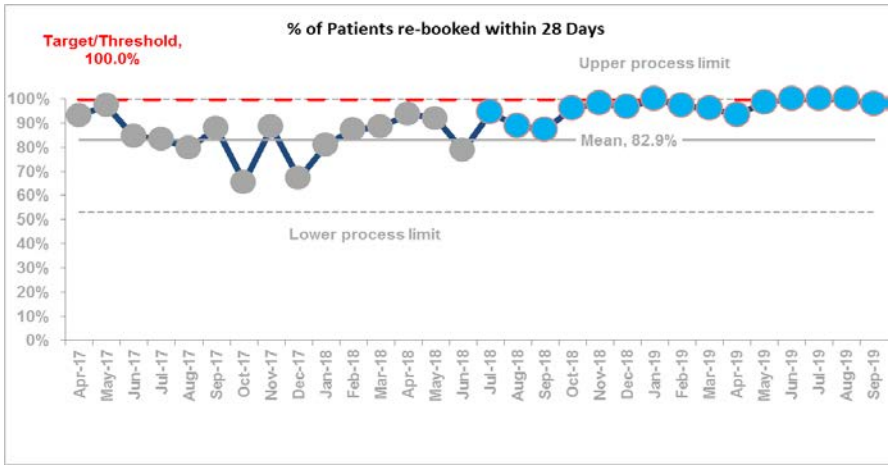




Our Process Perspective

On the Day Cancellations for Non Clinical Reasons





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 and has seen a reduction within the last three months reporting below the mean and cancelling a total of 46 on the day cancellations in the month of September.
- 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 September , 97.8% of patients were re-booked within 28 days.
- The main reason for on the day cancellations in September were due to the number of Trauma cases taking priority (11 cases cancelled), mainly affecting Cardiology and Cardiac Surgery. Timing issues with a number of lists over booked were the reason for ten cases being cancelled on the day with the highest proportion within Neuro Surgery.

Actions and Quality Improvement Projects

- Two way text reminders being rolled out for IP and DSU surgery dates, this will also include a firmer message to encourage patients to attend
- Netcall is being discussed, and we will look to roll out as part of the PPC office moves, this will ensure more of our calls are answered so patients calling to cancel/reschedule surgery dates can get through to someone quickly (51% of calls are currently answered)
- The Trust Directory is being updated to ensure the correct numbers for the PPCs are listed to support switchboard putting patients through to the right person
- Partial Bookings are being sent out to all patients added to the IP, and DSU waitlist, which asks patients if they are available at short notice (1 day, to 1 week before TCI) so we have a pool of patients to pull from when other patients cancel at short notice (for DSU, 65% of our total cancellation are patients cancelling at short notice)
- New Pre Operative Assessment (POA) targets have launched which ask PPCs to ensure all patients on the admitted DSU PTL have a POA booked, and 100% of patients 20 weeks + on the IP admitted PTL have a POA booked, this will ensure the PPCs have an adequate pool of 'fit' patients to pull from (this will also support short notice bookings)
- Information is now being entered on Theatreman (IP scheduling system) which highlights if a patient is on a cancer pathway, and their breach date, to mitigate the risk of these patients being cancelled because of bed flow challenges
- The PPC team are designing a 'Friends and Family test' for scheduling which will help us understand why patients cancel, so we can look to put actions in place to stop DNA's/short notice cancellations
- Non clinical on the day cancellations are discussed daily at the PPC huddle to ensure patients are dated within 28 days

Referral to Treatment

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RTT Incomplete Performance	92%	84.5%	85.2%	86.1%	85.8%	86.6%	86.0%	86.1%	85.0%							
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	41,658	41,259	41,945							
RTT Total Incomplete Waiting Lize Size Trajectory					39,890	39,880	39,870	39,860	39,850	39,840	39,830	39,820	39,810	39,800	39,790	39,780
Total waits greater than 18 weeks (inc 52Wk waiters)		5,921	5,929	5,515	5,812	5,717	5,820	5,739	6,305							
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	7	5	6							
Total waits greater than 52 weeks Trajectory				31	23	16	9	5	5	5	0	0	0	0	0	0
RTT Incomplete Performance - Admitted		65.5%	65.5%	66.6%	65.3%	68.8%	68.7%	66.3%	63.7%							
Total waits greater than 18 weeks - Admitted		1,563	1,563	1,428	1,511	1,459	1,494	1,523	1,655							
Total waits greater than 52 weeks - Admitted	0	62	63	18	7	8	4	1	2							
RTT Incomplete Performance -Non Admitted		87.7%	87.7%	88.5%	88.3%	88.8%	88.3%	88.5%	87.6%							
Total waits greater than 18 weeks - Non Admitted		4,358	4,366	4,087	4,301	4,258	4,326	4,216	4,650							
Total waits greater than 52 weeks - Non Admitted	0	56	53	9	15	8	3	4	4							

What the information tells us

- The above table relates to St George's (Tooting site only) Referral To Treatment (RTT) performance since returning to report in January 2019.
- Due to QMH migrating CliniCom PAS to Cerner Millennium from 14 September 2019, the Trust closed August month end three days earlier than usual. This contributed towards the increase in PTL size.
- The Trust has submitted performance below trajectory for the first month since returning to report in January 2019.
- The Trust reported six 52 week breaches in August-19 against a trajectory of 5. This is the first month the Trust as not met trajectory.

Actions and Quality Improvement Projects

- September 2019 submission will include Queen Mary's Hospital for the first time. This will show an increase in total PTL size to circa 47,500 pathways.
- The Trust continue to monitor daily the long waiting patients (28 weeks and above). The Trust are working towards having zero 52 week breaches reported for October month end.
- Undertake a review of all un-outcomed historic activity (admitted and non admitted) to ensure monthly submission is an accurate reflection of activity undertaken – this includes historic surgical dates
- On-going weekly review and monitoring of data quality metrics including duplicate encounters and code 11 outcomes (continuation of pathway following a ward discharge – these pathways should not routinely be on an RTT pathway).
- Following migration additional external support was brought on-live to support validation and migration data quality. The external validation resource will be used to support September month end and put the Trust back on trajectory in relation to performance – The PTL will remain higher than the trajectory.

Referral to Treatment

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	205	36.6%	699	80.5%	638	266	904	70.6%	54	3
Urology	321	58.3%	974	88.1%	1,045	250	1,295	80.7%	9	0
Trauma & Orthopaedics	131	49.6%	2,313	87.2%	2,083	361	2,444	85.2%	5	0
Ear, Nose & Throat (ENT)	473	41.2%	2,009	86.2%	1,927	555	2,482	77.6%	19	0
Ophthalmology	0	-	0	-	0	0	0	-	0	0
Oral Surgery	8	25.0%	628	93.3%	588	48	636	92.5%	1	0
Neurosurgery	154	72.1%	2,056	82.7%	1,812	398	2,210	82.0%	6	0
Plastic Surgery	516	61.0%	962	87.0%	1,152	326	1,478	77.9%	21	1
Cardiothoracic Surgery	0	-	2	100.0%	2	0	2	100.0%	0	0
General Medicine	0	-	30	96.7%	29	1	30	96.7%	0	0
Gastroenterology	535	90.7%	1,747	89.2%	2,043	239	2,282	89.5%	12	0
Cardiology	842	68.5%	2,729	84.6%	2,887	684	3,571	80.8%	8	0
Dermatology	1	100.0%	2,587	91.5%	2,368	220	2,588	91.5%	0	0
Thoracic Medicine	3	100.0%	1,786	87.8%	1,572	217	1,789	87.9%	0	0
Neurology	22	90.9%	2,492	90.7%	2,280	234	2,514	90.7%	3	0
Rheumatology	0	-	929	81.5%	757	172	929	81.5%	3	0
Geriatric Medicine	0	-	87	95.4%	83	4	87	95.4%	0	0
Gynaecology	334	56.9%	2,067	93.6%	2,124	277	2,401	88.5%	4	0
Other	1,015	66.9%	13,288	87.1%	12,250	2,053	14,303	85.6%	48	2
Total	**4,560**	**63.7%**	**37,385**	**87.6%**	**35,640**	**6,305**	**41,945**	**85.0%**	**193**	**6**

- 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.
- The six 52 week breach patients reported were General Surgery (5) and Plastic Surgery (1). Trajectory was 5.

Balance Scorecard

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment (A)	
OUR **PEOPLE** PERSPECTIVE	Workforce			Agency Use		

Our People Perspective

Workforce

What the information tells us

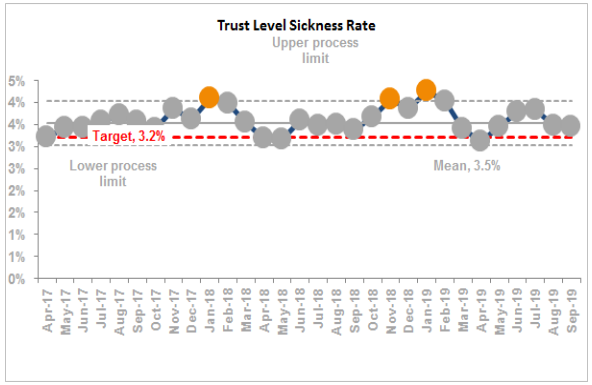
- Mandatory and Statutory Training figures for September were recorded at 89.9% with a mean of 86.2%, a reduction on last month's performance. This is primarily due to junior doctor rotation.
- Medical appraisal rates are now being reported by the new appraisal system and currently stands at 81.5%.
- Non-medical appraisal performance, remaining below target with a performance of 70.4% against a 90% target. The tight upper and lower process limits for the previous six months indicates a level of stability and the target of 90% not likely to be met without further intervention.
- The Trust's Total Funded Establishment and Trust Vacancy rate are both slightly above the lower control limits with both seeing a steady increase over the past four months. Work has started to understand and control this.
- In September, the monthly agency target set was £1.25m. The total agency cost is worse than the target by £0.44m.

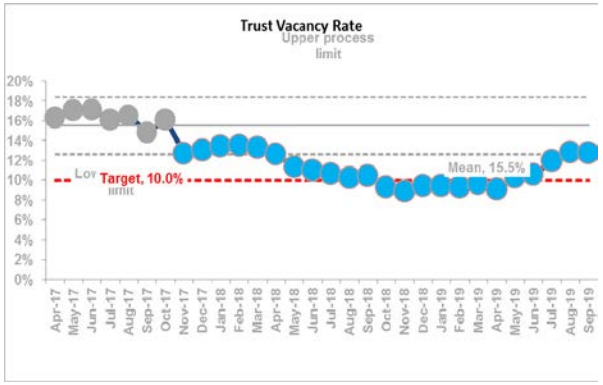
Actions and Quality Improvement Project
HR Managers will be meeting with Divisional Directors of Operations to discuss remedial actions to control agency costs.

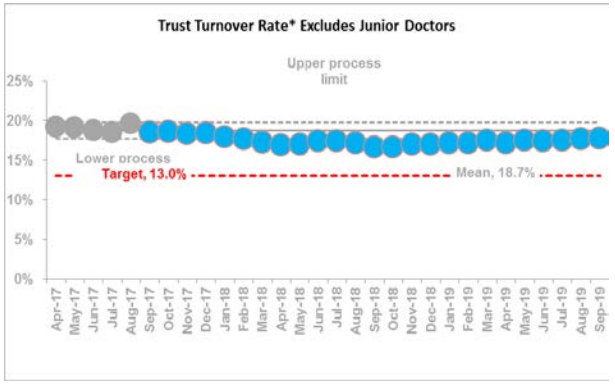
Indicator Description	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Trust Level Sickness Rate	3.2%	3.4%	3.7%	4.1%	3.8%	4.3%	4.0%	3.4%	3.1%	3.5%	3.8%	3.8%	3.5%	3.4%
Trust Vacancy Rate	10%	10.4%	9.3%	8.9%	9.4%	9.4%	9.3%	9.6%	9.1%	10.3%	10.5%	11.9%	12.8%	12.8%
Trust Turnover Rate* Excludes Junior Doctors	13%	16.6%	16.6%	16.9%	16.9%	17.1%	17.1%	17.5%	17.1%	17.4%	17.4%	17.5%	17.7%	17.7%
Total Funded Establishment		9,180	9,165	9,171	9,196	9,229	9,238	9,248	9,112	9,241	9,251	9,365	9,432	9,534
IPR Appraisal Rate - Medical Staff	90%	Data Unavailable								85.4%	84.5%	84.4%	85.7%	81.5%
IPR Appraisal Rate - Non Medical Staff	90%	69.7%	69.7%	71.8%	71.5%	70.9%	71.3%	70.4%	71.6%	72.5%	73.6%	73.3%	71.3%	70.4%
Overall MAST Compliance %	85%	88.2%	88.3%	88.3%	89.1%	89.3%	89.1%	89.4%	89.8%	90.6%	91.2%	91.2%	90.2%	89.9%
Ward Staffing Unfilled Duty Hours	10%	6.7%	6.6%	5.1%	6.1%	6.6%	6.7%	7.2%	5.7%	5.9%	6.1%	6.3%	5.4%	6.5%

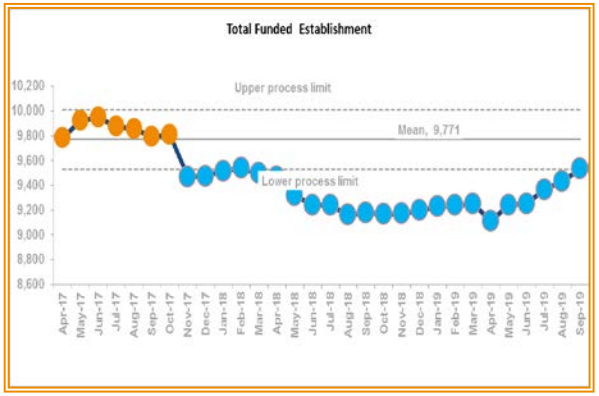
Workforce

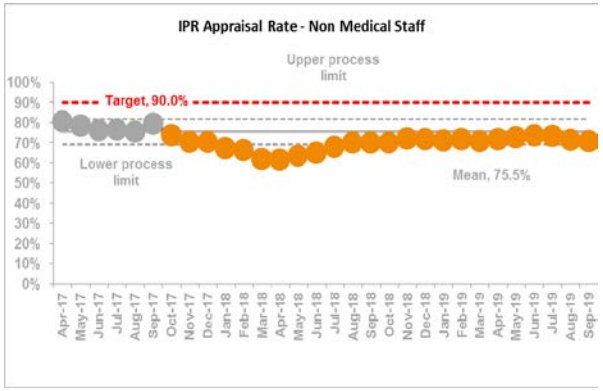
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

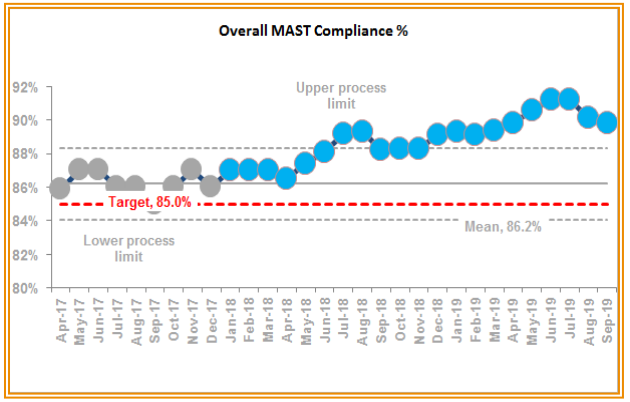


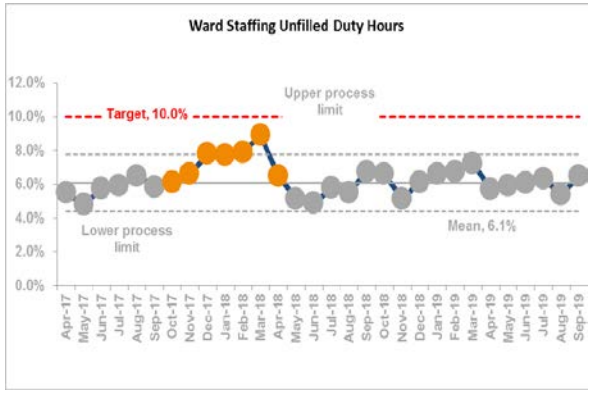




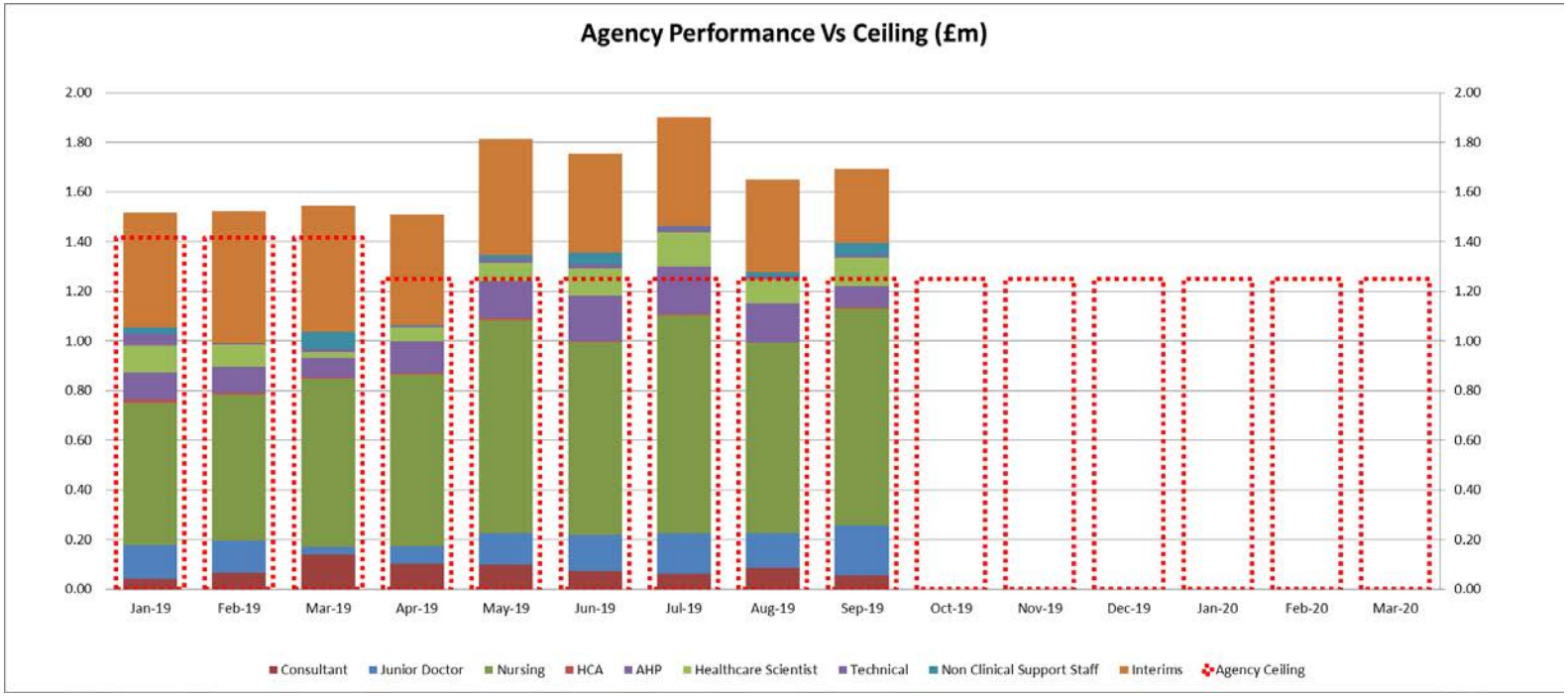








Agency use



The Trust's total pay for September was £44.70m. This is £0.05m adverse to a plan of £44.65m.

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 September was £1.69m or 3.8% of the total pay costs. For 2018/19, the average agency cost was 3.2% of total pay costs.

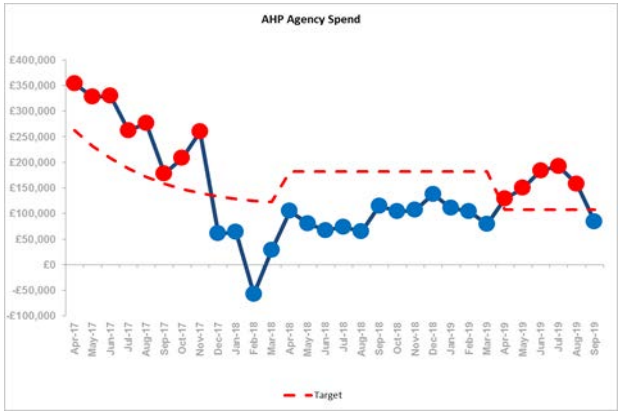
For September, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.44m.

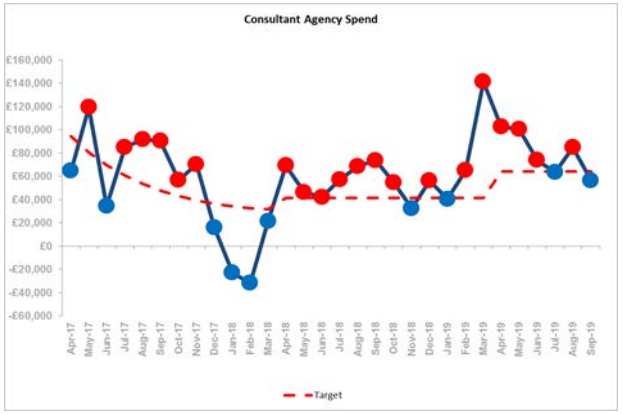
Agency cost is £0.04m higher compared to August. There have been increases mainly in Nursing (£0.11m) and Junior Doctor (£0.06m), partially offset by decreases in Interims (£0.08m) and Healthcare Scientist (£0.07m).

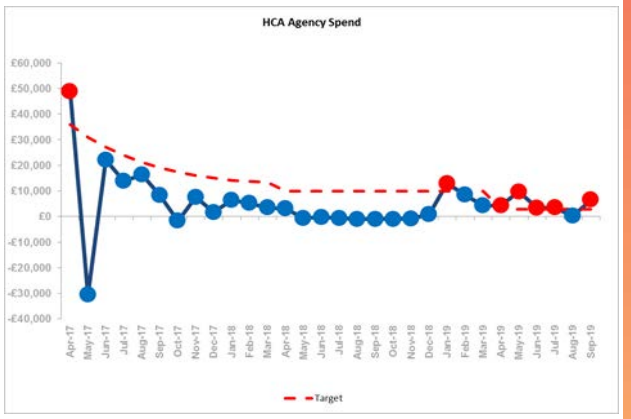
The biggest areas of overspend were Nursing (£0.29m) and Junior Doctor (£0.13m).

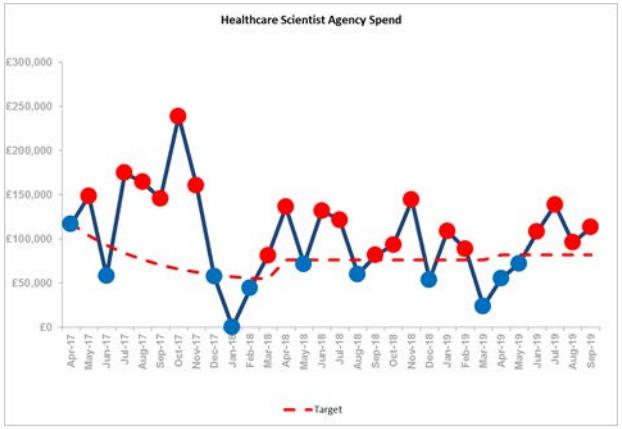
Agency use

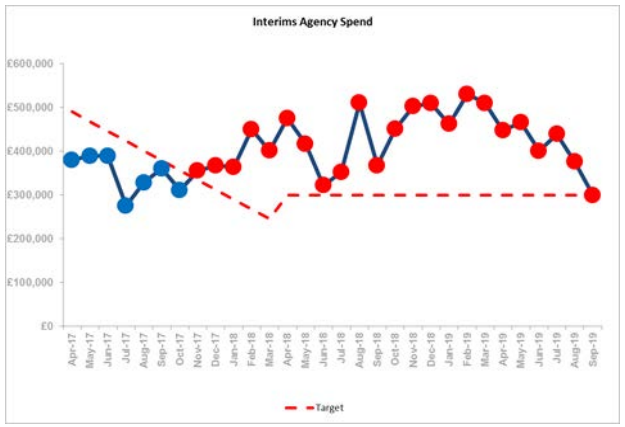
Below cap
Above cap

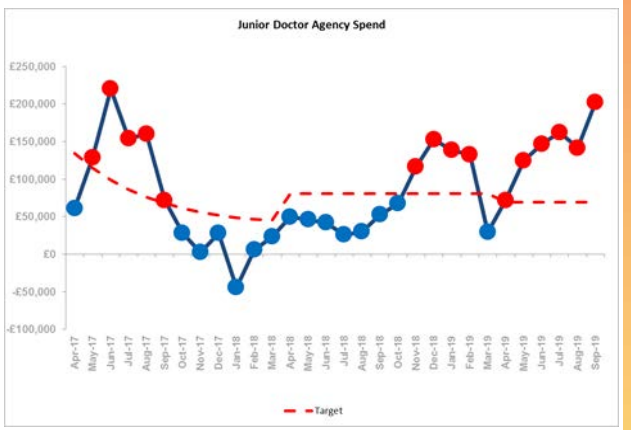


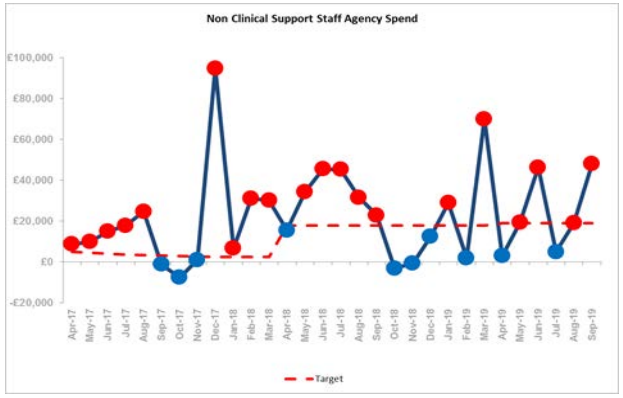


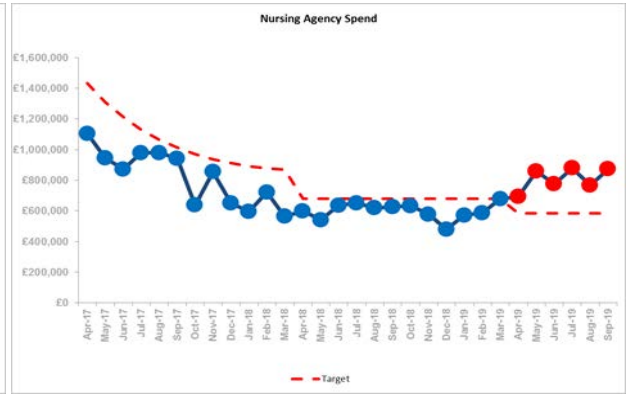


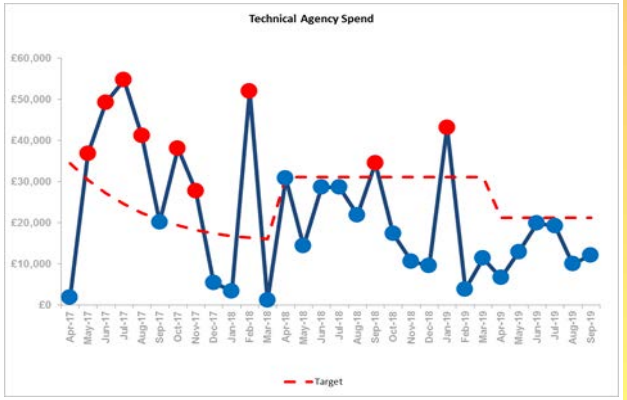








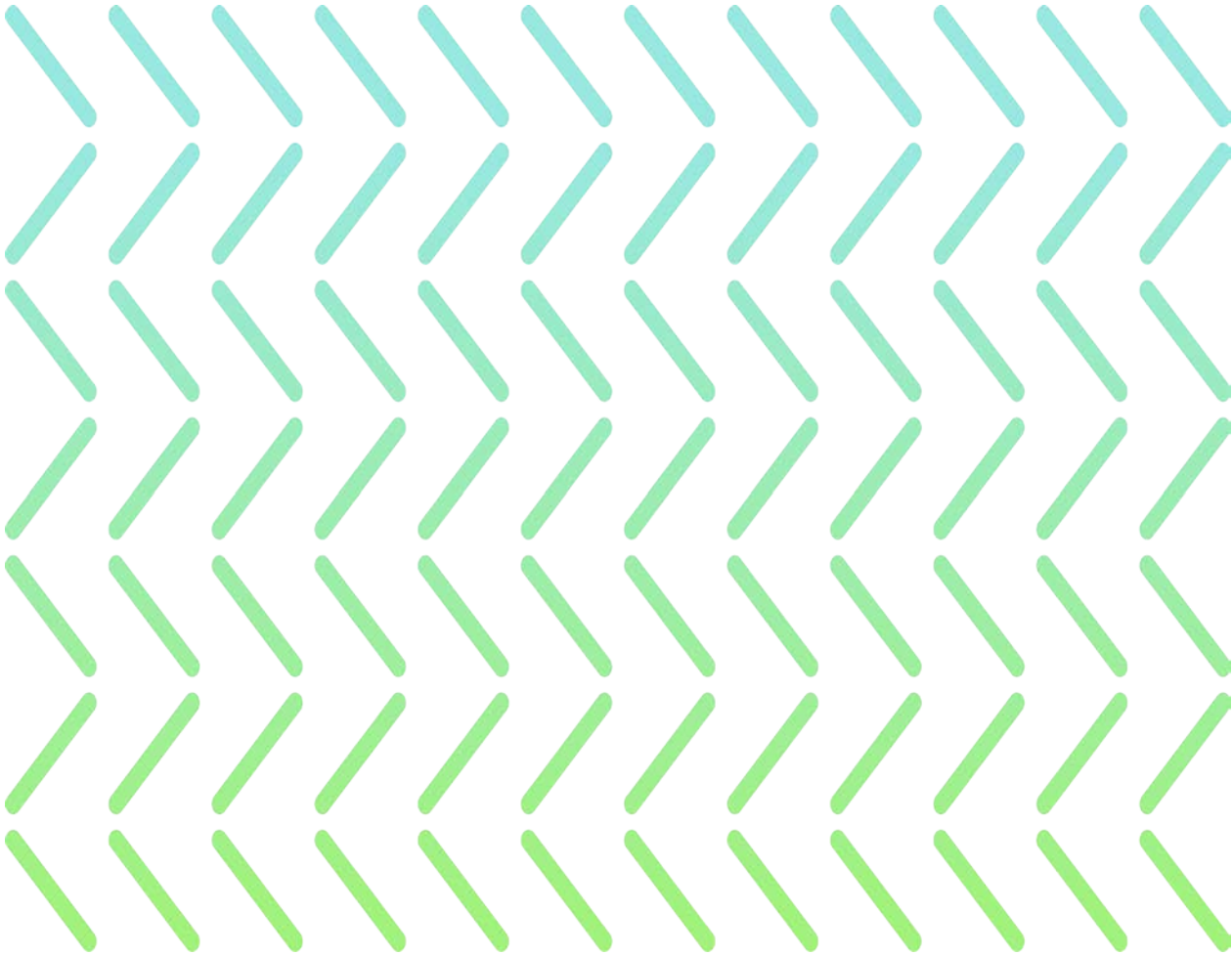




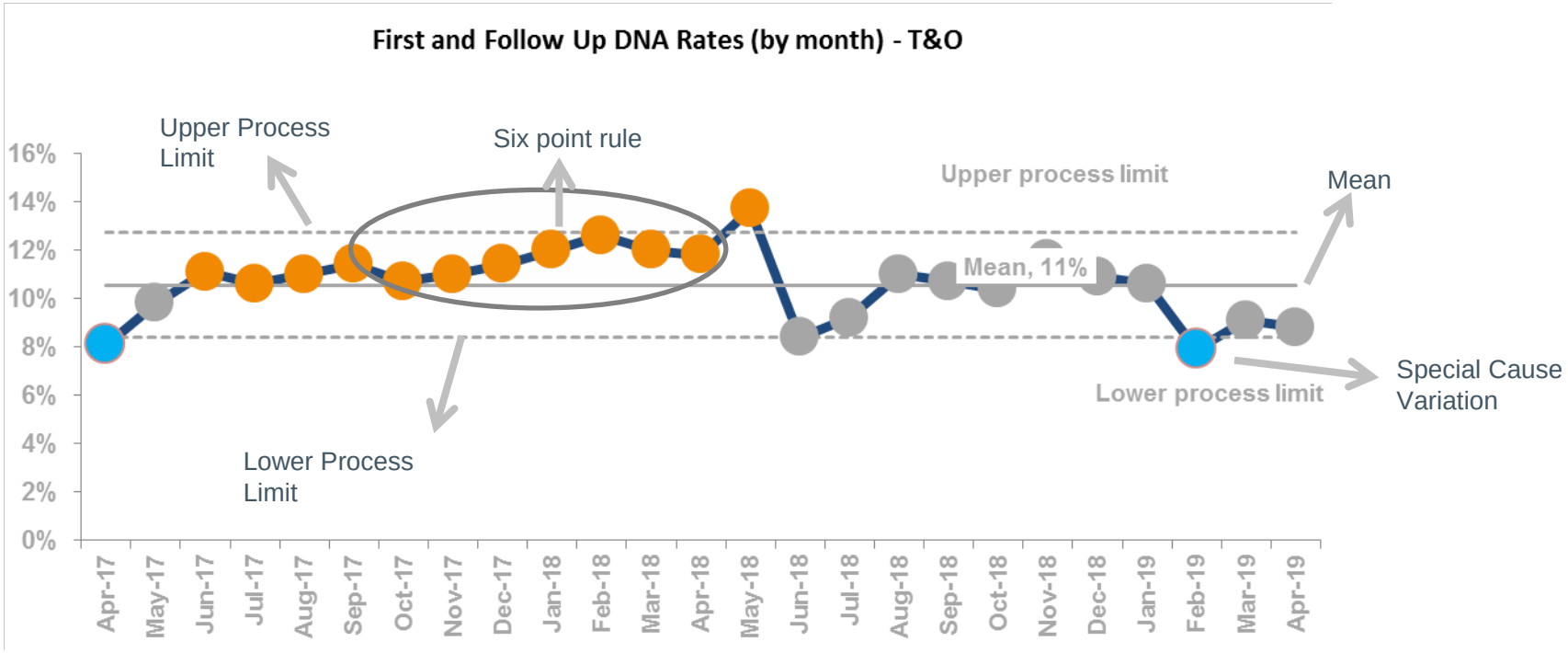
Our People Perspective

Appendix

Additional Information and Data Tables



Interpreting SPC (Statistical Process Control) Charts



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

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

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

Productivity Tables

First Outpatient Attendances (average per working day)

														First Outpatient Attendances per working day			
Directorate	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Attendances in the last month**	**2018-19 YTD**	**2019-20 YTD**	**Variance**	**Variance**
Cardiology, Cardiothoracic & Vascular Services	58	59	67	51	59	58	59	58	68	64	58	54	57	1,203	59	60	1	⇧ 0.9%
Children's Services	50	45	51	38	50	47	46	42	50	45	43	39	43	902	46	44	-2	⇩ -4.8%
Neurosciences	81	84	88	74	94	81	75	86	82	88	82	72	74	1,560	79	81	1	⇧ 1.9%
Renal & Oncology	23	27	28	23	26	25	24	25	25	27	25	24	27	569	25	26	0	⇧ 0.9%
Specialist Medicine	144	142	150	126	148	147	148	148	158	159	155	131	145	3,036	144	149	5	⇧ 3.8%
Surgery	270	279	275	257	268	264	278	250	252	269	253	243	234	4,921	271	250	-20	⇩ -7.5%
Womens Services	89	86	90	78	88	92	82	91	78	82	87	83	69	1,441	87	82	-5	⇩ -6.2%
T&O	55	52	55	48	53	54	51	52	51	54	53	42	56	1,177	56	51	-5	⇩ -9.0%
Other	36	37	34	36	39	33	32	60	60	62	59	52	56	1,167	38	58	20	⇧ 53.4%
Total	**805**	**812**	**838**	**731**	**826**	**801**	**791**	**812**	**823**	**850**	**813**	**740**	**761**	**15,976**	**805**	**800**	**-5**	⇩ -0.6%

