Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting
Thursday 19 December 2019

Agenda and papers

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NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 19 December 2019, 10:00-13:30**
Venue: **Hyde Park Room, 1st Lanesborough Wing**

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					
10:25	**B**	**Staff Values Award Presentation – Joanna Hardman, Deputy Head of Children's Therapies**	**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 28 November 2019**	**Chairman**	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
10:35	**1.5**	**CEO's Report**	**Chief Nurse**	Inform	Report
2.0 QUALITY & PERFORMANCE					
10:45	**2.1**	**Quality and Safety Committee Report**	**Committee Chairman**	Assure	Report
	2.1.1	***Annual Complaints Report (2018-2019)***	***Chief Nurse***	Assure	Report
11:00	**2.2**	**Integrated Quality & Performance Report**	**Chief Transformation Officer**	Assure	Report
11:20	**2.3**	**Emergency Care Update**	**Chief Operating Officer**	Assure	Report
11:30	**2.4**	**Cardiac Surgery Update**	**Chief Medical Officer**	Assure	Report
11:45	**2.5**	**Clinical Governance Review**	**Chief Medical Officer/ Chief Nurse**	Assure	Report
12:00	**2.6**	**RTT Clinical Harm Closure Report**	**Chief Medical Officer/ Chief Nurse**	Assure	Report
3.0 WORKFORCE					
12:15	**3.1**	**Workforce Committee Report**	**Committee Member**	Assure	Report
	3.1.1	***Freedom to Speak Up Guardian Report***	***Chief People Officer/ Freedom to Speak Up Guardian***	Assure	Report
	3.1.2	***Guardian of Safe Working Report***	***Chief Medical Officer/ Guardian of Safe Working Hours***	Assure	Report
4.0 FINANCE					
12:35	**4.1**	**Finance and Investment Committee Report**	**Committee Chairman**	Assure	Report

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Time	Item	Subject	Lead	Action	Format
12:45	**4.2**	**FIC (Estates) Report**	**NED Estates Lead**	Assure	Report
12:55	**4.3**	**Finance Report (Month 08)**	**Director of Financial Planning**	Update	Report
5.0 CLOSING ADMINISTRATION					
13:10	**5.1**	**Questions from the public**	**Chairman**	Note	Oral
	5.2	**Any new risks or issues identified**	**All**	Note	
	5.3	**Any Other Business**		Note	
	5.4	**Reflections on the meeting**		Note	
6.0 PATIENT/STAFF STORY					
13:20	**6.1**	**Patient Experience – Cancer Pathway**	**Mr Alan Cruchley** (Patient) **Deepa Leelamany** (Urology Clinical Nurse specialist Service Lead)	Note	Oral
13:30 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, 30 January 2020, 10:00-12:30
Hyde Park Meeting Room

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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
Ann Beasley	Non-Executive Director/Deputy Chairman	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
Richard Jennings	Chief Medical Officer	CMO
In Attendance		
Suzanne Marsello	Chief Strategy Officer	CSO
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
Karyn Richards-Wright	LIAiSE Adviser and Freedom to Speak Up Guardian (Item 3.1.1)	FTSUG
Serena Hayward	Guardian of Safe Working Hours (Item 3.1.2)	GOSWH
Andy Stephens	Director of Financial Planning	DoFP
Secretariat		
Tamara Croud	Interim Assistant Trust Secretary	IATS
Apologies		
Andrew Grimshaw	Chief Finance Officer/Deputy Chief Executive Officer	CFO/DCEO
Stephen Collier	Non-Executive Director	NED
Jacqueline Totterdell	Chief Executive Officer	CEO
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 19th December 2019, 08:30 – 09:45

Meet in the Hyde Park Room 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 room Hyde Park 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 Hyde Park Room at 08:30 and return to there 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- 19th December 2019

NED	Exec / Divisional Chair	Divisional Representation	Area Visiting, 08:30 – 09:45
Gillian Norton, Chair	Jacqueline Totterdell	Christine Wood (Matron)	Pinckney Ward (5th Floor LNS) Central Play Room (5th Floor LNS)
Ann Beasley	Ellis Pullinger Andrew Grimshaw	Victoria Cooper (Head of Nursing) Gemma Stott (Chief Therapist)	Emergency Department (Ground Floor STJ) Therapies Outpatients (Ground Floor STJ)
Sarah Wilton	Suzanne Marsello	Brendan McDermott (General Manager) Rathan Nagendra (Assistant Director Estates and Engineering)	Mortuary (Perimeter Road) Energy Centre (Perimeter Road)
Prof Jenny Higham	Stephen Jones James Friend	Sharon Lynagh (Matron) Linda Smith (Matron)	Heberden Ward (3rd Floor LNS) McEntee (Caesar Hawkins - 4th Floor LNS)
	Harbhajan Brar Richard Jennings	Aoife Boylan (Matron) Louise Ramadhan (Matron)	Holdsworth (5th Floor STJ) Gray (4th Floor STJ)
Tim Wright Parveen Kumar	Avey Bhatia	Kelly Davies (Head of Nursing) David Robinson (Matron)	Benjamin Weir (1st Floor AMW) Belgrave (1st Floor AMW)

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Meeting Title:	**TRUST BOARD**		
Date:	**19 December 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. Since the 1 October 2019, members of the public have been able to see what declarations our staff, including Board members, have made via our Declare portal. Given that this information is now readily accessible in the public domain we propose to cease bringing this paper as a regular item to the Board from January 2020, and will instead prompt members to update on any declarations as an oral update on the agenda. Members are asked to note that after expiry, an interest will remain on the public register for a minimum of 6 months with an end date recorded within the specific entry.		
Recommendation:	The Board is asked to note, review and provide any relevant updates.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and improvement capability (well-led) – Effective boards and governance.		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The public rightly expect the highest standards of behaviour in the NHS. Decisions involving the use of NHS funds should not be influenced by outside interests or expectations or private gain.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix A. Register of Board Members' interests		

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Appendix A. Register of Board Members' interests

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Gillian Norton	Chairman	Deputy Lieutenant (DL) Greater London Lieutenancy Representative DL for Richmond	October 2016	Present	
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	Non remunerated
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
Ann Beasley	Company Director	Alzheimer's Trading Limited	October 2019	Present	Non-Remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Advisory Board: 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	
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	

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 of NHS professionals Limited (provider of managed staff services to the NHS)	2018	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman and shareholder: Eden Futures (supported living provider)	2016	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman and shareholder: Cornerstone Healthcare group (dementia care provider)	2018	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Board Governor: Kingston University	November 2015	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Principal: St George's, University of London	November 2015	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Visiting Professor: Lee Kong Chian School of Medicine in Singapore	January 2010	Present	

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Honorary Consultant: Imperial College London	November 2011	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	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

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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	Non-remunerated

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Executive Board Members					
Jacqueline Totterdell	Chief Executive	Partner, NHS Interim Management and Support	2005	Present	
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			

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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

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Chief Transformation Officer	Church Warden, St John's The Evangelist, Wotton	2004	Present	Non-remunerated
James Friend	Chief Transformation Officer	Volunteer, 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			

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Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 28 November 2019, 10:00 – 13:30
Hyde Park Room, St George's Hospital, Tooting

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Ann Beasley	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Jacqueline Totterdell	Chief Executive Officer	CEO
Andrew Grimshaw	Chief Finance Officer/Deputy Chief Executive Officer	CFO/DCEO
Avey Bhatia	Chief Nurse and Director of Infection Prevention & Control	CN
Richard Jennings	Chief Medical Officer	CMO
IN ATTENDANCE		
Harbhajan Brar	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Ellis Pullinger	Chief Operating Officer	COO
Sally Herne	NHSI Improvement Director	NHSI-ID
SECRETARIAT		
Tamara Croud	Interim Assistant Trust Secretary (Minutes)	IATS
APOLOGIES		
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED

Feedback from Board Visits

Board Members provided feedback from the visits conducted in the following areas:

- Allingham Ward and Caesar Hawkins – Chairman, CMO and CSO
- Neuro Theatres and CTICU – Tim Wright, CCAO, COO and CTO
- Keate Ward and Florence Ward – CEO and CN
- Pharmacy and Jungle Ward – Ann Beasley, CFO/DCEO and CPO

A key observation from the visits related to the number of medically fit patients on wards. Due to system challenges and shortfalls in the social care infrastructure, the Trust had not been able to repatriate these patients to the appropriate care setting. These patients deserved the best possible care and whilst it was safe for them to remain in hospital it was not the right care setting. It was evident that staff were providing the highest level of care for these patients but as this trend continued it impacted on the Trust's ability to effectively deliver against performance standards and

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Feedback from Board Visits
improve patient pathway flows. Communication issues were raised in two areas. First, while the theatre teams were high performing, Board members heard reports of issues with theatre list planning and the impact of last minute changes requested by surgeons and how this affected the productivity of the team. Secondly, there were challenges with the cascade of information down through the organisation which needed to be addressed. Various staffing issues were noted on a number of wards, in particular high turnover and vacancy rates in some areas and doctors had flagged an issue of availability of junior doctors at the weekend to support ward rounds. The physical environment of the Trust was another key theme from the visits; staff had flagged an issue of there being too many computers on wheels in the ambulatory unit which impacted on physical space; Jungle Ward, although tidy, was severely constrained in terms of space; and cleaning was an issue on some wards. Some positives from the visits included the staff-led quality improvement initiative which had resulted in the introduction of the 'end of shift checklist' which was very impactful with staff reviewing what had gone well, how staff were feeling and what was difficult. While cleaning was an issue in some areas two long-serving housekeepers had demonstrated an admirable level of commitment. The introduction of e-prescribing was having a positive impact on how patients were cared for and the Pharmacy team were working with the Acute Provider Collaborative around designing a national programme for rotation of pharmacy staff. The Board noted the updates and agreed that the COO and CEO would link with system partners to address the issues related to 'super-stranded' patients. The CFO/DCEO would address the issues related to cleaning and keep under consideration the space constraints on the Jungle ward and other areas of the Trust. The Board also noted the updates on actions arising from previous Board visits across the Trust, and agreed to close those actions proposed for closure.

Values Award
The Board welcomed Kim Richmond, Mousumi Guha and Zainab Jadawji who collected the values award on behalf of the Medicines Information Team. The team had supported the Trust in responding to a drug alert which had impacted on over 600 patients and carers. The team volunteered to support the process and had helped manage the shortage and address all patient safety issues.

		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. Governors Mia Bayles, Nick de Bellaigue, Anneke de Boer, John Hallmark, and Val Collington were in attendance as observers.	
1.2	**Declarations of Interest** The Board noted the register of Board members' interests.	
1.3	**Minutes of the meetings held on 31 October 2019** The minutes of the meeting held on 31 October 2019 were agreed as an accurate record subject to the following change: Page 8, item 4.3: revise second sentence to read '*The most significant issues for the Trust related to delivering the agreed savings plan and maintaining grip and control against the budget*'.	

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		Action
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log and the following updates: • **TB27.06.19/02-03**: **The Chairman advised that the Clinical Governance Review must be presented to the December 2019 meeting given that it had been deferred on two previous occasions.** • **TB31.10.19/01:** The Board noted that CMO would circulate the email received from the National Institute of Cardiovascular Outcomes Research (NICOR) on its outcomes for the period April 2015 to March 2018. It was also noted that although the Cardiac Surgery report now provided an update on the actions taken by the Trust in response to the Bewick report, it did not yet contain the additional information requested by the Board. **As a result, the Board agreed that this action should stay open until the December iteration of the report.** • **TB31.10.19/04:** The CFO/DCEO reported that the Estates Strategy would be completed by March 2019.	**CMO** **CMO**
1.4.1	**Update on September Patient Story – Paediatric Patient Journey** The Board noted the update contained in the report on the questions raised by the patient's mother, Mrs Susannah Stevenson. The Board noted that it was good that the Mrs Susannah Stevenson felt listened to and it is important that the Trust followed up and made sure that the learning from the story was fully embedded. While it may not be possible for the Board to be fully assured that such issues will never reoccur, the Board was assured that the team was taking the feedback seriously and was taking action to address it. The Trust would continue to reinforce the standards of care expected to be delivered to patients. It was also noted that, going forward, all patient stories should be supported by a staff representative from the service who could speak to the actions taken to address any issues of concern and reflect on how good practice or learning had been embedded not only in the service but across the Trust.	
1.5	**Chief Executive Officer's Update** The CEO presented the Chief Executive Officer's Update. The Trust currently had a 79.9% uptake among staff of the flu vaccination and 56.4% of staff had completed the staff survey, which was already 2% higher than the response rate the previous year. The Trust was doing some focused work in the maternity service to improve the uptake of the flu vaccination. It was hoped that the staff survey engagement would increase over the remaining days on which the survey was live and that the flu vaccine uptake would exceed 80%.	
2.0	**QUALITY AND PERFORMANCE**	
2.1	**Quality and Safety Committee Report** Tim Wright, Interim Chair of the Committee, presented the report of the meeting held on 21 November 2019 which set out the key issues raised at the meeting. The Committee discussed mandatory training on resuscitation and supported proposals to write to consultants who did not attend training. The Committee heard about the challenges with completing self-assessments in relation the NICE guidance compliance and challenged the robustness of the processes to	

		Action
	improve performance and understand the risks associated with incomplete self-assessments. While barcode scanning of patient wrist bands and medication was taking place, this was not being completed in a uniform way and the Committee encouraged action to ensure that the system was being used routinely. The Committee also noted the forthcoming change to the way the friends and family test was being conducted which allowed trusts to take more frequent surveys of patient experience and also include a free text option but which would also impact how trusts report on performance and benchmarking both locally and nationally. The MRSA case, the first in over a year, was caused by a lapse in care and this was being investigated and would be reviewed by the Infection Prevention and Control Committee. The Board noted its disappointment at the lack of improvement in NICE compliance. It was reported that following a brief review of the non-compliant areas it was evident that the services were in fact compliant with the guidance and the issue related to having the paperwork in place to evidence that a self-assessment had been completed. The CN and CMO had committed to improving compliance by the end of January 2020. Ongoing compliance would be closely monitored by the Patient Safety and Quality Group. The Board noted the report.	
2.1.1	**Medication Incident and Controlled Drugs - Review of Q1-2 2019/20** The Board received the medication incident and controlled drugs report for quarters one and two 2019/20. It was reassuring that of the low levels of harm caused by medication incidents none were avoidable. Electronic prescribing was driving improvement but needed more focus to embed the practice. The Board noted, again, the issues related to barcode scanning and it was reported that there had been issues with the availability of equipment and Wi-Fi connection. New drugs trollies were being piloted and it was hoped that this would improve barcode scanning of patient wrist bands and medication. The Board reflected that while the report detailed performance it remained difficult to assess how the Trust was performing in comparison to other organisations and the national benchmark. The CFO/DCEO noted that given the challenges with equipment and connectivity, which were impacting on the Trust's ability to deliver key elements of the service, it was important that these issues were escalated to the relevant executive forums; the CMO and CN would follow this up. **The CMO agreed that the next iteration of the medicine incident and controlled drugs report would include relevant benchmarking data.** The Board noted the report.	**CMO**
2.1.2	**Annual Research Report** The Board received and noted the annual research report. The Board noted that while the Trust was conducting more clinical trials it tended to support others in their research as opposed to being the principal instigator of clinical trials. **The Board noted the annual research report and agreed that the next iteration would include comparative data to demonstrate where the Trust sits in relation to other organisations.**	**CMO**

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		Action
2.1.3	**Seven Day Services – Self Assessment** The CMO presented the Trust's self-assessment against the standards for delivering seven day services which the Trust must achieve by 1 April 2020. The CMO advised that since the Quality and Safety Committee meeting on 21 November it had come to light that the self-assessment provided to the Committee had made an inaccurate assessment of compliance against the measure for MRI availability at the weekend. As a result, the Board paper rated this as red whereas it had been green-rated for the Quality and Safety Committee. While there was MRI provision at the weekend it was available on an informal and *ad hoc* basis. The Board noted concerns about the change in the report since the Quality and Safety Committee had reviewed it the week before the Board meeting and queried the assurances processes that led to this error in reporting. More generally, the Chairman commented that the report was drafted in very reassuring terms, but the reality appeared to be that the Trust was not currently on track to meet the national requirements by April 2020 and that significant work was required to meet this deadline. There needed to be a clear action plan which detailed the steps that would be taken to ensure the Trust achieved the standards. The report also stated that the Trust should have a risk on its Board Assurance Framework and the requirements around this needed to be clarified and actioned as appropriate. It was important that the Trust could evidence how it was achieving weekend working standards. It was also important that the Trust monitored key performance indicators such as mortality at the weekend. Despite the wording of the report, the Chairman reflected that the Board could not be assured on compliance with the national standards for seven-day working and asked that the CMO bring a report to the Board, via the Quality and Safety Committee, in January 2020 – well in advance of the 1 April 2020 deadline – setting out a clear plan for achieving compliance. In this context, the Board noted and approved the self-assessment for submission to NHS Improvement by 29 November 2019 on the Trust's current position on compliance with the seven-day services standards. The Board agreed that: • **The CN would include a risk on the Board Assurance Framework related to seven day services;** • **The CMO would present an interim report to the Board via the Quality and Safety Committee in January 2020 on the Trust's progress against each standard and the report will include an action plan; and** • **The weekend mortality data would be included in the integrated quality and performance report each month.**	**CN** **CMO** **CTO**
2.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 7 (October 2019), which had been scrutinised at both the Finance and Investment Committee and the Quality and Safety Committee the previous week. The COO reported that the Trust was working through the DMO1s for echocardiograms and completing a forward trajectory which would enable the Trust to be back in line with the original plan by January 2020. The Board noted the report.	

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		Action
2.3	**Emergency Care Performance Report** The COO presented the report on emergency care performance. To improve the Trust's performance against the four-hour target the Trust would focus on two priorities. The first related to patient flow and, in particular, discharge processes and access to services. There were around 140 patients with an average length of stay of 21 days and over. Social services colleagues had now joined the Trust's long length of stay review meetings which were supporting the Trust repatriate these patients. If the Trust could reduce this cohort of long staying patients by 40 it could release adult beds and improve the type 1 performance by 5%. The Trust would also conduct a perfect process week the following week which would give effect to the recommendations from ECIST to improve the escalation of patient flow. The second priority related to reducing the numbers of patients waiting in the emergency department by introducing rapid assessments and triaging patients to the ambulatory unit. Other work in this area included improving the emergency department rota. By focusing on these priorities the Trust believed it could deliver the required improvement to ensure it met the 87% trajectory in December 2019. The introduction of the Emergency Care Delivery Board (ECDB), chaired by the CEO, had given the right level of focus. Members of the Board flagged that there continued to be a lack of consistency in delivering against the performance trajectory and reflected that there were days when the Trust only achieved circa 70% against the emergency standard. The Board also noted that the impact of capacity changes was being picked up through the ECDB. The Board noted the report, the priority actions and the internal trajectory for December 2019.	
2.4	**Cardiac Surgery Update** The Board received and noted the cardiac surgery update which included an update against the recommendations from the Bewick Review of July 2018. The CMO reported that the National Institute for Cardiovascular Outcomes Research (NICOR) had confirmed that the Trust's risk-adjusted mortality rates following cardiac surgery in the period April 2015 to March 2018 were within the normal range and that the Trust was no longer an outlier for mortality. The CMO added that the safety of the service was closely monitored and that all of the indicators suggested that the service was safe. The Board noted that the Trust's long term succession planning would be part of the discussions with system partners about the development of networked cardiac surgery services across south west London. The Chairman requested that the next report to the Board set out more information about the current performance of the service, including quality and safety metrics. **The Board noted the report and reiterated the need to have a comprehensive report at the next meeting which included performance data in line with TB31.10.19/01 discussed above.**	**CMO**
3.0	**FINANCE**	

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		Action
3.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meeting held on 21 November 2019. The Committee raised robust challenge in relation to emergency care performance, theatre productivity, and finance. On finance, the Committee noted that if the Trust continued on the same trajectory it would miss its 2019/20 financial target. This was particularly disappointing given the Trust had empowered local leaders and teams to develop the Cost Improvement Plans (CIP) and to deliver against agreed budgets. The Committee had asked that an action plan be developed to deliver the financial plan. The Board reflected that this was not a comfortable position for the Trust. A key aspect of delivering the required level of financial savings would be driving productivity and the Board will need to consider this when it considered long-term sustainability. The executive team had galvanised the Trust and more focus was being given to delivering financial targets under the new grip and control framework that was recently implemented. The Board noted the report.	
3.2	**Finance and Investment Committee (Estates) Report (FIC(E))** Tim Wright, NED Estates Lead, provided an update on the meeting held on 21 November 2019. The quality of reporting and engagement on estates issues was evident from the meetings. The Trust was working on plans for the new MRI scanners which were being centrally funded as well as working with PFI partners to progress the approved plan for upgrading the cardiac catheter laboratories. The Health and Safety Executive had carried out a follow-up inspection of the Trust on 7 November 2019 and initial feedback suggested that the Trust had made progress. The Trust was now progressing the recruitment of a substantive Director of Estates and Facilities. It was recognised that the test for progressing capital projects should include considerations of measures that would help improve flow through the hospital. The Board noted the report and acknowledged the work of the estates and facilities team and the CFO/DCEO in giving focus and driving improvement around estates and facilities issues.	
3.3	**Month 7 Finance Report** The Board noted the Month 7 finance report. The CFO/DCEO reported that the Trust remained on plan at month 7 but as things stood would not achieve its forecast year-end position. The current position was being driven by gaps in the savings programme and the run-rate. The revised forecast was circa £9-13m adverse variance to plan. The weekly finance focus meetings continued and some progress was being made in some areas but there were still significant challenges. The cash position was also very tight and managers were focusing on cash flow planning. The Trust was also keeping NHS England and NHS Improvement updated on the Trust's financial performance and the Board would be kept abreast of developments with the recovery plan. It was noted that the issue with coding related to technical issues and the Trust was catching up on the backlog. While this was an ongoing issue it was not impacting on the financial position. The Board queried the plans for £5m pipeline savings schemes that were RAG-rated as green and it was reported that part of the Trust's plan was to deliver a significant part of the savings	

		Action
	programme at the later date in the financial year. The Trust would now carry forward any green schemes into the recovery plan. Divisions were also reviewing budgets and savings programmes on a weekly basis and would use the quality improvement process to deliver plans where appropriate. The organisation was focused on delivering the financial target but it was challenging. The Board noted the report and noted the concerns around the delivering the financial plan.	
4.0	**STRATEGY & GOVERNANCE**	
4.1	**Draft Workforce Strategy 2019-2024** The Board received and discussed the draft workforce strategy for 2019-2024. The workforce strategy focused on three key priorities: retention, supply and new roles. By focusing on these areas the Trust would be better equipped to deal with the significant workforce challenges locally and system-wide. It was noted that a key element to retention was career and professional development, especially for clinicians. The key challenge to delivering the priorities would be ensuring that the Trust got the required traction on improving culture and leadership through the organisation. The Trust also needed to do more on flexible working and ensuring managers made the shift in thinking differently about the workforce and the structuring of jobs. The Board noted the importance of the Workforce and Education Committee receiving and monitoring the detailed action plan against each of the priorities. This would not be ready for the meeting of the Committee the following week but was currently being developed. The Board also reflected on the importance of identifying the unique selling point for the Trust and marketing this as part of the strategy, including for example the co-location of the Trust with St George's University. The Board approved the workforce strategy for 2019-2024 and noted that the Workforce and Education Committee would oversee the action plan and delivery of the priorities.	
4.2	**Fit and Proper Person Test** The Board noted and approved the revised policy on fit and proper person test.	
4.3	**Statement of Purpose – Care Quality Commission (CQC) Submission** The Board received and approved amendment to the Statement of Purpose. The Statement had been updated to reflect that the Trust no longer provided services at HMP Wandsworth. The updated Statement of Purpose would be submitted to the CQC and the Trust's website would be updated.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from the public** No questions from the public had been submitted. In the absence of questions from the public, the Chairman invited questions from Governors and Patient Partners. Patient partnership representative, Hazel Ingram, relayed her recent	

		Action
	experience of waiting in the emergency department and the impact on waiting times when patients had to wait for blood tests. The Chairman noted that this was a known issue and the Trust would ensure that it did not lose sight of this as it progressed plans to improve the performance of the emergency department.	
5.2	**Any other risks or issues identified** There were no other risks or issues identified.	
5.3	**Any Other Business** The Trust is keeping abreast with the developments and changes to the NHS pension scheme which impacted in particular on the consultant body. The Trust was communicating developments to consultants mindful of the fact that the decisions were part of government policy and were not within the control of the Trust.	
5.4	**Reflections on the meeting** The Chairman invited the CMO to offer reflections on the meeting. The CMO reflected on the powerful messages fed back from the ward visits. It was also good that the Board followed up on the patient story. There was a clear theme around ensuring the Board received the required assurance from the reports presented to it. There had been a lot of challenge from both executive and non-executive directors and this was encouraging. The discussion about the financial position was interesting and challenging and revealed the level of focus the organisation was giving to recovering the position. The Chairman noted that getting the balance right between managing the time on the agenda and allowing sufficient time for discussion would be kept under review, but on balance felt that it was important that the timings be flexed where appropriate to allow more in depth discussion of issues where required.	
6.0	**PATIENT & STAFF STORIES**	
6.1	**Patient Story: Patient Experience of Juniper Continuity of Carer (COC) Team** The Board welcomed new mother Gemma Legge who provided the Board with a moving overview of the care and treatment she received before and after entering the pilot for the midwife-led Juniper Continuity of Carer (COC) Team. She reflected on the level of support she had received from the COC team and how, as a new mother-to-be who was experiencing issues at the early part of her pregnancy, she was happy to be able to have a named clinician. Having the same clinicians support her before, during and after the pregnancy made a significant difference and she had grown to trust the team of people that supported her and she felt that the level of service she received was excellent. Chelone Lee-Wo, Consultant Midwife and Public Health and Maternity Transformation Co-Chair reported that the midwife-led Juniper Continuity of Carer Team was a model adopted as part of the Better Births plans in the Five Year Forward View. The COC model enabled each woman to have a named midwife leading her care, and this enabled optimal communication among all care givers, improved clinical outcomes and led to higher rates of maternal satisfaction. The model was introduced as the result of a transformation programme and the plan was to roll out this model more widely given the	

		Action
	evidence demonstrated that it was an effective system for supporting pregnant women. The Board thanked Gemma Legge for sharing her story and supported embedding the model across more widely where feasible.	
Date of next meeting: Thursday, 19 December 2019 in the Hyde Park Room, St George's Hospital, Tooting		

Trust Board Action Log Part 1 - December 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 Education Committee.	~~19/12/2019~~ 27/02/2020	CMO/CPO	**Workforce & Education Committee agreed to consider this at its next meeting on 18 February 2020 and would provide an update in its report to the Board.**	**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~~ 19/12/2019	CMO	**See agenda item 2.5** *Previous Update This report is in draft but further work is required to ensure it address the key points raised by the Board and with the agreement of the Trust Chairman the action is deferred until December with the view that the report is considered at Quality & Safety Committee via Trust Executive Committee.*	**PROPOSED FOR CLOSURE**
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~~ 19/12/2019	CMO	*Same as above update for TB27.06.19/02*	**PROPOSED FOR CLOSURE**
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 yet due.**	**NOT DUE**
TB31.10.19/01	**Cardiac Surgery Update**	**NICOR Letter to Board and Comprehensive Cardiac Surgery Report:** The Board noted the report, requested a comprehensive report at the next meeting and agreed that the CMO would circulate the letter from NICOR confirming the Trust was now out of alert to the Board. Update from November Board: *See also Addendums from Trust Board Meeting in November 2019 Minute items 1.4 and 2.4*	~~28/11/2019~~ 19/12/2019	CMO	**Board to decide if current report covers the level of detail previously requested.See agenda item 2.4** ***Completed - NICOR email circulated to the Board (28/11/2019).***	**PART COMPLETED**
TB31.10.19/02	**Workforce & Education Committee Report**	**Internal Staff Survey for Quarter 2:** The Board noted the report and agreed that the Trust would find another means of conducting the quarter two internal staff survey.	~~19/12/2019~~ 29/01/2020	CPO	**Verbal Update to be provides at the meeting.** *Previous Update: This action has been assigned to the Workforce and Education Committee and copied to its action log. An update will be provided in the Committee's Report to the Board in December .*	**OPEN**
TB31.10.19/03	**Corporate Objectives Quarterly Report**	**Embedding Corporate Objectives across Trust:** The CEO would speak to the CSO about how best to embed the corporate objectives across the organisation.	19/12/2019	CSO/ CFO-DCEO	**Verbal Update to be provided at the meeting** *Previous Update: Core reports to be made by each director lead to the relevant Board Sub-Committee on a monthly basis so that assurance can be provided on monthly basis as well as the formal quarterly report to Board.*	**OPEN**
TB28.11.19/01	**Medication Incidents and Controlled Drugs Q1-2 Report**	The CMO agreed that the next iteration of the medicine incident and controlled drugs report would include relevant benchmarking data.	May/June 2020	CMO		**NOT DUE**
TB28.11.19/02	**Seven Day Services**	The CN would include a risk on the Board Assurance Framework related to seven day services.	29/01/2020	CN		**NOT DUE**
TB28.11.19/03	**Seven Day Services**	The CMO would present an interim report to the Board via the Quality and Safety Committee in January 2020 on the Trust's progress against each standard and the report will include an action plan.	29/01/2020	CMO		**NOT DUE**
TB28.11.19/04	**Seven Day Services**	The weekend mortality data will be included in the integrated quality and performance report each month.	29/01/2020	CTO		**NOT DUE**
TB28.11.19/05	**Annual Research Report**	The Board noted the annual research report and agreed that the next iteration would include comparative data to demonstrate where the Trust sits in relation to other organisations.	Q1 2020/21	CMO		**NOT DUE**

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Meeting Title:	Trust Board		
Date:	19 December 2019	**Agenda No.**	**1.5**
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is asked 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

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

It is only three weeks since our last Trust Board meeting in November, but there have still been some significant developments in the short period since then, which I want to touch on this month.