Follow-up Outpatient Attendances (average per working day)

														FollowUp Outpatient Attendances per working day			
Directorate	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Attendances in the last month**	**2018-19 YTD**	**2019-20 YTD**	**Variance**	**Variance**
Cardiology, Cardiothoracic & Vascular Services	117	107	124	104	113	106	96	100	100	105	94	92	109	2,280	112	100	-12	⇩ -11.0%
Children's Services	87	81	90	73	83	84	70	78	82	78	72	70	73	1,525	78	75	-2	⇩ -2.8%
Neurosciences	122	117	123	104	124	118	101	121	118	122	107	103	99	2,080	113	112	-1	⇩ -1.1%
Renal & Oncology	248	245	243	229	238	223	230	242	229	221	219	211	222	4,656	224	224	0	⇩ -0.2%
Specialist Medicine	533	509	529	481	528	537	526	573	538	544	528	483	504	10,576	507	528	22	⇧ 4.3%
Surgery	357	352	362	331	382	350	335	317	331	327	321	291	306	6,067	355	316	-39	⇩ -11.0%
Womens Services	78	69	76	64	69	65	52	58	61	65	53	59	53	1,104	60	58	-2	⇩ -3.1%
T&O	82	85	93	76	86	85	76	82	79	81	75	70	77	1,469	82	77	-5	⇩ -5.5%
Other	97	92	91	77	91	92	87	119	121	125	125	104	109	2,287	94	117	23	⇧ 24.8%
Total	**1,721**	**1,656**	**1,730**	**1,539**	**1,713**	**1,661**	**1,574**	**1,689**	**1,659**	**1,668**	**1,593**	**1,483**	**1,550**	**30,108**	**1,624**	**1,607**	**-17**	⇩ **-1.0%**

First to Follow-up Ratio

														First to FollowUp Ratio			
Directorate	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**2018-19 YTD**	**2019-20 YTD**	**Variance**	**Variance**
Cardiothoracic & Vascular Services	2.01	1.81	1.85	2.04	1.92	1.83	1.63	1.72	1.46	1.65	1.62	1.69	1.90	1.89	1.67	-0.22	⇩ -11.6%
Children's Services	1.74	1.80	1.77	1.89	1.66	1.79	1.52	1.85	1.64	1.73	1.69	1.82	1.69	1.71	1.74	0.03	⇧ 1.8%
Neurosciences	1.51	1.39	1.40	1.40	1.32	1.46	1.35	1.40	1.44	1.39	1.30	1.43	1.33	1.43	1.38	-0.05	⇩ -3.4%
Renal & Oncology	10.77	9.08	8.68	10.13	9.15	8.92	9.58	9.68	9.17	8.06	8.76	8.70	8.18	8.92	8.76	-0.16	⇩ -1.8%
Specialist Medicine	3.70	3.58	3.53	3.81	3.57	3.65	3.55	3.87	3.41	3.41	3.42	3.67	3.48	3.53	3.54	0.01	⇧ 0.3%
Surgery	1.32	1.26	1.32	1.29	1.43	1.33	1.21	1.27	1.31	1.21	1.27	1.20	1.31	1.31	1.26	-0.05	⇩ -4.0%
Womens Services	0.88	0.80	0.84	0.82	0.78	0.71	0.63	0.64	0.78	0.79	0.61	0.72	0.77	0.69	0.72	0.03	⇧ 4.0%
T&O	1.49	1.63	1.69	1.59	1.62	1.57	1.49	1.58	1.55	1.51	1.43	1.65	1.38	1.46	1.51	0.06	⇧ 4.0%
Other	2.70	2.49	2.69	2.16	2.33	2.79	2.72	1.98	2.02	2.03	2.11	1.99	1.96	2.49	2.01	-0.47	⇩ -19.0%
Total	**2.14**	**2.04**	**2.06**	**2.10**	**2.07**	**2.07**	**1.99**	**2.08**	**2.02**	**1.96**	**1.96**	**2.00**	**2.04**	**2.02**	**2.01**	**-0.01**	⇩ -0.6%

Productivity Tables

First and Follow-up DNA Rate

														Patients not attending rate		
Directorate	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**DNA patients in the last month**	**2018-19 YTD**	**2019-20 YTD**	**Variance**
Cardiothoracic & Vascular Services	9.4%	11.5%	10.9%	10.5%	10.9%	10.3%	10.1%	9.0%	9.6%	9.8%	9.6%	8.5%	8.3%	262	10.4%	9.1%	⇩ -1.2%
Children's Services	10.0%	11.3%	10.1%	10.9%	10.9%	10.9%	10.2%	10.9%	12.3%	10.4%	11.1%	12.4%	11.1%	325	13.4%	11.4%	⇩ -2.0%
Neurosciences	10.0%	10.6%	9.6%	10.2%	10.3%	10.6%	11.0%	11.8%	11.9%	11.2%	10.1%	11.1%	10.2%	402	9.8%	11.1%	⇧ 1.2%
Renal & Oncology	10.5%	10.4%	11.0%	10.2%	9.7%	10.1%	9.4%	9.2%	9.9%	10.1%	8.2%	7.6%	7.9%	304	10.4%	8.8%	⇩ -1.6%
Specialist Medicine	11.6%	12.6%	13.1%	11.5%	12.3%	11.2%	10.8%	11.0%	12.8%	12.1%	10.2%	11.4%	11.1%	1,540	12.2%	11.4%	⇩ -0.8%
Surgery	10.2%	12.1%	11.6%	10.8%	10.4%	10.5%	10.4%	10.2%	10.3%	10.0%	8.8%	9.8%	8.8%	1,197	10.8%	9.7%	⇩ -1.2%
Womens Services	8.2%	8.7%	8.2%	7.4%	6.6%	7.4%	6.8%	8.0%	7.8%	7.8%	6.7%	7.4%	7.4%	522	8.5%	7.5%	⇩ -1.0%
T&O	10.7%	10.4%	11.6%	10.9%	10.6%	7.9%	9.1%	8.8%	10.7%	9.4%	9.3%	9.0%	10.5%	335	10.8%	9.6%	⇩ -1.2%
Other	12.5%	14.4%	15.4%	14.2%	12.9%	12.9%	14.3%	14.2%	13.4%	12.8%	12.6%	14.3%	14.8%	1,533	11.7%	13.7%	⇧ 2.0%
Total	**10.6%**	**10.5%**	**10.5%**	**10.9%**	**10.8%**	**10.5%**	**10.6%**	**10.7%**	**11.2%**	**10.7%**	**9.7%**	**10.6%**	**10.4%**	**6,420**	**11.3%**	**10.5%**	⇩ -0.7%

Elective & Daycase activity (average per working day)

Months	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**2018-19 YTD**	**2019-20 YTD**	**Variance**	**Discharges for month**
Cardiology & Cardiac Surgery	15.7	14.0	16.8	13.8	14.7	17.2	16.2	12.0	13.3	15.4	13.7	13.6	14.4	15.8	13.7	-12.9%	302
Clinical Haematology	2.2	1.7	1.5	1.8	1.0	1.3	1.4	0.8	0.8	0.7	1.4	1.1	0.4	1.9	0.9	-54.4%	8
Diabetes & Endocrinology	2.0	2.0	1.8	1.2	2.0	1.6	1.8	1.8	2.7	1.9	1.6	1.6	1.9	1.9	1.9	1.0%	39
Endoscopy & Gen Med	56.3	54.6	59.2	49.7	57.3	56.4	61.6	57.4	68.5	70.8	65.3	61.7	60.0	57.4	63.9	11.4%	1,261
Ear, Nose & Throat	9.1	8.9	7.8	7.1	9.5	7.9	7.9	8.5	8.3	8.9	8.3	7.5	8.1	8.2	8.3	0.3%	171
General Surgery	11.1	9.9	10.7	10.4	10.7	10.5	12.8	8.1	7.1	8.5	7.2	6.7	7.0	9.7	7.4	-23.3%	148
Gynaecology and Obstetrics	10.2	11.4	11.2	8.8	11.0	10.8	10.4	9.9	10.8	10.5	10.3	8.8	10.7	10.3	10.2	-1.3%	225
Max Fax & Dental	7.4	6.4	6.4	5.5	6.7	7.2	5.4	6.1	7.3	7.2	6.5	5.8	6.0	6.6	6.5	-2.3%	126
Neurosurgery	10.0	8.9	10.1	8.9	8.2	9.3	10.5	8.8	10.3	9.1	8.1	8.5	7.3	9.1	8.7	-4.7%	152
Neurology	25.6	30.0	28.8	24.2	28.7	34.3	31.0	32.4	33.3	32.1	31.9	27.8	27.7	25.5	30.9	21.2%	582
Oncology	1.6	1.8	1.2	1.5	2.8	2.7	1.8	4.0	3.4	3.6	3.8	4.1	3.3	1.7	3.7	112.9%	70
Paediatric Medicine	9.6	12.0	10.3	10.9	10.5	12.5	11.9	12.9	12.3	12.6	11.2	10.5	11.7	9.6	11.9	23.3%	245
Paediatric Surgery	9.9	9.2	10.7	8.4	9.6	10.0	10.0	8.9	10.3	8.2	8.9	9.0	7.8	8.6	8.9	2.6%	163
Pain Clinic	5.3	5.3	6.2	5.2	5.1	5.3	5.3	4.5	3.1	5.2	3.3	2.3	4.1	5.2	3.7	-27.8%	87
Plastic Surgery	18.8	17.1	18.3	15.9	17.1	17.4	16.5	15.0	19.3	18.5	15.1	16.6	14.0	18.0	16.4	-8.6%	293
Renal Medicine	5.4	4.7	3.8	4.4	3.2	5.2	3.7	4.3	6.5	5.1	4.3	5.5	4.7	5.3	5.1	-3.8%	99
Trauma & Orthopaedics	6.5	6.4	8.5	6.0	7.7	8.5	6.4	7.3	8.0	9.2	6.0	6.1	5.3	7.0	7.0	-0.1%	112
Urology	13.4	14.5	14.0	12.9	13.4	14.8	13.2	15.8	13.0	13.7	14.1	12.6	14.9	12.4	14.0	13.4%	61
Thoracic Surgery	2.4	2.5	2.9	2.7	2.3	3.2	3.1	2.2	3.0	3.3	2.9	3.2	2.9	2.9	2.9	1.5%	108
Vascular Surgery	4.7	5.1	4.6	4.3	5.1	3.9	4.4	4.4	4.8	4.1	4.5	3.7	5.1	4.9	4.4	-10.2%	313
Other	4.8	5.3	5.6	5.5	6.5	6.6	4.2	7.5	7.4	8.6	9.3	9.4	7.3	5.7	8.2	44.5%	154
Grand Total	**231.5**	**231.9**	**240.6**	**209.4**	**233.1**	**246.3**	**239.4**	**232.3**	**253.7**	**256.7**	**237.8**	**226.0**	**224.7**	227.6	238.5	4.8%	4,719

Daycase as a percentage of all Elective Activity	75.3%	76.6%	77.0%	75.0%	77.7%	77.1%	74.8%	77.0%	77.7%	77.2%	78.8%	76.8%	76.6%

Productivity Tables

Percentage of Daycase Activity

Months	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	2018-19 YTD	2019-20 YTD	Variance
Cardiology & Cardiac Surgery	54%	54%	56%	50%	51%	54%	54%	50%	49%	49%	50%	50%	51%	52%	50%	-2.4%
Clinical Haematology	68%	69%	50%	51%	57%	77%	45%	27%	17%	43%	52%	52%	58%	65%	41%	-23.7%
Diabetes & Endocrinology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0.0%
Endoscopy & Gen Med	98%	99%	99%	99%	99%	99%	98%	99%	97%	98%	97%	96%	96%	99%	97%	-1.3%
Ear, Nose & Throat	44%	40%	49%	31%	43%	39%	28%	39%	49%	37%	51%	42%	47%	47%	44%	-2.9%
General Surgery	50%	41%	42%	30%	52%	51%	31%	42%	40%	36%	42%	42%	44%	50%	41%	-9.0%
Gynaecology and Obstetrics	75%	75%	76%	76%	75%	73%	74%	72%	72%	69%	68%	70%	70%	74%	70%	-3.3%
Max Fax & Dental	55%	49%	57%	51%	63%	55%	57%	56%	62%	62%	58%	52%	53%	57%	57%	0.2%
Neurosurgery	33%	35%	34%	32%	34%	30%	31%	26%	31%	28%	33%	32%	33%	35%	30%	-4.2%
Neurology	93%	95%	96%	96%	94%	95%	95%	96%	96%	95%	96%	95%	96%	94%	96%	1.6%
Oncology	69%	56%	63%	62%	79%	76%	65%	82%	79%	82%	82%	81%	81%	57%	81%	24.6%
Paediatric Medicine	96%	94%	93%	98%	94%	96%	94%	95%	96%	96%	98%	95%	94%	89%	96%	6.5%
Paediatric Surgery	81%	85%	88%	84%	84%	81%	84%	80%	85%	77%	80%	79%	80%	80%	80%	0.6%
Pain Clinic	93%	92%	93%	94%	91%	93%	100%	92%	88%	92%	92%	100%	82%	92%	91%	-1.5%
Plastic Surgery	79%	81%	79%	81%	78%	80%	75%	79%	79%	83%	85%	81%	81%	78%	81%	3.5%
Renal Medicine	79%	81%	75%	81%	81%	81%	73%	77%	81%	84%	72%	73%	81%	78%	78%	-0.1%
Trauma & Orthopaedics	57%	63%	63%	60%	75%	71%	72%	63%	61%	69%	68%	66%	68%	65%	66%	0.7%
Urology	50%	54%	56%	55%	56%	52%	47%	58%	51%	50%	61%	54%	57%	50%	55%	5.1%
Thoracic Surgery	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%	0.0%	2%	0%	-2.2%
Vascular Surgery	42%	50.4%	50.5%	61.0%	52.7%	52.6%	48.9%	43%	52.5%	48%	48%	31%	58.1%	41%	47%	5.8%
Other	89%	89%	85%	84%	92%	93%	84%	77%	76%	79%	86.9%	75%	75%	90%	78%	-11.9%
Grand Total	75%	77%	77%	75%	78%	77%	75%	77%	78%	77%	79%	76%	76.8%	76%	77%	1.3%

Productivity Tables

Theatre Utilisation

Main List Specialty	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Number of Patients in the last month
Cardiothoracic	70%	70%	73%	72%	72%	80%	74%	70%	70%	75%	70%	73%	75%	76
ENT	76%	77%	82%	78%	80%	76%	74%	75%	78%	72%	73%	82%	82%	171
General Surgery	82%	80%	82%	84%	78%	78%	82%	81%	80%	88%	80%	72%	76%	129
Gynaecology	77%	83%	87%	81%	79%	88%	74%	81%	71%	78%	84%	81%	84%	135
Neurosurgery	78%	76%	81%	80%	82%	78%	75%	79%	78%	78%	79%	79%	81%	124
Oral and Maxillo Facial Surgery	82%	63%	84%	78%	84%	67%	91%	61%	72%	84%	87%	67%	65%	22
Paediatric Dentistry	55%	56%	60%	62%	65%	68%	65%	58%	80%	64%	59%	74%	68%	30
Paediatric Surgery	75%	74%	72%	75%	76%	82%	74%	77%	79%	79%	80%	78%	80%	111
Plastic Surgery	75%	77%	74%	78%	74%	75%	69%	76%	87%	72%	74%	74%	69%	175
Renal Medicine & Surgery	61%	67%	82%	60%	66%	67%	83%	66%	88%	69%	79%	77%	77%	18
Trauma & Orthopaedics	82%	90%	85%	90%	81%	83%	90%	83%	81%	84%	88%	84%	74%	93
Urology	84%	85%	86%	81%	86%	82%	80%	79%	78%	79%	82%	77%	79%	197
Vascular Surgery	74%	76%	70%	74%	76%	82%	75%	68%	73%	74%	72%	67%	75%	97
Grand Total	**78%**	**79%**	**80%**	**80%**	**79%**	**79%**	**77%**	**77%**	**77%**	**78%**	**78%**	**77%**	**77%**	**1,378**

Theatre Average Cases per Session

Main List Specialty	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Cardiothoracic	1.3	1.4	1.5	1.5	1.5	1.7	1.4	1.5	1.6	1.6	1.6	1.6	1.6
ENT	1.7	1.7	1.7	1.6	1.9	1.6	1.6	1.7	1.9	1.9	1.8	2.0	2.0
General Surgery	1.7	1.8	1.7	1.6	1.8	1.7	1.6	1.8	1.8	1.6	1.5	1.7	1.4
Gynaecology	2.5	2.6	2.5	2.9	2.7	2.6	2.3	2.5	2.2	2.4	2.5	2.4	2.7
Neurosurgery	1.0	1.0	1.1	1.2	1.1	1.0	1.1	1.1	1.1	1.1	1.1	1.1	0.9
Oral and Maxillo Facial Surgery	3.9	3.1	3.8	3.8	3.7	3.1	4.0	2.7	3.1	3.4	3.2	3.0	3.0
Paediatric Dentistry	4.1	3.9	4.5	4.7	4.4	4.3	4.1	3.9	4.9	4.2	3.8	3.8	3.8
Paediatric Surgery	2.7	2.6	2.7	2.7	2.6	2.5	2.6	2.4	2.7	2.2	2.5	2.2	2.8
Plastic Surgery	2.2	2.1	2.0	2.0	1.9	2.0	2.1	1.8	1.8	1.7	1.8	2.0	1.9
Renal Medicine & Surgery	1.3	1.6	1.5	1.4	1.2	1.8	1.5	1.9	2.0	1.2	1.1	1.0	1.4
Trauma & Orthopaedics	1.6	1.9	1.9	1.8	1.9	1.9	1.9	1.8	1.8	2.0	1.7	1.8	1.7
Urology	2.1	2.1	2.0	2.1	2.0	2.0	2.0	2.0	2.1	2.1	2.1	1.8	1.9
Vascular Surgery	1.2	1.1	1.1	1.1	1.0	1.0	1.1	1.0	1.1	1.4	1.4	1.3	1.5
Grand Total	1.7	1.8	1.8	1.8	1.8	1.8	1.7	1.7	1.8	1.8	1.8	1.7	1.7

Productivity Tables

Elective Length of Stay

Directorate	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Discharges in the last month	Average length of Stay 2018-19 YTD	Average length of Stay 2019-20 YTD	Variance
Cardiothoracic	2.9	3.8	3.3	3.7	3.5	4.2	3.6	3.0	3.5	3.9	3.7	3.6	3.6	213	4.0	3.5	⇩ -11%
Children's & Women	3.1	2.5	2.4	2.1	3.8	2.7	3.0	2.4	1.9	2.0	2.2	1.9	3.8	103	2.6	2.3	⇩ -9%
Neurosciences	10.0	8.0	9.3	10.6	10.2	8.4	5.9	10.1	7.8	6.9	11.1	9.4	8.9	149	9.1	9.0	⇩ -1%
Surgery & Trauma	3.4	3.7	3.5	4.6	4.5	3.9	3.5	2.6	2.5	2.6	2.4	2.9	2.0	536	3.8	2.5	⇩ -34%
Grand Total	**4.7**	**4.4**	**4.6**	**5.3**	**5.4**	**4.7**	**4.7**	**3.8**	**3.5**	**3.5**	**4.1**	**4.0**	**3.4**	**1,001**	**4.7**	**3.7**	⇩ -21%

Non-Elective Length of Stay

Directorate	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-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	2.5	2.5	2.7	2.9	2.8	2.8	2.7	2.7	2.5	2.6	2.9	3.4	2,382	2.7	2.8	⇧ 4.07%
Cardiothoracic	8.6	8.8	7.7	8.8	7.6	9.7	11.7	10.2	12.3	9.1	11.2	8.1	10.6	135	8.6	10.3	⇧ 19%
Children's & Women	2.4	2.3	2.4	2.4	2.4	2.9	3.1	3.4	3.6	3.7	3.7	3.2	3.3	795	2.5	3.5	⇧ 42%
Neurosciences	6.6	8.8	9.6	9.8	10.8	13.5	9.3	9.5	11.9	6.8	9.9	10.5	8.3	197	9.5	9.5	⇧ 0%
Senior Health	7.8	7.6	8.7	11.4	12.5	11.1	11.2	12.7	12.6	10.2	12.6	10.6	16.1	76	10.1	12.5	⇧ 23%
Specialist Medicine	6.8	6.4	7.6	7.5	8.3	6.8	8.5	9.5	11.1	11.2	7.9	9.3	7.7	128	7.4	9.4	⇧ 27%
Surgery & Trauma	4.4	4.6	5.1	4.2	5.3	5.0	4.0	4.3	4.2	4.1	4.8	4.1	4.2	868	4.4	4.2	⇩ -3.0%
Therapeutics	15.7	12.0	9.8	21.1	12.3	25.3	11.3	11.0	22.5	23.0	14.1	7.6	12.3	29	11.1	15.1	⇧ 36%
Grand Total	**3.6**	**3.6**	**3.7**	**3.8**	**4.0**	**4.3**	**4.0**	**4.1**	**4.3**	**3.9**	**4.2**	**4.1**	**4.4**	**4,610**	**3.9**	**4.2**	⇧ 8%

Patient Safety

Indicator Description	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Number of Never Events in Month	0	0	2	0	0	1	0	0	1	0	0	1	0	0
Number of SIs where Medication is a significant factor	0	0	1	1	0	0	0	0	0	0	0	0	0	0
Number of Serious Incidents	=<8 month	3	5	6	6	6	6	4	3	7	7	2	4	1
Serious Incidents - per 1000 bed days	N/A	0.13	0.20	0.26	0.26	0.25	0.27	0.16	0.13	0.29	0.30	0.08	0.17	0.04
Safety Thermometer - % of patients with harm free care (all harm)	95%	96.3%	95.1%	95.0%	95.6%	95.9%	96.5%	96.0%	96.1%	96.1%	94.6%	95.4%	95.3%	96.0%
Safety Thermometer - % of patients with harm free care (new harm)	95%	99.0%	98.3%	97.7%	97.6%	98.4%	98.6%	98.3%	98.3%	98.9%	98.0%	97.8%	98.7%	98.2%
Percentage of patients who have a VTE risk assessment	95%	96.2%	96.0%	96.2%	95.5%	95.9%	95.7%	95.5%	87.8%	88.2%	87.6%	93.8%	93.8%	93.9%
Number of Patient Falls	N/A	141	181	173	148	128	147	135	143	135	133	123	158	142
Falls (Moderate and Above Severity)	N/A	0	1	3	1	3	1	2	2	2	1	0	3	0
Number of patient falls- per 1000 bed days	N/A	6.26	7.40	7.50	6.32	5.31	6.57	5.38	6.08	5.63	5.75	4.99	6.58	6.03
Acquired Category 2 Pressure Ulcers	N/A	9	12	25	13	10	16	6	4	17	20	10	15	15
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.40	0.49	1.08	0.56	0.42	0.72	0.24	0.17	0.71	0.86	0.41	0.63	0.64
Acquired Category 3 Pressure Ulcers		2	1	3	7	7	4	11	8	5	8	8	2	3
Acquired Category 3 Pressure Ulcers per 1000 bed days		0.09	0.04	0.13	0.30	0.29	0.18	0.44	0.34	0.21	0.35	0.32	0.08	0.13
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Complaints

Indicator Description	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
% of Complaints responses to within 25 working days	85%	76%	76%	75%	78%	66%	55%	80%	72%	79%	78%	95%	100%	100%
% of Complaints responses to within 40 working days	95%	43%	60%	63%	48%	30%	64%	44%	56%	46%	57%	72%	96%	100%
% of Complaints responses to within 60 working days	95%	None Due	100%	None Due	None Due	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0		0	0	0	0	0	0	1	0	0	0	0	0
PALS Received		335	416	353	252	369	334	280	249	247	218	177	259	232

Patient Priorities

Indicator Description	Threshold/Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Number of 2222 calls / 1000 adult ordinary IP admissions		4.9	9.8	9.4	11.3	11.0	11.1	8.8	7.1	8.9	10.2	12.3	8.6	7.8
Number of Cardiac Arrests / 1000 adult ordinary IP admissions (to become avoidable cardiac arrests)		2.0	0.7	3.4	2.6	3.8	3.3	2.8	4.0	2.8	1.8	3.6	0.9	1.8
% of patients in ED with Red Flag sepsis receiving antibiotics within an hour (adults)	90%	91.6%	91.4%	95.3%	93.5%	94.5%	93.2%	88.3%	90.6%	91.4%	93.5%	87.2%	83.4%	90.3%
Compliance with appropriate response to EWS (adults)	85%	94.7%	92.4%	92.0%	93.3%	95.8%	87.3%	89.6%	92.7%	94.2%	92.9%	90.6%	93.9%	87.6%
Resuscitation BLS	85%	70.5%	70.5%	70.3%	69.8%	70.5%	71.5%	74.1%	76.2%	75.2%	76.0%	75.5%	75.9%	76.4%
Resuscitation ILS	85%	64.2%	64.3%	66.3%	68.5%	70.2%	69.3%	71.3%	72.1%	72.7%	72.0%	72.5%	69.2%	67.9%
Resuscitation ALS	85%	24.2%	27.1%	40.4%	51.2%	64.2%	67.0%	70.4%	72.7%	73.0%	73.5%	74.8%	59.1%	62.7%

Indicator Description	Threshold/Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	77.6%	79.5%	80.8%	83.4%	83.9%	86.3%	88.6%	89.8%	91.8%	90.8%	92.2%	92.1%	90.5%
Mental Capacity Act & Deprivation of Liberties - Level 2	85%					21.7%	32.2%	42.0%	53.2%	62.9%	70.9%	74.3%	73.0%	72.7%
%-age Staff knowledge of Mental Capacity Act - Fully Compliant								76.7%	100.0%	85.0%	75.0%	76.9%	100.0%	90.5%
Staff knowledge of Mental Capacity Act - Number of staff interviewed								30	15	20	12	13	8	21
Total Datix incidents reported in month		1,147	1,345	1,366	1,174	1,333	1,215	1,208	1,096	1,329	1,332	1,413	1,544	1,463
Monthly % of incidents low and no harm									Delayed Not yet available					
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%	92.0%	100.0%	97.0%	data two months in arrears	
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	47%	64%	66%	78%	67%	62%	Compliance timeframe changed from 10 working days to 20 working days						

Emergency Flow

Indicator Description	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
4 Hour Operating Standard	90.3%	90.1%	85.5%	85.6%	84.2%	82.2%	83.1%	85.4%	86.5%	87.0%	86.4%	83.3%	82.3%
Patients Waiting in ED for over 12 hours following DTA	1	0	1	2	0	0	1	1	0	1	2	3	1
Admitted patients with a length of stay 7 Days or Greater	266	287	294	291	315	321	315	298	301	290	314	302	315
Ambulance Handover - % under 15 minutes	46.4%	42.5%	37.4%	37.0%	33.9%	33.0%	33.0%	35.1%	35.2%	36.0%	32.9%	32.4%	
Ambulance Handover - % under 15 minutes (London Average)	52.6%	47.4%	46.5%	44.7%	41.6%	43.1%	45.4%	43.5%	44.4%	42.3%	43.9%	45.0%	
Ambulance Handover - number of patients not handed over within 30 minutes	109	111	138	135	145	87	94	76	112	119	134	172	
Ambulance Handover - % under 30 minutes	94.1%	94.5%	93.0%	93.6%	92.3%	95.1%	93.6%	95.5%	94.3%	93.5%	92.9%	90.8%	
Ambulance Handover - % under 30 minutes (London Average)	92.5%	92.2%	91.5%	90.5%	88.2%	90.3%	92.7%	91.7%	92.2%	90.6%	92.4%	92.3%	
Ambulance Handover - number over 60 minutes	3	0	3	1	13	6	8	6	0	4	2	1	

Diagnostics

Indicator Description	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
6 Week Diagnostic Performance	1%	0.4%	0.2%	0.5%	0.6%	0.5%	0.3%	0.5%	1.6%	0.7%	0.4%	0.95%	0.96%	0.92%
6 Week Diagnostic Breaches	N/A	30	18	39	37	41	24	40	115	59	31	74	74	75
6 Week Diagnostic Waiting List Size	N/A	7,617	7,593	7,322	6,652	7,649	7,754	7,622	7,247	8,274	7,992	7,772	7,737	8,153

Indicator Description	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
MRI	1%	0.1%	0.2%	0.3%	0.6%	0.4%	0.6%	0.1%	0.3%	0.3%	0.0%	0.0%	0.0%	0.1%
CT	1%	0.0%	0.2%	0.1%	0.7%	0.6%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Non Obstetric Ultrasound	1%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	1.0%	0.1%
Barium Enema	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dexa Scan	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	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%	0.8%	0.4%	4.3%	12.1%	4.2%	1.0%	9.0%	4.7%	7.3%
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%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.3%
Sleep Studies	1%	0.0%	0.0%	7.7%	2.4%	1.1%	0.8%	2.7%	4.6%	4.8%	1.4%	1.0%	0.9%	4.0%
Urodynamics	1%	13.9%	14.6%	10.2%	8.5%	16.3%	14.0%	0.0%	5.7%	0.0%	0.0%	2.9%	4.9%	0.0%
Colonoscopy	1%	0.0%	0.7%	3.0%	0.0%	2.9%	1.0%	0.0%	1.0%	0.6%	0.6%	0.9%	0.3%	0.4%
Flexi Sigmoidoscopy	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	0.6%	2.0%	1.4%	1.9%
Cystoscopy	1%	2.6%	3.0%	4.5%	5.4%	3.2%	0.0%	1.9%	3.2%	6.4%	2.6%	3.0%	2.6%	0.0%
Gastroscopy	1%	0.3%	0.0%	0.0%	0.6%	1.4%	0.6%	1.8%	2.1%	2.3%	3.1%	3.7%	2.8%	1.6%

Data tables

On the Day Cancellations

Indicator Description	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Number of on the Day Cancellations		44	55	52	53	60	86	73	49	45	69	69	54	38	46
Number of on the Day cancellations re-booked within 28 Days		39	48	50	52	58	86	71	47	42	68	69	54	38	45
% of Patients re-booked within 28 Days	100%	88.6%	87.3%	96.2%	98.1%	96.7%	100.0%	97.3%	95.9%	93.3%	98.6%	100.0%	100.0%	100.0%	97.8%

Cancer

Indicator Description	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	No of Patients
Cancer 14 Day Standard	93%	95.0%	95.5%	96.3%	95.9%	96.6%	94.4%	93.3%	94.4%	92.4%	90.2%	92.5%	95.6%	95.4%	1,421
Cancer 14 Day Standard Breast Symptomatic	93%	86.4%	97.9%	97.1%	95.4%	96.9%	97.4%	94.6%	94.7%	94.4%	94.9%	93.2%	94.9%	93.0%	158
Cancer 31 Day Diagnosis to Treatment	96%	98.5%	99.0%	99.1%	96.5%	98.2%	97.4%	98.4%	98.1%	96.2%	96.9%	96.0%	97.0%	98.5%	199
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	96.6%	100.0%	96.9%	96.6%	94.6%	97.9%	94.4%	96.2%	100.0%	95.7%	96.7%	100.0%	100.0%	33
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96
Cancer 62 Day Referral to Treatment Standard	85%	85.7%	80.6%	87.8%	88.1%	94.8%	86.2%	77.8%	85.0%	75.6%	71.4%	85.8%	92.7%	87.1%	85
Cancer 62 Day Referral to Treatment Screening	90%	91.6%	94.1%	91.8%	93.2%	82.0%	88.7%	70.5%	76.6%	87.7%	96.5%	93.8%	97.4%	100.0%	17.5

Meeting Title:	Trust Board		
Date:	31 October 2019	**Agenda No.**	2.3
Report Title:	Emergency Care Performance – October 2019		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Lisa Foweather, General Manager for Emergency Department and Acute Medicine Mandy Woodley, Divisional Director of Operations, MedCard		
Presented for:	Note/Assurance		
Executive Summary:	• This paper presents an update on performance against the 95% Emergency Care Operating Standard. • The paper describes the current issues and the actions being taken to improve flow and performance. • There has been deterioration in the Emergency Care standard since October / November 2018. The trust committed to a minimum of 90% delivery of the Emergency Care Operating Standard in 2019/20. • Performance for 2019/20 is currently 84.89% (17/10/2019). • To drive improvement and compliance with the 95% 4 hour standard and 100% ambulance off load standard at St Georges Hospital NHS Foundation Trust, an Emergency Care Delivery Board (ECDB) weekly meeting chaired by the Chief Executive that is accountable to the Trust Executive Committee has been established.		
Recommendation:	The Board is asked to note the update on performance against the 4 hour Emergency Care Operating Standard and the actions being taken to improve performance through the establishment of the Emergency Care Delivery Board.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person. Right care, right place, right time.		
CQC Theme:	Safe, Effective, Responsive, Well-led		
Single Oversight Framework Theme:	Operational Performance, Leadership and Improvement, Quality of Care		
Implications			
Risk:	Emergency Care Performance is on the Divisional risk register		
Legal/Regulatory:	NHS Operating Standard.		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee Finance & Investment Committee	**Date:**	24/10/2019
Appendices:	1. Emergency Care Delivery Board Workstreams		

1.0 Purpose

This paper presents an update on performance against the 95% Emergency Care Operating Standard. The paper describes the issues currently impacting upon performance and the actions being taken to maintain flow and performance.

2.0 Current Emergency Care Performance

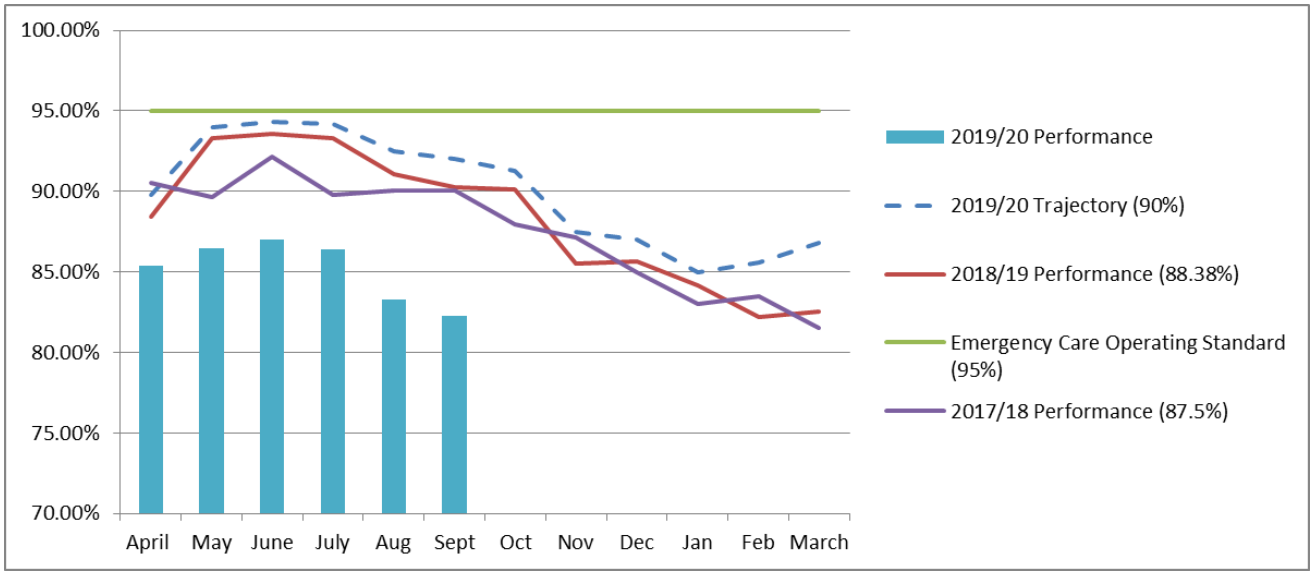
There has been deterioration in the Emergency Care standard since October / November 2018. The trust committed to a minimum of 90% delivery of the Emergency Care Operating Standard in 2019/20.

Performance for 2019/20 is currently 84.89% (17/10/2019)

- Admitted performance is at 55.36% against the original plan of 80%
- Non admitted performance is at 88.37% against a national requirement of 98%

The chart (Fig1) below outlines current performance against trajectory as at the end of September 2019.

Fig 1. Emergency Care Performance against Trajectory



Emergency Care Performance year on year

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2019/20 Trajectory (90%)	89.80%	94.00%	94.30%	94.20%	92.50%	92.00%	91.30%	87.50%	87.00%	85.00%	85.60%	86.80%
2019/20 Performance	85.36%	86.48%	87.00%	86.37%	83.30%	82.29%						
2018/19 Performance (88.38%)	88.41%	93.31%	93.59%	93.28%	91.09%	90.26%	90.11%	85.49%	85.64%	84.15%	82.23%	82.51%
Admitted Performance	56.82%	61.77%	56.63%	55.74%	49.87%	51.30%						
Non-Admitted Performance	88.98%	88.51%	90.71%	89.50%	87.08%	85.43%						
Emergency Care Operating Standard (95%)	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
2017/18 Performance (87.5%)	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	87.97%	87.17%	84.99%	83.02%	83.52%	81.50%

The number of Long Length of Stay (LLoS) patients with a length of stay of >7 days and >21 days remains high at 308 and 140 respectively. This has an impact on the bed occupancy across the trust impacting upon flow and admitted performance.

3.0 Actions to improve performance

There has been deterioration in the Emergency Care standard since October / November 2018. The system requested that ECIST assist in providing a clear diagnostic across all emergency care pathway in and out of the hospital. Verbal feedback was received at the end of the initial visit by ECIST and subsequently the initial draft report has been received which is being reviewed by the Trust's teams for factual accuracy (feedback on the draft and confirmation of factual accuracy to be returned to ECIST by close of play Wednesday 23rd October 2019).

To drive improvement and compliance with the 95% 4 hour standard and 100% ambulance off load standard at St Georges Hospital NHS Foundation Trust, an Emergency Care Delivery Board (ECDB) weekly meeting chaired by the Chief Executive that is accountable to the Trust Executive Committee has been established.

a. The ECDB will provide regular trust wide briefings, embedding the awareness and culture of the delivery of 4 hour standard and it being embedded across the organisation. The medicine and cardiovascular division remains responsible for the 4 hour standard on behalf of the trust.

b. The ECDB will specifically identify bottlenecks and pressures within each step of the patient's journey through the existing urgent and emergency care pathway:
    - Prior to ED
    - Flow within the hospital
    - Discharge and out of hospital care
    - Review and work with the whole urgent and emergency care system to strengthen and agree alternative pathways

c. The ECDB action plan has been divided into eight workstreams listed below and detailed in Appendix 1:
    - Inter professional standards
    - Recruitment and Retention
    - Leadership, Cultural Change, Care & Compassion
    - Flow (Access/Discharge)
    - Emergency Care Processes (All divisions)
    - Mental Health (ED)
    - UCC Waits and Direct Access
    - IT

4.0 Recommendation

4.1 The Finance and Improvement Committee is asked to note the update on performance against the 4 hour Emergency Care Operating Standard and the actions being taken to improve performance through the establishment of the Emergency Care Delivery Board.

Appendix 1: Emergency Care Delivery Board Workstreams

Emergency Care Delivery Board
Working Together

(Updated 11/10/19)

Workstreams

Inter professional Standards

LEADS
Medical: Richard Jenning
Nursing: Jo Hunter/Steph Sweeney/Alison Ludlum
DDO: Mandy/Anna/Emilie
Admin: All PAs

Audit IPR responses (to managing emergency admissions)
Identify alternative pathways
Specialties to actively Pull from ED
ED Consultants leading challenge to specialties pathways /protocaols all in one place from ED (all SOPS)

Recruitment and Retention

LEADS
Medical: Paul Holmes
Nursing: Tori Cooper
GM: Lisa Foweather
Admin: Katherine Hunt

Reduce agency spend
Reduce vacancy rate
Reduce turnover rate
Implement a live workforce tracker (Trust wide Visibility)

Leadership Cultural Change Care & Compassion

LEADS
Medical: Jane Evans
Nursing: Jo Hunter
DDO: Mandy Woodley
Admin support: Kirsty McKinnon

CIC leadership/pace
Employee Wellbeing
Governance
Culture and Behaviour
Team Working

Flow (Access/Discharge)

LEADS
Medical: Jane Evans/Tunde Odutoye
Nursing: Jo Hunter / Steph Sweeney/ Alison Ludlum
DDO: Mandy/Anna/Emilie
Admin: All PAs

Safer (R2G)/Discharge Planning
MFFD/Therapy input
Site - bed allocation OPEL - Escalation/de-scalation
Long Length of Stay
ED internal track & trigger outlier review process
QMH beds

Emergency Care Processes (All Divisions)

LEADS
Medical: All CD's/CG leads
Nursing: All HON & Matrons
GM: All GM's
Admin: All DGM's

Support all process change agreed in ECDB
Standardising ways of working (reduce variability)
Clinical Pathway Review
Safeguarding Patients
Overnight breach performance

Mental Health (ED)

LEADS
Medical: Sunil Dasan
Nursing: Tori Cooper
GM: Lisa Foweather
Admin: Katherine Hunt

Management of MH patients in ED
Review Provision of an appropriate safe environment (inc older patients with MH problems).
Provision of adequate mental health staff education/training

UCC Waits and Direct Access

LEADS
Medical: Phil Darcy
Nursing: All HON & Matrons
GM: All GM's
Admin: All DGM's

Standardised streaming to assessment areas
Improved productivity in UCC
Whole system comms re Direct Access Pathways

IT

LEADS
Medical: Paul Holmes
Nursing: Tori Cooper / Daryl Desmond
GM: Lisa Foweather
Admin: Katherine Hunt

Cerner Capability (Site visit)
Coding in ED
Depart Process
Hardware Review
Interoperability of systems

Meeting Title:	Trust Board		
Date:	31 October 2019	**Agenda No**	2.4
Report Title:	Cardiac Surgery Service Update		
Lead Director/ Manager:	Richard Jennings, Chief Medical Officer		
Report Author:	Richard Jennings, Chief Medical Officer		
Presented for:	Assurance		
Executive Summary:	This report provides an update to the Trust Board on the sources of assurance, internal and external, regarding the safety of the Cardiac Surgery Service and the on-going steps being taken to improve quality within the Service, following the National Institute for Cardiovascular Outcomes Research (NICOR) safety alerts in May 2017 and April 2018 and the findings of the independent report by Professor Bewick (July 2018). This report focusses particularly on the update from NICOR, now published by the Society for Cardiothoracic Surgery (SCTS) that confirms that the Risk Adjusted In-Hospital Survival Rate for the Service over the last 3 years is 'Within limits'.		
Recommendation:	The Trust Board is asked to discuss and take assurance from the update on progress and key performance indicators 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 (Well Led)		
Implications			
Risk:	As set out in the paper.		
Legal/Regulatory:	The paper details the Trust's engagement with regulators on this issue.		
Resources:	National Adult Cardiac Surgery Audit (NACSA) outcomes data, as published by National Institute for Cardiovascular Outcomes Research (NICOR).		
Equality and Diversity:	N/A		
Previously Considered by:	Trust Executive Committee Quality and Safety Committee	**Date**	23.10.19 24.10.19
Appendices:	None		

Cardiac Surgery Service Update
Trust Board, 31 October 2019

1.0 PURPOSE

1.1 To provide an update to the Trust Board on the progress being made with Cardiac Surgery since the presentation to the Trust Board in September 2019.

2.0 BACKGROUND

2.1 This report provides an update to the Trust Board on the steps being taken to improve the Cardiac Surgery Service following the National Institute for Cardiovascular Outcomes Research (NICOR) safety alerts in June 2017 and April 2018 and the findings of the independent report by Professor Bewick (July 2018).

3.0 UPDATE ON PATIENT SAFETY INDICATORS

a) External assurance; Update from NICOR

One key measure of patient safety in a Cardiac Surgery Unit is the Risk Adjusted In-Hospital Survival Rate. This Trust, in common with all other Trusts that undertake Cardiac Surgery, submits its outcome data to the National Institute for Cardiovascular Outcomes Research (NICOR), as part of National Adult Cardiac Surgery Audit (NACSA). NICOR uses this data to identify:

- Trusts that are 'Within limits' – in other words, with survival rates that are as expected nationally
- Trusts with significantly higher (i.e. better) survival than expected
- Trusts that are 'in alarm' because their survival is worse than expected

NICOR issues an alarm for Trusts with a survival rate that is 3 Standard Deviations (SD) below the national mean. NICOR issues an alert for Trusts with a survival rate that is 2SD below the national mean.

NICOR issues this classification every year, but in order to make the classification statistically meaningful, it is always based on the previous three years' outcomes on a rolling basis.

The NICOR data and classification is published by the Society for Cardiothoracic Surgery (SCTS).

NICOR issued St George's in an alert in May 2017 and April 2018.

St George's has never received a NICOR alarm.

Since the last paper to the Trust Board, the SCTS has published the most recent NICOR data and classification, which shows the Risk Adjusted In-Hospital Survival Rate for the period April 2015 – March 2018. This data shows that the Survival Rate for St George's Cardiac Surgery Service is 'Within limits' for this period, and NICOR has sent separate written assurance to the Associate Medical Director for Cardiac Surgery to confirm that the Cardiac Surgery Unit.

This is a very significant new source of assurance regarding the current safety of the unit.

b) External assurance; CQC

A CQC inspection of the Cardiac Surgery Service took place in August 2018 and the report was published in December 2018 and this report confirmed the CQC's view that the Service was safe**.**

c) Internal assurance; Cardiac Surgery monthly dashboard summary

Key patient safety metrics are collected and reviewed on the Cardiac Surgery monthly dashboard. This review occurs monthly at the Cardiac Surgery Steering Group. The patient safety metrics include, hospital acquired infections, pressure ulcers, post-operative stroke, post-operative renal failure, deep wound infection, repeat surgery for bleeding and post-operative deaths.

In accordance with the Trust's Standard Operating Procedure for post-operative deaths in Cardiac Surgery all deaths are considered at the Trust's Serious Incident Declaration Meeting (SIDM). Also in accordance with the Trust's Standard Operating Procedure, all decision making by the SIDM and investigations relating to post-operative deaths within Cardiac Surgery are independently reviewed by a Cardiac Surgery expert at another Trust in South London.

4.0 QUALITY IMPROVEMENT INITIATIVES; CARDIOTHORACIC INTENSIVE CARE UNIT (CTICU) OUT OF HOURS MEDICAL COVER

Under the auspices of the Cardiac Surgery Steering Group (chaired by the Chief Medical Officer), a quality improvement initiative is being undertaken to review, and as appropriate, strengthen out of hours medical cover on the CTICU. This work is being led by the Care Group Lead for CTICU, the Care Group Lead and Associate Medical Director for Cardiac Surgery and the Head of Nursing for Cardiovascular Services.

5.0 EXTERNAL GOVERNANCE; UPDATE

We continue to meet regularly with NHSEI and the CQC and other regional and local stakeholders to provide assurance on the safety of the service and the improvements being made.

6.0 EXTERNAL MORTALITY REVIEW

The Trust has been invited by NHSEI to provide responses on any substantial matters of factual accuracy in the Structured Judgement Reviews produced by the external mortality review panel. The External Mortality Review Panel continues to draft its report.

7.0 CARDIAC SURGERY RISK REGISTER; UPDATE

Since the Trust Board paper there has been no change in the Cardiac Surgery Risk Ratings.

8.0 RECOMMENDATIONS

The Trust Board is asked to discuss and take assurance from the update on progress and key performance indicators in Cardiac Surgery.

Meeting Title:	**Trust Board**		
Date:	31 October 2019	Agenda No.	**2.5**
Report Title:	Q2 - Quarterly Transformation Report		
Lead Director	James Friend, Chief Transformation Officer		
Report Author:	James Friend, Chief Transformation Officer		
Presented for:	Information		
Executive Summary:	This is the second quarterly report for 2019/20 setting out to the Trust Board the approach, progress and impact of the Transformation work.		
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:	Aug, Sept, Oct 2019.
Appendices:	Appendix One – Quarterly Transformation Report to Board 31 October 2019.		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Quarterly Transformation Report to Trust Board October 2019

James Friend

Chief Transformation Officer

17 October 2019

Quarterly Transformation Report to Trust Board
October 2019

Summary

– The Transformation Team have delivered the operationally commissioned improvement projects for Quarter Two and continued to hand back completed cycles to the operational teams.
– The team remain on budget, with a Clinical Fellow joining in Quarter Three to focus on Frailty pathways
– Weekly Delivery and Risk Management governance functions continue as part of the team's control framework.
– The key risks to sustained delivery remain IT system productivity and operational capacity.
– A plan for Transformation over the next two years is being collated with clinical leaders.

Contents

Outstanding care every time

Highlights of Quarter 2 2019-20

- The Trust was awarded as the most innovative trust in South London by the Health Improvement Network.
- More than 320,000 patients received their hospital communications digitally this quarter, helping to get them to the most appropriate environment for their assessment, their treatment and their care.
- The Hybrid Mail project has reduced the in-house printing and posting of 900 letters per week, saving the trust around £37,000 since this phase of the project launched.
- Ten more improvement “Plan-Do-Study-Act” cycles have been completed, with Post Implementation Review posters produced to help share the identified learning across the Trust and with partner organisations.
- The Digestive Health Ambulatory Care initiative has now benefitted over 200 patients, with 142 beddays saved in July alone. Patient feedback remains strong.
- An ambulatory (Same Day Emergency Care) casefile review event led by NHS Elect has identified that about a third of all patients admitted on a non-elective basis have been assessed, treated and cared for through ambulatory care so far this year, delivering the ambition in the NHS Long Term Plan.
- More than 5,000 patients have been assessed and treated in the Urgent Care Centre since the efficiency pilot began.

Outstanding care every time

Digital Transformation

Check-in-kiosks

- During the lifetime of the project there was an increase in the utilisation of outpatient check in kiosks and the number of weekly check-ins from around 600 patients to peak at around 1,400 each week, with 17,600 self check-ins performed in the quarter. The project has now been handed back to the outpatient service.

Text Messaging

- Overall more than 300,000 text reminders were sent from July to September 2019
- This functionality is now live and benefitting patients in Dermatology, Plastics, T&O, Haematology, Audiology, Audiological Medicine, ENT, Neurology, Maxillofacial General Surgery, Colorectal and Upper GI. More than with 77,000 two way text messages were sent in the quarter
- Patient response rates to the two way text reminder are over 40%.
- Project handover to business as usual has commenced

Hybrid Mail

- 102,000 outpatient follow-up appointment letters have been sent via Hybrid Mail in Quarter Two.
- Specialty service teams have been able to reduce the printing and posting of a further 900 letters per week and this level is expected to increase to over 2,000 letters during Quarter Three.

Voice reminders

- Voice reminders will be commenced with one way functionality to test the impact of responding patient call volumes to the Central Booking Service.

No wasted appointments

- The Urology Stones clinics pilot is identifying patients whose diagnostic test has been missed or is scheduled after their upcoming appointment.
- In Q2 the project reviewed 1,127 patients and identified 214 (19%) who required an administrative intervention to avoid the Outpatient appointment being a wasteful experience.

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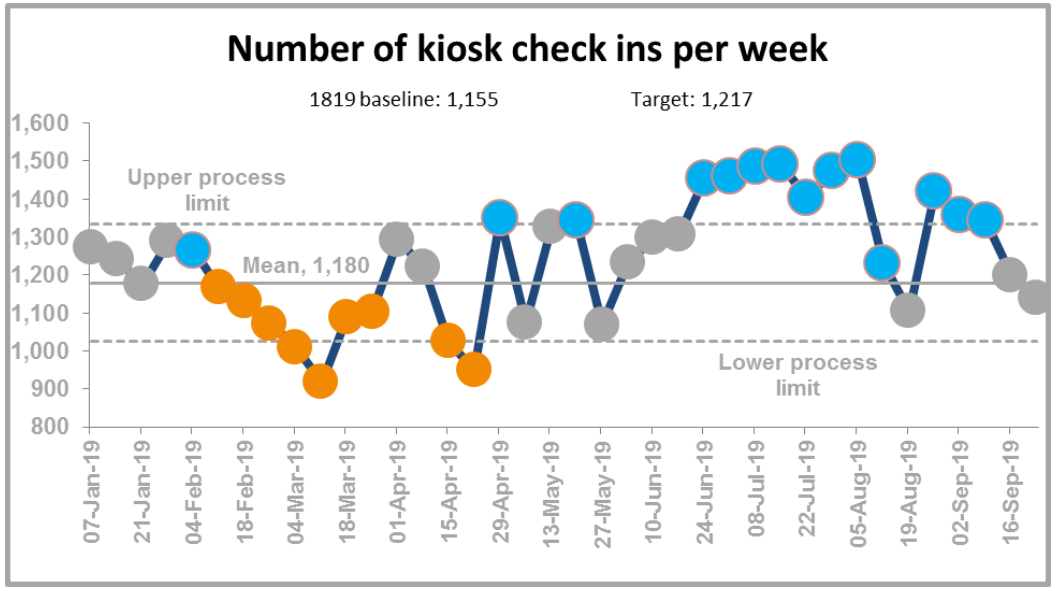
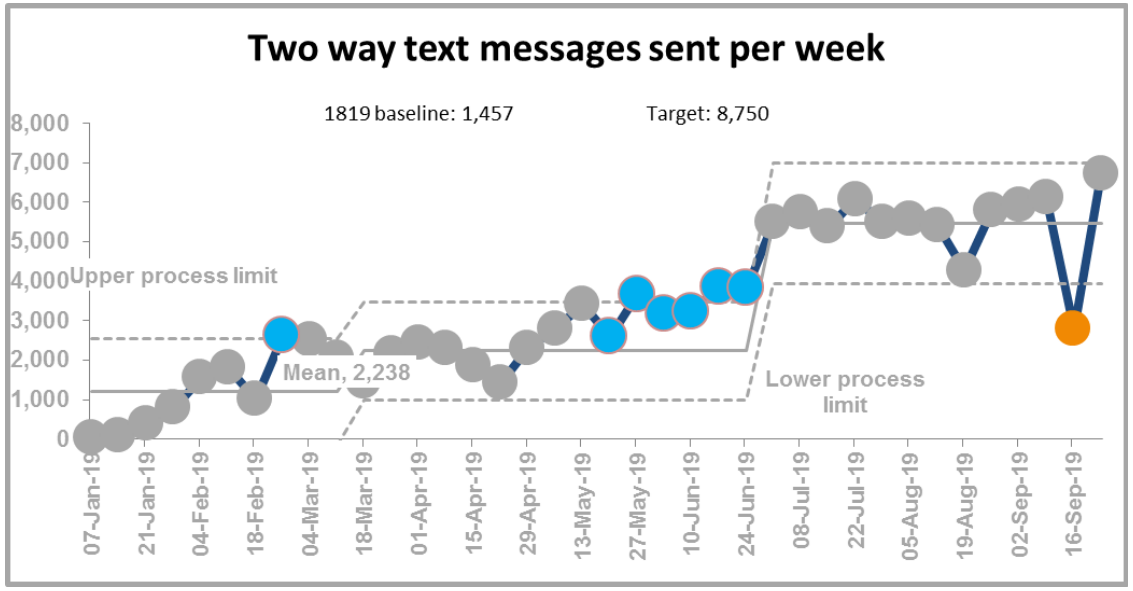
Key Improvement Indicators – Digital Transformation





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Patient Flow

Therapies & Frailty

- To identify a whole systems approach to service provision and gap analysis for frail patients, the Senior Health team completed a seven day service mapping exercise alongside Wandsworth and Merton health and social care partners.

Ambulatory Care & Base Wards

- Surgery Division have identified actions to support ambulatory care within their specialties.
- The Acute Ambulatory Assessment team have held process optimisation sessions to identify improvement opportunities.
- A Multi-Agency Discharge Event was held to expedite inpatient diagnostic tests and assessments that day
- User acceptance testing commenced on the Cerner development to support Red2Green

Place

- The workstream has been refreshed to support patients coming from primary care to directly access specialty assessment and ambulatory care pathways in acute medicine, surgery, paediatrics and gynaecology, helping patients to avoid unnecessary triage and waiting in the Emergency Department.

Urgency

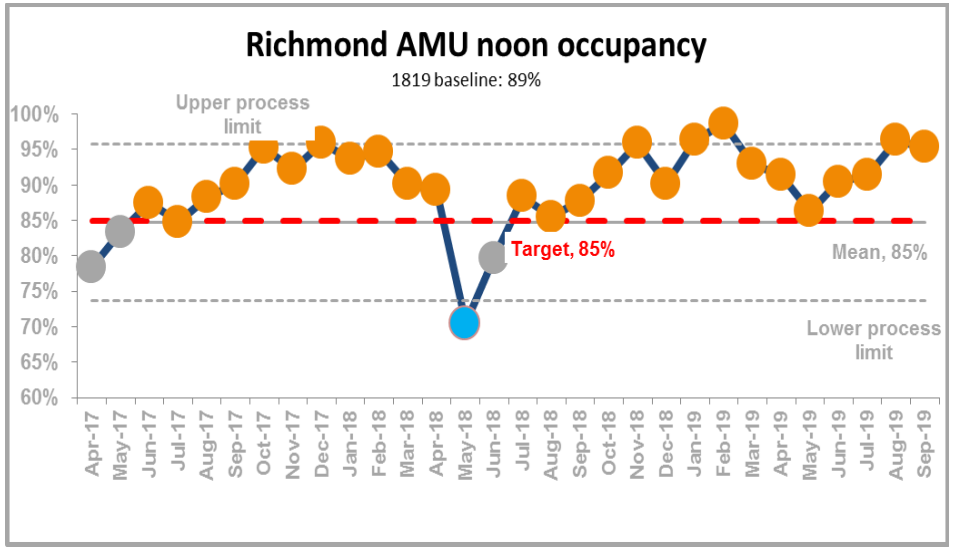
- The completed Urgent Care Centre Efficiency Project showed improvement in staff experience, reduced wasted patient time and a safer environment.
- Developed by St George's ED Consultant Dr Gabriel Jones, a pilot project has been established allowing Urgent and Emergency Care patients to use technology to help clinicians reduce the administration time for their assessment, with queue management functionality to come as a later phase.

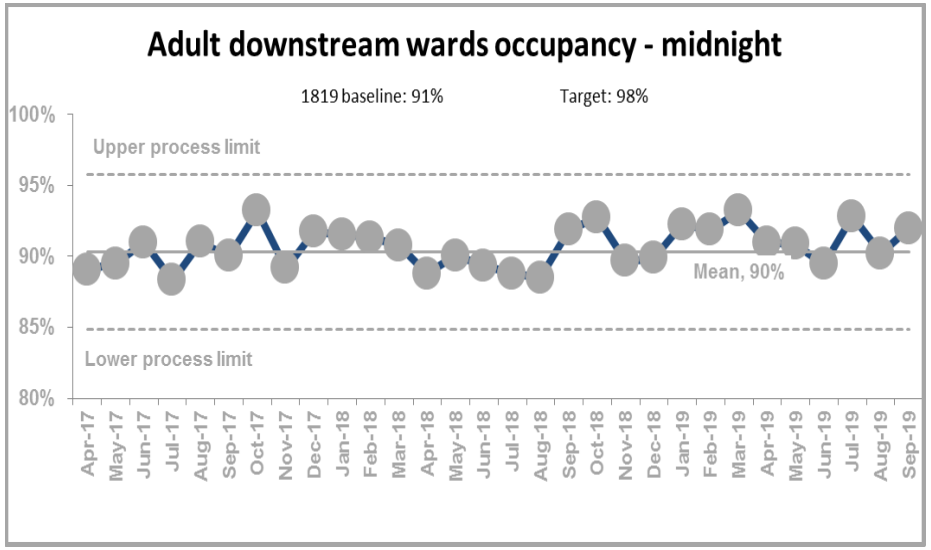
Emergency Floor

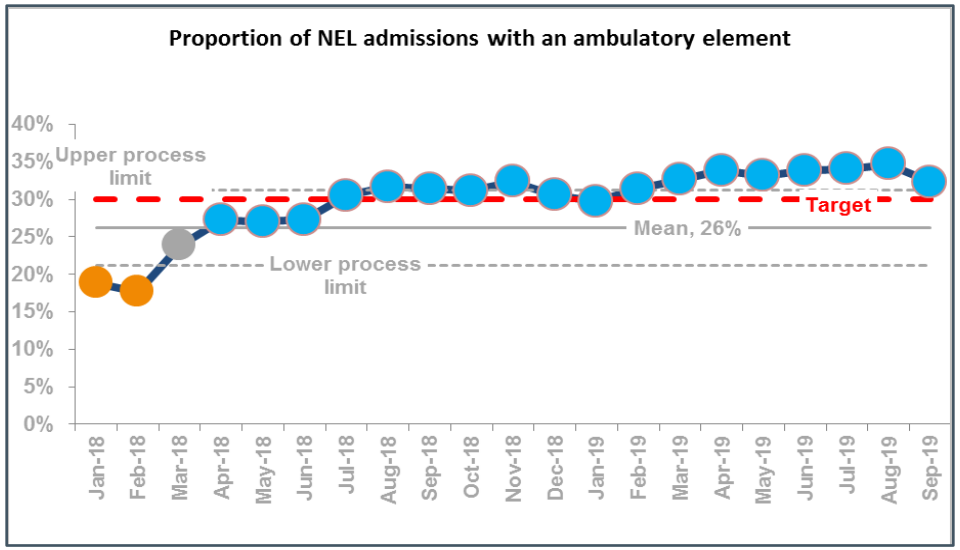
- Dr Jane Evans led a Clinical Reference Forum engagement workshop for more than 50 colleagues to help identify the ideal components and phasing for an Emergency Floor development, informed by exemplar site benchmarking.

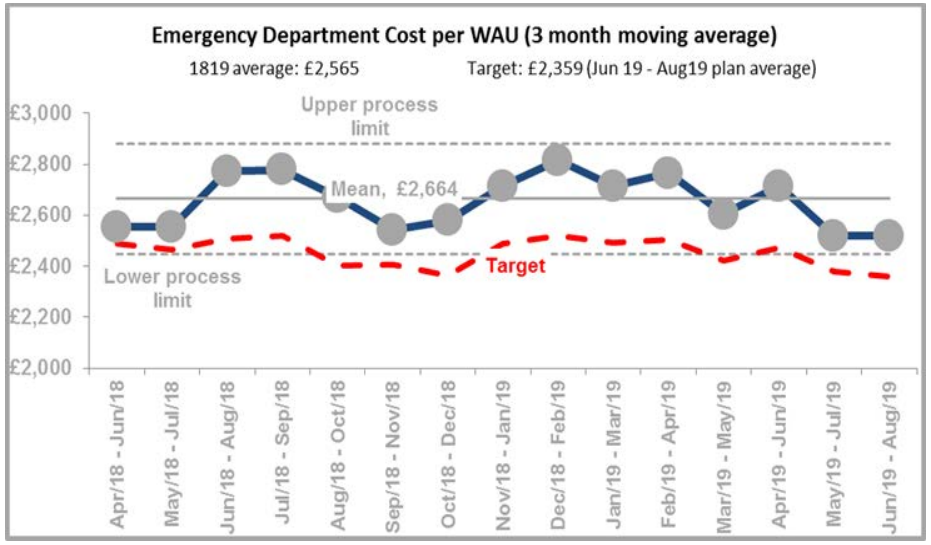
Outstanding care every time

Key Improvement Indicators – Patient Flow







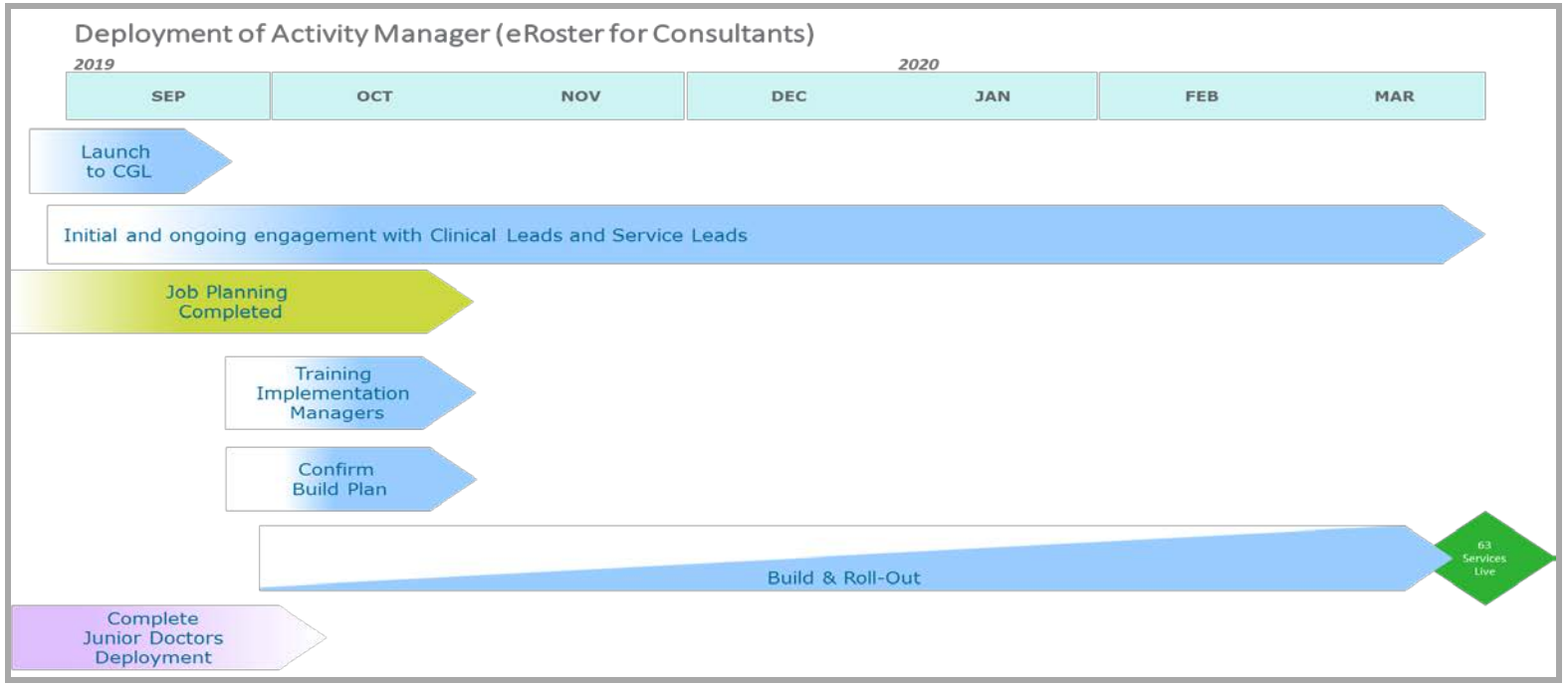


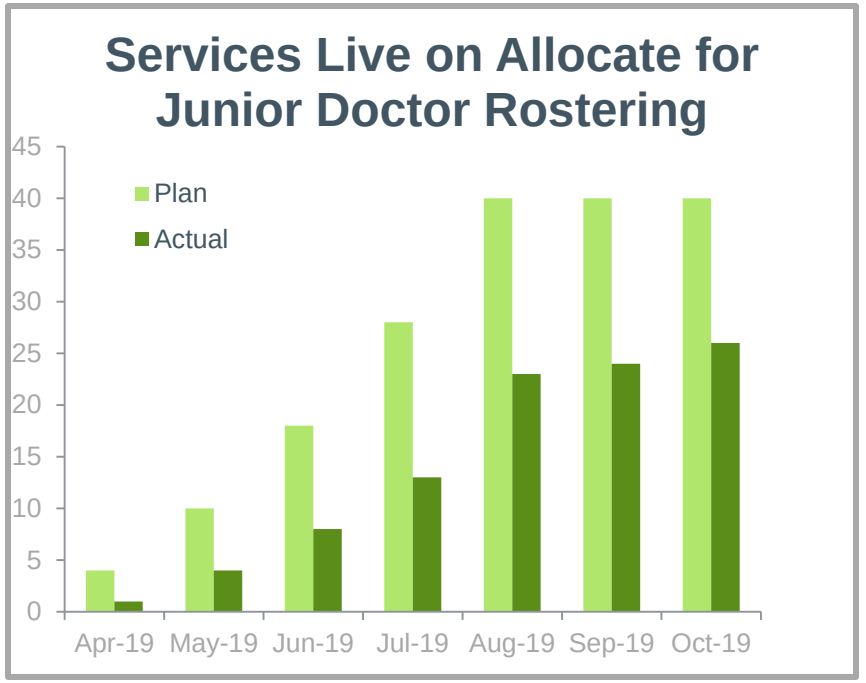
Outstanding care every time

Workforce Transformation

eRostering

- 16 more clinical services went live with eRosters for junior doctors during Quarter Two.
- As at the end of September there were 26 services live on eRoster for Junior Doctors, with fourteen still to go live.
- Planning is underway for the deployment of the Health Roster Activity Manager tool for Consultant eRostering.
- A Business Case was submitted to NHSE/I in their current initiative to accelerate NHS providers' utilisation of workforce deployment systems.
- Work is progressing to develop the reporting and business intelligence tools of eRoster as this will support the delivery of NHS Constitutional Standards, by the earlier identification of rota gaps, as well as help to identify opportunities to improve clinical productivity.