Cardiac surgery

As reported to the Trust Board in October, we recently received confirmation from the Society for Cardiothoracic Surgeons of Great Britain and Ireland (SCTS) that our outcomes for cardiac surgery are now back within the expected range.

As Trust Board members will be aware, we were issued with two separate alerts relating to cardiac surgery outcomes by the National Institute for Cardiovascular Outcomes Research (NICOR) in May 2017 and May 2018 relating to mortality following cardiac surgery in the period 1 April 2013 to 31 March 2018. The alerts informed our improvement plans for the service at the time, so the recent confirmation that the service is now out of alert status – with outcomes comparable to other centres nationally – is a positive step forward.

I would like to thank Mr Steve Livesey, cardiac surgeon, for the contribution he has made as associate medical director and clinical lead for the service since December 2018. But I would also like to thank staff, who have worked hard to deliver improvements, often in difficult and challenging circumstances.

The report on cardiac surgery submitted to the Trust Board this month sets out in more detail what we have changed, and what improvements this has helped bring about. When I arrived at the Trust, it was clear that some difficult, long-standing issues needed to be tackled with a degree of urgency – and cardiac surgery is one such example. It is right and proper that we took decisive action to address the challenges that both internal and external reviews have highlighted. We must not be complacent, but real progress has been made since then – although there are still further improvements we can and must make, and this must remain our focus.

Delivering on our vision and strategy

We are continuing to make progress with a number of supporting strategies, which are central to delivering our five year strategy – *Delivering outstanding care, every time* - announced in April this year.

The Trust Board has already agreed research and workforce strategies, and we held a seminar last week to discuss our emerging quality and safety strategy. This was an excellent opportunity to discuss new ideas, as well as patient safety initiatives already in train. For example, we launched our critical care outreach team at St George's this week, which provides mobile support out on the wards for deteriorating, acutely unwell adult patients.

Providing extra support for acutely unwell and deteriorating patients is one of our three clinical priorities for the year, so I am really pleased to see the critical care outreach service now up and running. The service involves a dedicated critical care consultant during the day (initially Monday-Friday), a registrar (Monday-Sunday), plus a minimum of one critical care nurse 24/7, 265. So a really positive step.

Of course, it is also important we continue to deliver excellent local services, which is one of our four strategic priorities. Our emergency care performance continues to be challenged, and whilst we are not the only Trust seeing spikes in demand, we know there are improvements we can make internally – including systems and processes, as well as the interaction between our Emergency Department (ED) and specialist services. Dr Paul Holmes has recently taken over as Clinical Director for the Emergency Department, which is positive news – but we know this is a Trust-wide problem to solve, not simply an ED one.

It is now nearly a year since we returned to reporting our referral to treatment data. The clinical harm review paper presented to the Trust Board provides a detailed summary of the steps we have taken – in consultation with our commissioners – to ensure all patients who may have experienced delays in treatment as a result of data quality problems have been contacted, and offered follow up appointments as appropriate. As reported to Board previously, some patients did come to harm as a result of historical data quality issues at the Trust. We have rightly apologised to the patients in question and, whilst we now have robust systems and processes in place for managing patients on our waiting lists, we shouldn't underestimate the distress caused.

Our staff

Our staff continue to excel in many areas, which we work hard to recognise and celebrate.

Our haematology department at St George's has been awarded a Clinical Service Excellent Programme (CSEP) accreditation from Myeloma UK – making us only the second Trust in London to achieve this. I was fortunate enough to meet the team, who were recognised for providing best practice care for Myeloma, a condition that affects around 17,500 people in the UK. The time I spent with the team was another reminder – not that it were needed – of the highly specialist services we provide in many areas.

I was also pleased to hear that our cardiac theatres team achieved gold in our ward accreditation scheme. The unit scored 100% in a number of areas – including for end of life care, environment, health and safety, management of pressure ulcers – and deserve huge praise for delivering improvements, which are benefiting patients and staff.

On a personal level, I would like to congratulate Dr Nigel Kennea on being made the Trust's first ever Medical Examiner. The role – which will involve improving the way we support bereaved families – is so important, and builds on a huge amount of work Nigel has already pioneered in the area of learning from deaths. I am delighted for Nigel, but also the wider organisation – we are lucky to have him.

Finally, we have also launched a project on culture this month, which is something I have been wanting to start for some time. I want approximately 15-20 members of staff to join me over the next six months to look at what our organisational culture is; in particularly, what works well, and where we need to improve.

This will give us valuable information that, alongside the results of the NHS staff survey, we can use to make a real, tangible different to the working lives of our staff, and how they feel about the organisation. It's exciting and daunting in equal measure, but the initial response from staff has been really positive.

Trust Executive Committee

With the approaching festive season approaching we brought forward our management, Board and Committee meetings. Therefore since my last report to the Board, we have held three Trust Executive Committee (TEC) meetings. In line with our new structure and rhythm for these meetings, we have focused on:

- Corporate reporting the Committee has effective oversight of each corporate area and the work of the governance groups reporting into TEC;
- Consideration of reports coming to the Board to ensure that what we bring to the Board is robust and has had the necessary input across the executive team and the divisions; and
- Performance scrutiny of each of the clinical and corporate divisions, and this time we focused on our Medicine and Cardiovascular and Surgery, Neurosciences, Cancer and Theatres divisions, to ensure there is effective accountability and reporting from the TEC down through the divisions to our clinical services and from the services up to the executive.

We continue to focus on our financial recovery plans and TEC has been monitoring the steps to deliver against our plan for 2019/20, including realising our CIPs. Like many Trusts, this has been a challenging area, and the Board will hear more about this later on the agenda.

We have continued to focus at TEC on addressing staff vacancies and turnover rates, the steps needed to increase appraisal rates for non-clinical staff, and to improve our plans around medical staffing. Our vacancy rates have improved and are again below 10%, but we recognise that our use of agency staff has increased and we are taking action to address this.

We have also focused on improving our planned care in theatres and outpatients. In addition, we have continued to focus on unplanned care and the steps needed to improve emergency care performance, flow, waiting times and to embed our inter-professional standards across the organisation. I continue to chair a weekly emergency performance board which ensures that there is a real focus on the actions needed to get our performance where it needs to be.

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While we await the report of our latest CQC inspection, we continue to focus on our three clinical priorities – treatment escalation plans, the deteriorating patient, and mental capacity and deprivation of liberty safeguards. Good progress is being made in these areas albeit we need to work on embedding them further.

Jacqueline Totterdell
Chief Executive
19 December 2019

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St George's University Hospitals NHS Foundation Trust

2.1

Meeting Title:	**Trust Board**		
Date:	**Thursday, 12 December 2019**	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	**Tim Wright, Interim Chairman of the Quality and Safety Committee**		
Report Author:	**Tim Wright, interim Chairman of the Quality and Safety Committee**		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting in December 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 12 December 2019 and agreed to bring the following matters to the Board's attention:

1. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality performance at month 8. The Committee discussions focused on the maternity services and quality and safety issues arising from the continued challenged emergency care services. The Trust's performance against the indicator for the percentage of women booked by 12 weeks and six days is within the standard deviation however there has not been much progress in increasing performance which needs close monitoring to observe impact of improvements underway. The Committee discussed the challenges which includes room availability and changes to processes. The Committee agreed that this would be an area of focus as part of its deep dive programme and will keep the Board abreast of developments. The Committee also heard that during October the total number of women giving birth increased. To manage this busy period the Trust deployed maternity staff from elsewhere to ensure that services remained safe.

The performance on the emergency care department will be discussed later in the Board agenda and was considered in depth at the Finance & Investment Committee, however, the Committee noted that given the pressures within the department a review of incidents would be undertaken including consideration of patient experience information to ensure there were no underlying quality and safety issues.

2. Exception Report: Care Quality Commission Outstanding Actions

The Committee noted that progress related to achieving mandatory training targets remained below target as a result of not being able to achieve 85% on resuscitation training. Enhanced scrutiny across the Trust at departmental/divisional level continues and the required resources and new systems to support delivery training were confirmed to be in place. The Chief Medical Officer and/or Chief Nurse have also sent personalised letters to staff that 'did not attend' (DNA) resuscitation training without good reason and it was noted that staff are already engaging and responding positively as a result. The Committee was disappointed to learn that despite these efforts the Trust faces a material risk of missing the 31 December 2019 deadline. Work is now underway to develop a revised trajectory for meeting the target in the event that the Trust misses the deadline. The Trust will update the Care Quality Commission on its progress. The Committee will continue to review this area each month.

3. Cardiac Surgery Update

The Committee noted the monthly Cardiac Surgery Update which is discussed later on the Board agenda.

4. Serious Incident Reporting

Following on from discussions in November 2019 the Committee considered a report on serious incidents declared and previous closed investigations. The Committee noted that the numbers of serious incidents were less than during the same period in the previous year and that in the last three months the number of serious incidents reported had reduced. The Committee agreed to receive a monthly report on serious incidents, the outputs of a 6 month thematic analysis and an annual report which focuses on learning and how it has been embedded across the organisation.

5. Clinical Governance Review

The Committee noted the Clinical Governance Review which is discussed later on the Board agenda and requested to see the consolidated action plan at a future meeting..

6. Referral to Treatment Clinical Harm Review – Closure Report

The Committee received and considered the closure report following the review into the potential impact of clinical harm as a result of delays in referral to treatment. This report will be discussed later on the Board agenda.

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

The Committee received a summary report from the PSQG meeting held in November 2019. The Committee heard that following the incident of wrong blood in tube (WBIT) all staff are now mandated to follow the standard operating procedure (SOP) which dictates that labelling of blood samples are only to be completed at the bedside of the patient. The Committee were also provided with an overview of the adverse incident and potential harm related to a backlog of of Initial Health Assessments (IHAs) for looked after children. These should normally be completed within 20 days of a child being accommodated in care. The Trust has completed all actions arising from the investigation and the Committee noted that all IHAs are now being completed within the required timeframe. As reported last month the Committee were disappointed to learn that a proportion of NICE guidance had not yet been assessed but noted that divisions have been instructed to complete and submit assessment documentation. A weekly task and finish group has been established to monitor completion of the outstanding assessments by 31 January 2020 and this will be a standard item on PSQG agenda with quarterly reports to the Committee.

8. Complaints Annual Report (2018-2019)

The Committee considered the annual complaints report which is covered later on the Board agenda (item 2.1.1). The Committee discussed the performance for 2018/19 and noted that significant improvements had been made during 2019/20. Sustaining the performance and focussing on learning is the priority. The Committee also welcomed contributions from the Healthwatch representative concerning the completion of satisfaction surveys and tracking improvement actions from complaints.

9. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Registers focusing on the four strategic risks (SR) which fall within its remit. The Committee agreed that in relation to strategic risks SR1, SR2, SR3 and SR16 to accept the partial assurance rating and risk scores but noted that some updates were required on the risk reduction schedule. The Committee requested, as discussed by the Board, that the risk be incorporated in the Board Assurance Framework related to seven day services. This will be considered at the next meeting.

10. Committee Effectiveness

The Committee received and discussed the update on its Committee Effectiveness action plan, agreed the approach for completing the next review and the timetable for reporting to the Board. The Committee recognised that more work was required on its workplan, the deep dive programme and developing formats and guidance for report authors and presenters some of which will be part of the wider work being conducted by the corporate governance team.

Tim Wright
Committee Chair
12 December 2019

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2.1

Meeting Title:	**Trust Board**		
Date:	**19 December 2019**	**Agenda No**	**2.1.1**
Report Title:	**Complaints Annual Report 2018/19**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	**Terence Joe, Head of Patient Experience and Partnership** **Alison Benincasa, Director of Quality Governance and Compliance**		
Presented for:	Assurance		
Executive Summary:	The Complaints Annual Report is a statutory requirement (Local Authority Social Services and National Health Service Complaints (England) Regulations 2009) and covers the financial year 2018/19 and is attached as Appendix 1. The key findings were: • 1,101 complaints were received, which is an increase of 13% (127) when compared to 2017/18 (974). However, when taken as a percentage of all attendances (0.11%) the number of complaints is effectively the same as 2017-18 (0.1%) • 82% of complaints were acknowledged within three days in comparison to 2017/18 (87%) • The top three complaints subjects related to Clinical Treatment, Communication and Information: provided to patients and Care, which was the same in 2017/18 • Overall complaints performance was 62% against the 85% performance target. This is broken down further by working day response as follows: ➢ 25 working day: 68% against 85% target ➢ 40 working day: 55% against 95% target ➢ 60 working day: 62% against 95% target • 108 complaints were reopened compared to 2017/18 (105), an increase of 2.8% • There were 7 requests for documentation from the Parliamentary Health Service Ombudsman's office (PHSO) compared with 10 requests in 2017/18. The final reports have been received for four of the seven cases. The PHSO upheld one of the four cases. Three cases remain under review. • 798 compliments were received and logged, an increase of 2% when compared with 2017/18 (780) • There were 6779 contacts raised with the patient advisory and liaison service (PALS): a contact refers to any enquiry or request which does not raise areas of concern within the Trust. This represents an increase of		

	3.6% when compared to 2017/18 (6541). Of these contacts 3858 related to concerns (when a patient or relative raises a concern about the Trust and does not want to follow the formal complaints procedure) which represents an increase of 22% when compared to 2017/18 (3153). The top three themes for contacts related to appointments, information and communication. • Examples of actions taken in response to the learning from our complaints were: ➢ Clinical Treatment: radiographers adjusted their practice where indicated in relation the application of pressure following removal of peripheral cannula in diagnostic services to reduce bruising ➢ Communication: developed a mandatory training End of Life Care awareness video aimed at all staff ➢ Care: concentrated on working with teams to ensure death certificates were completed within 24 hours of death In 2018/19 the Complaints and PALs team experienced a period of instability with changes in senior leadership. The service was also restructured to include senior posts with enhanced skills in root cause analysis and human factors. All new and revised posts have been recruited to. Since July 2019 performance in complaints investigation and response times has significantly improved and across 25 day, 40 day and 60 day response times and there are no overdue complaints.
Recommendation:	The Board is asked to receive and note the report.
Supports	
Trust Strategic Objective:	Treat the patient, treat the person
CQC Theme:	Responsive
Single Oversight Framework Theme:	1. Quality of care (safe, effective, caring, responsive) 2. Leadership and Improvement capability (well-led)
Implications	
Risk:	N/A
Legal/Regulatory:	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16: Receiving and acting on complaints
Resources:	N/A
Equality and Diversity:	No issues to consider
Previously Considered by:	Trust Executive Committee Quality and Safety Committee **Date** 11.12.2019 12.12.2019
Equality Impact Assessment:	N/A
Appendices:	Appendix 1 Complaints Annual Report 2018/19

St George's University Hospitals NHS
NHS Foundation Trust

Complaints Annual Report
1 April 2018 – 31 March 2019

Contents

1.0 Executive Summary

This is the executive summary of the complaints annual report for St George's University Hospitals NHS Foundation Trust. The report is for the period 1 April 2018 to 31 March 2019. In accordance with the NHS Complaints Regulations (2009) this report provides an analysis of the complaints received. It also includes an overview of PALS concerns and activity for the same period.