Maternity Transformation

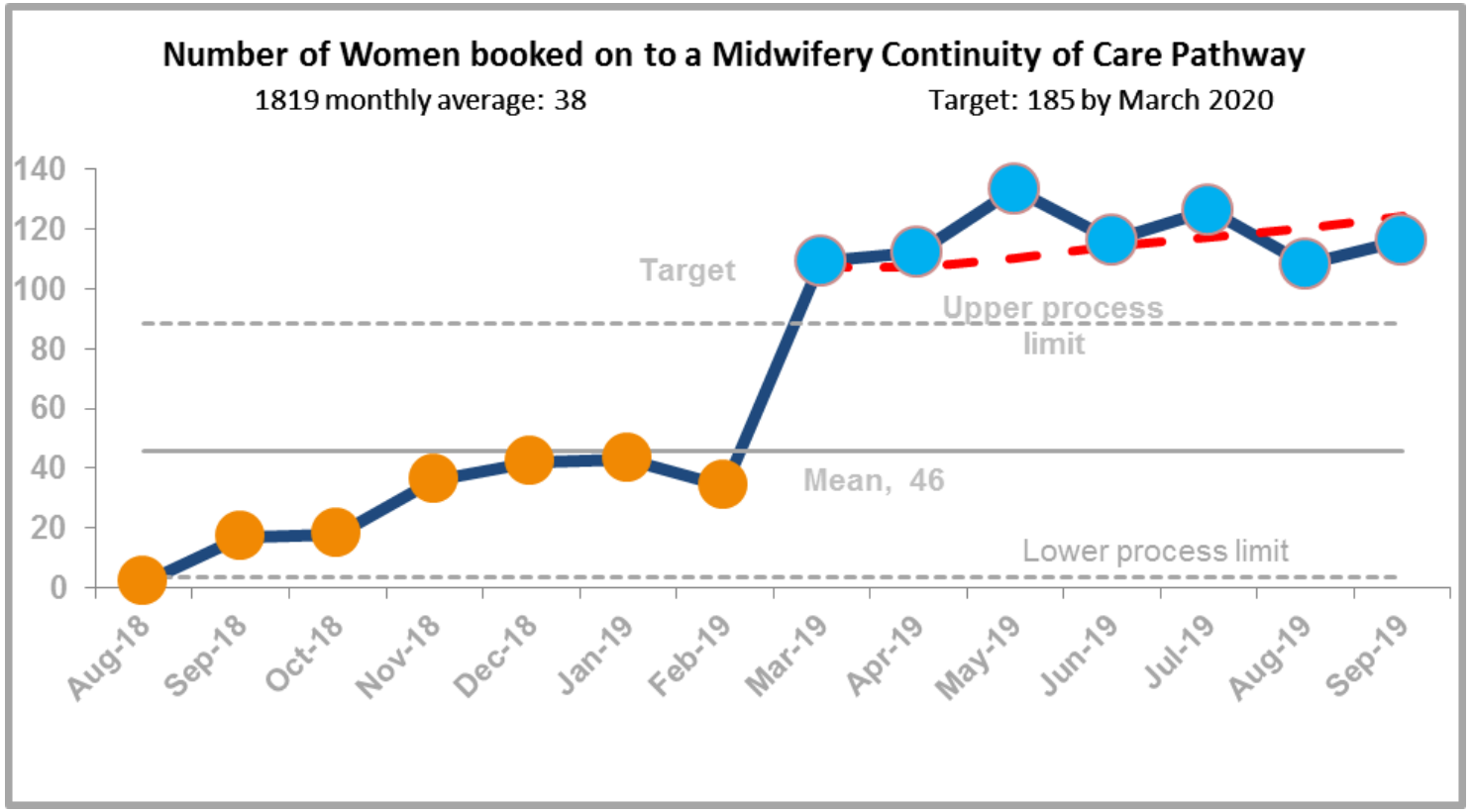
- Over 20% of women have been booked onto Continuity of Carer pathways during the quarter, with 24.4% booked into this service during September
- A celebration event was held for the New Beginnings project, with evaluation showing a number of benefits from it, including increased rate of skin to skin contact for babies at birth in theatre, and many positive birth stories from mothers and their partners.
- CNST assessment was submitted in August demonstrating compliance with all 10 safety standards

Patient Partners Engagement Group (PPEG)

- A presentation was given to the Patient Partners Engagement Group on the Emergency Floor project.
- Patient partner representatives have been engaged to help the design of the Emergency Department check in project

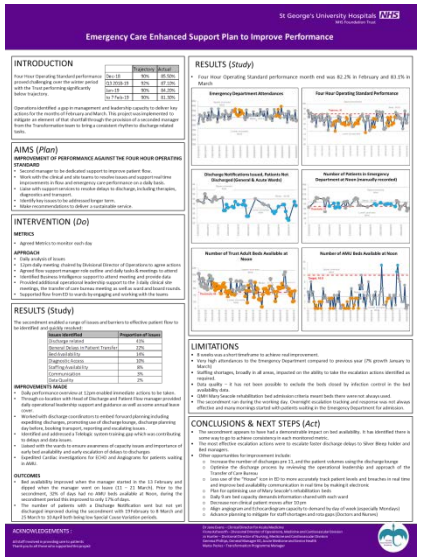
Outstanding care every time

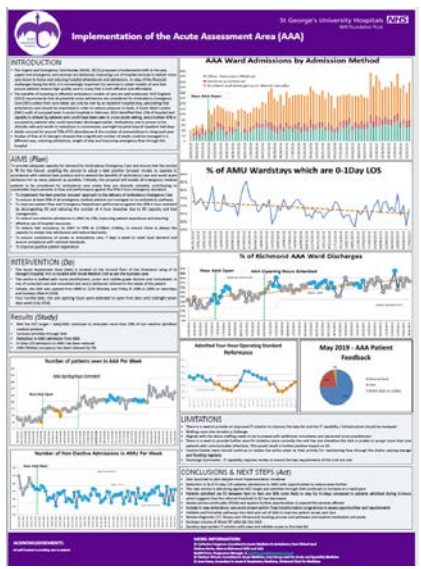
Key Improvement Indicators – Maternity Transformation

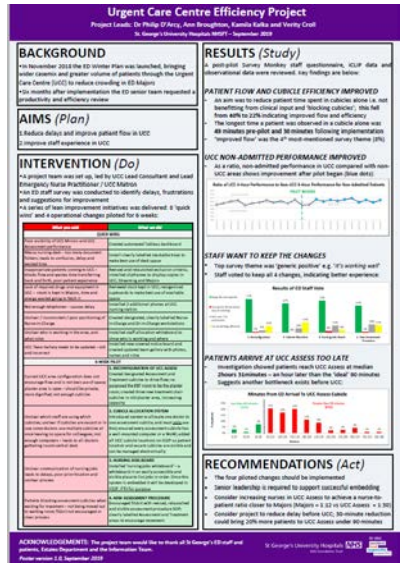


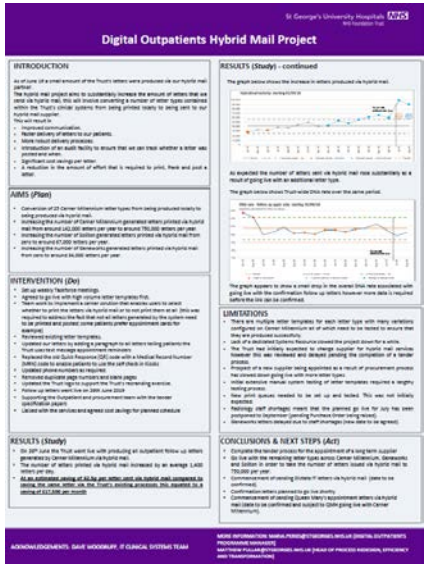
Outstanding care every time

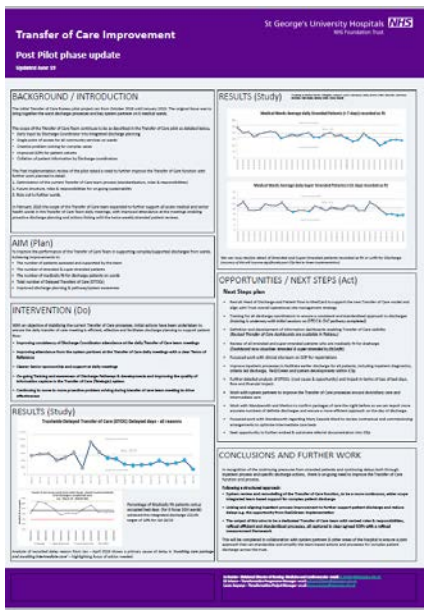
Ten Completed Plan Do Study Act Improvement Cycles

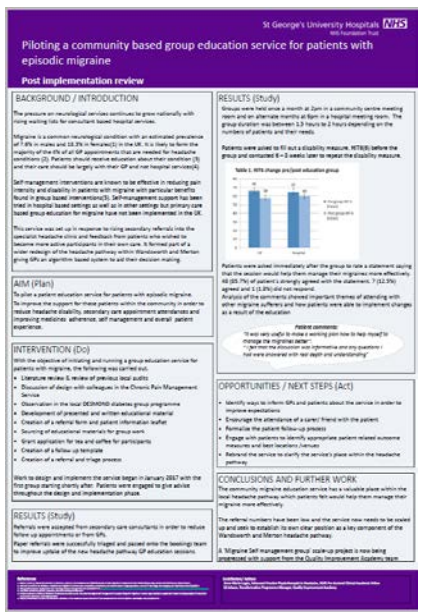


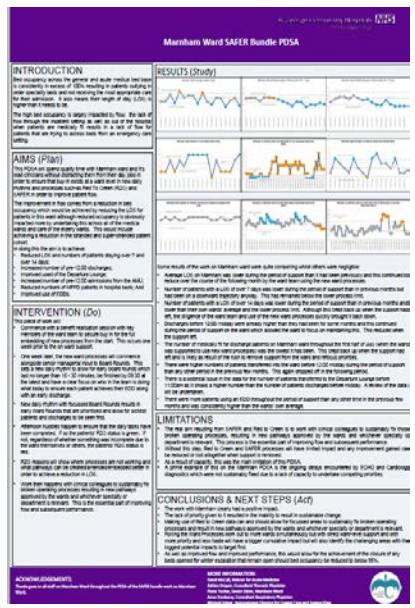


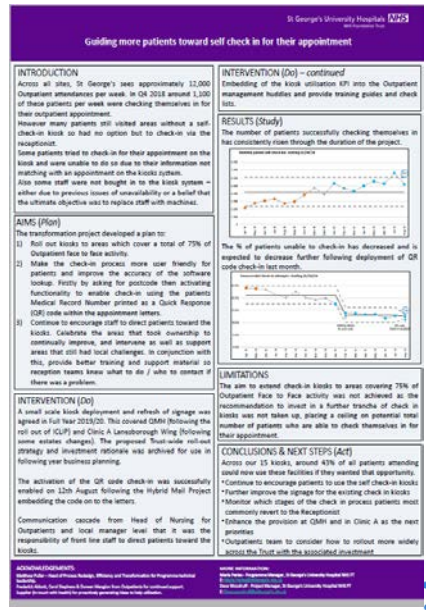










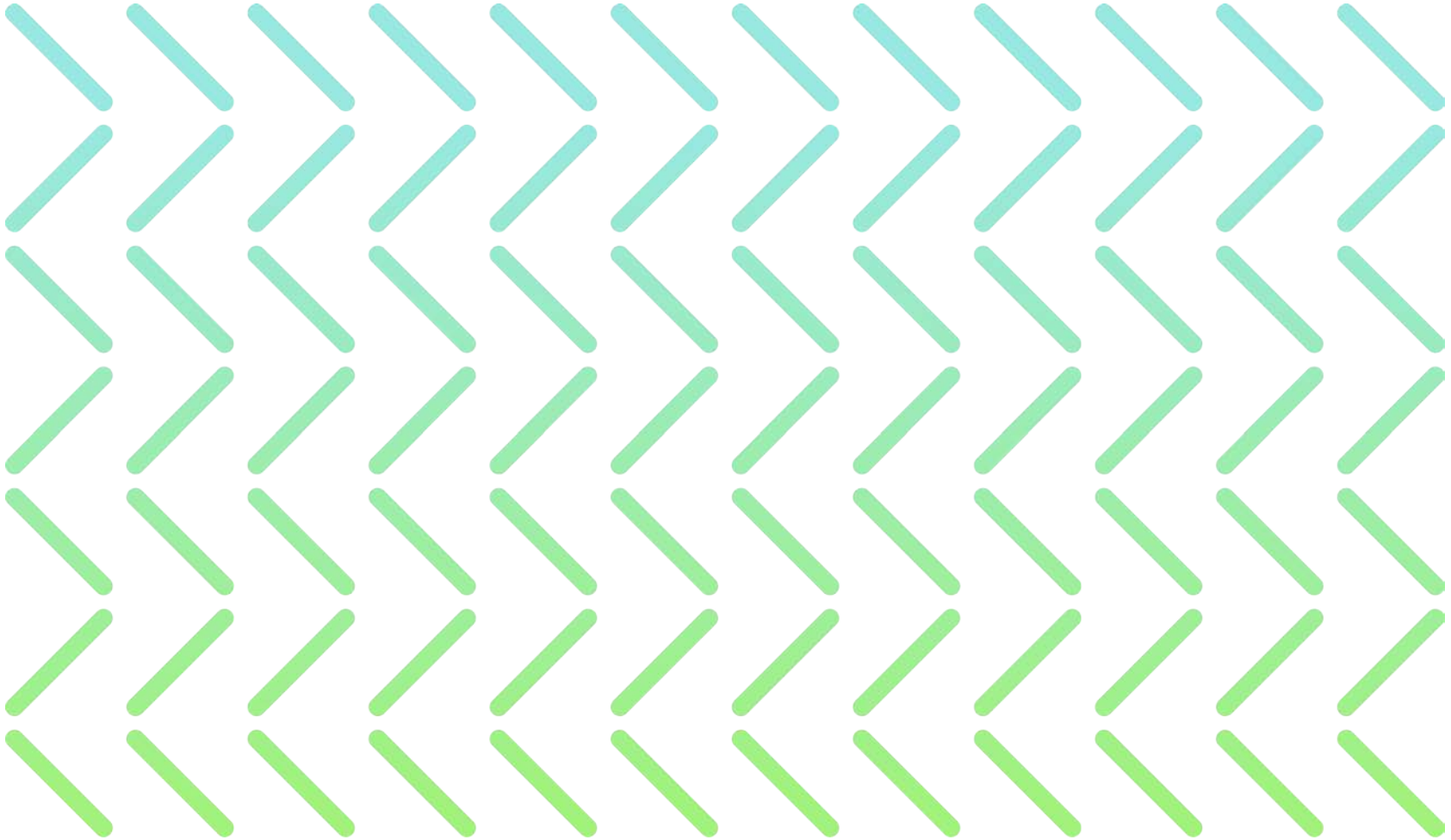


Outstanding care every time

Upcoming Plan Do Study Act Cycles

Already underway for Quarter Three

– Transferring patients to Queen Mary's
– Frailty Rapid Access Clinic
– ED Check In
– LOCSIPs in Obstetric Theatres
– Ear Wax Pathway
– Multi Agency Discharge Event
– No Wasted Appointments
– Place Based Transformation Business Case Development



Outstanding care every time

Meeting Title:	Trust Board Meeting		
Date:	31 October 2019	**Agenda No.**	**3.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Stephen Collier, Chair of Workforce and Education Committee		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Assurance		
Executive Summary:	This paper sets out the key risks and issues reviewed by the Committee at its meeting on 10 October 2019, including commenting on assurance to the Board on key risks allocated to the Committee. There are three points that need to be drawn to the attention of the Board:- 1. Whilst the overall requirement of the Trust for staff has been increasing, this has not led to a material increase in the level of unfilled shifts (a concern we previously had), and certainly not to a position where we are unable to deliver safe staffing. 2. Our review of staff deployed across the Trust in the context of the Trust's cost improvement plans (CIPs) has highlighted a material difference between the Trust establishment identified through the HR system, (ESR), and the Trust establishment identified via the finance system (Agresso). Whilst we are confident from previous experience that this can and will be resolved, the criticality here is the speed of resolution. 3. We noted with some concern that the Q2 Staff Survey which should have been undertaken internally by the Trust has not been as it had been hoped this information would have been captured via the Go-Engage tool. We characterise this as disappointing, rather than fatal.		
Recommendation:	The Board is asked to receive this report.		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		

Workforce and Education Committee
REPORT to Trust Board, 31 October 2019

1. Committee Chair's Overview

This was the second meeting of the Committee under its new Terms of Reference (TORs), and with the re-direction of certain more operationally-oriented matters to the new People Management Group (PMG), which has also met twice. The arrangement appears to be working well with a good flow of information coming from PMG which keeps the Committee sighted on operational developments.

Committee attendance dipped at our meeting and I will pick this up with those individuals who did not manage to attend (though I acknowledge that the Trust's operational pressures are a factor in this).

The areas of focus at this month's meeting were: a deep-dive on total staff levels across the Trust and the use of flexible staff; the accuracy of internal measures of the Trust's staffing establishment, in the context of changes to this as a consequence of cost improvement plans (CIPs); the measures to be used to assess the success of the Staff Engagement Plan; updates from the Speak-Up Guardian and the Safe Working Guardian; and an assessment of the risk-levels applicable to certain Trust-level risks allocated to the Committee for assurance.

2. Key points:-

Board Assurance

There are three points that need to be drawn to the attention of the Board. First, having previously asked for more detail around the level of unfilled shifts, we were pleased to be able to review a very helpful pack of analysis prepared by Sion Pennant-Williams showing total whole time equivalent (WTE) staff deployed across the Trust. An extract from this is set out in Appendix 1 for information. This demonstrated that whilst the overall requirements of the Trust for staff was increasing, this was not leading to a material increase in the level of unfilled shifts. Chief Nurse Avey Bhatia was also able to describe to the Committee the real-time processes used in ward nursing to flag any situations that would breach safe staffing levels, and we accepted her assurance that this received significant focus to ensure that safe staffing was maintained at all times.

Second, the review of staff deployed across the Trust has highlighted a material difference between the Trust establishment identified through the HR system, (ESR), and the Trust establishment identified via the finance system (Agresso). This had been an issue in the past, but one that was addressed by regular updating and reconciliation. The sense we had was that this practice had fallen away, leading now to a significant three-figure variance between the two systems. Given the importance to our CIP delivery of a reduction in establishment, it is critical that there is a single and agreed dataset against which staff cost reduction can be measured. Harbhajan Brar agreed to seek a rapid resolution of this point with the Trust's finance team. Whilst we are confident from previous experience that this can and will be achieved, the criticality here is the speed of resolution.

Third, we noted with some concern that the Q2 Staff Survey which should have been undertaken internally by the Trust over the summer, has not been. The Committee probed into this, and were advised that it arises is as a result of a delay of the new GoEngage system. The 'Go-Engage tool is going to be used as the new means of the delivery of the internal staff survey as evidence from other Trusts shows that it is able to deliver a significantly improved response rate, which had fallen significantly in prior months. The consequence though is that (a) the Trust has therefore missed one quarter's measurement of what is a critical indicator of staff opinion and sentiment, and (b) the next staff survey will be that for Q3, which is the NHS National Staff Survey. We characterise this as disappointing, rather than fatal – but it does reinforce a view of a busy team under continuing pressure.

The Committee has five Trust level risks[1] allocated to it by the Board as part of the Board Assurance Framework, and the Committee's assessment of two of these risks was discussed in detail. The Committee concluded that it would recommend to the Board that risk ratings for these should remain as currently set.

These are:

SR12 – **Diversity and Inclusion**, despite the encouraging progress seen on implementation of the Trust's programme around WRES, the risk rating should remain at 12, reflecting the early stage at which progress remains.

SR14 – **Recruitment and Retention**, the Committee concluded that this risk should have a new risk factor added to it, the impact of leaving the EU - given the current uncertainty over both the timing and the manner of this. The overall risk rating should remain at 16.

Strategic Themes

Theme 1 - Engagement

Staff Engagement Plan 2019-21 – we reviewed and endorsed the proposed measures suggested by Liz Woods to be used to evaluate the implementation success. We endorsed the measures proposed, and agreed with Liz that we would receive a progress report in December and then February. At the February report back, the measures will be used to set targets for 2020-21.

WRES - Given the continuing sickness of the Trust lead, the Trust has brought in interim support from Epsom and St Helier and this has been to good effect. We reviewed a WRES update setting out a programme of action to be implemented over the six-month period to the end of March 2020. The programme is ambitious in both content and timescale, and the initial indications are that there is very tangible support for this from Trust staff. We were encouraged by these early indications and the enthusiastic support reported, and will continue to monitor the position here.

Workforce Disability Equality Standard – The WDES standard is not something that has had particular focus within the Committee, so it was good to receive a proposed Action Plan for review. We had a full discussion on the logic underpinning the plan and the apparent under-reporting by staff with a disability – suggesting that self-reporting a disability within the Trust was not seen as psychologically safe space. The Action Plan begins to address this. We endorsed the proposal and look forward to regular updates on its implementation.

Theme 2 – Leadership and Progression

Mentorship and coaching – we received a helpful report from Sarah James on the progress of this initiative. The Trust has also set up an arrangement whereby staff who apply for an internal role, for which they are unsuccessful are to be offered support/coaching to help them prepare for future applications. In parallel, we have trained a further 12 internal mediators and 40 coaches who, it is hoped, will support less formal resolution of matters that might otherwise be run as disciplinary proceedings. We have asked to be kept updated on progress here, and in parallel Jacqueline McCullough will be updating us regularly on data relating to the use of formal disciplinary processes, so we can assess whether these initiatives are having an impact.

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

Theme 3 - Workforce Planning and Strategy

We reviewed a number of **workforce statistics**, with the caveat from Sion Pennant-Williams that as there was some uncertainty around the establishment number these data should be viewed as directional rather than absolute. Against that background we noted that sickness levels had fallen, but some areas of the Trust (Admin and Clerical, and Additional Clinical Services) both had sickness levels in excess of 5%. Turnover in some clinical areas (Nursing, AHP, and PST) stood at 20%, against Trust-average turnover of c 17.5%. Appraisal levels were somewhere between static and reducing. Whilst some of this movement in appraisal might be attributable) the move in the Trust's overall establishment, there is clearly also an underlying performance issue.

The Committee reviewed the variance in **time to recruit** across different divisions. In the absence of representatives from SNTC and MedCard, we were left with a number of unanswered questions – which we will have to carry forward to our next meeting.

In the light of the fact that the Trust Board had only recently held a workshop on **Workforce Strategy**, and that the final internal workshop was yet to be held, we did not further discuss the developing Workforce Strategy.

Theme 4 – Compliance.

Freedom to Speak Up – we reviewed a progress report from Liz Wood on the Trust's Guardian programme, and noted that the processes appeared to be working, with concerns being raised and escalated. The network of SGH internal Champions is now fully trained.

We reviewed the Trust's position and practices against a report which had been published by the National Guardian's Office the previous day. The conclusion reached was that, whilst there was still work to do to embed Freedom to Speak-Up in the Trust's DNA, good progress was being made and there was active support for this. The results of the NHS National Staff Survey will be a good barometer of the Trust's position.

Safe Working – Junior Doctors – we reviewed a detailed report from the Trust's Guardian, Dr Serena Haywood. The overall picture is of a continuing reduction (against prior comparative quarter, or PCQ) in exception reports. To be data-specific, the Q2 trend against PCQ is 2017-202; 2018-164; and 2019-97. However, two years into this reporting framework we should expect better, and Serena's Report highlighted a number of areas that should be of real concern to the Trust.

On the positive side, Serena's assessment is that our junior doctors are more willing to flag and report concerns, which suggests a positive shift in the divisional culture on this subject. On the negative side, there are still instances of negativity and cultural insensitivity to the wellbeing of our junior doctors, and a pattern of rota gaps going unresolved.

In parallel, one factor that emerged from the Committee's discussions was that, whilst internal concerns to the Guardian are being made on a timely basis, there may be an unwillingness for junior doctors to make a parallel notification through the operational line, and allow the situation to be addressed in real time. Offline from the Committee, Divisional Directors will assess how this situation can sensibly be addressed so as to ensure that they receive early notice of rota gaps and situations likely to lead to exception reports, so they can attempt to resolve them.

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

Stephen J Collier

11 October 2019

Appendix 1 – Whole Trust WTE and Fill charts (see over)

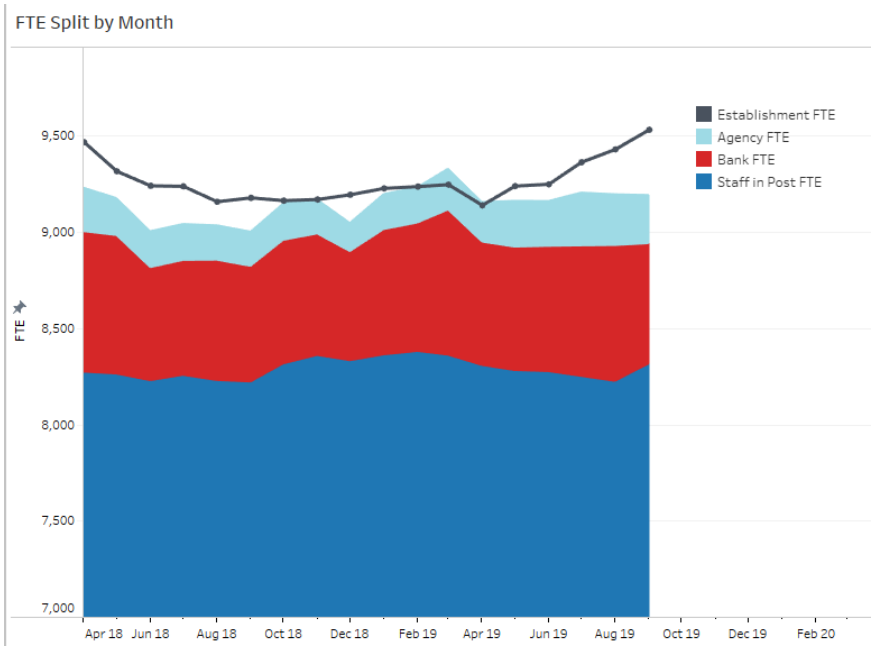


Chart 1 – FTEs deployed by month vs establishment (March 18-Sept 19)

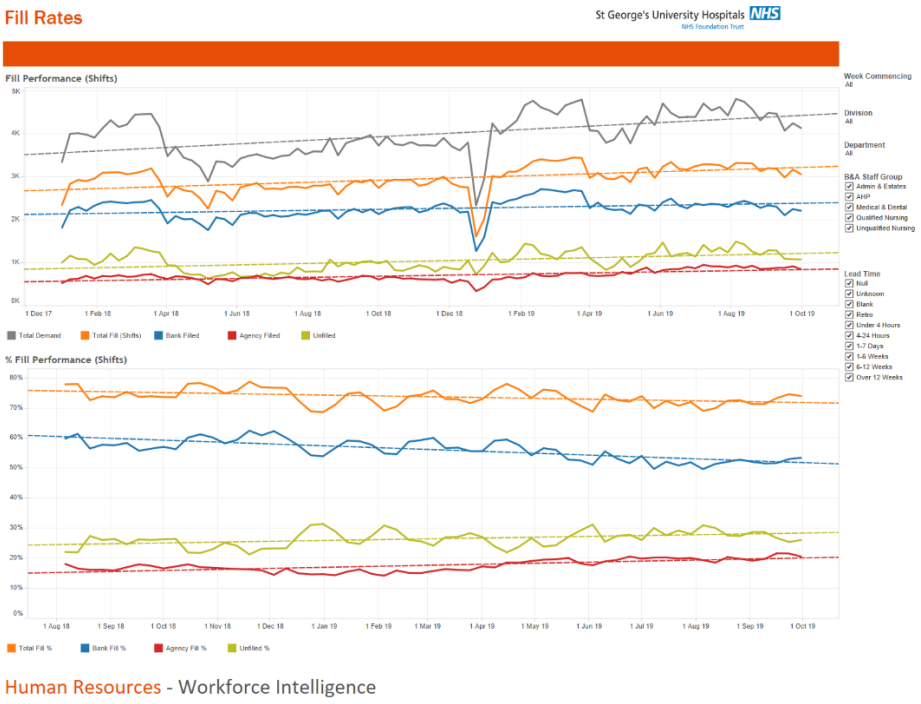


Chart 2 – Fill rates by flexible staff, by month (Aug 18 – Sept 19)

(NB – this covers flexible staff only, so the red and the light blue areas in the chart above)

Meeting Title:	Trust Executive Committee		
Date:	23 October 2019	**Agenda No**	6.1
Report Title:	Healthcare worker flu vaccination		
Lead Director/ Manager:	Harbhajan Brar, Chief People Officer Avey Bhatia, Chief Nurse and Director of Infection Prevention & Control		
Report Author:	Harbhajan Brar, Chief People Officer Patricia Anne Campbell, Flu Lead & Support – Occupational Health		
Presented for:	Assurance		
Executive Summary:	This paper provides the Trust Board with assurance that we are following the NHSE/I best practice to ensure optimal uptake of the flu vaccine.		
Recommendation:	This report asks the Board to note:- 1. The uptake of the flu vaccination in the previous years. 2. The St George's University Hospitals NHS self-assessment against the NHSI/E best practice management checklist (Appendix 1).		
Supports			
Trust Strategic Objective:	Champion team St Georges		
CQC Theme:	Well led		
Single Oversight Framework Theme:			
Implications			
Risk:	Vaccinating our staff against seasonal flu is a key action to help protect patients, staff and their families.		
Legal/Regulatory:			
Resources:			
Equality and Diversity:			
Previously Considered by:		**Date**	
Appendices:	Best Practice Management Checklist (appendix A)		

Healthcare worker flu vaccination

1. Background

1.1 The vaccination of healthcare workers against seasonal flu is a key action to help protect patients, staff and their families.

1.2 Healthcare workers with direct patient contact need to be vaccinated because:

- Flu contributes to unnecessary morbidity and mortality in vulnerable patients
- Up to 50% of confirmed influenza infections are sub-clinical (i.e. asymptomatic). Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues
- Flu-related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence
- Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated

1.3 Provider flu plans for 2018/19 saw a national uptake rate amongst front line staff of 70.3%, with some organisations vaccinating over 90% of staff.

1.4 Here at St George's we achieved 86.5% in 2018, which was the highest in London and 90.4% in 2017.

1.5 NHS England and NHS Improvement have written to all Trust Chief Executives (17th September 2019) asking that we share our plan to ensure that all of our frontline staff are offered the vaccine and how your organisation will achieve the highest possible level of vaccine coverage this winter.

1.6 We have been asked to complete the best practice management checklist for healthcare worker vaccination and publish a self-assessment against these measures in our Trust Board papers before the end of December 2019.

1.7 We are also required to report our flu vaccination uptake monthly (weekly for those with a low uptake) during the vaccination season so that NHSI/E can track all Trusts overall progress towards the 100% ambition.

1.8 To support this, the healthcare worker flu vaccination CQUIN is in place again this year. New thresholds for payment have been set at 60% (minimum) and 80% (maximum).

1.9 For those Trusts with low uptake, they will be required to buddy with a higher uptake Trust, working with them will provide an opportunity to learn how to prepare, implement and deliver a successful vaccination programme.

2. Recommendations

2.1 This report asks the Board to note:-

- The uptake of the flu vaccination in the previous years.

- The St George's University Hospitals NHS self-assessment against the NHSI/E best practice management checklist (Appendix 1).

Appendix 1

Healthcare worker flu vaccination best practice management checklist – for public assurance via Trust Boards by December 2019

A	**Committed Leadership** (number in brackets relates to references listed below the table)	**Trust Self-Assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	The Trust Board supports the ambition of achieving a 100%. We do however need to recognise that some staff will have allergies that prevent them from being vaccinated. At St. Georges we do not anonymise the decliners as we use this information to follow up, engage and discuss the reasons for the decline, with the view to getting staff to change their mind when they are better informed.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	Yes.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	Yes.
A4	Agree on a board champion for flu campaign	Yes.
A5	All board members receive flu vaccination and publicise this	Yes.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Yes. We do not have TU direct involvement in the flu team, but we do engage with them via the Partnership Forum.
A7	Flu team to meet regularly from September 2019	Yes. This is not always done face to face due to shift patterns etc. Weekly emails are sent for updates, to discuss issues and team encouragement.

B	**Communications Plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Yes.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Yes.
B3	Board and senior managers having their vaccinations to be publicised	Yes.
B4	Flu vaccination programme and access to vaccination on induction programmes	This is signposted during induction.
B5	Programme to be publicised on screensavers, posters and social media	Yes - except screen savers due to limitation in systems.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Yes.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Yes.
C2	Schedule for easy access drop in clinics agreed	Yes.
C3	Schedule for 24 hour mobile vaccinations to be agreed	No.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	We only provide sweets and a sticker, as incentives are not required as in previous years our uptake has been over 85%
D2	Success to be celebrated weekly	Yes.

Meeting Title:	Trust Board		
Date:	31 October 2019	**Agenda No**	4.1
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 24 October 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:	Finance and Use of Resources Operational Performance Strategic Change Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee (Core) – October 2019

The Committee met on 24 October and in addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on 5 year Financial Planning, Costing, Procurement and an SWLP report.

Committee members discussed the BAF risks on finance and IT. A review of financial risk recommended a new functional risk on unsupported financial systems as well as other functional risk changes that left the over-arching strategy risk unaltered. IT risk discussion mainly focussed on the data centre, and QMH IClip deployment with risk scores that have changed following implementation. The Committee also noted encouraging performance on metrics reported in the IQPR (including RTT, Diagnostics and Cancer Targets). Emergency Flow was the exception, where a specific paper outlined next steps following a review by ECIST. Agency Expenditure was noted as continuing to be above internal cap and that led into discussions regarding the financial forecast for 2019/20. The Committee discussed actions being undertaken to improve the current financial performance in view of the scenarios presented in the forecast paper and the impact on the financial plan for 2020/21.

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

1.1 Finance Risks- the Deputy Chief Financial Officer (DCFO) introduced a paper on financial risks. He observed the formal recognition that the functional risk 'Managing Income & Expenditure in line with budget' would need to increase to a '20', as well as noting changes to 'Maintaining a five year forward view' (decreasing the score from 12 to 9) and the introduction of the new risk 'Unsupported finance and procurement system' as an '8'. The Committee agreed with this assessment and the overall finance risk assurance rating at quarter 2 remained 'limited'.

1.2 ICT Risks- the Chief Information Officer (CIO) introduced a paper on ICT risks. The Committee welcomed the assurance provided and the closure of risk associated with the QMH deployment of IClip. Discussion also focussed on the risk of the trust having a single data centre, and the committee also agreed that while progress has been made, the overall assurance remained 'limited' for quarter 2.

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

1.4 Cancer update – the Trust has met all 7 standards met in August. The Committee was encouraged by this information.

1.5 RTT Update- the CTO updated the Committee on Referral to Treatment (RTT) targets. Performance of 85.0% in August against the 92% Incomplete Pathway target was behind agreed trajectory although this was owing to the early closure of data in preparation for the QMH migration to Cerner. He noted the September performance was expected to be ahead of trajectory, at 86.1%. He also noted the 52 week performance as being higher than trajectory in August, at 6 52 week waiters compared to a target of 5. This was expected to be

repeated in September. The Committee noted the impact of the QMH migration expected in September, with a total PTL expected to rise to 47,500 patients.

1.6 Emergency Department (ED) update - the Divisional Chair of the Medicine and Cardiovascular Division introduced a paper updating on the ED performance in September and noted an Emergency Care Delivery Board (ECDB) weekly meeting chaired by the Chief Executive that is accountable to the Trust Executive Committee that has been established. The Committee welcomed this development and looked forward to seeing improvements in performance.

1.7 Agency Performance- the Chief People Officer (CPO) outlined some of the challenge in Agency expenditure that continues in September. He also noted some of the other performance metrics, for example flu vaccination and staff survey progress.

1.8 Financial Performance- the Chief Financial Officer (CFO) noted performance to date at month 6 was in line with plan showing a £34.8m Pre-PSF/FRF/MRET deficit. The Committee reviewed the underlying position and discussed the impact of a 'straight line' performance in the coming months.

1.9 Financial Forecast- the CFO provided an update for the committee on the trust's financial forecast. The Committee discussed the scenarios outlined in the financial forecast paper and the impact of CIP performance. The Committee discussed methods for improving financial performance and the role of management to drive these changes.

1.10 SWLP report – the Managing Director of SWLP introduced an update to the committee on SWLP. He noted the move to cost per case, the LIMS project and the work undertaken with Epsom & St Helier University Hospitals. The Committee welcomed this update.

1.11 Procurement Update & SWL partnership – the Head of Procurement introduced the two papers, second of which was the Outline Business Case (OBC); to support closer working with other procurement departments in South West London. The Committee supported this development with the trusts in the Acute Provider Collaborative (APC).

1.12 5 year Planning update – the Director of Financial Planning (DFP) introduced the Committee to the paper providing a final update on the STP submission to be submitted in November. In particular he outlined the impact of the current year's scenarios on the plan for the next 5 years.

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
October 2019

Meeting Title:	Trust Board		
Date:	31 October 2019	**Agenda No**	4.2
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 24 October 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:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee (Estates) – October 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 October meeting was constructive and helpful, at which members received updates from the Assistant Directors (ADs) of Estates on their respective domains. In addition, the committee received a number of papers including a review on Divisional Engagement, an update on the Premises Assurance Model (PAM), a Water Safety summary and a BAF risks document. Committee members praised the good quality of papers produced and thanked the Estates team for their continued efforts in challenging circumstances.

The Committee welcomed updates from the ADs that included information on the Mitie contract, the Non-Emergency Patient Transport contract, the Procure 22 (P22) project, Fire Safety and Health & Safety.

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

1.1 Risk Review - the Chief Financial Officer (CFO) began the meeting by introducing a paper on overall Estates BAF risks. He noted no major changes to individual or strategic risks and a discussion was had on medical equipment, where the specific high risk for the MRI scanner was considered alongside the overall medical equipment risk.

1.2 Water Safety Update - the CFO noted the paper that outlined details of the Trust's improved assessment of 'limited assurance' in water safety. The Committee welcomed this update and noted that further work continues.

1.3 Policy Update - the CFO introduced a policy update which noted the focus on ensuring particular policies are reviewed and stay 'in date'. The Committee welcomed the approach which prioritised those policies closest to expiry.

1.4 AD Report - Overview - the Deputy Director of Estates & Facilities (DDE&F) noted the increased stability following the changes in the Mitie contract implemented in August. The Committee welcomed assurance from the Chief Nurse that the quality of ward cleaning was satisfactory and noted that this would be further tested by the change to the new model of cleaning in teams. The Committee observed that further work was required to improve theatre turnaround times and to improve consistency of cleaning in non-patient areas.

1.5 AD Report - Estates - the Assistant Director of Estates (ADE) introduced a paper on the key forward plans in some of the Estates areas. The Committee discussed the persistent issues around leaking roofs and sewage that are dealt with by the Estates team.

1.6 AD Report - Facilities - the DDE&F introduced a paper which included an update on Non-Emergency patient transport, demand for which remains high. The Committee also discussed the use of space on the Tooting hospital site and the progress being made on uploading space usage data to the Insight system which will help optimise space utilisation in the future.

1.7 AD Report – Capital Projects - the Assistant Director of Capital Projects (ADCP) introduced an update on Capital projects which noted further progress on the P22 project with more surveys completed. The Committee welcomed the progress made and noted that

the contractor, Interserve, were now in a position to prepare detailed plans and costings which will inform agreement of a delivery timetable. Although the 2019/20 delivery window is tight the team are confident that the majority, if not all, programmed spend can be achieved in-year.

1.8 AD Report- Medical Physics & Clinical Engineering – the DDE&F noted further progress made in Medical Physics and that there are now no non-compliant Medical Physics areas. This news was welcomed by the Committee.