The key findings were:

- 1,101 complaints were received, which is an increase of 13% (127) when compared to 2017/18 (974). However, when taken as a percentage of all attendances (0.11%) the number of complaints is effectively the same as 2017-18 (0.1%)

- 82% of complaints were acknowledged within three days in comparison to 2017/18 (87%)

- The top three complaints subjects related to Clinical Treatment, Communication and Information: provided to patients and Care, which was the same in 2017/18

- Overall complaints performance was 62% against the 85% performance target. This is broken down further by working day response as follows:

    - 25 working day: 68% against 85% target
    - 40 working day: 55% against 95% target
    - 60 working day: 62% against 95% target

- 108 complaints were reopened compared to 2017/18 (105), an increase of 2.8%

- There were 7 requests for documentation from the Parliamentary Health Service Ombudsman's office (PHSO) compared with 10 requests in 2017/18

- 798 compliments were received and logged, an increase of 2% when compared with 2017/18 (780)

- There were 6779 contacts raised with the patient advisory and liaison service (PALS): a contact refers to any enquiry or request which does not raise areas of concern within the Trust. This represents an increase of 3.6% when compared to 2017/18 (6541). Of these contacts 3858 related to concerns (when a patient or relative raises a concern about the Trust and does not want to follow the formal complaints procedure) which represents an increase of 22% when compared to 2017/18 (3153). The top three themes for contacts related to appointments, information and communication.

- Examples of actions taken in response to the learning from our complaints were:
    - Clinical Treatment: radiographers adjusted their practice where indicated in relation the application of pressure following removal of peripheral cannula in diagnostic services to reduce bruising
    - Communication: developed a mandatory training End of Life Care awareness video aimed at all staff
    - Care: concentrated on working with teams to ensure death certificates were completed within 24 hours of death

2.0 Purpose of the Report

The Complaints Annual Report is a statutory requirement (Local Authority Social Services and National Health Service Complaints (England) Regulations 2009).

This purpose of the report is to provide:

- assurance the Trust is managing its formal complaints in accordance with the Trust complaints policy and procedure
- information relating to the complaints activity for the Trust with specific focus on each of the divisions
- examples of where complaints have led to service improvement and shared learning Trust-wide.

3.0 Introduction

The Complaints Annual Report for St George's University Hospitals NHS Foundation Trust is for the period 1 April 2018 to 31 March 2019. The report provides an overview and analysis of the complaints received, the key identified themes and trends, compliance with performance targets, and the changes and impact on services in accordance with the NHS Complaints Regulations (2009). It also includes an overview of PALS enquiries and activity for the same period.

Complaints received provide much learning for the Trust on where and how we need to improve. The themes and trends identified from complaints in 2018/19, and previously in 2017/18, highlight the need to improve communication and information provided to patients, carers and families, improve communication on clinical treatment, improving waiting times and improving the care provided.

A key objective of the Trust, and one we need to do better at, is to learn, change, improve and evolve in response to complaints. The lessons learned and trends identified through monitoring data collected through complaints plays a key role in improving the quality of care received by patients and their experience and is a priority for the Trust reaching its vision of outstanding care every time.

The efficient and effective handling of complaints by the Trust matters to the people who have taken the time to raise their concerns with us. They deserve an appropriate apology for their experience alongside a recognition where substandard and inadequate care was provided and assurance that we will put actions in place to ensure other patients are not affected by a reoccurrence of the same concerns. This assurance comes through robust investigation with

identification of a root cause and contributory factors and putting meaningful actions in place.

Posters and leaflets are displayed around the Trust and there is information on the Trust website to ensure that patients are made more aware about their options and the process for raising a complaint. We view all types of patient feedback as positive and we are constantly looking at ways in which we encourage patients, carers and families to give their views.

4.0 Accountability for complaints management within the Trust

The Board has corporate responsibility for the quality of care and the management and monitoring of complaints received by our Trust. The Chief Executive has delegated the responsibility for the management of complaints to the Chief Nurse and Director of Infection Prevention and Control. The Head of Patient Experience, reporting to the Director of Quality Governance, is responsible for the management of the complaint process and ensuring:

- All complaints are investigated appropriately to the complaint
- All complaints receive a comprehensive written response or meeting as requested to address their concerns
- Complaints are responded to within the set local standard response times
- When a complaint is referred to the PHSO, all enquiries are responded to promptly and openly

Each month the following information is reported through the Integrated Quality Performance Report to the Board:

- Numbers of complaints received
- Number of complaints closed by working day response time and compliance with performance targets
- Numbers of reopened complaints
- Number of complaints breaching the 6 month response timeframe
- The number of PALs enquiries received

Each quarter the following information is reported to the Patient Safety and Quality Group:

- Number of written complaints received as a comparison against previous quarters and per 1000 episodes of care and further classified according to the division and primary subjects
- Compliance with locally set working day response time target for final response and the nationally set acknowledgement target by division
- Number of PHSO cases received during the quarter and the resolution during that quarter of any existing PHSO cases including the outcome of closed cases
- Type and themes of complaints received and any learning and improvements taken from the complaints

5.0 Total complaints received in 2018/19

During 2018/19 the Trust received 1,101 complaints which equates to an average of approximately 21 complaints received per week or 92 complaints per month. This shows an increase of 13% on the number of complaints received in 2017/18 (974).

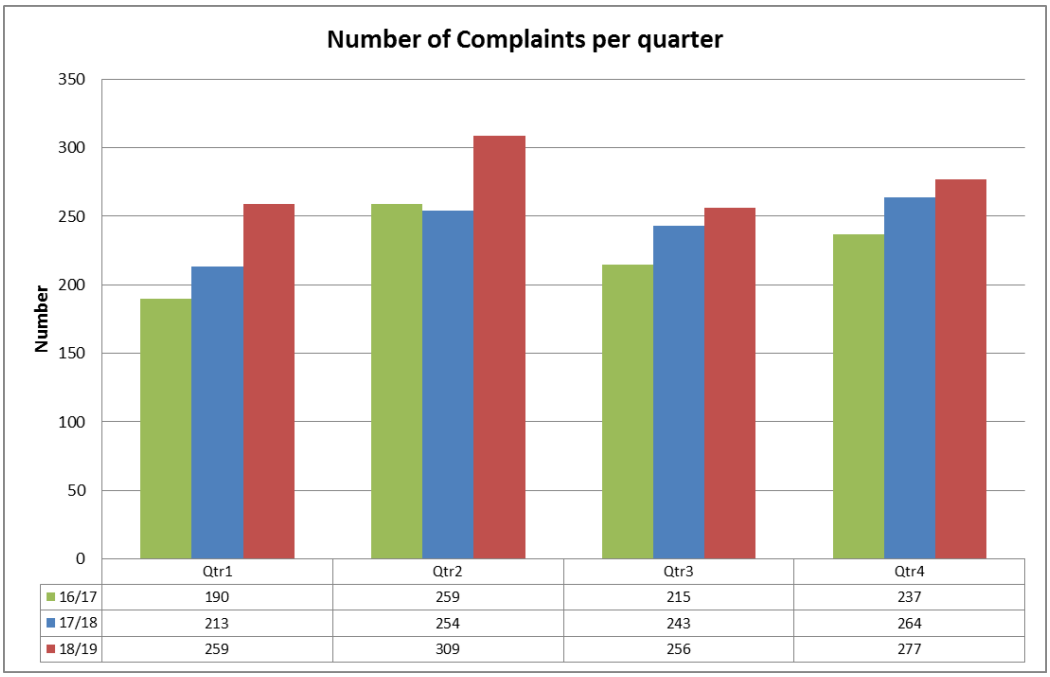
Table 1 below shows the 1,101 complaints received related to all attendances equates to a complaint versus attendance ratio of 0.11%. This figure equates to approximately 1.63% complaints as a percentage of inpatient activity.

Table 1

Activity		**17/18**	**18/19**
Inpatient Emergency, Maternity, Other and Transfers		58157	67569
Elective, Day cases, Regular Attends		74800	84940
A&E Attends (including Streaming and EPU)		171781	176483
Outpatient Attends (New and Follow Ups)		646691	680064
Total attendances		**951429**	**1009056**
Number of Complaints		**974**	**1101**
Complaints as % of all Attendances		**0.1**	**0.11**
Complaints as % of Inpatient Activity		**1.66**	**1.63**

The table 2 overleaf demonstrates the number of complaints received in each quarter during 2018/19 when compared to 2016/17 and 2017/18. Since 2016, with the exception of one quarter, there has been a noted upward trend in the number of complaints received each year. There were significant increases seen across quarters 1 and 2 with smaller increases in quarters 3 and 4 in 2018/19.

Table 2



	Qtr1	Qtr2	Qtr3	Qtr4
16/17	190	259	215	237
17/18	213	254	243	264
18/19	259	309	256	277

The table 3 below shows a breakdown of complaints received by month and year for the years 2016/17, 2017/18 and 2018/19.

Table 3

Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
57	58	75	74	94	91	67	92	56	85	73	79	901

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
63	75	75	56	99	99	96	78	69	90	80	94	974

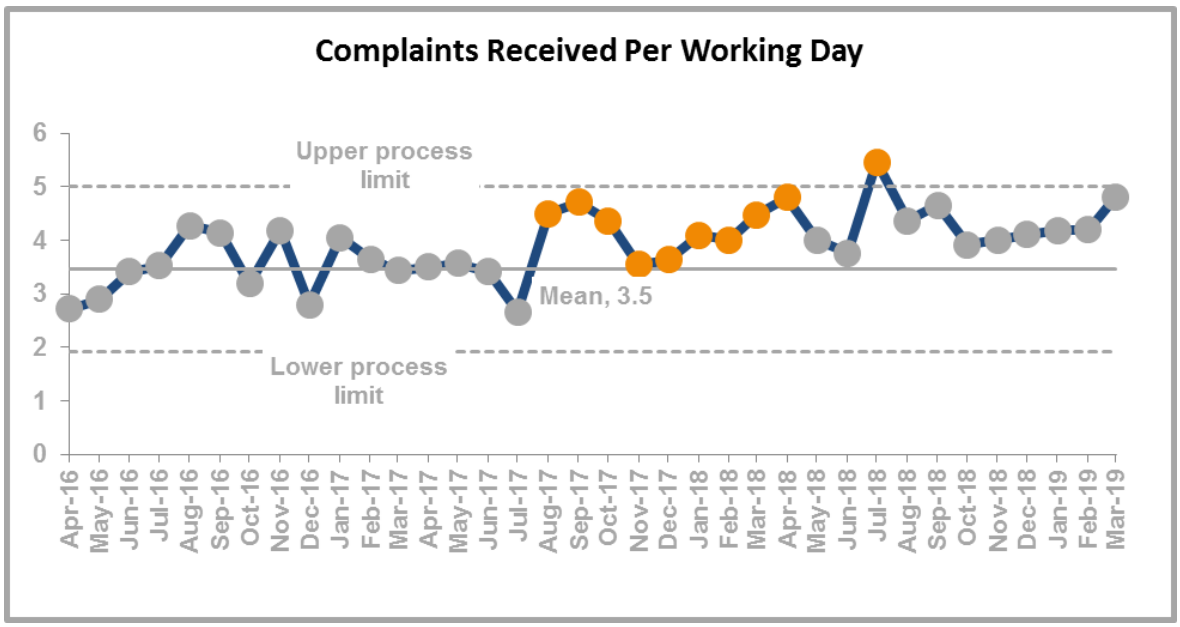
Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
96	84	79	120	96	93	90	88	78	92	84	101	1101

Table 4 overleaf is a statistical process control (SPC) chart which enables a broader understanding of the differences and norms of complaints received during 2018/19 compared with 2016/17. The monthly complaint rates are plotted within upper and lower process limits which measure whether variations on a monthly basis are stable and thereby predictable (common cause variation shown in grey), or in contrast were unstable and thereby unpredictable (special cause variation shown in orange).

Table 4 illustrates a period of relative stability in complaints received per working day between April 2016 and July 2017 (16 months). This was followed by a period of unpredictable instability between August 2017 and April 2018 (9 months).

From April 2018 to March 2019 the monthly complaint rates were within upper and lower process limits (except July 2018) and were therefore stable and predictable. The Trust was not able to identify the cause of the unpredictable increase in the number of complaints received during July 2018.

Table 4



Indicator	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Complaints Received Per Working Day	2.7	2.9	3.4	3.5	4.3	4.1	3.2	4.2	2.8	4.0	3.7	3.4

Indicator	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Complaints Received Per Working Day	3.5	3.6	3.4	2.7	4.5	4.7	4.4	3.5	3.6	4.1	4.0	4.5

Indicator	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Complaints Received Per Working Day	4.8	4.0	3.8	5.5	4.4	4.7	3.9	4.0	4.1	4.2	4.2	4.8

6.0 Complaint themes

The Department of Health (DH) classifies complaints in to 18 distinct categories by the subject of the complaint. Each complaint may involve more than one issue depending on the nature and complexity of the complaint. By theming our complaints by subject it allows us to identify whether any trends are developing. Table 5 below identifies the top five themes and trends from our complaints by subject during each quarter of 2018/19. The data is related to the primary subject raised within each complaint. Using the DH classifications, the five most commonly identified complaints were related to:

1. Communication / information to patients (written and oral)
2. Clinical Treatment
3. Care
4. Staff Attitude
5. Cancellation

Table 5

SUBJECT	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	Total
Admission arrangements	6	0	0	0	6
***Attitude**	20	31	23	34	109
***Cancellation**	11	23	21	23	78
Cancellation of surgery	3	5	10	8	26
***Care**	47	48	38	43	178
Car Parking	0	1	4	0	5
***Clinical treatment**	55	64	46	48	214
***Communication**	72	67	75	67	284
Discrimination	0	2	0	2	4
Discharge arrangements	5	5	5	12	27
Hotel and site services	1	3	4	0	8
Request for Information	0	0	1	0	1
Other	8	21	5	21	55
Respect for privacy	1	3	0	0	4
Medical records	2	2	5	1	10
Transport arrangements	8	2	4	2	16
Transfer arrangements	2	0	0	0	2
Unhelpful	0	1	2	1	5
Waiting times	19	28	9	13	69
Totals:	**260**	**306**	**252**	**275**	**1101**

The top two subjects of communication and clinical treatment were the same in 2017/18. Staff attitude was a new subject included in the top five. Care moved up to third place from being fourth in 2017/18.

Table 6 below shows the top five primary subjects of complaints received by each of the Trust's directorates in 2018/19 compared with the previous year. Directional arrows indicate the total change compared to the previous fiscal year. There was a 10% increase in the number of complaints related to attitude from 63 cases in 2017/18 to 109 cases in 2018/19. This was particularly marked within the Emergency Department Directorate where the increase was from five complaints in 2017/18 to 21 complaints in 2018/19. Smaller increases were noted within Estates and Facilities and Neurosciences Clinical Directorates.

Table 6

Directorates	Attitude	Cancellation	Care	Clinical treatment	Communication	Total for top 5 primary subject
(MC) Emergency Department	21	0	20	32	12	**84**
(MC) Acute Medicine Clinical	4	0	17	11	8	**40**
(MC) Cardiology Clinical Academic Group	3	5	10	9	14	**41**
(CW) Children's	4	4	8	17	20	**53**
(CW) Community Services	4	1	11	6	9	**31**
Corporate Affairs	0	0	0	0	1	**1**
Corporate Nursing	1	0	2	0	5	**89**
(CW) Critical Care	0	0	2	4	0	**6**
(MC) Cardiac, Vascular, Thoracic Surgery	0	1	7	11	13	**32**
(CW) Diagnostics Clinical	5	3	6	17	13	**44**
Estates & Facilities	8	0	1	0	5	**14**
Finance	2	0	0	0	0	**2**
Information Communication Technology	0	0	0	0	1	**1**
(SN) Neurosciences Clinical	10	3	14	14	29	**70**
(MC) Renal, Haematology, Palliative Care & Oncology	4	1	8	5	5	**23**
(MC) Specialist Medicine Clinical	3	12	8	14	15	**52**
(SN) Surgery Clinical (inc. Trauma and Orthopaedics)	12	34	27	47	81	**201**
(SN) Theatres Clinical	2	0	1	2	0	**5**
(CW) Therapeutics Clinical	12	12	13	3	35	**74**
(CW) Women's	14	2	23	22	18	**79**
Totals for top 5 primary subjects	**109**	**78**	**178**	**214**	**283**	

7.0 Analysis of the top five complaints subjects and examples of learning

Analysis of the top five subjects is included below with examples of actions taken in response to the learning from the concerns raised.

7.1 Communication

There were 283 complaints received where communication was recorded as the primary subject of concern and were related to a wide range of directorates and services. Surgery clinical directorate

was noted to have the largest increase with complaints where communication was the primary subject.

An example of a complaint in general surgery was with reference to an on the day cancellation of a patient's procedure with no explanation provided as to the reason why. The surgery team reviewed the process associated with communication of this type. It was found that there was no standard format in terms of the information provided to patients. In circumstances such as on the day cancellations communication with patients has now been standardised to include an apology on behalf of the Trust, the reason for the cancellation and what happens next. A record of all patient contacts is now maintained which is monitored by the Deputy General Manager to ensure that our patients receive appropriate and full information.

An example of a complaint in the Medicine and Cardiovascular division related to communication with relatives when the patient was at the end of their life. Training was provided for staff on how to have sensitive discussions with patients and their families as end of life approaches. The Trust developed a mandatory end of life care awareness video for all staff which also addresses key elements of communication at this important time.

A patient raised a complaint Women and Children's services following pregnancy loss. The information on the maternity page of the Trust website was reviewed and updated to include information for women who have experienced pregnancy loss with a link to a stillbirth and neonatal death charity.

An example of Trust wide learning was related to a concern that our main hospital system was unable to update patient details to include details of their Scottish GP. The Trust found that Scottish GPs had not been included in the reference files of GPs which are used within the central spine system and therefore no Scottish GP was offered for the user to select. Following the investigation, contact was made with the system supplier and the reference file of Scottish GPs has been uploaded for use onto the Trust system.

7.2 Clinical Treatment

There were 214 complaints received where clinical treatment was recorded as the primary subject of concern. These complaints were recorded for Emergency Department (ED), Surgery, Women's, Children's and Diagnostics. There was a marked increase within the Diagnostics directorate.

An example of a complaint raised with diagnostic services was with reference to bruising experienced following the removal of a peripheral cannula. The investigation identified that pressure may not have been applied to the cannula site for a long enough period of time following removal. This was fed back to the radiographers who have reflected and where needed adjusted their practice.

Within ED, complaints are reviewed and discussed within governance meetings. Where complaints have related to delay, failure to diagnose or the deteriorating patient further teaching sessions have been provided to highlight the key points raised in the complaints received.

7.3 Care

There were 178 complaints received where care was recorded as the primary subject of concern. It is noted that there was a significant decrease in the number of complaints relating to care within the surgery directorate. Small increases were noted within cardiology and the women's directorates. There was an even spread of complaints across wards and outpatient areas.

For complaints related to the care of patients at the end of their lives in 2018/19 the Trust focussed on End of Life Care as part of the Trust's Quality Improvement Plan with the ultimate aim of delivering the Trust's End of life Care strategy, which focussed the achieving priorities of care for the dying patient

Two elements of the strategy were the implementation of the Achieving Priorities of Care for adults in the Last Hours and Days of Life Nursing Care Plan and the provision of End of Life Care bags to relatives (providing toiletries, information about what to expect when someone close to you is dying, and food and drink vouchers). We also concentrated on working with teams to ensure death certificates were completed within 24 hours of death. The EoLC Strategy played a central role in supporting staff to ensure a high standard of care was provided for our patients and those important to them in the last days and hours of their lives.

7.4 Staff Attitude

There were 109 complaints received where attitude was recorded as the primary subject of concern. This represents an increase of 3% when compared with 2017/18. The directorates where a significant upward trend was noted were the Emergency Department, Estates and Facilities, Neurosciences and Women's.

In relation to staff attitude, staff are encouraged to read the complaint letter and are supported by their line manager to reflect by providing a reflective statement on how they could have responded differently. The reflection is further reviewed with the staff member to ensure learning has taken place. Where indicated, training on values based leadership and effective people management is provided. Customer service is also provided by PALS for staff teams. For medical staff, staff are required to discuss the complaint with their medical supervisor and agree a corresponding development plan. In some cases staff attitude was investigated in line with the Trust human resource policies and escalated to the Chief Nurse, Chief Medical Officer and/or Chief Operating Officer as appropriate.

7.5 Cancellation

There were 77 complaints received where cancellation was recorded as the primary subject of concern. Increases were seen in specialist medicine, surgery, therapeutics and cardiology when compared to 2017/18. In surgery, the majority of complaints received were around cancellation and appointment issues. An example within Ear Nose and Throat (ENT) is that the management of clinics was transferred from the Outpatient Service to the direct management of the ENT Service. A full time member of staff now manages all referrals on the day they arrive in the Trust giving patients a more prompt and responsive service.

8.0 Primary complaint subject by directorate

Table 7 below shows totals of the primary subjects identified during 2018/19 within each directorate.

	Admission arrangements	Attitude	Cancellation	Cancellation of surgery	Care	Car Parking	Clinical treatment	Communication	Discrimination	Discharge arrangements	Hotel and site services	Request for Information	Other	Respect for privacy	Medical records	Transport arrangements	Transfer arrangements	Unhelpful	Waiting times	Total
(MC) Emergency Department Directorate	0	21	0	0	20	0	32	11	0	3	0	0	3	0	0	0	0	0	5	**96**
(MC) Acute Medicine Clinical Directorate	0	4	0	0	17	0	11	8	0	4	0	0	8	0	2	1	0	0	0	**55**
(MC) Cardiology Clinical Academic Group	0	3	5	2	10	0	9	14	0	0	0	0	2	1	0	0	0	0	6	**52**
(CW) Childrens Directorate	0	4	4	2	8	0	17	20	0	3	0	0	3	0	0	0	0	1	3	**65**
(CW) Community Services	0	4	1	0	11	0	6	9	2	3	0	0	5	0	0	0	0	0	1	**42**
Corporate Nursing Directorate	0	1	0	0	2	0	0	6	0	0	0	0	0	0	0	0	0	0	0	**9**
(CW) Critical Care Directorate	0	0	0	0	2	0	4	0	0	0	0	0	0	0	0	0	0	0	0	**6**
(MC) Cardiac,Vascular,Thoracic Surgery	0	0	1	4	7	0	11	13	0	4	0	0	3	0	1	1	0	0	1	**46**
(CW) Diagnostics Clinical Directorate	0	5	3	0	6	0	17	13	0	0	2	0	3	2	0	0	0	0	0	**51**
Estates & Facilties Directorate	0	8	0	0	1	6	0	5	0	0	5	0	5	0	0	10	1	0	0	**41**
Finance Directorate	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Information Communication Techonology Directorate	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	**2**
(SN) Neurosciences Clinical Directorate	2	10	3	3	14	0	14	29	0	2	0	0	5	0	1	0	1	0	2	**86**
(MC) Renal, Haematology, Palliative Care & Oncology Directorate	0	4	1	0	8	0	5	5	0	2	0	0	0	0	0	1	0	0	2	**28**
(MC) Specialist Medicine Clinical Directorate	0	3	12	0	8	0	14	15	1	0	0	1	3	0	1	0	0	0	2	**60**
(SN) Surgery Clinical Directorate (inc. Trauma and Orthopaedics)	2	12	34	14	27	1	47	81	0	3	0	0	9	1	2	1	0	2	34	**270**
(SN) Theatres Clinical Directorate	0	2	0	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0	2	**7**
(CW) Therapeutics Clinical Directorate	0	12	11	0	13	0	3	35	1	3	1	0	2	0	1	0	0	0	9	**91**
(CW) Womens Directorate	2	14	2	3	23	0	22	18	0	0	1	0	1	0	1	0	0	0	5	**92**
Totals:	**6**	**109**	**78**	**28**	**178**	**7**	**214**	**283**	**4**	**27**	**9**	**1**	**52**	**4**	**10**	**14**	**2**	**3**	**72**	**1101**

9.0 Complaints compliance and performance

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 set out the rights of complainants and the expectations on the Trust to investigate and respond in an appropriate and timely manner. Best practice is that each complainant is contacted to discuss their complaints and agree both the process of resolution and the timescale.

The NHS complaints regulations state that complaints should be acknowledged within 3 working days. In 2018/19 the Trust achieved 82% of complaints acknowledged within 3 working days, a decrease in performance when compared to 87% achieved in 2017/18. The reasons for this were staff vacancies and changes in staff management. Going forward the structure and composition of the complaints team will be reviewed to ensure the team has sufficient capacity and capability to meet this performance target.

For a number of years the Trust's complaints performance has remained below the Trust's internal targets with an average of 65% of complaints being responded to within 25 working days. To improve responsiveness complaints management became one of the work streams in the Quality Improvement Plan (QIP) 2017/18 focussing on three main areas for improvement:

1. Responsiveness – timeliness and engagement
2. Quality of complaint responses
3. Learning from complaints and improving the service we provide

During 2017/18 the Trust revised the complaint triage process and introduced three standard response times based on the complexity and severity of the complaint. The purpose of this change was to improve our responsiveness to complaints by setting a clear standard which gave a reasonable response time for a complaint which the Trust was then committed to meeting. This was to prevent complaints that should be responded to within 25 days taking much longer than necessary while recognising that more complex complaints involving clinical care and decisions needed the time for a comprehensive investigation to take place.

Table 8 identifies the proportion of complaints responded to within target and table 9 shows the response rate by directorate.

Table 8

KPI	Category	Target	2018/19 performance
25 working days	Green	85%	68%
40 working days	Amber	95%	55%
60 working days	Red	95%	62%

Table 9

	Within 25 working days	Outside 25 working days	Response Rate	Total
(MC) Emergency Department	52	45	**54%**	97
(MC) Acute Medicine Clinical	28	28	**50%**	56
(MC) Cardiology Clinical Academic Group	27	26	**51%**	53
(CW) Children's	31	31	**50%**	62
(CW) Community Services	27	15	**64%**	42
Corporate Affairs	0	1	**0%**	1
Corporate Nursing	3	5	**38%**	8
(CW) Critical Care	1	5	**17%**	6
(MC) Cardiac,Vascular,Thoracic Surgery	20	26	**43%**	46
(CW) Diagnostics Clinical	34	15	**69%**	49
Estates & Facilities	31	11	**74%**	42
Finance	1	1	**50%**	2
Information Communication Technology	1	2	**33%**	3
(SN) Neurosciences Clinical	45	45	**50%**	90
(MC) Renal, Haematology, Palliative Care & Oncology	22	6	**79%**	28
(MC) Specialist Medicine Clinical	45	14	**76%**	59
(SN) Surgery Clinical (inc. Trauma and Orthopaedics)	109	158	**41%**	267
(SN) Theatres Clinical	6	1	**86%**	7
(CW) Therapeutics Clinical	71	21	**77%**	92
(CW) Women's	45	46	**49%**	91
Totals:	**599**	**502**	**53%**	**1101**

To try to deliver against the working day performance target the Divisional Directors of Nursing and Governance (DDNGs) for each of the divisions within the Trust held weekly monitoring meetings with input and support from the Complaints Co-ordinators. Although this led to some improvement in compliance the performance targets were not met.

9.1 Reopened Complaints

The number of complaints that do not achieve resolution with the first response is used as a proxy measure for the quality of the complaint response. A complainant who does not feel the Trust has

listened to them is unlikely to be satisfied with their response. 108 complaints were reopened during 2018/19 compared with 2017/18 (105), an increase of 2.85%.

10.0 Parliamentary and Health Service Ombudsman (PHSO) Complaints

Seven requests for documentation were received from the PHSO compared with ten requests in 2017/18. The requests related to complaints from seven different service areas: Women's Service, Renal, Emergency Department, Acute Medicine, Surgery, Specialist Medicine and Cardiology Clinical Academic Group.

For four of the seven cases final reports have been received from the PHSO. Of the four cases the PHSO did not uphold one complaint and partially upheld three cases. The Trust accepted the recommendations made in the final reports. There are three cases still under review.

11.0 Positive feedback

In addition to complaints, staff in the Complaints and Improvements Department also log compliments and positive feedback from users of Trust services. This provides valuable insight into the things the Trust does well and identifies good practice from which lessons can be learnt. I798 good news/ thank you letters were received and logged centrally, an increase of 2% on 2017/2018 (780).

12.0 Upheld Complaints

It is a requirement of the complaints regulations that Trusts set out in their annual report the number of complaints which the Trust decided were upheld during the financial year. Historically, the Trust's position has been to determine that all complaints are 'upheld' on the basis that even if a complaint is considered by the Trust to be unjustified, the complainant was aggrieved enough by what happened for them to take the time to complain. This means it was not possible for the Trust to provide the number of upheld complaints.

In 2018/19 the Trust undertook to record the number of complaints that were upheld, not upheld and partially upheld. However, due to instability in the complaints team and changes in senior leadership this did not happen consistently. The Trust will implement a robust recording system to enable consistent and full year reporting from April 2020.

13.0 Training

Throughout 2018/19 the Complaints and Improvements and PALS teams have offered training sessions for staff on both handling complaints and concerns on the frontline and on investigating

complaints. All new staff received a session about customer care and handling concerns on the frontline as part of the Corporate Trust induction.