1.9 AD Report- Health & Safety –The AD- Health & Safety introduced a paper which focussed on Fire, as well as other elements of Health & Safety. The discussion on fire focussed on evacuation testing and the Health & Safety conversation concerned patient safety on roof terrace areas and on Sharps incident management. The Committee noted that the Trust was well prepared for the forthcoming HSE inspection on 7th November.

1.10 PAM update- The Committee noted an update on the Premises Assurance Model and welcomed the quality of the paper. The DDE&F noted that she was looking for a more summarised presentation for the committee and was looking at software solutions for this. It was agreed that the Committee would receive a further update in 2 months' time with a view to quarterly review thereafter.

1.11 Divisional Engagement – The Committee welcomed an update on how the department was looking to improve the effectiveness of engagement with clinical divisions to report upon Estates performance and to get feedback on what divisions wanted most urgently from the estates teams.

1.12 Estates Strategy – The CFO introduced a paper on the Estates strategy, which is expected to be completed by the end of the financial year. The Committee took comfort that this was progressing to the expected timescales and supported a proposal that specialist external support should be investigated to ensure that all Estates options are fully considered.

2.0 Recommendation

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

Tim Wright
Lead Non-Executive Director, Estates
October 2019

Meeting Title:	**TRUST BOARD**		
Date:	**31 October 2019**	**Agenda No.**	**4.3**
Report Title:	**M06 Finance Report 2019/20**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer/Deputy Chief Executive Officer		
Report Author:	Tom Shearer, Deputy Chief Financial Officer Michael Armour, Head of Finance – Reporting		
Presented for:	Update		
Executive Summary:	The Trust has reported a deficit to date in M6 of £34.8m which is equal to the Pre-PSF/FRF/MRET plan. Within the position, income is adverse to plan by £0.7m, and expenditure is underspent by £0.7m. CIP performance to date is £11.0m which is in line with plan. The Trust has recognised £13.7m of PSF/FRF/MRET funding YTD to Month 6 in line with plan. The Trust also recognised £0.5m of prior year PSF.		
Recommendation:	The Board is asked to note the Trust's financial performance to M6.		
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 (Core)	Date	24/10/19
Appendices:	N/A		

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St George's University Hospitals NHS Foundation Trust

Financial Report Month 06 (September 2019)

Trust Board

Andrew Grimshaw
Chief Finance Officer

31st October 2019

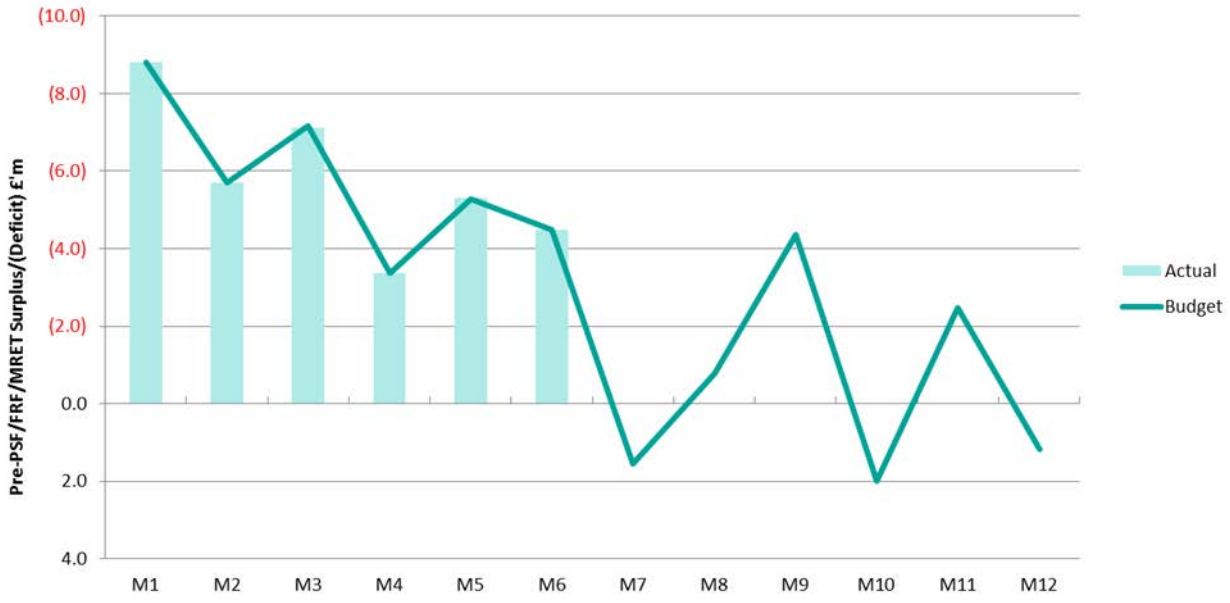
Executive Summary – Month 06 (September)

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The trust is reporting a Pre-PSF/MRET/FRF deficit of £34.8m** at the end of September, which is **on plan**. Within the position, income is adverse to plan by £0.7m, and expenditure is underspent by £0.7m. **M06 YTD PSF/MRET/FRF income of £13.1m** in the plan has **been achieved** in the Year-to-date position. **£3.3m of this is MRET which is expected to be received in all scenarios, and the remaining £9.8m has been achieved** 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 £0.7m adverse to plan year to date. SLA income is £2.0m over plan, mainly due to decreased Challenges and excluded Drugs and Devices which are offset in non-pay. Non-SLA income is £2.7m adverse to plan, which is mainly owing to shortfalls in Pharmacy and Pathology income, both of which are offset by lower costs.	£0.7m Adv to plan	£0.1m Adv to plan
Expenditure	Expenditure is £0.7m favourable to plan year to date in September. This is caused by Pay favourable variance of £0.7m, mainly driven by non-clinical underspends. Non Pay is on plan.	£0.7m Fav to plan	£0.1m Fav to plan
CIP	The Trust planned to deliver £11.0m of CIPs by the end of September. To date, £11.0m of CIPs have been delivered; which is on plan. Income actions of £2.3m and Expenditure reductions of £8.7m have impacted on the position. A £3.0m gap remains in Green schemes identified against the £45.8m target.	On plan	On plan
Capital	Capital expenditure of £22.4m has been incurred year to date. This is to plan. The current month YTD position is £22.4m and the previous month YTD position is £19.2m.	£22.4m To plan	£19.2m To plan
Cash	At the end of Month 6, the Trust's cash balance was £3.3m. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.	On plan	£0.3m Fav to plan
Use of Resources (UOR)	At the end of September, the Trust's UOR score was 4 as per plan.	UOR score 4	UOR score 4

Contents

1. Month 06 Financial Performance

			Full Year Budget (£m)	M6 Budget (£m)	M6 Actual (£m)	M6 Variance (£m)	M6 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF/FRF/MRET	**Income**	SLA Income	678.8	55.1	54.8	(0.3)	(0.5%)	334.8	336.8	2.0	0.6%
		Other Income	158.5	13.8	13.5	(0.3)	(2.1%)	80.0	77.3	(2.7)	(3.4%)
	Income Total		**837.3**	**68.8**	**68.3**	**(0.6)**	**(0.8%)**	**414.8**	**414.1**	**(0.7)**	**(0.2%)**
	Expenditure	Pay	(532.6)	(44.7)	(44.7)	(0.1)	(0.1%)	(274.4)	(273.6)	0.7	0.3%
		Non Pay	(306.6)	(25.7)	(25.1)	0.6	2.3%	(157.3)	(157.6)	(0.3)	(0.2%)
	Expenditure Total		**(839.2)**	**(70.4)**	**(69.8)**	**0.5**	**0.8%**	**(431.7)**	**(431.2)**	**0.5**	**0.1%**
	Post Ebitda		(35.8)	(3.0)	(2.9)	0.0	1.4%	(18.0)	(17.7)	0.2	1.4%
Pre-PSF/FRF/MRET Total			**(37.7)**	**(4.5)**	**(4.5)**	**0.0**	**0.1%**	**(34.8)**	**(34.8)**	**0.0**	**0.0%**
PSF/FRF/MRET			34.7	2.4	2.4	0.0	0.0 %	13.1	13.1	0.0	0.0 %
Total			**(3.0)**	**(2.1)**	**(2.1)**	**0.0**	**0.1%**	**(21.7)**	**(21.7)**	**0.0**	**0.0%**
Prior Year PSF			0.0	0.0	0.0	0.0	0.0 %	0.0	0.5	0.5	0.0 %
Grand Total			**(3.0)**	**(2.1)**	**(2.1)**	**0.0**	**0.1%**	**(21.7)**	**(21.2)**	**0.5**	**2.3%**



- Overall the Trust is reporting a Pre-PSF deficit of £34.8m at the end of Month 06, which is on plan.
- **SLA Income** is £2.0m ahead of plan, after adjustment for block contract values. There remains a large level of estimation within the M06 income position due to delays in coding in some specialties.
- **Other income** is £2.7m under plan, which is owing to Pharmacy services income, and Pathology income, both of which are offset by reduced cost.
- **Pay** is on £0.7m underspent due to Non-Clinical pay underspend caused by vacancies.
- **Non-pay** is £0.3m overspent, mainly related to pass-through income.
- **PSF/FRF/MRET Income** is on plan at M06 YTD, at £13.1m. The Trust has met the pre-PSF control total target of a £34.8m 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 £11.0m is on plan. Delivery to plan is:
  - Non-pay £0.2m favourable
  - Income £0.1m favourable
  - Pay £0.3m adverse

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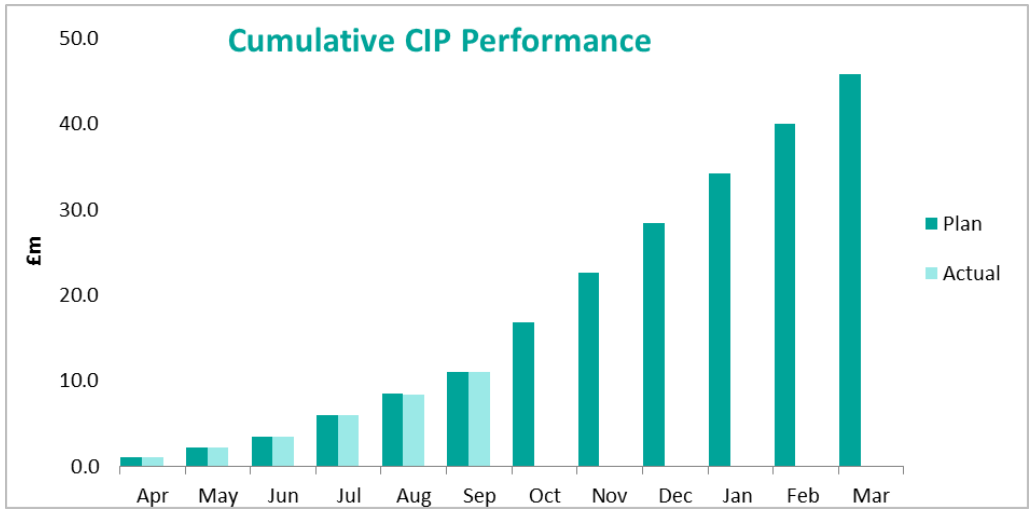
2. CIP Performance M06



YTD (£ m)			
Category	**Plan**	**Act**	**Variance**
Income	2.2	2.3	0.1
Pay	5.6	5.3	(0.3)
Non Pay	3.1	3.3	0.2
Total	**11.0**	**11.0**	**(0.0)**

2019/20 (£ m)			
Category	**Plan**	**Green Schemes**	**Variance**
Income	9.4	7.1	(2.3)
Pay	23.4	18.8	(4.6)
Non Pay	13.0	16.9	3.9
Total	**45.8**	**42.8**	**(3.0)**

CIP Delivery and Variance

- CIP delivery at the end of M6 is on track compared to plan
- Green schemes now total £42.8m, which is 93% of the £45.8m target
- This includes £10m of non-recurrent schemes

CIPs at Risk / Under Delivery

- The CIP delivery profile steps up at M7, by when the £3m gap to 100% Green will need to be closed, to assure delivery of the target in full
- The CIP detailed forecast is being worked up alongside the I&E forecast with divisions.

CIP Pipeline / Mitigations

- Deep dives with each division has resulted in the following action to mitigate the under delivery risks as follows:
  - Corporate, Estate and Facilities delivery risk mitigation actions of £3m
  - Clinical divisions action to improve Green schemes by £1m
  - Clinical divisions action to translate £5m pipeline schemes to Green through the remainder of the year to mitigate the delivery risk, £3m relates to procurement schemes
- If delivered operationally, this would reduce the Green gap and mitigate any delivery risk in full.
- The Financial Recovery programme will provide the grip and control needed to support divisions with delivery and identify new schemes to close the current £3m Green gap forecast and mitigate further risks as they arise

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3. Balance Sheet as at Month 06

	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**	**400.7**	**7.5**
Stock	**7.8**	6.5	6.5	7.6	1.1
Debtors	**101.9**	84.2	93.2	96.3	3.1
Cash	**3.2**	3.0	3.0	3.3	0.3
Creditors	**(122.4)**	(86.5)	(109.5)	(121.2)	(11.7)
Capital creditors	**(4.3)**	(3.6)	(3.6)	(16.3)	(12.7)
PDC div creditor	**0.0**	0.0	0.0	0.0	0.0
Int payable creditor	**(1.2)**	(1.2)	(1.2)	(1.4)	(0.2)
Provisions< 1 year	**(0.5)**	(0.4)	(0.4)	(0.4)	0.0
Borrowings< 1 year	**(57.6)**	(82.5)	(81.2)	(159.3)	(78.1)
Net current assets/-liabilities	**(73.1)**	**(80.5)**	**(93.2)**	**(191.4)**	**(98.2)**
Provisions> 1 year	**(1.0)**	0.0	0.0	(1.0)	(1.0)
Borrowings> 1 year	**(284.3)**	(299.3)	(290.1)	(197.7)	92.4
Long-term liabilities	**(285.3)**	**(299.3)**	**(290.1)**	**(198.7)**	**91.4**
Net assets	**32.1**	**29.0**	**9.9**	**10.6**	**0.7**
Taxpayer's equity					
Public Dividend Capital	**133.4**	133.4	133.4	133.4	0.0
Retained Earnings	**(213.4)**	(216.5)	(235.6)	(234.9)	0.7
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**	**9.9**	**10.6**	**0.7**

M06 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 £7.5m higher than the plan. This includes depreciation charges and capital spend to month 6 .
- Stock is £1.1m higher than plan, mainly due to an increase in pharmacy area.
- Debtors is £3.1m higher than plan in month and has reduced by £5.6m from March 2019. Target reduction of £ 18m by year end is being actively pursued.
- The cash position is £0.3m higher than planned. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.
- Creditors are £11.7 higher than plan in month. However have been reduced by £1.2m since March 2019.
- Capital creditors are £12.7m higher than the plan. This is an accruals for commitments to September.
- £15.5m of capital loan was received as at September subject to an interest rate of 1.55%. The Trust has requested drawdown of capital loan in October of £1.9m with the same interest rate as in September.
- 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 since June.
- The deficit financing borrowings are subject to an interest rate 3.5%

4. Month 06 YTD Analysis of Cash Movement

	Revised YTD Plan £m	YTD Actual £m	YTD Variance £m
Opening Cash balance	**3.2**	**3.2**	**(0.0)**
Income and expenditure deficit	(22.1)	(21.4)	0.7
Depreciation	12.3	12.3	0.0
Interest payable	6.0	6.0	0.0
PDC dividend	0.0	0.0	0.0
Other non-cash items	(0.1)	(0.1)	0.0
Operating deficit	**(3.9)**	**(3.2)**	**0.7**
Change in stock	(0.9)	0.2	1.1
Change in debtors	7.1	10.2	3.1
Change in creditors	(17.9)	(6.2)	11.7
Net change in working capital	**(11.7)**	**4.2**	**15.9**
Capital spend (excl leases)	(22.5)	(9.8)	12.7
Interest paid	(3.7)	(5.9)	(2.2)
PDC dividend paid/refund	0.8	0.8	0.0
Other	(0.2)	(0.2)	0.0
Investing activities	**(25.6)**	**(15.1)**	**10.5**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	27.3	11.6	(15.7)
Capital loans	15.5	15.5	0.0
Loan/finance lease repayments	(1.8)	(12.9)	(11.1)
Cash balance 30.09.19	**3.0**	**3.3**	**0.3**

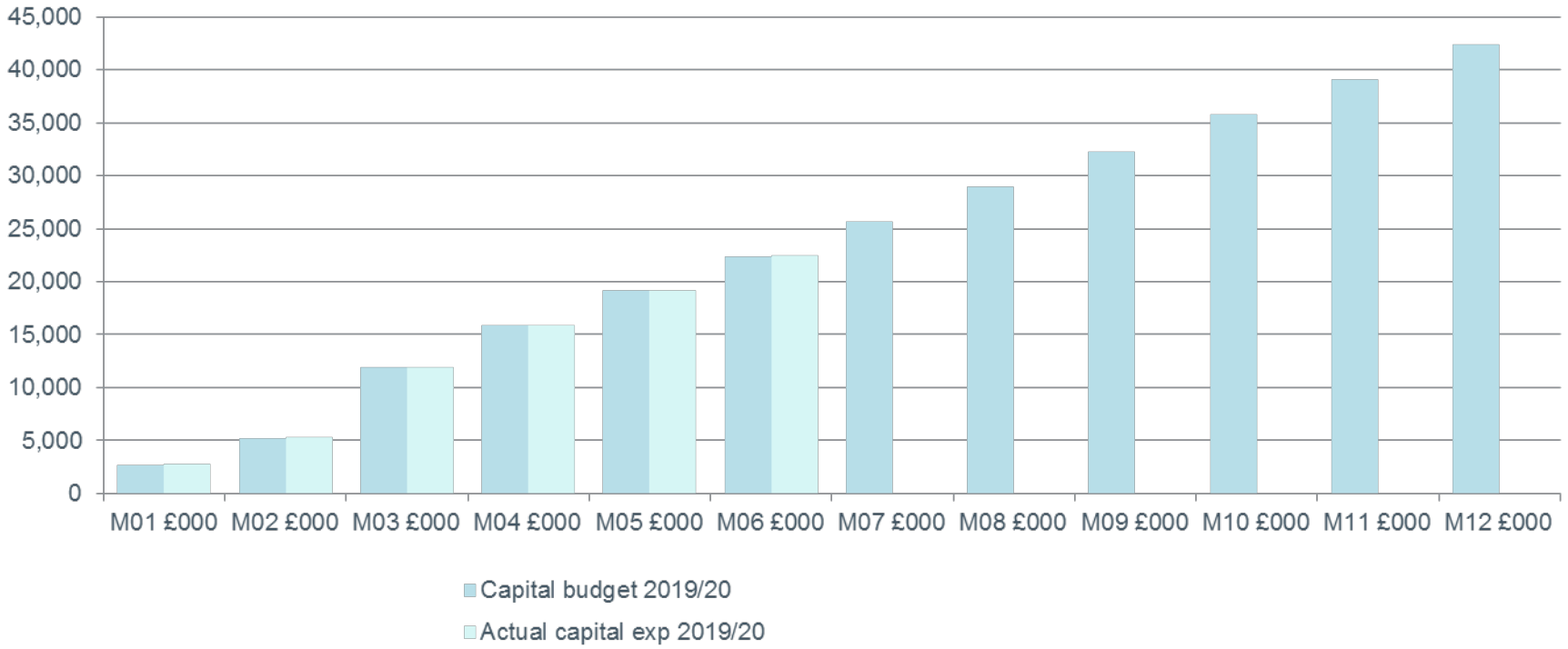
M01-M6 YTD cash movement

- The cumulative M6 I&E deficit is £21.4m, £0.7m 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 £21.4m, depreciation (£12.3m) does not impact cash. The charges for interest payable (£6m) 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 £3.2m.
- The operating deficit variance from plan is £0.7m.
- Working capital is better than plan by £15.9m. This favourable variance comprises of £3.1m higher on debtors and £11.7m better on creditors. The change of stock level is £1.1m better than the plan.
- The Trust has borrowed £11.6m to fund the YTD deficit.
- The Trust has received £15.5m for capital loan. The working capital borrowing is £15.7 lower than the YTD plan. The Trust has requested a drawdown of capital loan in October of £1.9m with an interest rate of 1.55%. Although the Trust can borrow up to £27.3m, however due to the phasing of the I&E at month 6, we have not requested any loans since June. The Trust would have had to repay any excess as the maximum loan cannot exceed £12.8 at the yearend.

September cash position

- The Trust achieved a cash balance of £3.3m on 30 September 2019, £0.3m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 15 week cash flow submitted last month.

5. Capital budget and expenditure at M06



- The Trust's funded capital expenditure budget for 2019/20 is £47.489m.
- The Trust has incurred capital expenditure of £22.427m in the first six months of the year. This spend is against a capital plan of £22.427m but the spend includes a spend to plan accrual of £9.652m for commitments.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M06 YTD)	Actual (M06 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[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of September, 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 (5.10%) minus planned % YTD I&E deficit (5.10%). 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.

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

Audit Committee Report – October 2019

Matters for the Board's attention:

1. External Audit – Progress Report

The Committee received the External Auditors progress report which included an outline of the issues that will feature in the annual audit for financial year-end 2019/20 and some useful information on key emerging national and NHS economic matters which will impact on the Trust.

2. Internal Audit Report

The Committee considered the following reports from the Internal Auditor:

- Progress Report against the Internal Audit Plan 2019/20
- Internal Audit Review Recommendation Tracker
- Refreshed Internal Audit Plan 2019/20
- Final Internal Audit Report:
  - Safeguarding Adults (Reasonable Assurance)
  - Diagnostic Test Reporting (Limited Assurance)
  - Financial Reporting: Board Budget Setting (Substantive Assurance)
  - Estates and Facilities Reactive Maintenance (Limited Assurance)
  - ICT Review of Cyber Security (Limited Assurance)

The Committee noted that the Trust was broadly on plan with the internal audit plan however was disappointed with the delay in some audits. The Committee heard from executive directors the rationale for some of the delays however agreed to discuss the key issues with internal auditors at its next meeting to understanding if there were any underlying issues which would benefit from Committee engagement. The Committee considered and approved the updated version of the plan following the Trust Executive Committee review to ensure that it was fit for purpose and responsive to the current risk environment. The Committee were concerned at the delay in the Diversity and Inclusion internal audit review and heard that the Chief People Officer, in lieu of a substantive D&I resource, would meet with the internal auditors to progress the audit as a matter of priority.

Good progress continued to be made on completing internal audit recommendations and the Committee noted that of the five outstanding recommendations the Trust Medical and Dental Staff Appraisal Policy was completed and the finance team were on track to complete the management training for budget holders by 01 November 2019.

The Committee welcomed the substantial assurance rating for the financial reporting board budget audit review noting that this is a step change and reflected the significant improvement in the financial planning processes. Whilst the Committee were also pleased to note the reasonable assurance rating for the Safeguarding Adults audit review it queried what else the Trust needed to do to ensure that it received an assurance rating of substantive given that of the three recommendations, two were routine, one important and none were urgent of materiality. Internal Auditors agreed to reflect on the feedback on Safeguarding Adults and respond to the Committee at its next meeting. The Committee recognised that the audit review of estates and facilities reactive maintenance was completed before the Trust had put in place the enhanced governance processes for estate management acknowledging that these issues are now being regularly scrutinised by the Estate Management Group and at the Finance & Investment Committee (Estates). The Committee asked management to review the management responses to include more specificity and also revisit the timelines. The Committee suggested that FIC (E) regularly the backlog of reactive maintenance jobs on the system. The Committee also heard that the

Trust is given priority to completing the actions from the Diagnostic Waits and ICT Review of Cyber Security audits reviews.

3. Internal Compliance and Assurance

The Committee received and discussed the following reports pertaining to the Trust's internal governance mechanisms.

3.1. Freedom Speak Up Guardian

The Committee considered the Freedom to Speak Up (FTSU) Guardian report which outlined the number FTSU concerns raised during July-September 2019. Of the 19 concerns raised 15 had elements of bullying and harassment related to culture and leadership. The Committee noted that a new electronic system is will be put in place and that the Trust will respond to these concerns within the agreed timeframe. The Committee requested that future reports include details on trends analysis and information response rates. The Committee welcomed the plans for currently being explored to centralise the process and create more independent support.

3.2. Counter Fraud Report

In considering the Counter Fraud Update the Committee recognised the magnitude/volume of work that is going into managing counter fraud activities in the Trust with limited internal resources supported by the TIAA, Internal Auditors. Accordingly the Committee will consider a report which sets out the plans for resourcing counter fraud activity and an enhanced report which details work around detecting and deterring fraudulent activity, any key trends or hotspots and the monetary value of these cases.

3.3. Aged Debts, Losses & Compensation Payments and Breaches & Waivers Reports

The Committee were pleased to note the evident grip on the management of the Trust's aged debts, losses and compensations and breaches and waivers processes with marked improvement in all three areas. It also noted that the procurement team have worked hard and engaged with the organisation to ensure that breaches and waivers are being robustly managed. The Committee heard that the planned implementation of the new '*Agresso'* system did not proceed as planned and there are some significant lessons learned which the Trust will address internally and with the suppliers and the project report would be presented to the Finance & Investment Committee (Core) (FIC(C)). The Committee welcomed the news that the management team would be enhancing the aged debts report to reflect accrued debts and percentage change in performance.

3.4. Review of Internal Audit Effectiveness

The Committee agreed that the timeframe for reviewing the effectiveness of the internal auditors now that the new contract has been issued. The Committee also asked management to ensure that Internal Auditors are circulating the internal audit surveys to service users.

Recommendation

The Board is asked to note the update on the key issues considered by the Audit Committee at its meeting on 10 October 2019.

Sarah Wilton
Audit Committee Chair, NED
October 2019

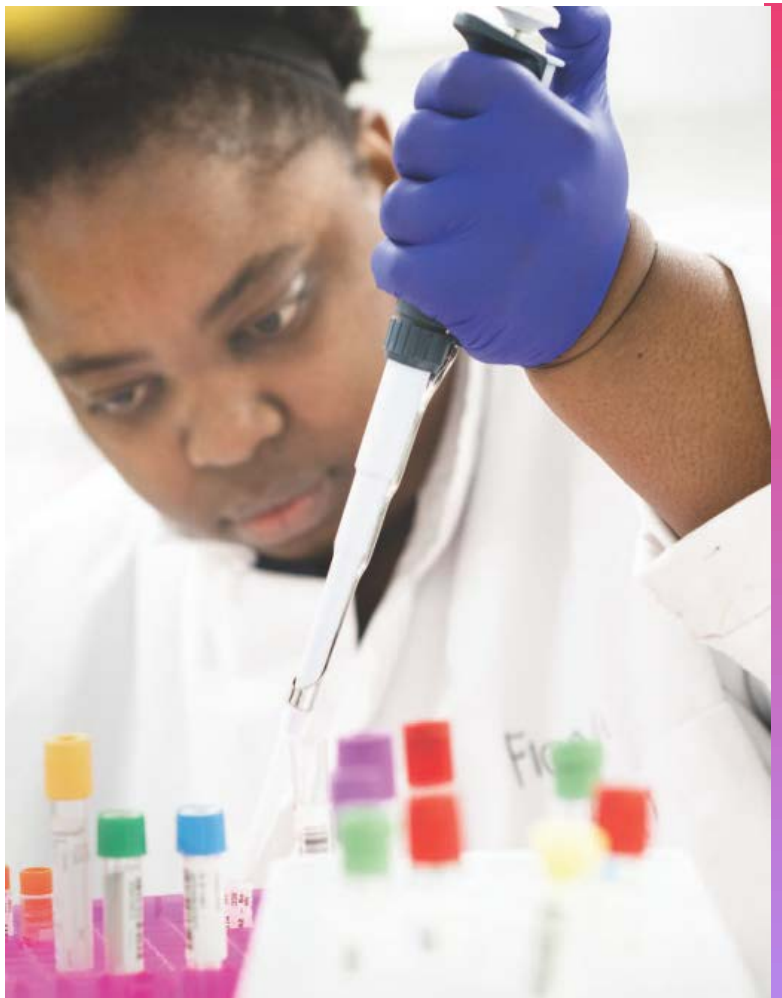
Meeting Title:	**Trust Board**		
Date:	31 October 2019	**Agenda No**	**5.2**
Report Title:	**Research Strategy**		
Lead Director/ Manager:	Richard Jennings, Chief Medical Officer Dan Forton, Associate Medical Director, Research		
Report Author:	Ralph Michell, Head of Strategy		
Presented for:	Approval		
Executive Summary:	A draft of the Trust's five year research strategy is attached for approval. The draft strategy is based on work over the course of 19/20, overseen by a steering group of Trust and University staff, and involving a significant degree of staff and public engagement, including: - A staff survey receiving over 400 responses - Staff events with around 250 attendees - A survey of Trust members (primarily current or former patients), with around 60 responses At a board seminar on 2 October, a range of options for the strategy were presented for board discussion. The draft strategy attached is based on the Board's preferred options as confirmed in that seminar. At the board seminar, estimates of the investment required to deliver the strategy were also set out and discussed. The draft strategy is based on those estimates. The Trust Executive committee agreed to treat those estimates of required investment as a planning assumption going into the business planning round, with the detail of any investment to be agreed through the normal process of business planning. Following sign-off by Trust Board, there will be a launch of the strategy, with support from the corporate communications team. An implementation group, chaired by the Associated Medical Director for Research, be established to oversee delivery of the strategy, with regular updates to TEC.		
Recommendation:	Board is asked to approve the draft strategy.		
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:	As detailed in the body of the paper		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Council of Governors Trust Executive Committee Quality and Safety Committee	**Date:**	22 October 2019 23 October 2019 24 October 2019
Appendices:	• Draft Research Strategy		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Research Strategy 2019 – 2024



October 2019

Contents

Introduction

Research is core to the purpose of St George's, and is a key part of our strategy for 2019 – 2024.

Delivering outstanding care, every time

Our strategy for 2019-2024

Our vision is to provide outstanding care, every time for our patients, staff and the communities we serve.
We have agreed four priorities that will drive what we do and influence the decisions we will take over the next five years.

Strong foundations

To provide outstanding care, every time

- We will provide outstanding care, every time
- We will provide the right care, in the right place, at the right time
- We will invest in our staff
- We will manage our funding and spending, and invest in our future
- We will improve our buildings and hospital estate
- We will make sure our staff and patients have access to the digital technology and information they need, when and where they need it

Excellent local services

To provide excellent local hospital services for the people of Wandsworth and Merton

- We will provide planned care that fits around our patients' lives using the latest technology
- We will provide more same day emergency care

Closer collaboration

To work with others to provide health services for people across south west London

- We will work with our partners to provide care closer to patients' homes
- We will work with neighbouring hospitals to make sure patients get the care they need
- We will work with others to meet the changing needs of our ageing population

Leading specialist healthcare

To provide specialist healthcare for the people of south west London, Surrey, Sussex and beyond

- We will continue to be the main provider of specialist services for our region, including as the major trauma centre
- We will be a major centre for cancer, children's and neuroscience services
- We will take part in commercial opportunities that enable us to invest more in NHS care
- We will develop tomorrow's treatments, today, through innovation, research and training

Through research, we play our part in developing the treatments of tomorrow. But the evidence[1] shows that research-active organisations also attract high-quality staff, and that the pursuit of research positively impacts on the delivery of clinical care.

St George's has a proud history in this field, and is increasingly active in research. This strategy sets out our ambitions for building on that success over the coming five years, working in close partnership with St George's, University of London.

1 See for instance: Bennett W, Bird J, Burrows S et al. (2012); Ozdemir BA, Kathikesalingam A, Singha S et al. (2015); Boaz A, Hanny S, Jones T, Soper B (2015).

Outstanding care every time

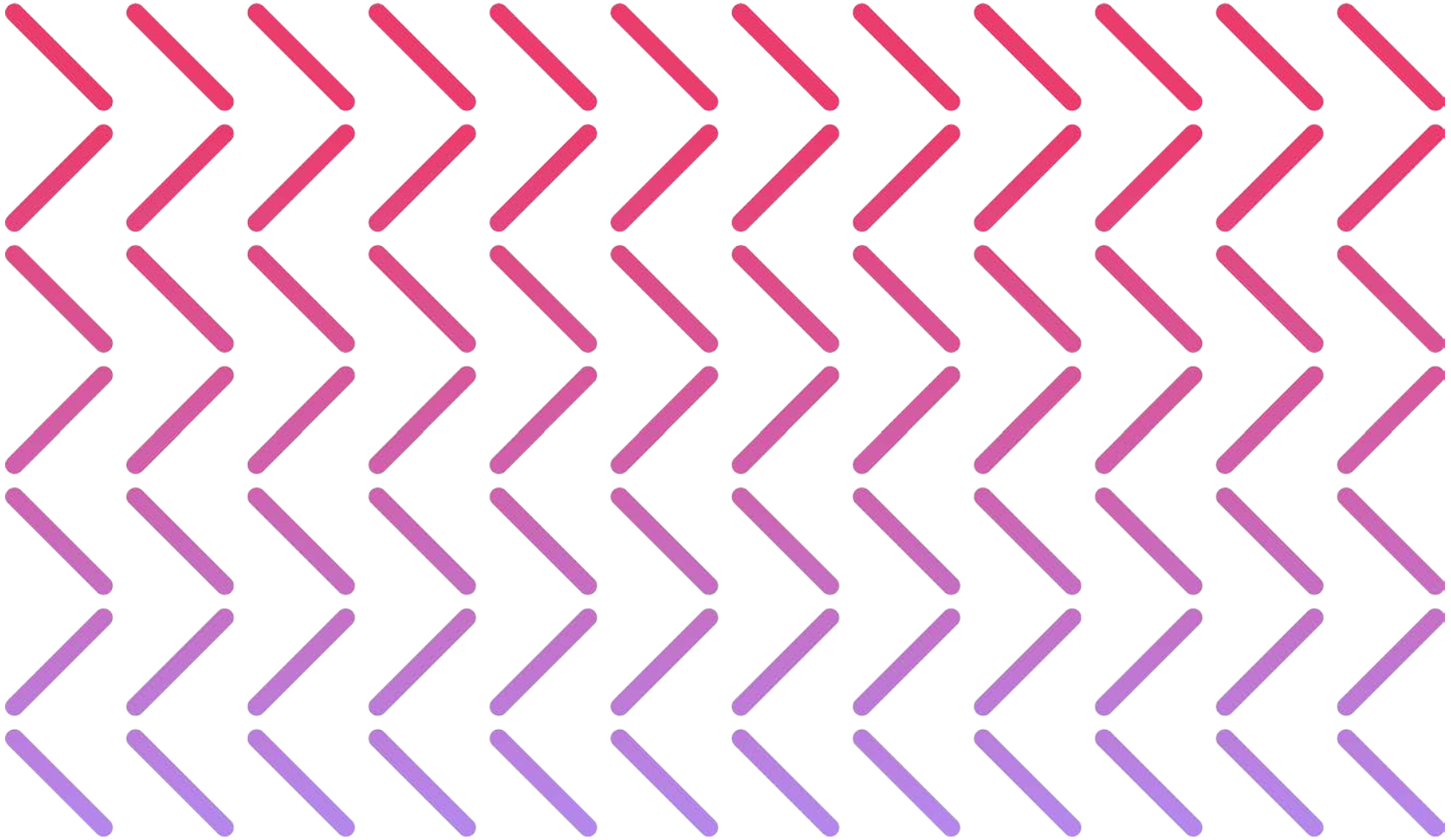
Engaging with our staff and patients

In developing this strategy, we:

- Surveyed our staff, receiving over 400 responses
- Held staff events with around 250 attendees
- Surveyed our members (primarily current or former patients), with around 60 responses
- Engaged with a range of staff and patient groups

The feedback we received helped shape our plans for the future.

Where we have come from, and where we are now



Outstanding care every time

Research matters to our staff and patients

Staff

- 60% of investigators agree (vs 18% disagreeing) that conducting clinical research had improved their experience of being a St George's employee
- 82% of investigators and 57% of other staff say they would like to become involved in clinical research or devote more time to it.