"Responding to Complaints" and "Effective Customer Care" training sessions are provided monthly in the Training and Development Department. 91 staff attended training for effective customer care in 2018/19.

Additional bespoke training was also delivered to groups of staff and individuals where indicated and requested.

14.0 Patient Advice and Liaison Service (PALS)

The PALS team provided the following:

- Assistance to patients and their representatives with concerns and requests for information. Some examples of recurring enquiries are patients being unable to contact outpatient departments, patients concerned about waiting times for an operation and assisting with transport queries

- Act as a liaison between patients and services and offer suggestions for improvements drawing on the patient experience

- Deliver customer care training to staff in partnership with training and development and on a bespoke basis to wards and services Trust wide

- Raise the profile of PALS throughout the Trust by linking in with wards and departments and representing the service and views of patients on relevant committees

- Provide accessible information to patients, relatives, visitors and staff on the intranet and internet

The PALS values are to:

- offer on the spot resolution
- ensure patients receive appropriate information
- resolve patient concerns at an early stage
- provide a seamless service
- inform and educate staff

- monitor concerns and outcomes
- be a catalyst for service improvement and change

14.1 PALS Activity

A PALS ***contact*** refers to any enquiry or request which does not raise areas of concern within the Trust. An example of this is where a patient wanting information about a service or a member of staff requested information on how to contact an external organisation. It also included expressions of thanks from patients and relatives. The number of PALS ***contacts*** was 6779 in 2018/19. This represents an increase of 3.6% when compared to 2017/18 (6541).

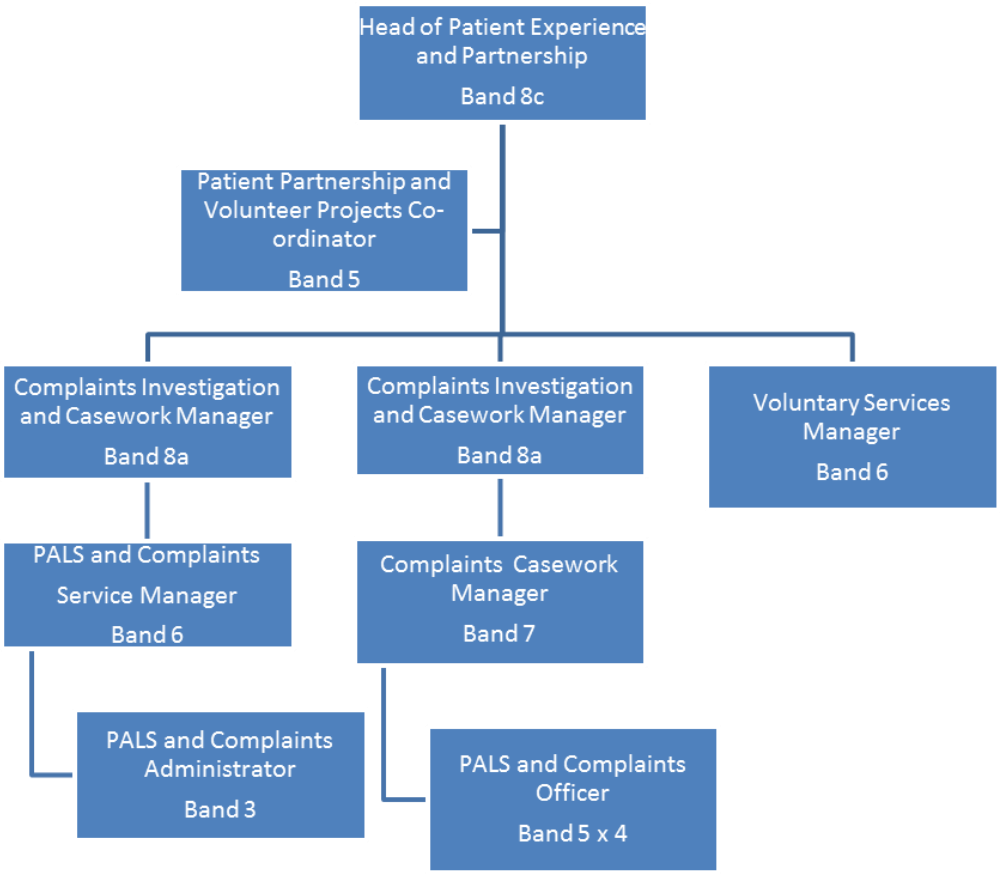
A PALS ***concern*** refers to when a patient or relative raises a concern about the Trust and does not want to follow the formal complaints procedure. The number of PALS ***concerns*** raised was 3858 in 2018/19 which represents an increase of 22% when compared with 2017/18 (3153). The most common themes related to appointments, information and communication.

15.0 Looking Forward

The Trust will continue to proactively manage complaints, improve the process and quality of the responses, and embed the learning from complaints in practice.

In order to achieve this in July 2019 a ‘complaints huddle’ was established to focus on better management of complaints to ensure complaint responses went out on time. In addition, the PALS and complaints service was restructured in December 2019 to include senior posts with enhanced skills in root cause analysis and human factors (see organogram overleaf).

Patient Experience Team



In 2019/20 to strengthen the assurance process for learning from complaints the Trust will include a summary of the actions to be taken in the complaint response letter to support the monitoring and delivery of the improvement actions. The Trust will also review the process for the complaints satisfaction survey with a view to increasing our feedback to facilitate further improvement where indicated.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

2.2

Meeting Title:	**Trust Board**		
Date:	19 December 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 7		
Executive Summary:	This report consolidates the latest management information and improvement actions across our quality, patient access and performance. Due to the timings of this month's sub-committee meetings, a number of data items are unavailable and therefore a shorter pack is included. The Trust does not intend to produce a full report in this cycle and a full report will be provided in January. The Trust continues to perform positively against all Cancer Standards achieving all seven standards for the month of October. However the Four Hour Operating Standard continues to be below trajectory with performance of 79.4% against a recovery plan of target 87.5%. The Trust also did not achieve the October RTT Trajectory reporting 85.1% against a trajectory of 86.1%. The Trust had a lower rate in Caesarean sections with no labour due to the recent data reclassification, and this is in line with experience. The Chief Operating Officer and the Chief Nurse will provide verbal updates on other key performance and key quality metrics respectively where appropriate within the Trust Board meeting. As per NHS Improvement recommendations, where appropriate, metrics are displayed using Statistical Process Control charts.		
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**	12/12/19 12/12/19
Equality Impact Assessment:	N/A		
Appendices:			

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

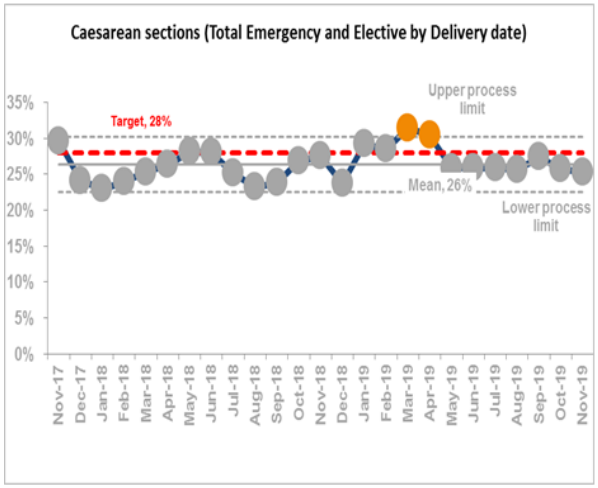
Integrated Quality and Performance Report

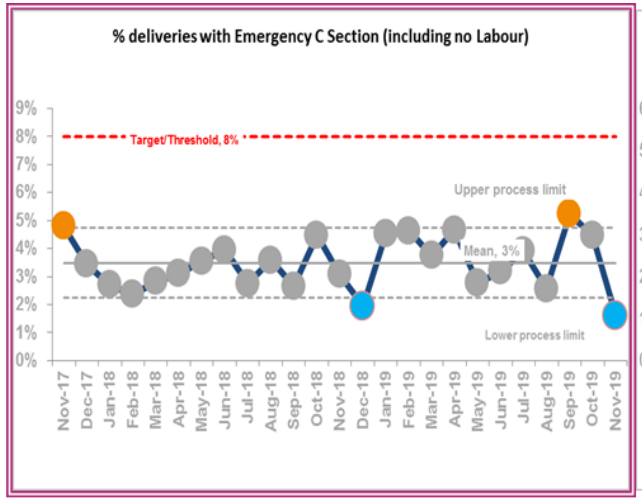
For Trust Board
Meeting Date – 19 December 2019
Reporting Period – November 2019

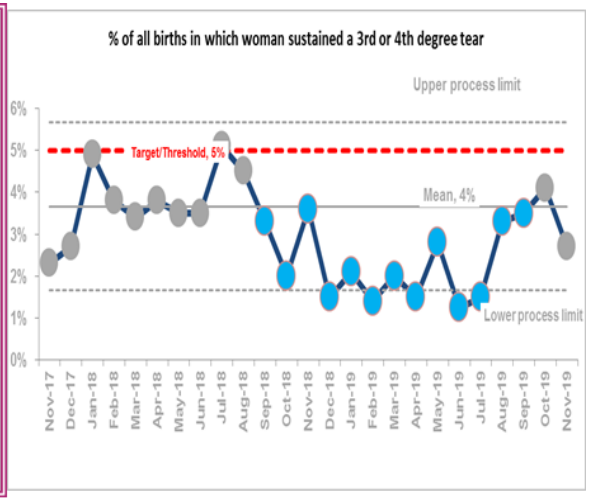
James Friend
Chief Transformation Officer

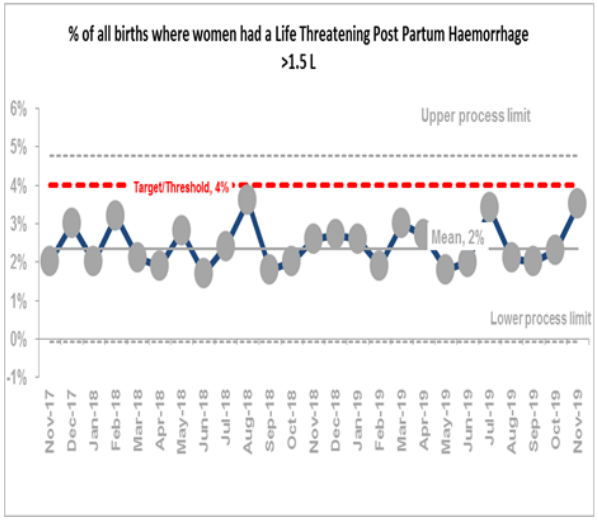
5 December 2019

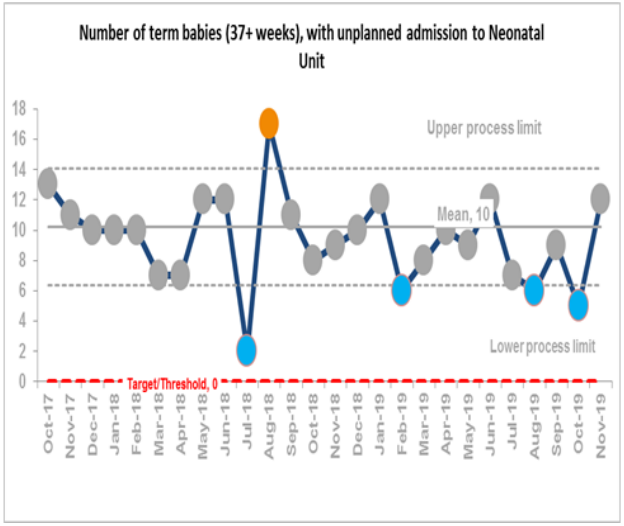
Maternity


Caesarean sections (Total Emergency and Elective by Delivery date)
Target, 28%
Upper process limit
Mean, 26%
Lower process limit

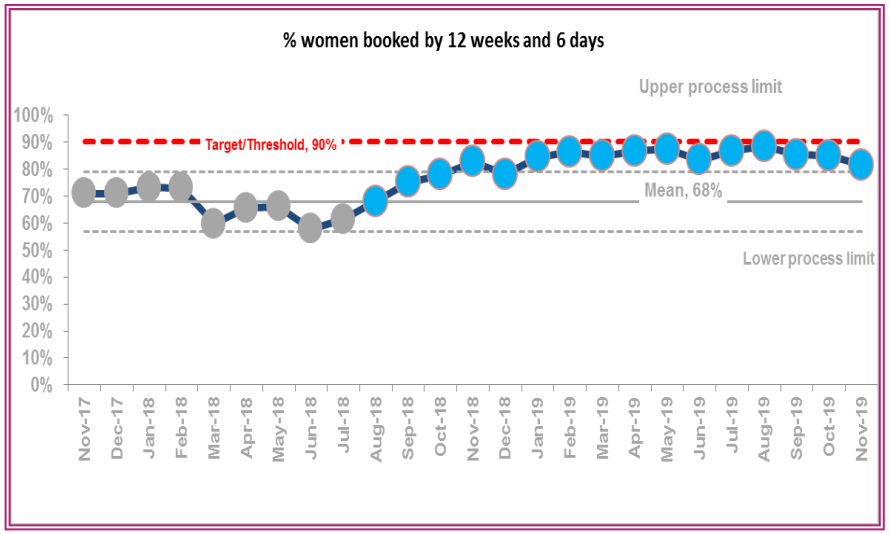

% deliveries with Emergency C Section (including no Labour)
Target/Threshold, 8%
Upper process limit
Mean, 3%
Lower process limit

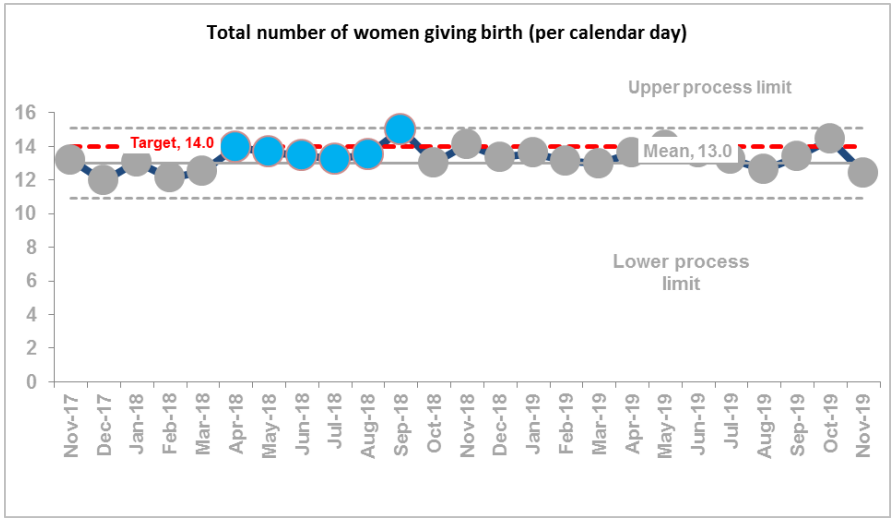

% of all births in which woman sustained a 3rd or 4th degree tear
Upper process limit
Target/Threshold, 5%
Mean, 4%
Lower process limit


% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L
Upper process limit
Target/Threshold, 4%
Mean, 2%
Lower process limit


Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit
Upper process limit
Mean, 10
Lower process limit
Target/Threshold, 0

Maternity





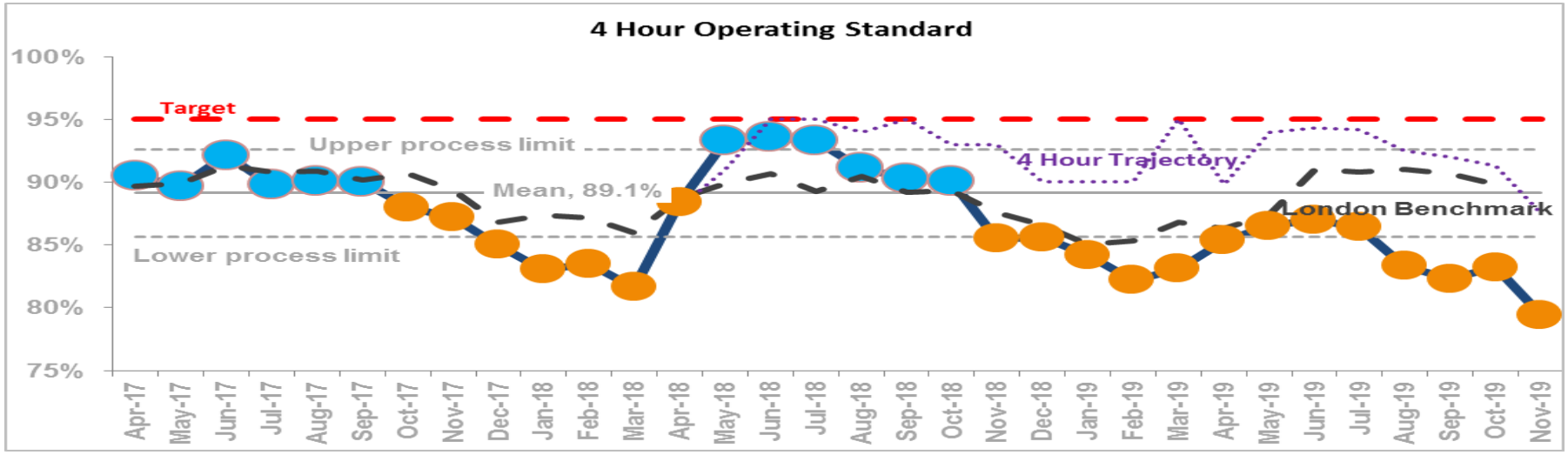
What the information tells us

- The birth rate dropped in November after a very busy month in October.
- The re-classification of data to ensure that we are correctly reporting ‘no-labour’ and ‘intrapartum’ emergencies correctly resulted in a further reduction in deliveries with Emergency C Section (including no Labour) with performance now below lower process limits.
- The percentage of women booked by 12 Weeks and 6 days continues to be below target.

Actions and Quality Improvement Projects

The antenatal clinic templates have been reviewed and the number of booking slots have been increased which should help to facilitate an improvement in the % of women booking within the first 10 weeks of pregnancy.

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 83.2% in October to 79.4% in November, with performance now significantly lower than the lower control limits.
- Performance remains below the monthly improvement trajectory of 87.5% for the month of November in order to achieve a year end position of 90%.
- Attendance numbers remain within the upper and lower control limits, the number of patients are comparable to the same period last year however above plan and shows variability on a daily basis.
- Both admitted and non-admitted performance continues to be below its lower process limit, falling significantly below performance for the same period last year.
- The AMU occupancy at midday is above the targeted 85% remaining above the mean and 9% higher than the same period last year.
- The Trust's general and acute bed occupancy continues to see an increase and remains above the mean nearing the upper control limit.
- The number of patients staying in a hospital bed greater than 7, 14 and 21 days all show special cause concern reporting above the upper control limits.
- Ambulance handover times remain below the lower control limit and are below the London average.
- Nine patients were reported as waiting in the emergency department for over twelve hours following a decision to admit.

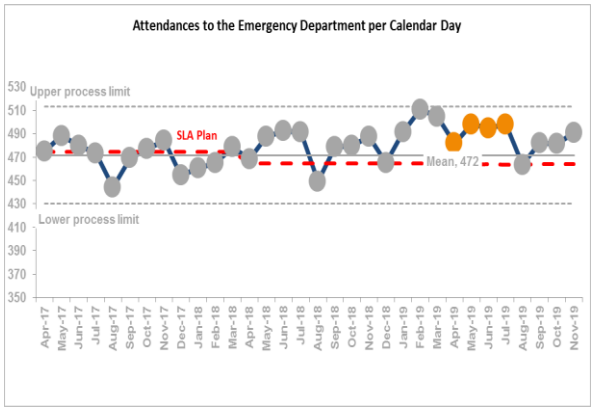
Actions and Quality Improvement Projects

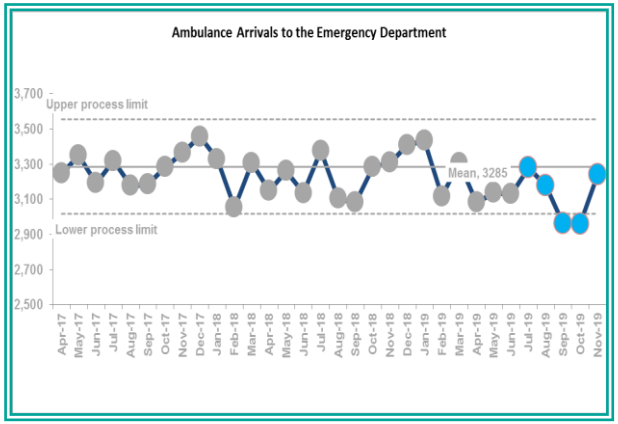
Specifically, in the last month we have undertaken the following to improve the emergency department (ED) Flow:

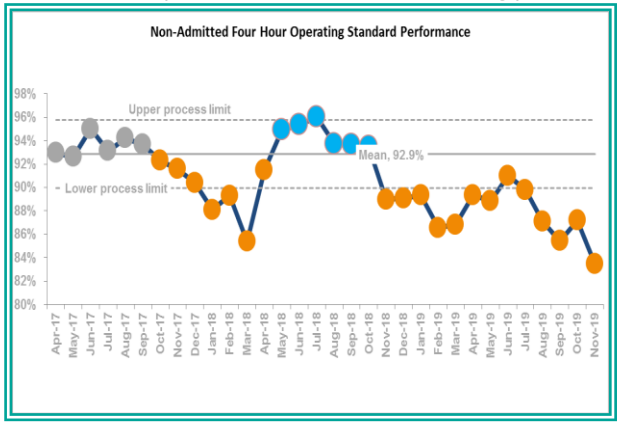
1. Implementation of Rapid Assessment Zone (RAZ). This is a team consisting of Consultant / Registrar, Nurse and Health Care Assistant located within the space formally used by CDU2 to provide earlier senior decision making within the patient journey
2. Trial of the ED capacity policy and associated action cards
3. Work with LAS & ECIST continues including the completion of time & motion study of ambulance handovers which will be used to redraft action plan and improvement trajectory
4. Review of the medical staffing models and rotas to include AHP's and PA's

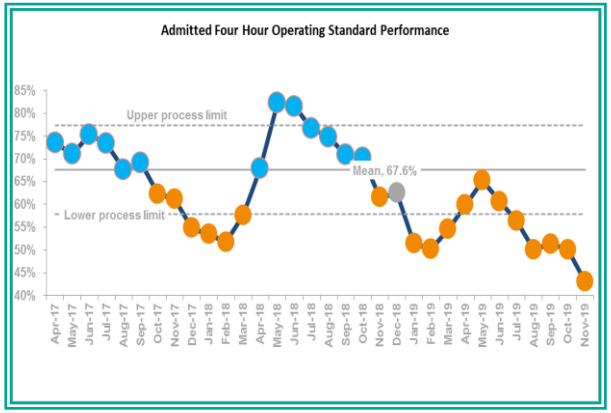
Emergency Flow

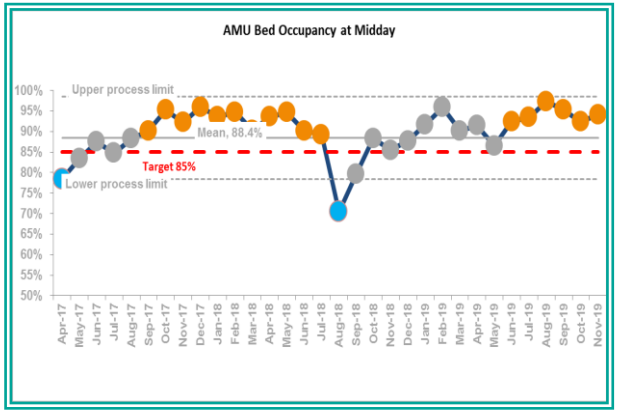
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