(Based on survey of Trust staff in May 2019, with 422 responses)

Patients/public

- Over 95% agree that "St George's should treat research as a core part of its purpose, alongside patient care"
- Over 95% agree that all patients at St George's should be offered an opportunity to participate in research

(Based on survey of Trust members in August 2019, with 58 responses)

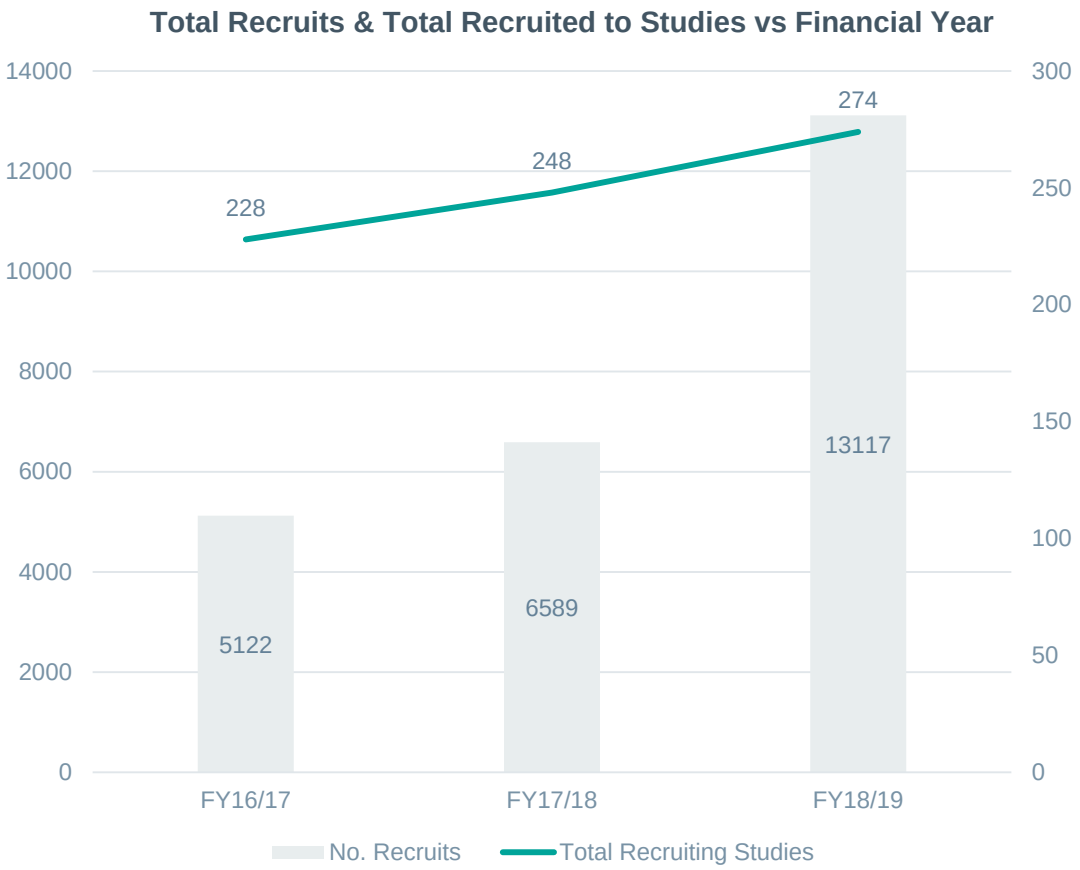
In the last 5 years, we have made some progress against our 2013-18 research strategy

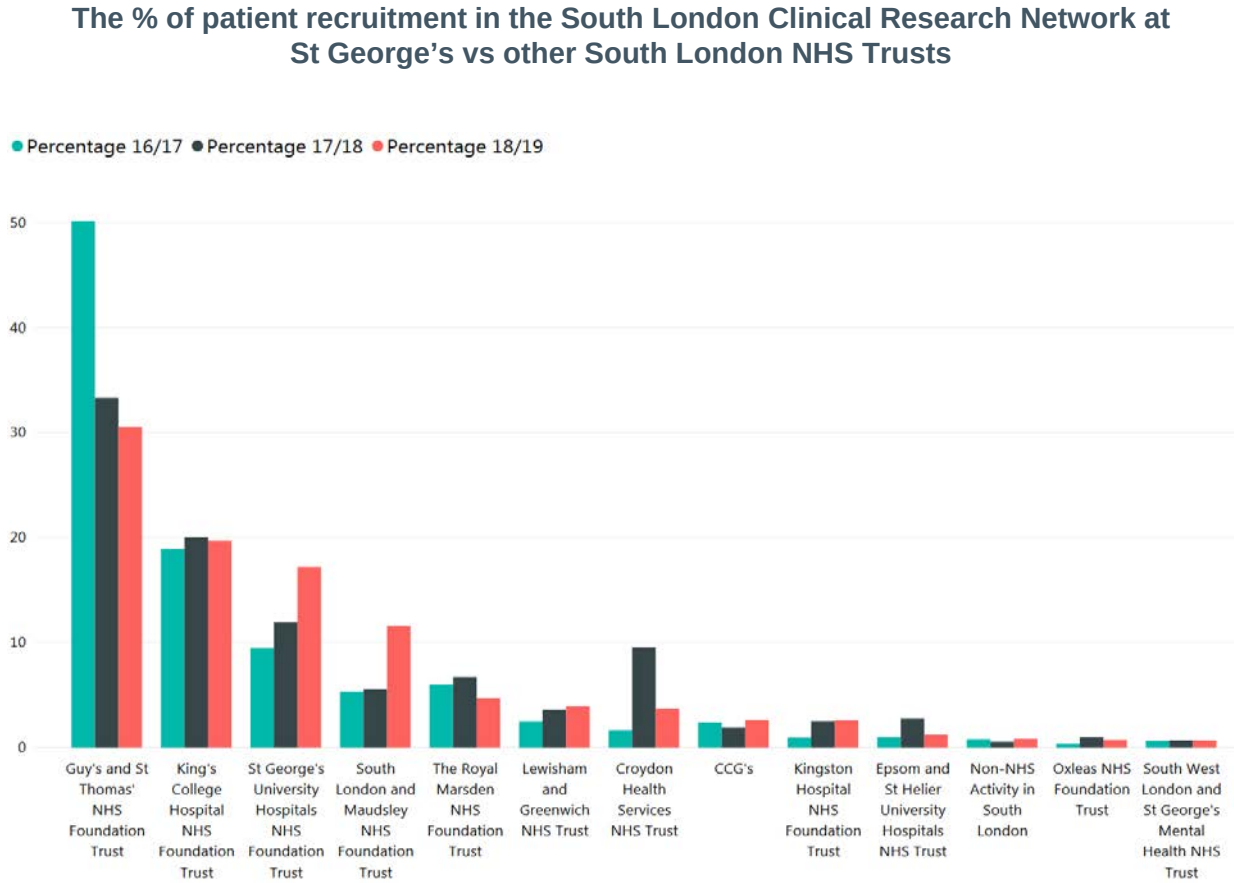
Objective in 2013-18 strategy	Overall progress	Key developments/remaining issues:
Develop a culture that places research at the core of St George's work	The wider issues in the Trust have meant the research culture envisaged for the 2013-18 research strategy has not been established.	• Research is not seen as a Trust priority by investigators – in a 2019 survey, 50% viewed research as not a key priority, with only 25% viewing research as a key priority (more detail in subsequent slide) • Lack of protected research time is seen as biggest barrier to research – 92% see it as a barrier. • A lack of Trust ownership and prioritisation of research is widely perceived, with 88% seeing "lack of support from Trust management" as a barrier. • The vast majority of research is consultant led – limited numbers of AHPs and nurses are currently leading research. • The Trust has been successful in research delivery i.e. increasing the number of patients to clinical trials, but these are mostly led elsewhere and there is scope for original research at St George's
Maximise the benefits of our partnership with St George's, University of London	The partnership with St George's, University of London, is not fully utilised, although there have been some improvements in joint working and infrastructure	• There have been very few joint clinical academic appointments • Only 17% of Trust investigators agree that they have a good understanding of research in St George's University, with 52% disagreeing. • The establishment of the cardiology Clinical Academic Group (CAG) in 2015 has provided a structure for cardiologists to collaborate across the Trust/University divide., but setting up CAGs in all Trust areas is not possible due to the University's focused research interests. • There have been improvements in the joint research infrastructure, with Joint Research & Enterprise Services and the Clinical Research Facility now not widely felt to be 'barriers to research' – a very different situation to 2013
Partner with an Academic Health Sciences Centre at the heart of a vibrant South London Academic Health Science Network	St George's has partnered with King's Health Partners to an extent; and played a role in South London research networks	• The Trust collaborates with KHP in the areas of cardiology and haematology (albeit not in research). • St George's Trust and University were successful (as a partner with King's) in securing a NIHR funded CLAHRC in 2014, and in securing its renewal as a successor NIHR funded ARC in 2019. • The Trust plays a full role as a major partner in South London Clinical Research Network, including holding leadership roles.

In the last 5 years, we have made some progress against our 2013-18 research strategy

Objective in 2013-28 strategy	Overall progress	Key developments/remaining issues:
Increase the success of research funding from research networks and grant giving bodies	There has been some success in increasing income from research networks and grant giving bodies, though there remains much room for improvement	• The core funding for research delivery which St George's receives from the CRN has increased from £1.69M in 2017/18 to £1.97M in 2019/20, due to the relative increase in patient recruitment in the South London CRN (from 9% in 2016/17 to 17% in 2018/19). • We have had some success in increasing NIHR grant funding, with the number of grants awarded increasing from one to seven in the last two years. This is still low for a university hospital the size of St George's and needs to improve • Research Capacity Funding, awarded to research-active Trusts on the basis of NIHR grants, has increased from the minimum of £20K in 2016/17 to £110K In 2019/20. This is our only core funding which is small compared to competing organisations in London.
Become a preferred partner with industry for pharmaceutical research and medical innovation	There has been a recent increase in the number of patients recruited to industry sponsored clinical trials, although there remains room for improvement	• The number of patients recruited to industry sponsored clinical trials has increased from 412 in 2016/17 to 1,089 in 2018/19. • There are a number of key opinion leaders in the Trust who are able to bring landmark pharmaceutically sponsored trials to St George's, ranging from phase I (first in man) to IV. • We have worked to improve our service offering to industry, and have been successful in reducing the average set up time for clinical trials from 80 days to 50 days over the last two years. • There has been important medical innovation, and the development of the Brecker Wire which was sold to Medtronic in 2014 was a notable success. We have recently partnered with Health Enterprise East, an NHS Innovation Hub, to help improve our innovation.
Establish a robust Trust infrastructure to support research	We have seen major infrastructure improvements, with more planned	• There have been significant improvements in Joint Research & Enterprise Services, with a new structure, policies, and the development of a pro-active service culture. • An effective approach to supporting clinical research has been established, including horizon scanning and securing new clinical research, strategic allocation of CRN funding, improved trial set up processes, and improved data management & reporting. • There have also been improvements in costing and financial management processes, with robust costing processes implemented, and invoicing processes improved. Further improvements, including regular reporting to Principal Investigators, are planned. • A Head of Research Nursing has been appointed to lead research nurses and other delivery staff, and a streamlined structure is being implemented. • Trust employed researchers do not have access to statistical support, which is considered a barrier to research by 80% of investigators alongside the Trust's poor IT infrastructure (>80%).

We have seen substantial improvement in clinical trial delivery at St George's





Outstanding care every time

But staff tell us they face a range of barriers to conducting research

A survey was sent to all staff in St George's Trust in May 2019. A total of 422 responses were received – 26% doctors, 21% AHPs, 32% nurses and 21% in a support role. Of the responders, 116 were current investigators and 253 were not current investigators.

Key findings included:

- 82% of investigators and 57% of other staff wanted to have more time for clinical research
- 95% of respondents thought that AHPs, pharmacists and nurses should be given the opportunity to lead clinical research
- The biggest barriers to conducting research were lack of protected research time (92%), lack of internal research funding (90%) and poor IT infrastructure (89%)

There is scope for closer alignment between the Trust and University

St George's strategy for 2019-24

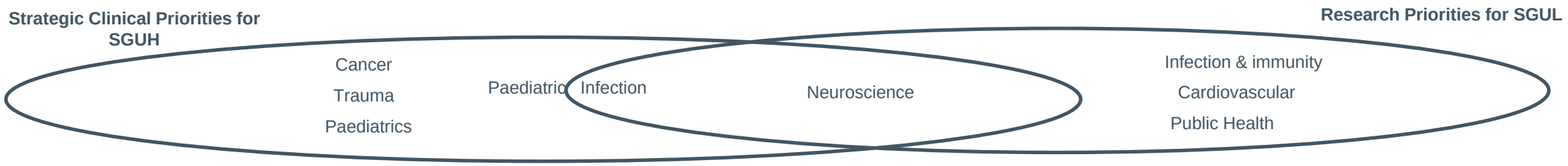
In 2019, the Trust published a new strategy for 2019-24. It sees "the development of tomorrow's treatments today" as a key priority, and commits to building on our partnership with St George's, University of London to increase our impact through research.

The Trust strategy also commits the Trust to being a major centre for:

- Cancer
- Paediatrics
- Neuroscience
- And remaining the regional Major Trauma Centre

Alignment with the priorities of St George's, University of London

One issue inherent in our partnership with St George's University is that the research focus of the University does not cover the full range of Trust specialties, including some of these priority areas for the Trust. This leaves many areas of the Trust without an equivalent academic research partner in the University.



These in turn overlap with, but are not fully aligned to, existing clinical academic groups (which reflect areas of common academic strength/collaborative endeavour across the Trust and University) in neuroscience, cardiology, genomics and infection.

The external environment is changing, bringing new opportunities

Increased national focus on research

- NHS Constitution: commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population
- Research now part of CQC inspection framework for the well-led category

The Funding environment

- Calls for five year NIHR funded Biomedical Research Centres and NIHR Clinical Facility funding are expected in 2021
- The NIHR Local Clinical Research Network model, established for five years in 2014, has been renewed until 2022, and the Network is now chaired by the Trust's chief executive.

Partnerships

- With regards to clinical services, acute Trusts in South West London are increasingly collaborating via the Acute Provider Collaborative
- St George's and Epsom St Helier now have a chair in common, which both organisations see as a helpful step towards further collaboration
- St George's is assisting Epsom and St Helier with its Research and Development function.

What does this mean for St George's research strategy?

- Research is increasingly central to what we do as an organisation
- Opportunities to secure NIHR core funding are within the lifespan of this strategy
- Potential to build research collaborations across South West London with other Acute Provider Collaborative trusts, including Epsom St Helier. This would have a positive impact on our collective research impact and our ability to involve a broader population in St George's led research.

We face a range of strengths, weaknesses, opportunities, & threats – which drive where we go next

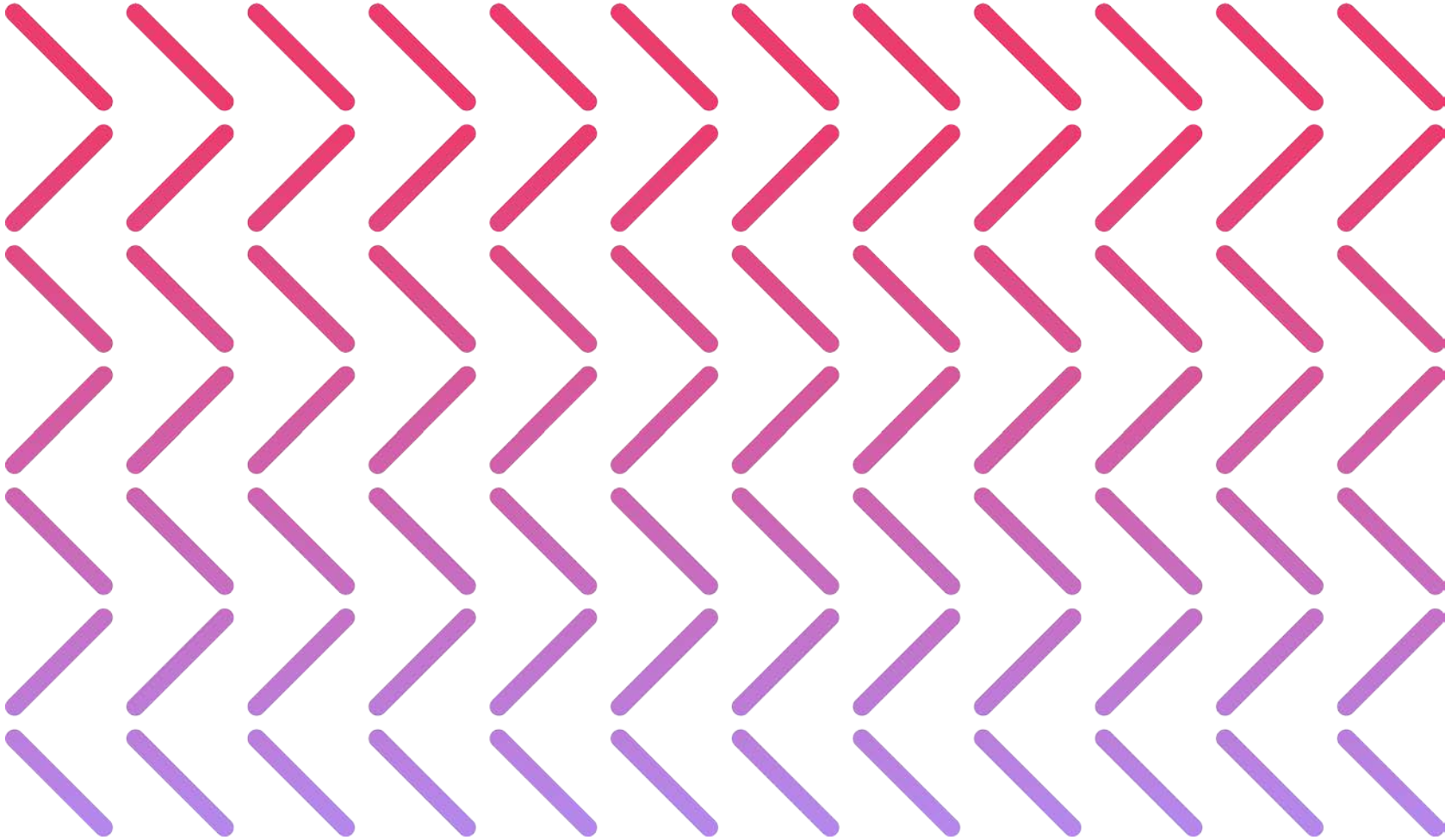
Strengths
- Major university hospital with very broad services and large sector population
- Unique partnership with St George's University
- Research motivated workforce and strong support for research from staff
- Big increases in clinical research patient recruitment
- Improving research infrastructure
- Key role in South London CRN
- St George's Charity as a source of funding (£420k in 18/19 and £1.4m in 19/20 to SGUL investigators working with the trust)

Weaknesses
- Relatively low number of research projects and trials led by SGUL/H (or St George's) staff
- Not widely recognised for academic profile
- Lack of protected research time
- Few clinical academics
- Little AHP/nurse led research
- No BRC or CRF core funding
- Poor IT infrastructure
- Many areas of Trust activity are not reflected in SGUL research

Opportunities
- Motivate staff with research strategy
- NIHR call for core CRF/BRC funding in 2021
- Closer collaboration with SGUL
- More grant funding for St George's-led clinical research
- Opportunities for a greater research leadership role in SW London/partnership with other Trusts
- Potential to further grow charitable investment in research via St George's charity

Threats
- Failure to recognise and manage research as a core activity with further weakening of academic credentials, university hospital status and patients
- Failure to attract and retain the best staff
- Competition from neighbouring Trusts who have core funding
- Failure to attract core NIHR funding
- The fixed national/S. London amount of NIHR funding available for research delivery

Where we go next



Outstanding care every time

We will seek NIHR core funding to underpin our ambition

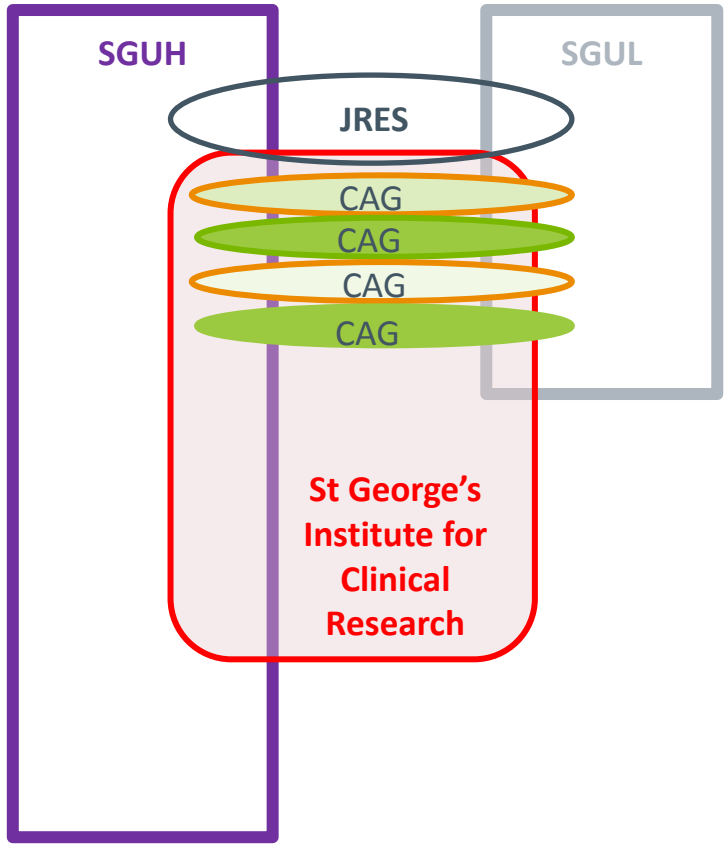
We have seen substantial improvement in clinical trial delivery at St George's, giving thousands more of our patients access to innovative treatments.

We will continue to build on this success over the coming five years, across all service areas.

But in addition to recruiting patients to trials (wherever they may be led), we also want to develop our own academic outputs as an institution, and lead more of our own research.

To do this we will seek core NIHR funding at the next available opportunity (expected to be 2021). Pending the detail of NIHR's call for bids, we expect to bid for Clinical Research Facility funding, focusing on shared areas of strength with St George's, University of London. We will also explore with our partners across the region (including other acute trusts and South West London and St George's Mental Health Trust) the potential for a "partnership bid".

We will establish a St George's Institute of Clinical Research, alongside our existing Clinical Academic Groups



Clinical Academic Groups

A Clinical Academic Group (CAG) is a formal structure designed to bring together academics and clinical academics within St. George's, University of London and clinicians at St George's University Hospital NHS Foundation Trust with a view to increasing and improving research and educational activity in specific areas where both institutions have expertise and critical mass. The vision is for each CAG to be a local, national and international hub for excellence which provides outstanding and unique research, teaching, and training. We plan to maintain and develop our CAGs in cardiology, neuroscience, infection/immunity, and genetics/genomics. Over time, as research activity develops, we will consider the potential to establish CAGs in other areas.

St George's Institute of Clinical Research

Sitting alongside the CAGs, we will establish St George's Institute of Clinical Research. Hosted by the Trust, this will be a joint structure with SGUL to provide critical mass and "esprit de corps" for clinical researchers (medical, AHP and nurses) to collaborate, develop research interests, skills and careers with increased success in grant applications – including those without an obvious 'home' in the university. It will:

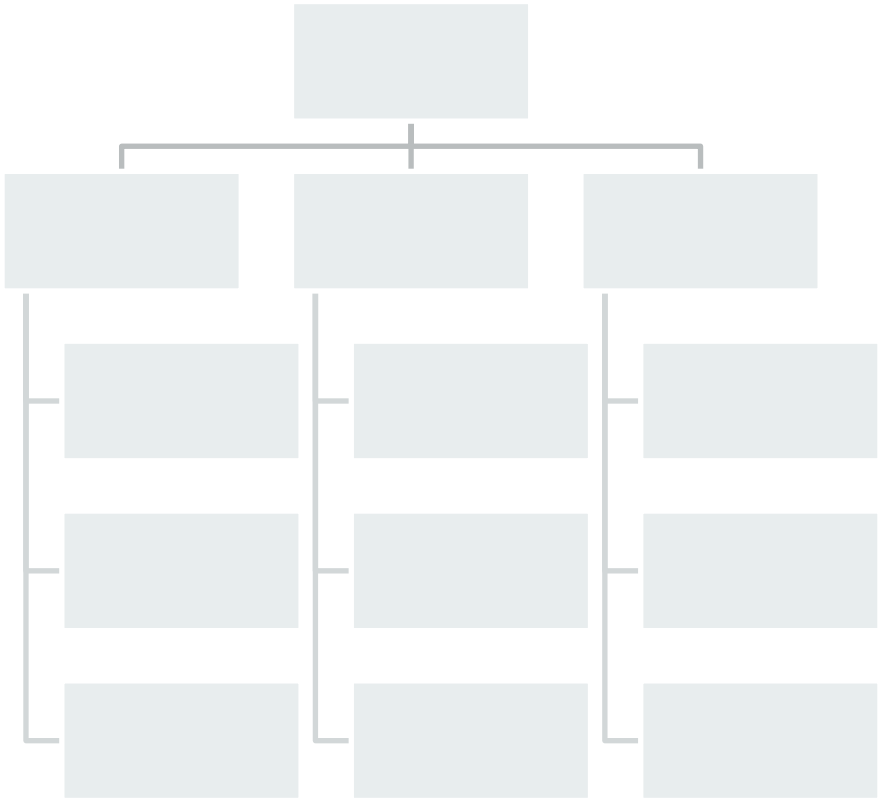
- Enable both non-University and SGUL investigators to access resources and seminar series, develop ideas, learn from success, collaborate and grow site specific research.
- Provide information, training and mentorship to researchers in relation to funding and career development opportunities.
- Organise to collect data on all research outputs from SGUH and publicise success.
- Establish a strong and robust governance structure led by an executive (that includes active researchers) to guide and inform future strategic developments.

We will invest in our staff to support their research ambitions

Like the rest of the NHS, St George's is facing a challenging financial environment. But within those constraints, we will invest in our staff, from all professional groups, to give them the time and skills to pursue their research ambitions. For instance, we will:

- Support Allied Health Professionals and nurses by funding training on research skills and methods, and fund 'backfill' to enable those staff to prepare applications for NIHR internships, pre-doctoral clinical academic fellowships, and clinical doctoral fellowships, working with SGUL and/or the Joint Faculty
- Provide short-term funding to trainees, to generate pilot data or write formal fellowship applications, working with George's Academic Training (GAT)
- Provide finite funding for research sabbaticals for newly appointed consultants, allowing them to prepare grant applications with SGUL or other collaborators, and providing them with mentorship.
- We will provide time in job plans for successful researchers, enabling them to build on their achievements either with further research or as mentors.

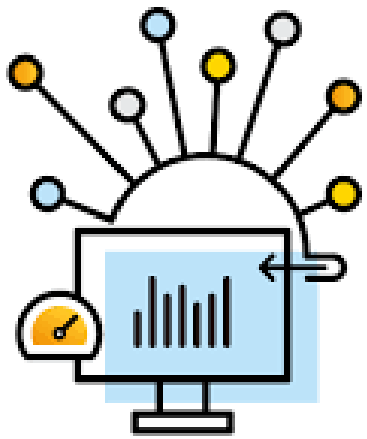
We will treat research as ‘core business’



The demands of running a busy hospital in a financially challenging environment can make it difficult for staff across the organisation to focus on research. But we will treat research as ‘core business’, and the responsibility of all Trust staff.

At all levels of the organisation – care group, directorate, division and Trust-wide – research will be reflected in planning, objective-setting, and governance arrangements.

We will invest in IT infrastructure for research



As the Trust invests in improving its IT infrastructure, we will ensure that it does so in a way that maximises the benefits to research.

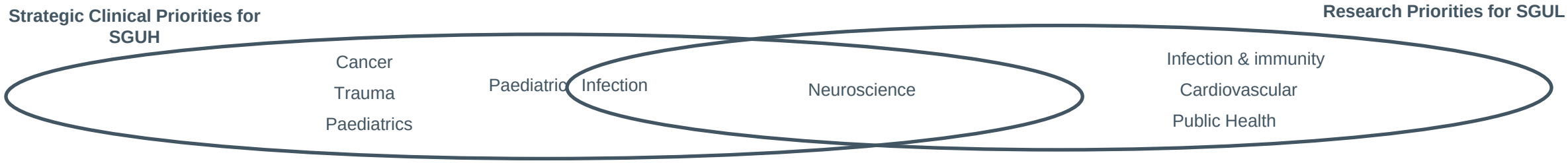
As a key step, we will ensure that the Trust's new data warehouse can act as a research resource for SGUH and SGUL investigators.

Incorporating linked and searchable clinical, radiological and pathological datasets with associated data management and information governance processes, this powerful resource could enable multiple applications and outputs for site and sector specific research.

We will establish a Bioinformatics Research Group together with SGUL to oversee governance and use of this resource, and will establish the appropriate analytical expertise to support clinical investigators.

We will work with St George's, University of London on areas of shared strength

As outlined above, one issue inherent in our partnership with St George's University is that the research focus of the University does not cover the full range of Trust specialties, including some of these priority areas for the Trust. This leaves many areas of the Trust without an equivalent academic research partner in the University.



These in turn overlap with, but are not fully aligned to, existing clinical academic groups (which reflect areas of common academic strength/collaborative endeavour across the Trust and University) in neuroscience, cardiology, genomics and infection.

Over 2019 – 2024, we will:

- continue to support delivery of research across all specialties within the trust, including priority areas in the Trust's clinical strategy such as cancer and paediatrics,
- work with the University, prioritising efforts to lead our own research at St George's in areas where we share existing relative strength: cardiology, neuroscience, infection/immunity, genetics/genomics,
- work with the University in establishing the Institute for Clinical Research to grow academic research in smaller areas outside of the Clinical Academic Groups (CAGs)

We will back this strategy with investment and implementation

Like the NHS as a whole, St George's is operating in a challenging financial environment. But we recognise that delivering this strategy will require investment, which will be reflected in annual business plans over the coming years.

An implementation plan will be produced to set out actions to deliver on the ambitions set out in this strategy, and the Trust Board will track progress against the strategy on a regular basis.

On-going patient and public involvement will be a key part of implementing our ambitions.

Delivering this strategy will mean that in 2024 St George's will be a thriving centre for research

Our vision is that by 2024, St George's will be a thriving centre for research, offering opportunities to take part in research to patients across all our clinical services. We will have an NIHR-funded Clinical Research Facility for early translational research, rank nationally in the top 10 Trusts for research outputs and performance, act as a hub for research in South West London, and boast an international reputation in key areas.

- Clinical research will be fully integrated into the activity of St George's University Hospitals NHS Foundation Trust and be seen as 'core business' by Trust management
- Infrastructure, training and support will be available to increase the number of our staff who both lead and deliver research.
- We will be successful in attracting grant funding from all the major grant giving bodies
- St George's will be regarded as a system leader in research alongside education, training and our clinical services.
- We will be well placed to seize further opportunities emerging in the second half of the decade

Meeting Title:	Trust Board		
Date:	31 October 2019	**Agenda No**	**5.3**
Report Title:	2019/20 Corporate Objectives – Quarter 2 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 TEC and Trust Board on a quarterly basis. As at the end of Q2, of the 18 objectives, 4 have been rated green, 11 amber, 2 red and 1 had no milestones for Q2. Progress has been made on those milestones not rated green in Q1 with only 2 remaining amber at Q2 and 2 remaining red. The two red milestones relate to 'Build a better St George's' which are being reviewed (see note at paragraph 2.4). In summary those delays which are linked to BAF risk are**:** • 1.2 We will map, standardise, support and improve our departmental-level governance of quality, safety and learning (BAF risk SR4) • 2.1 Patients will not wait long for treatment (BAF risk SR3) • 3.1 We are in financial balance (BAF risk SR7)) • 3.4 Improve management of commercial relationships (BAF risk SR8) • 4.1 We have a clear estates strategy (BAF risk SR10) • 4.2 Our environment is safe for our patients and our staff (BAF risk SR10) • 5.3 A zero tolerance approach to bullying and harassment (BAF risk SR13) • 5.4 Working to deliver our Diversity and Inclusion strategy (BAF risk SR12) • 5.5 Empowering our staff to make real change (BAF risk SR11)		
Recommendation:	The Trust Board is asked to asked to: • Review the update • Note the additional milestones relating to 'Champion Team St George's' as set out in paragraphs 2.3 and the proposed review of milestones relating to 'Build a better St George's' as set out in paragraph 2.4 of the paper.		
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 7.		
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:	▪ Any risks associated with the corporate objectives are covered within the BAF, Trust Risk Register or local risk registers		
Legal/Regulatory:	As legal/regulatory issues associated with the Corporate Objectives are covered by the governance underpinning that particular area of delivery of the trusts work programme		
Resources:	Delivery core business as usual of the trust, and supported by trust leadership cohort		
Previously Considered by:	Trust Executive Committee	**Date:**	23rd October 2019
Appendices:			

2019/20 Corporate Objectives
Quarter Two Report
Trust Board 31st October 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 Q2

2.1 Corporate objectives for Q2 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 At the end of Q2. 4 objectives have been rated green, a decrease of 4 from Q1, 11 amber, an increase of 3 from Q1, and 2 red (no change). 1 had no applicable milestones for Q2. Progress has been made on those milestones not completed in Q1 with only 2 remaining amber at Q2 and 2 remaining red. The two red milestones relate to 'Build a better St George's' which are being reviewed (see note at paragraph 2.4). The overall RAG rating for Q2 is amber and has not changed since Q1 (see RAG table below).

2.3 The Q3 and Q4 milestones and measures of success for objective 5 (Champion Team St George's) have now been developed in line with the agreed objective for Q1and 2.

2.4 With regard to Objective 4 'Build a better St George's' following the recent changes in the Management of the Estates and Facilities directorate and increased scrutiny via the Finance and Investment committee (Estates) meeting it is proposed that the current milestones and timelines expressed within the two Corporate Objectives are reviewed. A revised timeline will be presented to the October meeting of the FIC(E) for review and agreement.

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	2	2					-
Build a better St. George's		1	1				-
Champion Team St. George's	1	3	1	1			↓
Develop tomorrow's treatments today	1	1					-
OVERALL	**4**	**11**	**2**	**1**			-

3.0 Risks & mitigating actions

3.1 All deliverables not met as at Q2 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. This also includes any outstanding milestones from Q1.

In summary those delays which are linked to BAF risk are**:**

- 1.2 We will map, standardise, support and improve our departmental-level governance of quality, safety and learning (BAF risk SR4)
- 2.1 Patients will not wait long for treatment (BAF risk SR3)
- 3.1 We are in financial balance (BAF risk SR7))
- 3.4 Improve management of commercial relationships (BAF risk SR8)
- 4.1 We have a clear estates strategy (BAF risk SR10)
- 4.2 Our environment is safe for our patients and our staff (BAF risk SR10)
- 5.3 A zero tolerance approach to bullying and harassment (BAF risk SR13)
- 5.4 Working to deliver our Diversity and Inclusion strategy (BAF risk SR12)
- 5.5 Empowering our staff to make real change (BAF risk SR11)

4.0 Recommendations

4.1 The Trust Board Committee is asked to:

- Review the update
- Consider the additional milestones as set out in paragraphs 2.3 and the proposed view of milestones relating to ‘Build a better St George’s’ as set out in paragraph 2.4 of the paper.

Annex A – Deliverables not met YTD

Objective	Deliverables not delivered & causing amber or red RAG rating	Progress update	Mitigation	Material risk? (Link to BAF)	Overall RAG Position On Delivery of Objective in Q2
Treat the patient, treat the person					
1.1 Reduce harm to patients	An electronic Treatment Escalation Plan will be developed in iClip for implementation in Q2	Partially achieved: built and in testing domain for roll out Q3. Delay due timescales for testing	No additional actions being taken as plan is now on track for delivery in Q3	No – not linked to BAF risk	
	The Trust will achieve over 85% compliance for level 2 Mental Capacity Assessment (MCA) training. Achieve 85% compliance for Early Warning Score (EWS) mandatory training Achieve 85% compliance for resus training across all levels.	Not Achieved- compliance at 72% (although this in an increase on Q1 when compliance was 65%) Not Achieved: 83% compliance Q2 Not achieved: TEC agreed to move milestone to December 19. This is monitored regularly through Quality and Safety Committee and TEC	To have on-going focus at Divisional level to drive improvement is achieving compliance. Staff recruited to resus team Additional training slots established and e-learning package for ILS	No – not linked to BAF risk	
	Implement staff quick reference cards within high risk ward areas. (These are set of pocket reference cards for staff covering key subjects such as EWS, MCA, Safeguarding, FGM, Pressure Ulcer prevention, Freedom to speak up etc)	Partially Achieved - modified approach, all new staff to be issues cards, these are designed published,	All new staff to be issues cards from October. Pocket reference cards are being issues to all new starters as part of their induction and a programme of roll-out	No – not linked to BAF risk	

			to other staff is underway.		
1.2 We will map, standardise, support and improve our departmental-level governance of quality, safety and learning	Deliver relevant actions in Mortality and morbidity, MDT and Clinical Governance action	Partially delivered**.** Work underway but delayed due to capacity constraints.	Medical Directorate Business Manager now in post and actions expected to be delivered by the end of Q4	Potentially a material risk as linked to the BAF (SR4)	
Right care, right place, right time					
2.1 Patients will not wait long for treatment	Accident and Emergency 92% at the end of month 6. RTT (18weeks or less) 86.5% at the end of month 6. Diagnostics Testing 0.7% at the end of month 6.	Trust achieved 83.3% against the 92.5% A&E trajectory in August 2019, a deterioration from 86.4% in July The Trust achieved 85.0% against the 85.5% RTT trajectory in August 2019; a deterioration from 86.1% in July 2019. However, figures for September (yet to be reported) indicate that the improvements have been made to bring performance in line with the trajectory. The Trust achieved 0.92% against the 0.7% Diagnostic trajectory in September 2019.	An improvement programme is in progress. Speciality areas which have experienced the most challenges in meeting the 18 week RTT will be targeted.	Yes – this is a BAF risk (SR3)	
2.2 Our IT is easier to use and supports our	The emergency department will be able to prescribe electronically.	**Not delivered,** due to capacity constraints in	Expected to be delivered in Q3	Not a material risk	

staff to provide the best care for patients		both corporate IT and ED.			
Balance the books, invest in our future					
3.1 We are in financial balance	E&I is currently on plan CIP delivery on plan (not delivered)	All thought the E&I is on plan the full year quantum of CIPS has yet to be found	Services continue to look for opportunities to identify CIP opportunities. Service development for 2019/20 not agreed until CIP target reached	Yes – although E&I is on plan for Q2 there remains a risk around CIP - is a BAF risk (SR7)	
3.4 Improve management of commercial relationships	Commercial strategy for service offers developed. To include milestone plan for key areas of improvement Supplier contract management framework developed.	Partially delivered: in development for completion Q3 Draft developed, to be presented for approval in November.	In development on track for completion Q3	Although linked to BAF risk (SR8) it is not a material risk due to progress made	
Build a better St George's					
4.1 We have a clear estates strategy	Finalise estates strategy objective how do we get there Create initial Development Control Plan Undertake Estates Strategy workshop with clinical teams Liaise and agree principles with Trust Board and partners e.g. NHSI and SWL HCP Programme Board	**Not delivered:** Work has commenced on the development of an Estates Strategy. A key element of this is the completion of a 6 facet survey to ensure the condition of the current site is fully understood. This is expected to be completed in XXX. The Estates Management team has commenced working on the development of the Strategy supported by the	CFO to review the milestones and timelines and agree through FIC9E) the timescales	Yes – BAF risk (SR(10)	

		Strategy Team.			
4.2 Our environment is safe for our patients and our staff	Finalise review of maintenance contracts and funding options.	**Partially Delivered:** A full risk review of the Estates and Facilities environment is underway and the initial risk rating have been reported to TEC and the FIC(E). Detailed assessments at department level are underway and once these are complete action plans will be developed to mitigate any issues. Action continues to address known high priority risks such as water safety and these are reported through TEC and the FIC(E).	CFO to review the milestones and timelines and agree through FIC9E) the timescales	Yes – BAF risk (SR10)	
	Utilise PAM to monitor trends and emerging issues				
	Utilise quarterly review of statutory compliance by AEs to advise FIC/QSC/Board Review validation and compliance documentations				
	Reduce CRR BAF risks and reduce outstanding historic jobs on maintenance system				
Champion team St George's					
5.2 Developing outstanding leaders and effective teams	OD for Triumvirate launched Roll-out of Master class schedule	Partially delivered**:** The CEO is taking a lead on this and work has begun to scoping this out Not delivered	Appointment to new lead OD post	No	
5.3 A zero tolerance approach to bullying and harassment	Zero tolerance action plan launched (delivery over Q2/3/4)	Partially delivered: The policy has been reviewed and approved	Publicity for new policy has started, action plan in development	Not a material risk due to timeline for completion but is linked to a BAF risk (SR13)	
5.4 Working to deliver our Diversity and	Develop action plan based on results of review of disciplinary cases.	Partially delivered: A fixed-term project	The appointment of the project manager	Potentially a material risk as linked to a BAF risk	

Inclusion strategy	Roll-out diversity leadership programme Embed D&I networks across the Trust	manager has been appointed to draw up the action plan and re-start the network meetings	has been taken as mitigation and to get things on track	(SR12)	
5.5 Empowering our staff to make real change	Carry out Go Engage survey 25% of the workforce) on 10 areas of staff engagement to identify concerns	Not delivered: The Go Engage survey has been delayed as the timing is too close to the national staff survey.	Survey time lines under review post staff survey closure Plan launch Q4	A material risk as linked to the BAF risk (SR11) and the timelines for delivery still to be determined.	
Develop tomorrow's treatments today					
6.1 Produce a new education strategy aligned to the new clinical strategy that articulates the vision and strategic aims	Finalise scoping of the education strategy Agree stakeholder engagement plan Commence stakeholder engagement	Partially delivered: stakeholder engagement planned but not yet delivered	Engagement session on track for completion early Q3	No	

Annex B - approach to RAG-rating

1. The RAG ratings for Q2 derived as follows. Each objective is shown as:

   - Green for Q2 if all its Q2 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 Q2 if some of the associated Q2 milestones have been delivered, and some not, or if the milestones are partially delivered.
   - Red if the milestones for Q2 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.

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Meeting Title:	The Trust Board		
Date:	31st October 2019	**Agenda No**	**5.4**
Report Title:	**St. George's Hospital Charity: Quarterly Update (Q2 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:	Trustees' Board Meeting took place on September 27th 2019. Grant approvals in Quarter 2 authorised under charity internal processes to the value of £120,518, have been processed and are listed in the main report. The charity is setting up a Grants Committee which will meet on October 29th 2019. The charity continues to work closely with the Trust by meeting at divisional and directorate level to introduce the charity's activities, review and update Special Purpose Funds, and review grant application processes. The charity now has project managers for its capital projects and attends the Medical Devices Committee to ensure joined up working. The charity highlights below some capital projects which are experiencing delays. Marketing materials and fundraising events are well underway to support the Renal Appeal. A draft Memorandum of Understanding between the charity and the trust for the Renal Appeal is with Trust Finance Team for consideration.		
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 achieve 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:**	23rd October 2019
Appendices:	none		

St. George's Hospital Charity Q2 2019/20 Update

1.0 Purpose

1.1 The report is provided to give the Trust Board an update regarding the activities of the Charity in Q2 2019/20.

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

2.0 St George's Hospital Charity Grants Update

Trustees met on September 27th 2019. There were no grant applications submitted to approve.

The Trust's £200,000 grant application for the renovation of the Surgical Assessment Lounge was not submitted as planned to the September Board due to further review and approvals required by the Trust. The application is expected for submission at November Board.

A Grants Committee is being established to meet separately to the main trustees' board meetings. The first meeting will take place on October 29th 2019. The purpose of the Grants Committee is to review grant governance and oversee grant applications for recommendation to the trustees' board.

In Quarter 2 approvals to the value of £120,518 were processed. These approvals were authorised under the charity's internal processes falling outside of board meetings and are detailed below.

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

2.1 Special Purpose Funds (SPF)

Grant Ref.:	SPF 19-20 006
Amount:	£25,100
Grant	The part time salary of a postdoctoral fellow at St George's University Hospital for 16 hours per week for 12 months. Research into the HOX genes in lymphoproliferative disease to establish whether lymphoma cells are sensitive to killing by an inhibitor of HOX function which could lead to HOX genes being used to help the prognosis and management of lymphoma patients.
Funds	SPF - The Lymphoma Fund

Grant Ref.:	SPF 19-20 007
Amount	£8,423
Grant	2 x Air Con 'Comfort Cooling system for trauma and orthopaedic Gym and Office at St George's Hospital. Therapy in gym proving very hard without air conditioning with temperatures ranging from 26 to 30 degrees during the summer – 60- 80 patients per week and 10-12 therapists, sessions cancelled due to heat.
Funds:	SPF – The General Community Fund

Grant Ref.:	SPF 19-20 009
Amount:	£15,744
Grant	To fund the post of a Data Manager for 6 months using Bank staff - to enrol patients on the St George's Hospital patient database, retrospectively and prospectively. The data will be collected to provide information to the Melanoma database which will serve as a national registry system
Funds:	SPF Melanoma Foundation

Grant Ref.:	SPF 19-20 010
Amount:	£9,000 Vat exempt
Grant	A rehabilitation chair to allow patients who would otherwise be confined to their bed to receive therapy
Funds:	SPF - Intensive Therapy Unit

Grant Ref.:	SPF 19-20 011
Amount:	£9,846.75
Grant	A video laryngoscope for teaching and in an emergency for when they have a difficult airway to treat.
Funds:	SPF Paediatric ICU

Grant Ref.:	GEN 19-20 002
Amount:	£20,000
Grant	The salary of an Arts & Crafts Co-ordinator for children in isolation. 12 months fixed term contract 22.5 hours per week, working in the hospital's Play Team.
Funds:	£10,000 funded by the Taylor Family Foundation and £10,000 by the charity.

2.2 Funding from Appeals/Donations:

Grant Ref.:	N/A
Amount:	£24,142.12
Grant	Children's Garden Renovation – next to the Dragon's Centre Improvements focus on better access, new play equipment and creating a safe and fun environment for all children to enjoy Please note this project is now in question – please see below.
Funds:	Donation

Grant Ref.:	N/A
Amount:	£4,100
Grant	Medical equipment Accuvein - a device which when shone on the body shows up the veins making it easier to locate a vein. For children's wards.
Funds:	Children's Appeal – Big Theme

Grant Ref.:	N/A
Amount:	£1,600
Grant	Medical equipment Spot Monitor - provides vital signs measurement including blood pressure. For children's wards.
Funds:	Children's Appeal – Big Theme

Grant Ref.:	N/A
Amount:	£2,562.75
Grant	Philips Efficia CM 100 patient monitor and consumables for children's wards
Funds:	Children's Appeal – Big Theme

2.3 The Renal Appeal

The target the charity is aiming to raise is £1,000,000 of which originally £300,000 was expected from the Kidney Patient Association. The £300,000 is still to be confirmed. The charity's fundraising team are working very hard on the renal appeal. Marketing materials, case studies and website page have been created with further materials in the pipeline. A series of fundraising events are planned including a Pub Quiz with Trust staff which took place in the October 2019.

A Memorandum of Understanding between the charity and the Trust for the Renal Appeal is being drafted and under review by the Trust Finance Team.

2.4 Other Capital Projects

The following is a sample of capital projects which the charity would like to highlight:

1) The proposal for the refurbishment of Nicholls, Freddy Hewitt and Pinkney Wards is to be submitted to the Business Case Review panel for the first time. The charity welcomes this and hopes the project will be progressed as a result.
2) The Trust's £200,000 grant application for the renovation of the Surgical Assessment Lounge has not been submitted yet because it is currently with the Trust's Business Case Review panel.
3) The £60,000 Maternity Transformation grant for the refurbishment of three Maternity Receptions (level 1, level 4 and Foetal Medicine Unit) awarded last year is delayed as the costings are being reviewed. The £60,000 may only be enough to cover one reception (rather than three) with some funds possibly left over. The charity is waiting on final costings and confirmation from Trust management about which reception of the three should be refurbished.
4) The costs of refurbishing the Forget Me Not Suite in maternity are higher than expected. Donors who suffered a loss themselves have worked hard to raise £51,000. The charity expects to receive final costs imminently on what work can be undertaken within the £51,000 budget.
5) Roof Terrace Garden for the Neuro Intensive Care Unit for non-ambulatory and ventilated patients, with a separate section for staff. £19,000 has been raised towards the £27,000 budget. The original risk assessment for the project regarding patient safety has been reviewed with a recommendation to undertake further work. It is expected this will have a significant impact on the overall target required which is likely to impact on the feasibility of the project.
6) The Children's Garden Renovation £24,000 - funded by a kind donation.. This garden is next to the Dragon's Centre. The project aims to improve access, provide new play equipment and create a safe and fun environment for all children to enjoy. The project has experienced delays though completion is expected by the end of the year.

7) Functional Walking Course – Queen Mary's Hospital – this is a walking course for amputees with prostheses to assist them to learn how to negotiate various surfaces before they go out into the real world. The project was approved on March 22nd.
8) ED Research Facility – the charity funded this and was delighted that the unit was delivered on July 20th this year.

3.0 Working with the Trust

The charity has attended the divisional board meetings for all three divisions to highlight the charity's activities and draw attention to the funds available in the Special Purpose Funds held by the charity. The charity requested support from all directorates to update its records regarding information held for special purpose funds. Meetings are taking place individually with each directorate in order to progress this piece of work. A paper was circulated explaining the grant application process.

Working with the Trust Strategy Team, the charity's grant application forms have a comprehensive set of Trust required approvals, designed to ensure the smooth progress of a grant application. The set of required approvals is currently with the Trust undergoing internal review. The charity has aligned itself with the Trust's Strategic Priorities in terms of reporting outcomes, enabling applicants to report easily by fitting in with the Trust's own framework.

Regarding capital projects the charity now has Trust project managers assigned to its capital projects and meets monthly with the lead capital projects' manager. The charity has also developed a process for seeking approval to fundraise for capital projects, which involves the Trust from the outset. This process is being reviewed by the Trust in the context of its own internal governance systems. This work aims to ensure that costs and approvals are as reliable as possible before fundraising commences.

The charity is also attending the Medical Devices Committee which meets bi monthly. This helps its work in funding medical equipment.

4.0 Recommendation

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

<u>Forthcoming Charity Trustee Board meetings</u>

Charity Trustees will next meet on 22nd November 2019.

Meeting Title:	Trust Board		
Date:	31 October 2019	**Agenda No**	**5.5**
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, Director of Compliance and Quality Improvement**		
Presented for:	Assurance		
Executive Summary:	Attached is the summary BAF for quarter 2 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 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 2 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.		
Recommendation:	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 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		
Equality and Diversity:	No equality and diversity issues to consider		
Previously Considered by:	Trust Executive Committee Quality and Safety Committee Finance and Investment Committee Finance and Investment Committee – Estates & IT	**Date**	23.10.2019 24.10.2019 24.10.2019 24.20.2019
Appendices:	Appendix 1. Summary Board Assurance Framework (BAF) Appendix 2. BAF Assurance Report for Q2 2019/20 on BAF Strategic Risks and Corporate Risk Register Appendix 3. Assurance ratings – definitions		

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.

BOARD ASSURANCE FRAMEWORK OVERVIEW QUARTER 2 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 performance metrics within the IQPR, the progress of the implementation of the Critical Care Outreach service and use of Treatment Escalation Plans for adults. A progress report was received demonstrating the on-going work of the Quality Improvement Academy supporting the use of improvement methodology for service improvement initiatives. The CQC inspected the Trust during this quarter, no regulatory concerns were raised with the Trust and the Trust is awaiting the CQC inspection report. Although the committee received assurance on progress in some areas the assurance rating is currently partial to reflect the need for further work and improvement*	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. A risk associated with the Trust's ability to respond to the recommendations from the external governance reviews was added to the corporate nursing risk register with associated mitigations. The assurance rating is currently partial as the implementation of the recommendations from the external governance reviews has recently commenced and further assurance with reference to delivery is required*	Chief Medical Officer	Quality & Safety Committee	15
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 4 hour operating standard and the management of patient pathways. The 4 hour operating standard risk was reviewed at the Committee's request in terms of how it is presented and is now presented as two separate risks in terms of patient safety and Trust reputation. The risk associated with a no deal exit from the EU and planned mitigations was recognised in relation to the provision of medication and supplies and the impact on patients. The committee requested a review of the risk relating to an aging MRI scanner as current mitigations were reported to be impact positively. The assurance rating is currently partial to reflect the need for further work and improvement*	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 successful risk mitigation of fragmented medical records as the implementation of iClip at QMH addresses the most material issue. Assurance was also provided for four contributing risks resulting in reduced risk scores following the completion of planned mitigations. While improvement was noted in these areas the overall assurance rating remains limited reflecting the need to complete the remainder of the planned works*	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					<u>For Decision after discussion at Trust Board:</u> *Implementation plans have been agreed by the divisions and the first 6 monthly progress report will be considered by Trust Board in October. As this is the first progress report to be considered by the Board, the assurance rating is 'limited' until the Board have had opportunity to consider the progress. In addition, progress with supporting strategies is being reported to TEC on a monthly basis with the research strategy due to be considered by Trust Board in October. It is likely that the assurance rating may then move to from limited to partial.*	CEO (Chief Strategy Officer)	Board	16
	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.					<u>For Decision after discussion at Trust Board:</u> 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 Trust is very much an active partner in the various stakeholder groups considering this. The committee is reasonably assured that controls are generally adequate but indicates a partial assurance rating to remain for Q2 to reflect that the progress still to be made across the system in SWL and the changing commissioning landscape.	CEO (Chief Strategy Officer)	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)					*It was reported to the committee the current financial forecast indicates the delivery of the target deficit in 2019/20 is at risk. Failure to achieve this will increase the challenge of returning to unsupported balance. The risks associated with the process aspects of this risk remain largely unchanged from Q1. An assessment addressing the risks associated with a no deal exit from the EU has been included within this section together with mitigations available to the Trust. The assurance rating remains limited*	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 in relation to 2019/20 funding; for later years work is on-going. The assurance rating remains limited as a consequence*	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 and will continue to be updated to reflect the strategic developments over time*	Chief Finance Officer	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 received a risk assessment across the key areas covered by this risk together with assurance on actions undertaken and improvements in governance processes across Estates. The assurance rating is currently limited to reflect the condition of some of the estate and the need for further work. Actions are underway to mitigate risks*	Chief Finance Officer	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 2019-2020 Staff Engagement Plan, implementation of the new engagement methodology Go-Engage and revised Raising Concerns at Work Policy. The assurance rating remains partial, controls are generally adequate but the committee continues to seek further assurance that the controls will deliver demonstrable progress particularly with reference to the Staff Engagement Strategy and implementation of the new engagement methodology*	Chief People Officer	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 that additional resource has been brought in to the Trust to support the delivery of the D&I strategy and that the staff groups have been re-launched. Assurance is further supported a D&I focussed Board workshop. The assurance rating has improved to partial, controls are generally adequate but the committee requires further assurance with reference to visibility of agreed performance metrics*	Chief People Officer	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 that the raising Concerns Policy has been revised and re-launched in the Trust supported by communications. The assurance rating remains partial, controls are generally adequate but the committee requires further assurance with reference to visibility of agreed performance metrics*	Chief People Officer	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 about the Trust vacancy rate and on the recent HSJ award with reference to nursing recruitment. The assurance rating remains limited to reflect the concerns related to some staff groups and the need for further work*	Chief People Officer	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 for the Trust Board in October 2019. The assurance rating remains partial to reflect the need for further work*	Chief People Officer	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 that there continues to be 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

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Board Assurance Framework Q2 2019/20: Strategic risk 5 & 6

Trust Board
31 October 2019

Individual risks contributing to strategic risks

		* Overall SR score is based on the highest risk score		
Risk short form title	Description	Open Date	Initial Score*	Current Score Q2 19/20*
SR5 - There is a risk that we fail to make progress in delivering our clinical services strategy			16	16
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	12
Commissioners' support	Risk that the Trust does not have Commissioners' support to implement the strategy	Jul 2019	10	10
Capacity and capability to implement strategy	Risk that the Trust does not have capacity and capability to implement the strategy *(cross referenced to HR risk Recruit and retain sufficient workforce)*	Jul 2019	16	16
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	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**	**9**
Workforce - Non viable clinical rotas	Risk of non-viable clinical rotas	Jul 2019	9	9
Increase demand on provided services	Risk that services continue to see current or increase demand on provided services	Jul 2019	9	9
Clinical pathways variation	Risk we do not eliminate variation across clinical pathways leading to poor patient experience	Jul 2019	9	9

Risk Reduction Assurances and Rating

Key	Extreme Risk	High Risk	Moderate Risk	Mitigated Risk	Expected changes	O	Original timescale	X	Subsequent timescale

Short form of risk description	Risk Score October 2019	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
SR5 - There is a risk that we fail to make progress in delivering our clinical services strategy														
Capital availability to implement strategy	12													
Commissioners' support	10													
Capacity and capability to implement strategy	16													
Other providers' strategies conflicting with Trust strategy	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														
Workforce - Non viable clinical rotas	9													
Increase demand on provided services	9													
Clinical pathways variation	9													

Risk Reduction Assurances and Rating

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 risk by HR SWL STP attended by chief executives. The Trust attends key meeting & forums attended by commissioners and other providers.	Limited	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	Partial		

Risk Matrix
CxL=RS

CONSEQUENCE INDEX			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.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	31 October 2019	**Agenda No**	5.6.1
Report Title:	Horizon Scanning Report, Q2 2019/20: Emerging policy, political, legislative and regulatory issues		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Information		
Executive Summary:	This report provides the second in 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 Q2 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 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 is reported in a separate slide deck under this agenda item. A report on emerging political, legislative, policy and regulatory issues covering Q1 2019/20 developments was presented to the Board at its meeting in July 2019.		
Recommendation:	The Board is asked to note the update on emerging policy, legislative and regulatory issues for Q2 2019/20.		
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**	23 October 2019
Appendices:	Horizon Scanning Report, Q2 2019/20: Emerging policy, political, legislative and regulatory issues		

Outstanding care every time

St George's University Hospitals
NHS Foundation Trust

Horizon Scanning report
Q2 2019/20

Emerging policy, political, legislative and regulatory issues

Stephen Jones
Chief Corporate Affairs Officer

25 October 2019

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

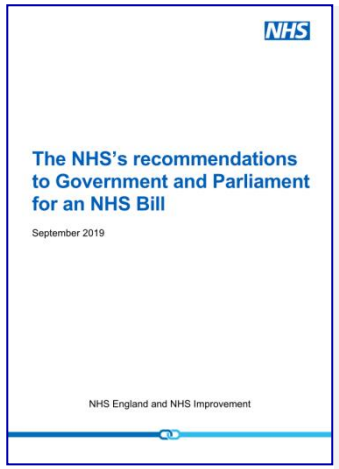
- **Political and legislative developments**: Current and emerging political and parliamentary developments at a national level with direct or indirect implications, or potential implications, for the Trust; key changes, or potential future changes, to primary legislation and regulations.
- **NHS policy 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 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 second such report to the Board and the format and issues will be kept under review 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 report which focuses on regional and local issues.

2. Political and legislative developments

UK withdrawal from the EU

- The Government announced that it had reached a withdrawal agreement with the EU on 17 October. At the time of writing, it is unclear whether Parliament will support the EU Withdrawal Bill within the Parliamentary time allowed or whether an extension of the Article 50 will be made.
- The Board held a seminar on 2 October 2019 on its preparations for the UK's withdrawal from the EU. As part of this, it reviewed guidance from the Government to NHS providers and the actions the Trust was taking to mitigate the associated risks.



Queen's Speech and NHS legislative reform

- As anticipated, in the Queen's Speech on 14 October 2019, the Government committed to brining forward legislation "in due course" to support the implementation of the NHS Long Term Plan. This followed the publication, on 26 September 2019, of NHS England and NHS Improvement's recommendations to Government and Parliament for an NHS Bill. The NHSE&I report accepted the recommendations of the Health and Social Care Select Committee on earlier proposals. It also set out that the core purpose of a Bill should be to free up different parts of the NHS to work together and with partners more easily.
- The NHSE&I report reaffirmed that the role of the Competition and Markets Authority in the NHS as set out in the 2012 Act should be repealed along with removing commissioning from the scope of the Public Contract Regulations, removing the automatic presumption of tendering of NHS healthcare services over £615,000. In addition, it proposed that Monitor's roles in relation to competition should be repealed. However, it reaffirmed the commitment to patient choice which it said must be included in the Bill.
- The Queen's Speech also contained a commitment to bring forward a second piece of health legislation, a Health Service Safety Investigations Bill. A restatement of the 2017 Queen's Speech commitment, this Bill would establish an independent investigator of breaches of patient safety across the health system, in both the public and private sectors. Fundamentally, the Bill would create and empower the Health Service Safety Investigation Branch to investigate patient safety incidents with the sole purpose of learning.
- In addition, the Queen's Speech contained a commitment to reform adult social care and to review the Mental Health Act.

3. NHS policy and institutional landscape

Capital investment announcement, August 2019

- In August 2019, the Government announced a £1.8bn capital package for the NHS. This included £850m new funding for 20 trusts to upgrade outdated facilities and equipment, along with an additional £950m increase in the Department of Health and Social Care's capital expenditure limit (CDEL). St George's was not among the 20 trusts in receipt of this funding, though within South West London, Epsom St Helier and Croydon both received a share of the funding.

- The September 2019 spending round committed the Government to a multi-year capital settlement for the NHS in the next spending review, which is expected in Spring 2020.

- On 30 September 2019, the Department of Health and Social Care released a new healthcare infrastructure plan (HIP), setting out changes for how capital funding will be prioritised and allocated to the frontline. The HIP sets out the broad objectives of the government's plan for capital spending both in terms of core NHS capital spending and also on the wider health and care infrastructure, including genomics, research and development and public health.

- The Government's plans set out a five year rolling strategy of indicative capital allocations. While including capital to build new hospitals, the Government has also signalled its intention to modernise the primary care estate, invest in new diagnostics and technology, and to eradicate critical safety issues in the NHS estate. The HIP acknowledges that the demand for capital exceeds current funding levels and recognises the present system for investing capital is outdated.

- The Government has set out three objectives for the HIP:
    - A five year rolling programme of investment in NHS infrastructure across hospitals, primary and community care estates, and health infrastructure;
    - A reformed system underpinning capital to ensure funding addresses needed;
    - Obtaining the support of wider health and care sectors with funding at the capital review.

3. NHS policy and institutional landscape

Future Financial Architecture, October 2019

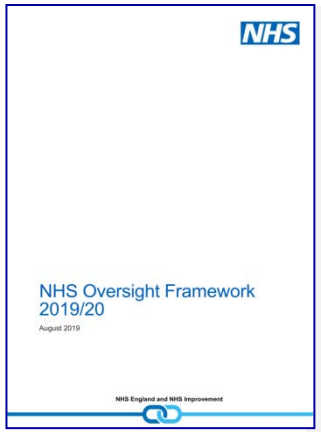
- On 4 October 2019, NHS England and NHS Improvement sent out letters to commissioners and providers detailing a new financial architecture to replace the existing system of control totals and provider sustainability funding. In the letters, NHSE&I set out the long term role of the financial recovery fund, financial improvement trajectories, and announced a new transitional reward payment for trusts able to maintain a break even or surplus position.

- Under the NHS Long Term Plan, NHSE&I committed to developing a series of government set financial objectives to improve frontline NHS finances including:
    - Continuing to balance the NHS national and aggregate provider/commissioner positions;
    - Reducing the aggregate provider sector deficit each year, with the provider sector achieving overall balance by 2020/21; and
    - Reducing the number of trusts in deficit year on year with every NHS organisation in balance by 2023/24.

- To support the delivery of these objectives, NHSE&I is creating a new financial architecture. This reshapes financial support for the provider sector, moving from centrally set control totals and a provider sustainability fund (PSF) available to all trusts, to a financial recovery fund (FRF), targeted at trusts with deficits. The underlying NHSE&I aim is to:
    - Set a more realistic financial task for providers, with a more deliverable efficiency requirement, enabling more trusts to deliver a surplus without central financial support;
    - Move away from a centrally set control total regime to one where trusts in surplus set and deliver their own year end financial position, so that trusts in surplus explicitly get greater regulatory freedom;
    - Over time, concentrate central financial support on trusts and systems in deficit to support their return to surplus.
    - Over time, lower the amount of central financial support and enable appropriate delivery of recurrent efficiency savings to help providers return to financial balance.

- NHSE&I has now issued each STP/ICS and constituent provider/CCG with a deficit trajectory for each year between 2020/21 and 2023/24, set at a level and improvement rate that they believe is reasonably deliverable. They are also issuing FRF allocations by each year, making clear that from 2020/21 FRF support will only be available to trusts in deficit.

4. System and professional regulation



Publication of the NHS Oversight Framework for 2019/20

- In August 2019, NHS England and NHS Improvement published the new NHS Oversight Framework for 2019/20. It sets out the joint approach that the newly combined organisations will take to overseeing organisational performance and identifying where commissioners and providers may need support. It has replaced the Single Oversight Framework for providers and the Improvement and Assessment Framework for Clinical Commissioning Groups. It is the product of NHS England and NHS Improvement aligning their operating models to support system working. The new approach sets out how NHSE&I regional teams will review performance and identify support needs across STPs and ICSs.

- Changes to the approach to oversight are characterised by several key principles:
    - NHS England and NHS Improvement teams speaking with a single voice, setting consistent expectations of systems and their constituent organisations;
    - A greater emphasis on system performance, alongside the contribution of individual healthcare providers and commissioners to system goals;
    - Working with and through system leaders, wherever possible, to tackle problems;
    - Matching accountability for results with improvement support, as appropriate;
    - Greater autonomy for systems with evidenced capability for collective working and track record of successful delivery of NHS priorities.

- The Framework makes clear that during 2019/20 NHSE&I will develop proposals for a new framework for 2020 and onwards. The metrics that will be used for this will include the measures identified in the NHS Long Term Plan Implementation Framework.

- As part of the 2019/20 Oversight Framework there are a set out provider oversight metrics which NHSE&I will be using to monitor and assess provider performance under the following headings:
    - New service models
    - Quality of care and outcomes
    - Leadership and workforce
    - Finance and use of resources

4. System and professional regulation

New guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts, July 2019

- In July 2019, NHSE&I and the National Guardian's Office updated its guidance of FTSU to Trust Boards in the context of the new NHS Interim People Plan. The guide is intended to support the culture of ensuring everyone feels they have a voice, control and influence which is set out in the interim plan.

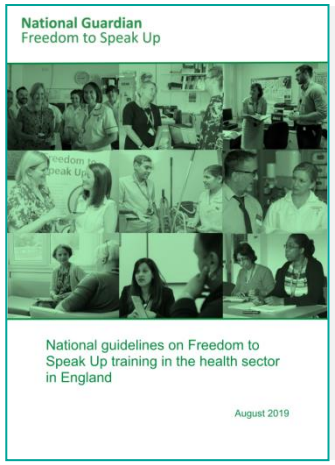
- Trust Executive Leads for FTSU are expected to use the guide to help Boards reflect on their current position and the improvements needed, using the self review tool. There is an expectation this review is undertaken by the Board every two years. It sets out the expectations of executive directors in relation to FTSU and how Board should demonstrate their commitment to creating an open and honest culture where staff feel safe to speak up. These measures include:
    - Having named executive and non-executive leads responsible for FTSU
    - Including speaking up and other related cultural issues on the Board development programme
    - Having a sustained and ongoing focus on reduction of bullying, harassment and incivility
    - Sending out clear messages that the Board will not tolerate the victimisation of those who speak up
    - Investing in sustained and continuous leadership and development
    - Having a well-resourced FTSU Guardian and champion model
    - Supporting the creation of an effective communication and engagement strategy that encourages staff to speak up
    - Inviting staff who speak up to present their stories to the Board in person

- The new guidance makes clear that Boards should have a clear vision for FTSU and a strategy for FTSU. There is an expectation that the Board should discuss and agree the strategy and be provided with regular updates. The strategy should be reviewed by the executive lead annually, and must contain well thought out goals that are measurable and which have been signed off by the Board.

- The executive lead is expected to ensure the Board receives a range of assurance and regular updates in relation to the FTSU strategy. A key part of that assurance is the report provided in person by the FTSU Guardian to the Board, which the guidance states should be at least every six months. It also sets out the kind of information the Board should expect to be in the FTSU Guardian's report, while also making clear that this should not be the only assurance the Board receives on FTSU issues.

- On 8 October 2019, NHS E&I also announced plans to roll out dedicated support to members of staff who raise the alarm about unsafe practice. This will involve practical support to doctors, nurses and other workers who need support to rebuild their careers after raising concerns at work. The scheme will involve staff career coaching, shadowing opportunities, work experience, and resilience training.

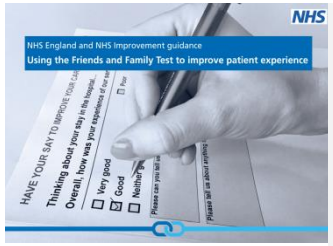
4. System and professional regulation



National guidelines on Freedom to Speak Up training, August 2019

- In August 2019, the National Guardian's Office (NGO) published new national guidelines on Freedom to Speak Up training. The guidelines seek to improve the quality, clarity and consistency of training on speaking up across the health sector.

- The new guidance sets out a number of principles for FTSU training, including that training should be provided to all workers on FTSU and that this should be treated with parity to other training, that the training should be repeated regularly to ensure the messages are reinforced, that training is accessible, that it is included in leadership development programmes, and relevant to the organisation. The guidance also requires the routine monitoring of completion of training and its quality. The guidance sets out what should be covered as part of "core training" for all staff, the additional content that should be covered in training for "line and middle managers", and further training for "senior leaders".



Revised guidance on the Friends and Family Test (from 1 April 2020), September 2019

- In September 2019, NHS England and NHS Improvement published revised guidance on the Friends and Family Test (FFT) which are effective from 1 April 2020. The guidance replaces all previous implementation guidance on FFT.

- The key changes in the revised guidance are:
  - There is a new standard question for all services – "Overall, how was your experience of our service?", with a new response scale from "very good" to "very poor".
  - If the mandatory question is being used as part of a wider survey, it no longer need to be the first question asked.
  - New recommended free-text questions e.g. "tell us why you gave your answer" or "tell us about any thing we could have done better"
  - Changes to timing requirements, with the previous requirement that feedback be given at discharge or within 48 hours having been removed and an expectation that patients should be able to give real time feedback and be able to use the FFT for this.
  - Response rates will no longer be published as there is no longer a limit on how often a patient can give feedback.

4. System and professional regulation

Whistleblowing disclosures report by healthcare professional regulators, September 2019

- In September 2019, eight of the healthcare professional regulators published an annual report on whistleblowing issues raised with them in the period April 2018 to March 2019.
    - General Medical Council: Reviewed 35 whistleblowing disclosures, an increase of 12 over the previous year. Of these, 15 cases developed into preliminary or full investigations. 13 of the concerns were raised by doctors, 10 by healthcare organisations, and 12 were anonymous.
    - Nursing and Midwifery Council: Received 34 whistleblowing disclosures. In 18 cases regulatory action was taken, and 16 cases were referred to an alternative body and regulatory action was taken.
    - General Pharmaceutical Council: Received 16 whistleblowing disclosures. In 5 of these cases, regulatory action was taken and 7 are under review.
    - Health and Care Professions Council: Received 9 whistleblowing disclosures, of which 1 case involved regulatory action and 8 were referred to alternative bodies.

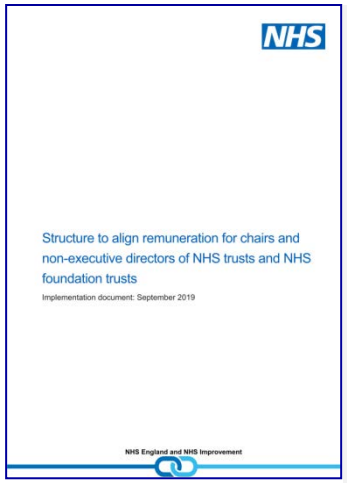
Future Midwifery Standards, October 2019

- On 3 October 2019, the Nursing and Midwifery Council approved new midwifery standards which seek to ensure that the next generation of midwives are equipped with the knowledge, understanding and skills needed to deliver high quality maternity services.
- The Standards are intended to ensure the role of the midwife evolves to meet changing individual needs and the changing needs of the system. They place particular emphasis on perinatal mental health and also recognise the role of midwives in improving public health.

4. System and professional regulation

GMC's Workforce Report: The State of Medical Education and Practice in the UK, October 2019

- On 24 October 2019, the General Medical Council published its annual *Workforce Report*. The key findings of the report are:
  - The workforce is increasingly international and diverse. For the first time, more non-UK medical graduates took up a licence to practise than UK medical graduates. And, UK medical graduates were more ethnically diverse than ever before.
  - There are significant threats to retaining existing doctors. The UK is struggling to retain substantial numbers of doctors who, in the face of pressures, are reducing their hours or intending to leave UK practice.
  - Wellbeing is key to improving retention of doctors and quality of patient care. Better planned and resourced medical leadership can spread the positive, inclusive and supportive cultures that are evident in many places across the UK.
  - A different mix of specialties is required for the future workforce. Meeting future patient demand requires more expert generalists, as well as more specialists identified in national workforce plans as being in increasing demand, such as psychiatrists and radiologists. Greater flexibility in training and job design is also needed.



Remuneration of Chairs and Non-Executive Directors

- In September 2019, NHS England and NHS Improvement wrote to provider chairs setting out changes to align the remuneration for chairs and non-executive directors of NHS Trusts and NHS Foundation Trusts. There have been significant differences between the remuneration levels of chairs and NEDs in the FT and non-FT sectors with the result that some trusts have experienced challenges attracting, appointing and retaining high calibre NEDs. The guidance recognises the role of Councils of Governors in FTs in setting the remuneration of chairs and NEDs, but also states that there is an expectation that Governors will work within ranges. The changes will be implemented over a 2.5 year period starting in October 2019. The key changes are:
  - For non-executive directors, a single annual uniform rate of £13,000 will apply, with local discretion to award supplementary payments of up to £2,000 per annum (up to a maximum number based on the size of the Trust) in recognition of designated extra responsibilities such as chairing committees and undertaking the duties of Senior Independent Director.
  - For chairs, it is intended that ranges will apply according to respective trust destination based on the organisation's turnover and complexity. For "supra large trusts" with an annual turnover of more than £750m, the chair remuneration range will be between £55,500 and £63,000.

5. Reports and updates from key stakeholders

CQC State of Care Report, October 2019

- On 15 October 2019, the CQC published its *State of health care and adult social care services in England 2018/19* report. The report is the CQC's annual assessment of health and social care trends and looks at trends in quality, shares examples of good and outstanding care and highlights where care needs to improve. The highlights of this year's report are:
    - CQC found that the overall quality of care that people receive in England has improved very slightly from last year. When people are receiving care, it is mostly of good quality. However, even where care services are of good quality, CQC found many people can struggle to get access to the care they need and want, impacting on their experience of care.
    - Access and staffing are presenting challenges across all care settings, with geographic disparities in provision presenting particular barriers in some parts of the country.
    - The report highlights pressures in A&E and across the system. It states figures for emergency attendances and admissions are continuing to rise year-on-year, and patients struggling to access non-urgent services in their local community can have a direct impact on secondary care services.
    - This year's report focuses particularly on inpatient mental health and learning disability services as this is an area CQC is seeing some decline in quality.
    - CQC has also seen too many people using mental health and learning disability services being looked after by staff who lack the right skills, training, experience or support from clinical staff.
    - In adult social care, CQC states issues around workforce and funding continue to contribute to the fragility of the sector. 2018/19 saw providers continuing to exit the market and CQC has highlighted sustainability as a particular concern.
    - The report calls for actions in the following areas: more and better services in the community; innovation in technology, workforce and models of care; system-wide action on workforce planning; and long-term sustainable funding for social care.

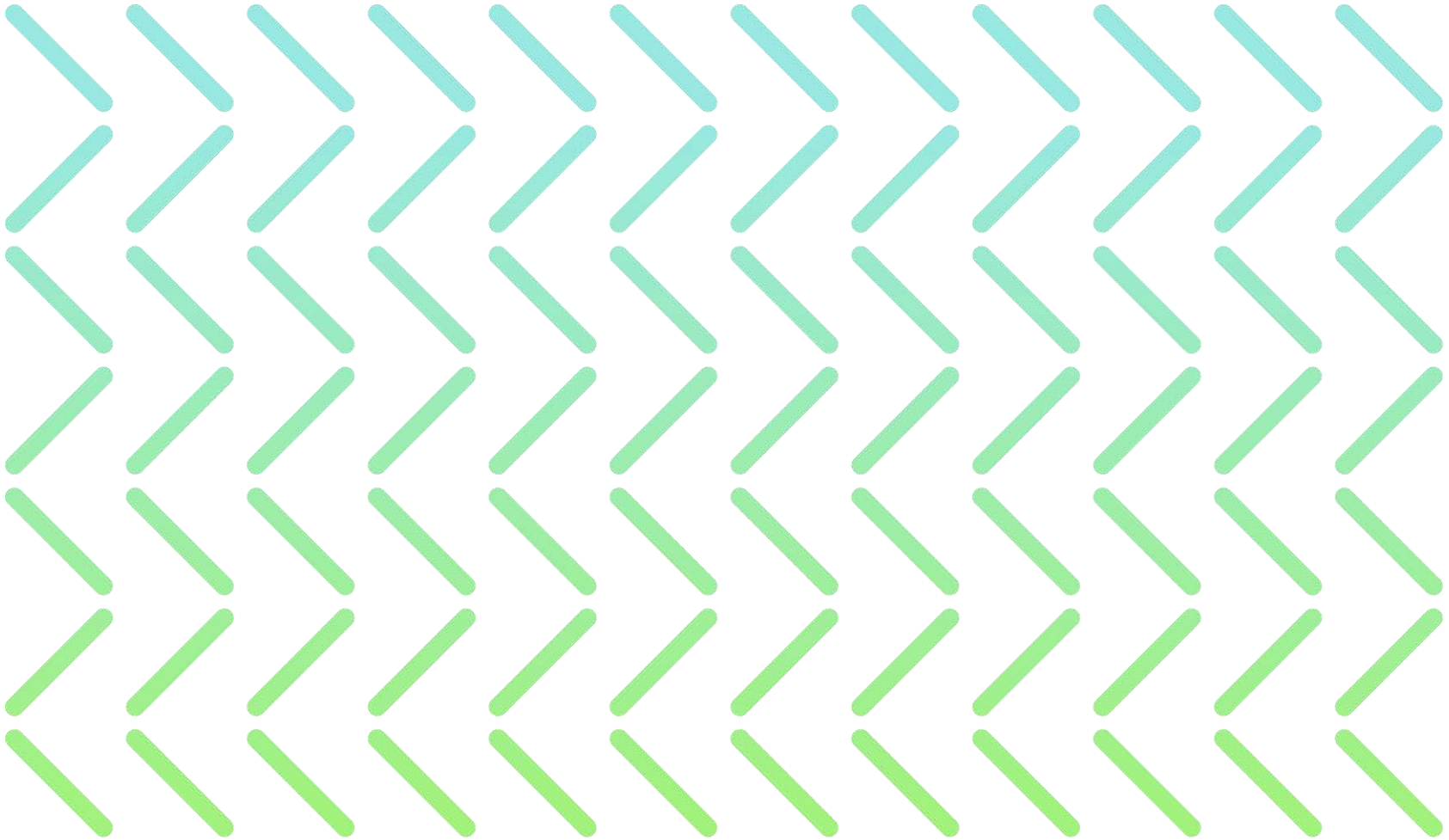
5. Reports and updates from key stakeholders

NHS Providers, State of the NHS Provider Sector Report, October 2019

- On 8 October 2019, NHS Providers published its fourth report examining the state of the provider sector. The report provides a commentary on how the provider sector is performing, the challenges that trusts and their partners are facing and the support they need to deliver on the vision set out in the NHS Long Term Plan.

- The key issues highlighted in the report are the need for:

    - Realism about the scale of the challenges facing the NHS, underpinned by an informed public debate on its future direction.
    - A funded, credible NHS people plan
    - Clarity around the quality standards the public can expect from the NHS, with the underpinning resources for trusts and their partners to deliver them
    - Whole system investment
    - Support for integrated care and system working



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Meeting Title:	Trust Board		
Date:	31 October 2019	**Agenda No**	**5.6.2**
Report Title:	**Horizon Scanning Report YTD, 2019-20 – Regional and Local Updates**		
Lead Director/ Manager:	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Ralph Michell, Head of Strategy Laura Carberry, Strategy and Partnership Manager		
Presented for:	Information		
Executive Summary:	This Horizon Scanning Report is the first of its kind and is intended to apprise Trust Board of the latest local developments in south west London, based on CCG Governing Body and Health and Wellbeing Board papers, and on current and future Clinical Tender opportunities; it is envisaged that going forwards this will be a quarterly report. Both DMBs and TEC have commented and fed back on a previous version of this report. It should be considered alongside the Corporate Office's Horizon Scanning Report Q2, 2019/20 on National Policy.		
Recommendation:	Trust Board is asked to: • Note the update.		
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:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously	Trust Executive Committee	**Date**	23.10.2019

Considered by:			
Appendices:	N/A		

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NHS
St George's University Hospitals
NHS Foundation Trust

Horizon Scanning Report YTD, 2019-20

Regional and Local Updates

This Horizon Scanning Report is intended to apprise Trust Board of the latest Regional and Local Updates

Suzanne Marsello
Chief Strategy Officer

October 2019

CONTENTS

INTRODUCTION

This report is intended to keep Trust Board informed of

a) local developments in South West London, based on summaries of CCG Governing Body and Health and Wellbeing Board papers, and

b) Clinical tender opportunities on the horizon.

It should be read alongside the horizon scanning report on national policy produced by the Corporate Office.

Both DMBs and TEC considered an earlier version of this report in September/ October and agreed the format / content was useful. It is proposed to share this updated version with the Trust Board, and then produce an equivalent update every quarter for TEC/ Trust Board.

HIGHLIGHTS

Some key highlights / common themes of particular relevance to the Trust are set out below. NB this does not summarise all the items set out in the main body of the report.

Item	Notes	Likely to be of particular interest to…
Local health and care plans	CCG Governing Bodies and Health and Wellbeing Boards across South West London have been considering local health and care plans, which are now either published or due to be published imminently. The area of these plans most likely to impact the Trust are those focused on supporting older people more effectively.	• Chief Strategy Officer • MedCard Triumvirate
Finance plans for 2019/20	CCG Governing Bodies all received financial plans for 2019/20 in Q1, with a range of potential implications for the Trust	• Deputy Chief Executive / Chief Finance Officer
Junction health centre	Wandsworth CCG Governing Body approved proposals to change the model of care provided at the Junction Health Centre - increasing the number of primary care appointments available, and removing walk-in services. The proposal suggests that the CCG believes the risk of increased pressure on A&Es can be managed but the Trust will need to keep a watchful eye on the development	• Chief Operating Officer • MedCard Triumvirate
Merger of CCGs & options for delegation	CCG Governing Bodies and Health and Wellbeing Boards across South West London have been considering the potential merger of CCGs in the region, and the options for then delegating some responsibilities back to borough level. The CCGs intend to start consultation imminently and formalise a merger on 1 April	• Chief Strategy Officer • Deputy Chief Executive / Chief Finance Officer
Croydon MOU	Croydon CCG and Croydon Health Services NHS Trust agreed an MoU for working more closely together in future, including shared forums for key functions; joint executive posts; a single leader; and a single budget and financial plan. This model will have a direct impact on the Trust but may also be a foretaste of moves towards integrated working between commissioners and providers elsewhere	• Chief Strategy Officer • Deputy Chief Executive / Chief Finance Officer
Tenders	Tenders are on the horizon for: a gender identity surgical unit; haemoglobinopathy coordinating centres; integrated wheelchair provision (Surrey Downs); abnormally invasive placenta specialist services; termination of pregnancy services; intestinal failure; radiopharmacy.	• CWDT Triumvirate • MedCard Triumvirate • SNCT Triumvirate

WANDSWORTH CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY

CCG Board (May, July and September 2019) *Bi-Monthly Meetings*

- Discussed the **Local Health and Care Plan**, covering priority activity that benefits from collective approach amongst providers and commissioners. The plan was published at the end of Q2.
- Discussed the **South West London five-year plan**, setting out how SWL will deliver ambitions in the national NHS Long Term Plan.
- Approved proposals to change the **model of care provided at the Junction Health Centre**, located next to Clapham Junction station (increasing the number of primary care appointments available, and removing walk-in services). The proposal suggests that the CCG believes the risk of increased pressure on A&Es can be managed.
- Approved the **CCG financial plan**, which sets a target of an in-year break-even position, with a QIPP plan of £15m net of investment. Noted the CCG's financial position at the end of financial year 2018/19, with the CCG hitting its control total of a £3.09m surplus, but with a significant overspend in acute, balanced by use of non-recurrent reserves.
- Discussed the potential **merger of CCGs in South West London**. A "moving forward together" programme has been created, aimed at supporting the 6 CCGs across SW London in their consideration of a potential merger, and the process for developing options for what is held at SWL level and what is delegated to 'place' level. The CCG governing body considered a draft case for change in Q2, and the CCGs are expected to submit their proposal to regulators for a merger, conduct a membership vote on the proposals, and create a SWL CCG by 1 April 2020.
- Received monthly **update from the STP** SRO, highlighting the development of local health and care plans, new perinatal mental health services, work in schools to promote health and social care career choices, sharing records, expansion in GP appointments, and a diabetes education scheme.
- Received an update on the development of **Primary Care Networks** in Wandsworth. Nine Primary Care Network applications from groups of GP practices had been approved by the CCG Primary Care Committee in May, covering 100% of practices in the borough. £2.2m of transformation funding will be spent in 2019/20 on strengthening/developing these Primary Care Networks.
- Reviewed its **Board Assurance Framework**, with key risks of relevance to the Trust including: a risk that health and care integration will not be delivered, that Queen Mary's Hospital will not be fully utilised, and that the CCG may not achieve financial balance.
- Considered plans for new South West London-wide **Child Death Overview Panel** arrangements, to comply with national standards.

WANDSWORTH CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY continued…

Board Papers can be found at: https://www.wandsworthccg.nhs.uk/aboutus/OurBoard/Wandsworth%20Board%20Papers/Wandsworth%20Board%20Wednesday%201st%20May%202019.pdf, https://www.wandsworthccg.nhs.uk/aboutus/OurBoard/Wandsworth%20Board%20Papers/Wandsworth%20Board%20Wednesday%203rd%20July%202019%20v2.pdf and https://www.wandsworthccg.nhs.uk/aboutus/OurBoard/Wandsworth%20Board%20Papers/Wandsworth%20Board%20papers%20Sept%202019.pdf

Health and Wellbeing Board (June and September 2019) *Quarterly Meetings*

- Approved the **Local Health and Care Plan**, anticipating that the plan would be published in the autumn, accompanied by further detail on the priorities, an action plan, and information on South West London-wide work
- Agreed an approach to refreshing the borough's **Joint Strategic Needs Assessment (JSNA)**, to be presented to the Health and Wellbeing Board next year.
- Noted the **work programme for the Health and Wellbeing Board** for 2019/20, with items of particular relevant to the Trust including: CAMHS, the potential South West London CCG merger, the Health and Care Plan implementation phase, Better Care Fund, Learning Disability strategy; CCG commissioning intentions, potential CCG merger, CAMHS; Child Death Overview Panel report.
- Discussed a refresh of the local **CAMHS Transformation plan**, including ongoing work to improve support to children with mental illness presenting in ED.
- Discussed the **Better Care Fund** plan for 2019/20 (designed to be a continuation of local priorities set out in the 2017-19 process, and due to be submitted to NHSE at the end of Q2), including ongoing work with the Trust to tackle issues such as delayed transfers of care.

Board Papers can be found at: https://democracy.wandsworth.gov.uk/ieListDocuments.aspx?CId=508&MId=6188&Ver=4 and https://democracy.wandsworth.gov.uk/ieListDocuments.aspx?CId=508&MId=6189&Ver=4

MERTON CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY

CCG Board (May, July and September 2019) *Bi-Monthly Meetings*

- Received **finance update**, CCG is forecasting achievement of Merton is showing an overspend of £1.7m on acute, and £1.2m on continuing care. This is covered by release of £2.4m of reserves along with underspends in corporate and Primary Care. There are minimal reserves to cover additional overspends.
- Received and reviewed the CCG's **Business Assurance Framework**. Relevant risks noted - reference to CCG's ability to secure appropriate acute hospital services for patients with in St Helier Hospital catchment area in the medium to long term , and workforce pressures in primary care to support local Acute transformation plans
- Considered SWL Health and Care Partnerships governing body paper- **Moving Forward Together** which detailed a draft case for change for a potential merger of the 6 SW London CCG's
- Received an update on South West London CCGs Child **Death Overview Panel Arrangements** -a new joint partnership of local authorities and clinical commissioning groups. Changes implemented by 29th September 2019
- Merton **Annual Public Health Report** 2019 presented- focussed on tackling diabetes as the number of people in Merton affected are increasing year on year, and diabetes is a priority for the boroughs Health and Wellbeing Board to support the development of a system wider approach to prevention.
- Considered an **update from the STP**, highlighting the development of local health and care plans, new perinatal mental health services, work in schools to promote health and social care career choices, sharing records, expansion in GP appointments, and a diabetes education scheme.
- SWL STP Update - Development and delivery of the SW London 5-year Strategy to meet the NHS Long Term Plan and local requirements discussed

Board Papers can be found at: https://www.mertonccg.nhs.uk/about-us/Our-Governing-Body/Merton%20Board%20Papers/2019-05-01/MCCG%20GOVERNING%20BODY%2020190501-MEETING%20PACK.pdf, https://www.mertonccg.nhs.uk/about-us/Our-Governing-Body/Merton%20Board%20Papers/Merton%20CCG%20GB%20Part%201%20papers%203%20July%202019.pdf and https://www.mertonccg.nhs.uk/about-us/Our-Governing-Body/Merton%20Board%20Papers/MCCG%20GB%20PT1%20MEETING%20PACK%20-%204.9.19.pdf

MERTON CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY continued…

Health and Wellbeing Board (June 2019) *Quarterly Meetings*

- Received the **Safeguarding Adults Annual Report**.
- Received a draft **sexual health strategy**, primarily focused on public and community health services, with an implementation plan due to be developed by the end of August.
- Received the final draft of the **health and wellbeing strategy for 2019-24** for agreement , explicitly aligned to the local draft Health and Care Plan but with a stronger focus on public health/the social and economic determinants of health, where the health and care plan focuses on health and care services.
- Received a report on the **transformation of child and adolescent with mental health services (CAMHS)**, which inter alia states that a focus for 2019 will be to explore what additional hours of CAMHS A&E emergency care and liaison might be possible.
- Received an update on the **NHS Long Term Plan**, and an update on the **potential merger of CCGs** in South West London.

Board Papers can be found at: https://democracy.merton.gov.uk/ieListDocuments.aspx?CId=184&MId=3478&Ver=4

CROYDON CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY

CCG Board (May, July and September 2019)

Bi-Monthly Meetings

- Approved the **operating plan and financial plan for 2019/20**. The plans include a focus, amongst other things, on repatriating elective activity to the local Trust (just under 25% of which would come from St George's). It envisages the CCG and local Trust delivering a joint control total of a £9.7m deficit (made up of £3.5m surplus for the CCG and £13.2m deficit for the local Trust), with any variance against the joint control total shared 50/50. The governing body also received a report on 2018/19 finances, which noted that for the first time the CCG had achieved a balanced position.
- Received updates on the potential **merger of CCGs in South West London**. A "moving forward together" programme has been created, aimed at supporting the 6 CCGs across SW London in their consideration of a potential merger, and the process for developing options for what is held at SWL level and what is delegated to 'place' level. The CCG governing body considered a draft case for change in Q2, and the CCGs are expected to submit their proposal to regulators for a merger, conduct a membership vote on the proposals, create a SWL CCG by 1 April 2020.
- Discussed the development of the **Croydon Local Health and Care Plan**, and the **South West London 5-year plan**.
- Discussed the development of 9 **Primary Care Networks** across Croydon.
- Approved a draft strategy for 2019-22 for children and young people with **special education needs and/or disabilities** (SEND); received an update on **integrating pathways** for planned care in gynaecology, diabetes, anti-coagulation, ophthalmology and dermatology; and approved proposals to change **child safeguarding** partnership arrangements, in response to changes to national guidance.

Board Papers can be found at: https://www.croydonccg.nhs.uk/about-us/Governing%20body/Pages/Governing-body-papers.aspx

CCG and Croydon Health Services NHS Trust Board Meeting in Common (May 2019)

Extraordinary Meeting

- Approved a **Memorandum of Understanding setting out how the CCG and Trust would work more closely together** in future. This includes: shared forums for key functions such as finance and quality; shared functions and/or roles employed jointly by both organisations; joint executive posts including a single leader; shared strategic priorities and a single delivery plan; a single budget and financial plan. The organisations intend to put these arrangements in place over the course of 2019/20.

Board Papers can be found at: https://www.croydonccg.nhs.uk/about-us/Governing%20body/Governing%20Boday%20Papers/AGENDA%20%20and%20Papers%20Meeting%20in%20Common%20with%20CHS%20Trust%20Board%2014%20May%202019.pdf

CROYDON CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY continued…

Health and Wellbeing Board (April and June 2019) *Quarterly Meetings*

- In April, the Board received reports on **social prescribing** initiatives in Croydon, the impact of **Universal Credit** locally, the transformation of **mental health community and crisis pathways**, and an update on **Brexit** planning. It also discussed the draft Croydon Health and Care Transformation Plan.
- In June, the Board received a report on **integrated working at locality level**, the **annual report** for the health and wellbeing board for 18/19, and a report on **Measles and MMR** vaccination in Croydon. It also once again discussed the **draft Croydon Health and Care Transformation Plan**, expected to be published in the autumn.

Board Papers can be found at: https://democracy.croydon.gov.uk/ieListDocuments.aspx?CId=172&MId=1758&Ver=4 and https://democracy.croydon.gov.uk/ieListDocuments.aspx?CId=172&MId=1961&Ver=4

KINGSTON CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY

CCG Board (May, July and September 2019)

Bi-Monthly Meetings

- **Kingston Local Health and Care Plan** was presented to the CCG's Governing Body for approval in July. Priorities within the LHCP are Prevention and early intervention, Start Well, Live Well, Age Well and Unpaid carers. In the year to date the Governing Body has also considered the **South West London 5-year plan**
- The Governing Body discussed the potential **merger of CCGs in South West London**. A "moving forward together" programme has been created, aimed at supporting the 6 CCGs across SW London in their consideration of a potential merger, and the process for developing options for what is held at SWL level and what is delegated to 'place' level. The CCG governing body considered a draft case for change in Q2, and the CCGs are expected to submit their proposal to regulators for a merger, conduct a membership vote on the proposals, and create a SWL CCG by 1 April 2020.
- **South West London CCGs Child Death - Overview Panel Arrangements & Kingston and Richmond Local Safeguarding Children's Partnership arrangements**. Following publication of The Children and Social Work Act (2017) and statutory guidance ('Working Together to Safeguard Children, 2018' there have been reforms to the Child Death Processes in England. This includes the establishment of a minimum geographical footprint for each CDOP. To comply with the new CDOP requirements, there will be one CDOP across SWL CCGs that will be operational from September 2019. The SWL CDOP will review all children's deaths across the SWL area and will be independently chaired by a director of public health.
- **Estates Strategy**- the existing Richmond primary care forum has been extended to include representatives from Kingston Hospital Trust, South West London & St George's, the local authority (LA) and community, and a similar forum has been established for Kingston. The strategy is being updated in the following areas: Developing the local database to update on gaps (building condition/usage); Model impact of expected population growth; Model transformation impact (PCN/use of digital/community mental health); Review with partner opportunity of combined estates infrastructure/support arrangements (trusts/LA/NHS Property Services (NHSPS)); Relocation of shared acute trusts' back office teams offsite (example HR support), and Liaison arrangements with NHSPS/Community Health Partnership.
- **All Age learning disabilities strategy** has been produced. The aim of the strategy is to: reduce health inequalities, maximize independence and wellbeing and reduce stigma and discrimination.

Board Papers can be found at: https://www.kingstonccg.nhs.uk/about-us/7-may-2019.htm , https://www.kingstonccg.nhs.uk/about-us/2-july-2019.htm and https://www.kingstonccg.nhs.uk/about-us/3-september-2019.htm

KINGSTON CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY continued…

Health and Wellbeing Board (March, June and September 2019) *Quarterly Meetings*

- The **CCG Merger (Moving Forward Together) planned for April 2020** and **Place Based Governance proposals in SWL** were discussed. **Consultation is expected formally on 'Moving Forward Together' in October/ November 2019.**
- It is expected that the **Kingston Health and Care Plan** will be published imminently; a discussion document detailing the different initiatives on 'Start Well', 'Live Well' and 'Age Well' as well as 'Prevention' and 'Carers' was produced in the Spring 2019 and a draft has since been iterated. The **local Health and Care Plans (x6)** will inform the **SWL Health and Care Partnership's 5 year Long Term Plan/ Strategy** which is being progressed and will be published in November 2019 following review in September/ October 2019.
- It was confirmed that GP Practices had formed into **5 x Kingston Primary Care Networks** in June 2019 with the appointment of Clinical Directors as well as the establishment of extended hours of Operation since the Summer 2019. The availability of a 5 year development programme for PCNs delivered by the Healthy London Partnership was also reported in September 2019.
- The **2019/20 Better Care Fund Plan (BCF)** was presented; it builds on and continues to deliver Health and Social Care integration as a programme of work with a focus on admission and ambulance call avoidance; the development of a 7 day Community and Integrated Intermediate Care Services; discharges, LoS and patients that are stranded supported by a MD; fewer Nursing and Residential Home placements and, the introduction of a Trusted Assessor Model.
- Kingston's **Health and Wellbeing Strategy 2017-2019** was discussed with progress on recommendations reported.
- **Special Educational Needs and Disabilities** (SEND) transformation plan approved for publication.
- Ofsted and CQC **SEND inspection**- progress update on Written Statement of Action.

Board Papers can be found at: https://moderngov.kingston.gov.uk/ieListDocuments.aspx?CId=488&MId=8545&Ver=4, https://moderngov.kingston.gov.uk/ieListDocuments.aspx?CId=488&MId=8789&Ver=4 and https://moderngov.kingston.gov.uk/ieListDocuments.aspx?CId=488&MId=8790&Ver=4

RICHMOND CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY

CCG Board (May, July and September 2019) *Bi-Monthly Meetings*

- Noted the national **NHS Long Term Plan** places emphasis on the new primary care networks, and the indication that NHS England expects to see CCG's coming together under each STP area. For SWL this means exploring what function a single CCG could hold. Discussions are currently being held by each governing body on how to approach this change, noting need to delegate to borough level, to ensure local accountability and delivery. All systems are required to share a draft of their plans by **27 September 2019**. It is expected that these plans will then be agreed with system leads and regional teams ready for publication by **15 November 2019**.
- Noted for people registered with a GP in Richmond ,**Connecting your Care** will be joining up GP and Hospital records. The 4 hospital that are linked to the system are Kingston, Croydon, St Georges and Epsom & St Helier. Chelsea & Westminster is currently not included.
- Approved the new **Richmond Sexual Health Strategy 2019-24**. Priority areas in the strategy are: Promote healthy sexual behaviour and reduce risky behaviour, Reduce STI rates with targeted interventions for at risk groups, Reduce unintended pregnancies, Continue to reduce under 18 conceptions and Work towards eliminating late diagnosis and onward transmission of HIV.
- Richmond's **Health and Care Plan 2019-2021** has been finalised , awaiting design sign off prior to publication
- Update on the Kingston and Richmond's joint **End of Life Care (EOLC) Strategy** 2017–2020, 18/19 deliverables and priorities for 19/20
- Received an update on South West London CCGs **Child Death Overview Panel Arrangements** -a new joint partnership of local authorities and clinical commissioning groups. Changes implemented by 29th September 2019
- Considered SWL Health and Care Partnerships governing body paper- **Moving Forward Together** which detailed a draft case for change for a potential merger of the 6 SW London CCG's
- Noted Kingston & Richmond Estates Update, In March, each SWL CCG held a workshop, with local partners, to initiate development of a set of local plans. It is expected that these initiatives will enable the CCGs to be prepared to submit capital business cases in future funding cycles.
- Received and reviewed the CCG's **Business Assurance Framework**. Relevant risks noted – Failure to deliver QIPP targets reference to CCG's ability to secure appropriate acute hospital services for patients with in St Hellier Hospital catchment area in the medium to long term , and workforce pressures in primary care to support local Acute transformation plans

Board Papers can be found at: http://www.richmondccg.nhs.uk/about-us/governing-body/governing-body-papers

RICHMOND CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY continued…

Health and Wellbeing Board (July 2019) *Quarterly Meetings*

- The **Richmond Health and Wellbeing Board** is a partnership between Richmond Council, local GPs, Clinical Commissioning Group and Voluntary Sector. The focus of the board is to:
  - Improve population health and reduce health inequalities;
  - Reform the way the health and care system works, and;
  - Protect the health of residents.
- Board approved the Richmond health and Care plan content, design process and next steps.
- Board asked to approve the collaborative approach to the development of the Joint Strategic Needs Assessment due for refresh in 2020.
- Board endorsed the Richmond upon Thames Suicide prevention Strategy.
- Board endorsed the development of a Children and families Strategic Partnership for Richmond.

Board Papers can be found at: https://cabnet.richmond.gov.uk/ieListDocuments.aspx?CId=643&MId=4423&Ver=4

SUTTON CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY

CCG Board (May, July and September 2019)

Bi-Monthly Meetings

- In December 2018, a **draft Pre-Consultation Business Case (PCBC)** from the **Improving Healthcare Together (IHT) 2020-2030 Programme** to the Joint Clinical Senates of London and the South East, NHS England and NHS Improvement was submitted. The Clinical Senate's Report and an interim Integrated Impact Assessment Report (covering the environment, equalities, health and travel) were published in June 2019. An **assessment of the deliverability** of the 3 Epsom and St Helier future scenarios and the **impact on, and implications for, neighbouring NHS Trusts** is being produced with the **aim of assurance being completed over the Summer 2019** and the **commencement of consultation formally on proposals in the Autumn 2019**.
- The **CCG Merger (Moving Forward Together) planned for April 2020** and **Place Based Governance proposals in SWL** were discussed; the development of **local Health and Care Plans (x6)** and **Primary Care Networks** is in progress with **Health and Care Partnerships** being strengthened. Approval of the 5-year **Sutton Health and Care Plan** was reported in June 2019 and a discussion document detailing the different initiatives on 'Start Well', 'Live Well' and 'Age Well' been produced subsequently. It was confirmed that GP Practices had formed into **4 x Primary Care Networks in Sutton** (covering Carshalton, Cheam and South Sutton, Central Sutton and Wallington) in July 2019 with the appointment of 10 Clinical Directors across the 4 Primary Care Networks. Finally, the development of the **SWL Health and Care Partnership's 5 year Long Term Plan/ Strategy** was being progressed and would be published in November 2019 following review in September/ October 2019. **Consultation is expected formally on 'Moving Forward Together' in October/ November 2019.**
- **Agreement between the CCG and Epsom and St Helier University Hospitals NHS Trust on the NHS Contract** includes addressing challenges locally in partnership as a system as well as the beginnings in establishing an **Integrated Care Place in Sutton**.
- Arrangements for **Children's Safeguarding** compliance were discussed **Adolescent Self-Harm** and the advancement of a **Children and Young People's Mental Health and Wellbeing Strategy** were covered in a presentation with a further **Mental Health Support in Schools** presentation received on the resulting **SWL Whole School Approach.** In December 2018, Sutton CCG became a **Mental Health in Schools Trailblazer** which is continuing to deliver education and health input and resource to schools in Sutton including a **Child Wellbeing Practitioner Programme**. In addition to an award of £1.85m in December 2018, a £4.3m bid to expand and include Further Education Colleges and Special Schools was successful as part of Wave 2.
- The approval of the **End of Life Care Strategy** and **confirmation of the future of St Raphael's Hospice** were reported.

Board Papers can be found at: https://www.suttonccg.nhs.uk/Aboutus/Our-board/Sutton%20board%20papers/FINAL%20SCCG%20GB%20020519.pdf , https://www.suttonccg.nhs.uk/Aboutus/Our-board/Sutton%20board%20papers/FINAL%20SCCG%20Governing%20Body%20meeting%20040719.pdf and http://www.suttonccg.nhs.uk/Aboutus/Our-board/Sutton%20board%20papers/FINAL%20SCCG%20GB%20050919.pdf

SUTTON CCG AND HWB: YTD, 2019-20

BOARD PAPERS SUMMARY continued…

Health and Wellbeing Board (March, June and September 2019) *Quarterly Meetings*

- The **Improving Healthcare Together Programme 2020-2030** advised that assurance was being completed by NHSE/ I of the Pre-Consultation Business Case (PCBC) over the Summer 2019 and that Capital funding 'in principle' would need to be secured ahead of Consultation formally on proposals in the Autumn 2019.
- Healthwatch Sutton's findings from the **Young People's Mental Health and Wellbeing Survey** and the **Perinatal Mental Wellbeing Survey** were presented along with recommendations ; it was agreed that these will be incorporated into the Children's and Commissioning Reviews being led by the London Borough of Sutton and Sutton CCG.
- The **CAMHS Local Transformation Plan (LTP)** to date was presented; challenges were considered including the current Crisis Care Pathway in Sutton and future opportunities . The final CAMHS LTP is due at the end October 2019 and will also be incorporated into the Children's and Commissioning Reviews being led by the London Borough of Sutton and Sutton CCG. This will add to building Children and Young People's emotional resilience- a key priority for SWL and Sutton.
- The **2019/20 Better Care Fund Plan (BCF)** was presented; it builds on and continues to deliver Health and Social Care integration as a programme of work with a focus on the administration of the Disabled Facilities Grant, the alignment of the Health and Social Care plans , Integrated Services, Metrics and Person-Centred Outcomes.
- The development of **Primary Care Networks in Sutton** and a discussion on the progress of the **Sutton Health and Care Partnership (an Integrated Care Place for Sutton)**- as a collaboration between the London Borough of Sutton, Sutton CCG and Sutton Health and Care Provider Alliance- as well as the **Sutton Health and Care Plan** including initiatives on 'Start Well', 'Live Well' and 'Age Well were reported.
- The **2019 - 2020 Annual Public Health Report** emphasised 3 focused priorities: Children and families with Special Educational Needs, Children's Mental Wellbeing and also Readiness for School. It was agreed to incorporate these priorities into the Children's and Commissioning Reviews being led by the London Borough of Sutton and Sutton CCG.

Board Papers can be found at: https://moderngov.sutton.gov.uk/ieListDocuments.aspx?CId=471&MId=5048&Ver=4, https://moderngov.sutton.gov.uk/ieListDocuments.aspx?CId=471&MId=5062&Ver=4 and https://moderngov.sutton.gov.uk/ieListDocuments.aspx?CId=471&MId=5254&Ver=4

CURRENT OPPORTUNITIES FOR ST GEORGE'S

CLINICAL TENDERS

The following clinical tenders are have been open to tender or due to be open which may provide St Georges' to introduce new clinical services, expand current provision or retain existing services:

Specialist Haemaglobinopathy Coordination Centres

- This is being commissioned by NHS England and is to establish specialist haemablobinopathy co-ordination centres.
- As part of this, the Trust successfully submitted a bid to become a:
  - Sickle Cell Haemoglobinopathy Coordinating Centre (HCC) in partnership with Imperial College Healthcare NHS Trust (Imperial) and the London North West University Healthcare NHS Trust (London North West).
  - Thalassaemia HCC in partnership with University College London Hospital NHS Foundation Trust (UCLH) and the Whittington Hospital.

Abnormally Invasive Placenta Specialist Services

- Ahead of formal tender notification, a market engagement exercise has been carried out by NHS England on their intention to tender for services to provide specialised maternity services to women diagnosed with abnormally invasive placenta.
- Women's service (CWDT) have submitted a response to the market engagement exercise and await the formal tender notification.
- An options paper was presented to IDG in August outlining the services' intention to bid.

CURRENT OPPORTUNITIES FOR ST GEORGE'S

CLINICAL TENDERS continued…

Termination of Pregnancy Services (TOPS) for Patients with Complex Co-Morbidities

- Women's services (CWDT) contributed to a market engagement exercise in August
- It is anticipated that between 30- 40 Centres will be commissioned in England; activity of 3,000 cases per annum nationally with costs covered by the National Tariff for Termination Services.
- NHS England expect to formally procure 'Termination of Pregnancy Services (TOPS) for Patients with Complex Co-Morbidities', with a contract commencement date in April 2020.
- The Trust is currently considering options

Intestinal Failure centres

- NHS England are tendering for specialist Intestinal Failure centres, with "North West and South West London" being one lot.
- The deadline for bids is 7th November
- The Trust is currently exploring its options, including the potential to bid as a subcontractor to London North West