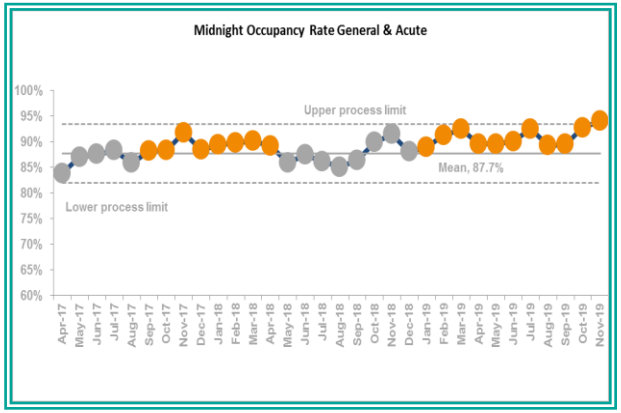


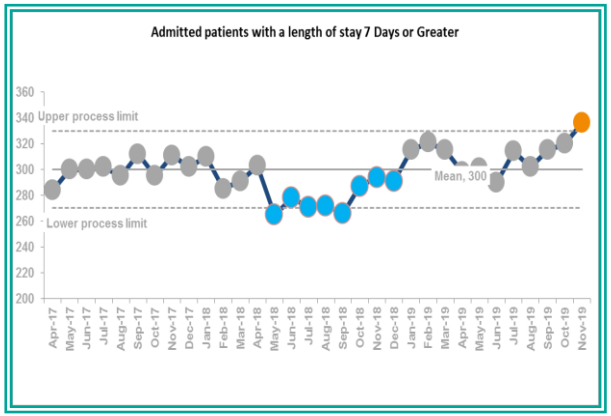


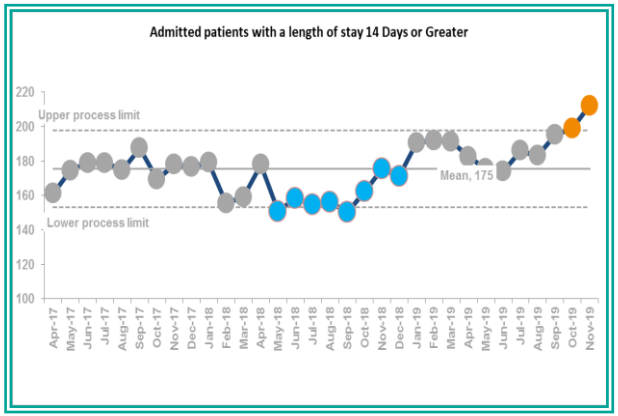


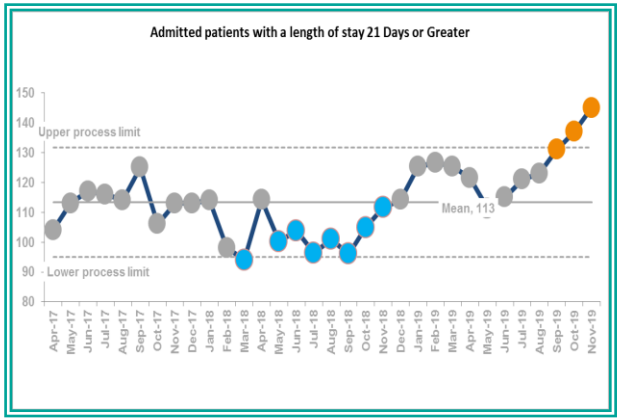




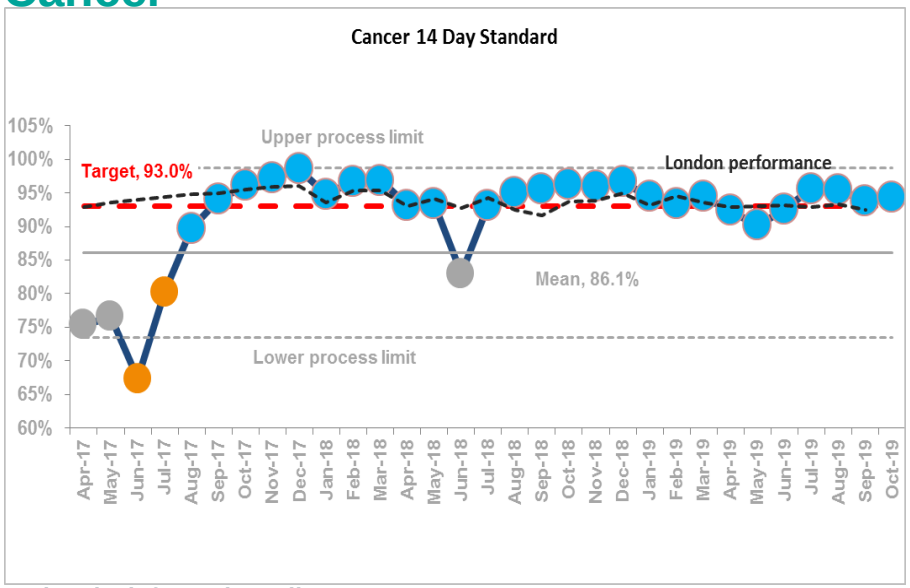


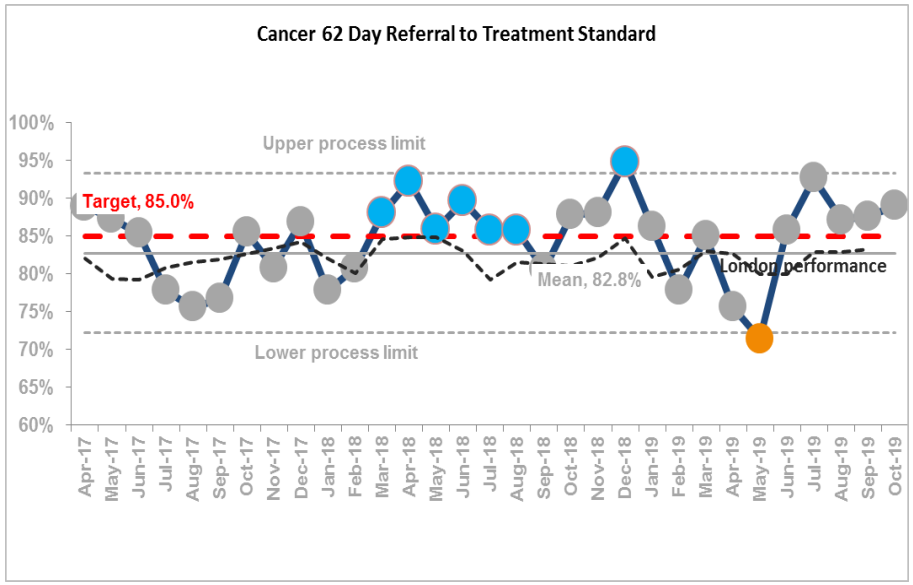






Cancer





What the information tells us

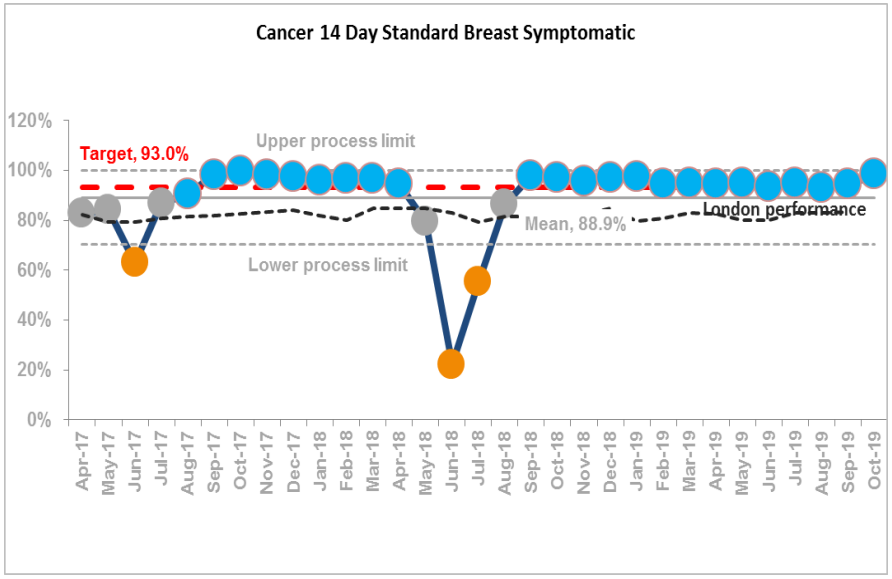
- The Trust has continued to achieve all seven cancer standards for the month of October, remaining compliant against the 14 Day Standard and 62 Day Standard.
- Within the 14 Day Standard, three tumour groups were non-compliant against the 93% national target, these were Lower GI, Upper GI and Urology overall Trust performance remains within the upper and lower control limits. Urology performance has fallen below the mean with recent improvement within Gynaecology has being maintained and Skin performance has returned to being compliant after falling below national target in September.
- Performance against 62 days from referral was 89% in the month of October 2019 against the target of 85% with four tumour groups non-compliant (Gynaecology, Head & Neck, Upper GI and Urology). All tumour groups remain within the upper and lower control limit with no special cause variation seen.

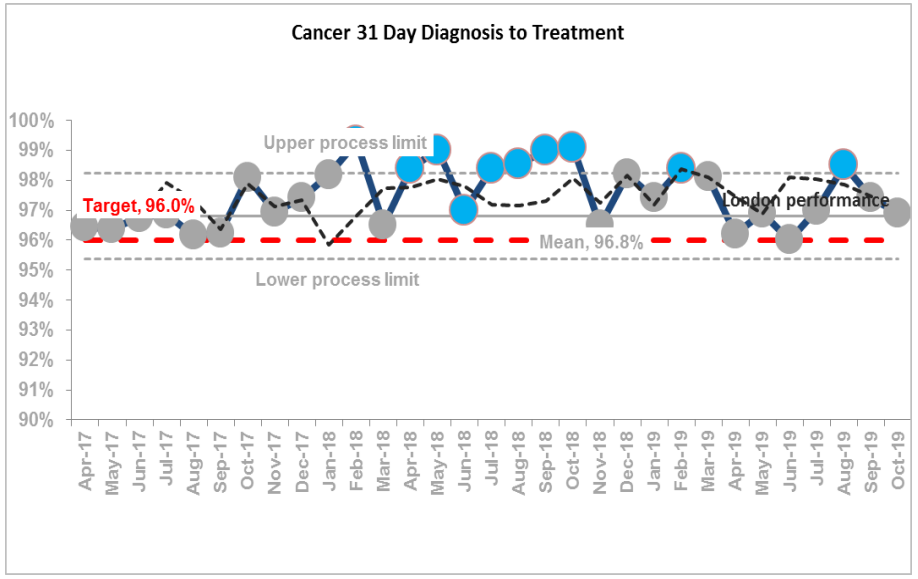
Actions and Quality Improvement Projects

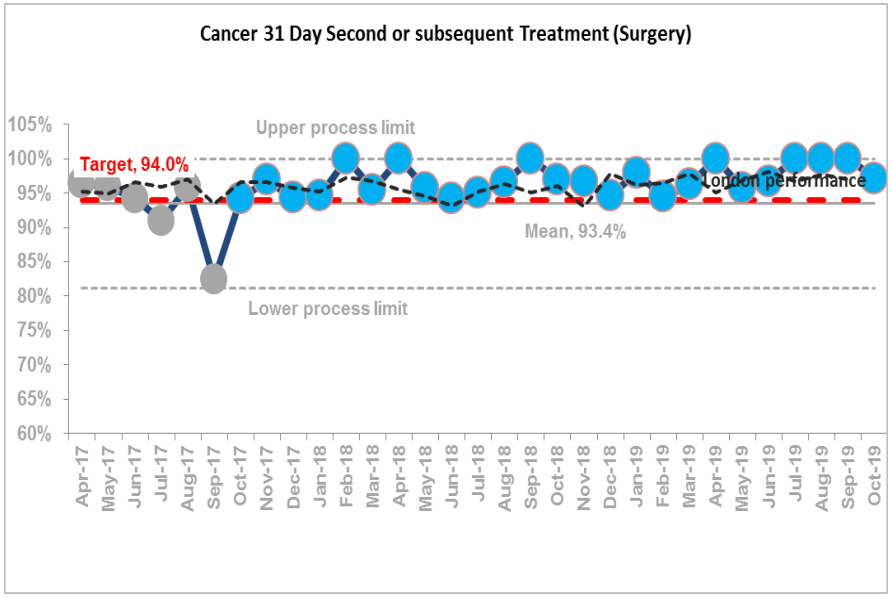
- TWR - Demand and capacity modelling continues with all services to ensure the right capacity is in place to meet the demand. Plans for services to review further demand and capacity planning to meet this requirement. The focus in November is on the ASI list due recent increase in total numbers due to ERS down time. Whilst this is moving back down, work is on going to bring all service to optimal capacity against demand.
- Continued targeted support to the colorectal pathway (Upper and Lower GI). Access to endoscopy continues to be a challenge in view of increasing referrals (5%) which is factored in endoscopy planning. The main focus will be to increasing direct to test slots to 70 to meet current demand and introducing virtual triage clinics for the UGI pathway. Additional work is being done to review and improve the colorectal pathway through joint work being done with RM partners.
- 62 day focus has been on service engagement, the development of the diagnostic dashboard to enhance and manage diagnostic capacity. Other projects have been developed with the view of automating internal processes such as reporting and management of breaches live.

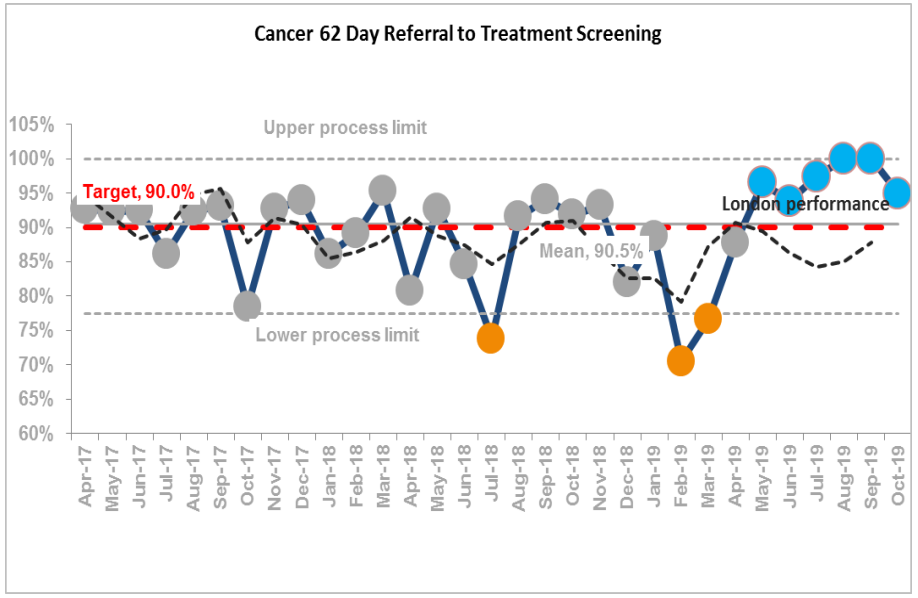
Cancer

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	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	No of Patients
Brain	93%	100.0%	-	100.0%	100.0%	100.0%	-	100.0%	-	100.0%	-	100.0%	100.0%	-	0
Breast	93%	99.4%	97.4%	98.8%	97.4%	98.6%	97.9%	99.5%	96.3%	96.9%	95.4%	94.9%	95.9%	100.0%	237
Children's	93%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	5
Gynaecology	93%	87.8%	87.5%	95.9%	69.5%	65.3%	80.0%	75.0%	59.3%	78.0%	95.5%	97.2%	95.4%	97.6%	126
Haematology	93%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	86.7%	95.2%	21
Head & Neck	93%	99.8%	98.1%	96.0%	98.5%	100.0%	99.3%	98.0%	97.8%	100.0%	98.9%	96.4%	96.6%	99.0%	203
Lower Gastrointestinal	93%	98.1%	95.8%	94.5%	97.2%	92.1%	94.5%	85.6%	91.1%	87.9%	93.7%	93.1%	92.8%	89.7%	292
Lung	93%	100.0%	100.0%	100.0%	93.3%	100.0%	96.9%	100.0%	95.6%	96.8%	95.7%	100.0%	97.1%	97.7%	44
Skin	93%	96.6%	97.4%	97.6%	97.1%	95.9%	97.6%	96.9%	95.5%	94.8%	96.0%	98.0%	91.8%	95.9%	412
Upper Gastrointestinal	93%	98.8%	95.4%	94.1%	91.8%	90.9%	83.5%	87.9%	70.2%	90.9%	95.1%	88.9%	87.2%	82.5%	120
Urology	93%	92.4%	93.4%	96.6%	94.5%	94.2%	92.2%	90.1%	95.4%	92.1%	93.8%	93.0%	97.0%	88.4%	138

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	No of Treatments
Brain	85%	-	100.0%	100.0%	-	-	-	-	-	-	-	-	-	-	0
Breast	85%	100.0%	100.0%	100.0%	100.0%	82.4%	90.9%	83.3%	80.0%	87.5%	73.3%	88.6%	100.0%	100.0%	18
Children's	85%	-	-	-	-	-	-	-	-	-	-	100.0%	-	-	0
Gynaecology	85%	90.0%	100.0%	83.3%	88.9%	50.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%	60.0%	5
Haematology	85%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	30.0%	33.3%	77.8%	100.0%	100.0%	100.0%	100.0%	2
Head & Neck	85%	100.0%	86.7%	87.5%	46.2%	85.7%	80.0%	77.8%	40.0%	28.6%	80.0%	80.0%	75.0%	76.5%	8.5
Lower Gastrointestinal	85%	88.9%	100.0%	100.0%	100.0%	81.8%	66.7%	41.7%	100.0%	69.2%	83.3%	63.6%	90.0%	100.0%	2.5
Lung	85%	50.0%	70.0%	72.7%	80.0%	75.0%	70.0%	71.4%	100.0%	100.0%	91.7%	89.5%	60.0%	100.0%	2.5
Skin	85%	92.3%	100.0%	100.0%	92.3%	100.0%	89.7%	100.0%	75.8%	95.7%	100.0%	100.0%	78.9%	100.0%	10
Upper Gastrointestinal	85%	54.5%	100.0%	100.0%	0.0%	50.0%	60.0%	100.0%	20.0%	75.0%	100.0%	53.8%	66.7%	80.0%	5
Urology	85%	88.9%	77.8%	95.0%	89.5%	71.1%	88.9%	83.0%	75.8%	93.9%	100.0%	94.4%	100.0%	83.8%	18.5
Other	85%	100.0%	100.0%	-	0.0%	-	100.0%	-	-	100.0%	-	-	-	100.0%	1

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%	86.1%	85.1%					
RTT Incomplete Trajectory		83%	84%	84%	84.3%	84.6%	84.9%	85.3%	85.5%	85.8%	86.1%	86.5%	86.8%	87.2%	87.7%	88.1%
RTT Total Incomplete Waiting Lize Size		40,016	40,037	39,674	41,013	42,671	41,658	41,259	41,945	47,714	49,495					
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	6,651	7,353					
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	6	1					
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%	65.9%	65.3%					
Total waits greater than 18 weeks - Admitted		1,563	1,563	1,428	1,511	1,459	1,494	1,523	1,655	1,643	1,686					
Total waits greater than 52 weeks - Admitted	0	62	63	18	7	8	4	1	2	4	0					
RTT Incomplete Performance -Non Admitted		87.7%	87.7%	88.5%	88.3%	88.8%	88.3%	88.5%	87.6%	88.3%	87.3%					
Total waits greater than 18 weeks - Non Admitted		4,358	4,366	4,087	4,301	4,258	4,326	4,216	4,650	5,008	5,667					
Total waits greater than 52 weeks - Non Admitted	0	56	53	9	15	8	3	4	4	2	1					

What the information tells us

- From September month end performance includes Queen Mary's Hospital (QMH) following the Patient Administration System (PAS) migration which happened weekend 13th and 14th September 2019.
- In October the Trust reported 85.1% performance, below the trajectory which was set at 86.1%.
- The Trust overall waiting list increased to 49,495 pathways. At the point the trajectory was set, the QMH waiting list was not included .
- The Trust reported one 52 week wait breach against a trajectory of zero.

Actions and Quality Improvement Projects

- Detailed review of all un-outcomed out patient appointments. Closely working with the outpatients department to ensure deadlines are aligned to ensure all RTT activity is accurately recorded ahead of submission for October performance. (October performance will be submitted on Tuesday 19th November 2019
- Review of all past and historic To Come In (TCI) dates to ensure accurate reporting.
- Weekly monitoring and action planning of all Data Quality (DQ) metrics which now include all QMH activity.
- On-going daily review of all long waiting patients weeks 28 and above for month end 52 week reporting. This highlights month end high risk patients October 2019 – April 2020.
- Improvements in the General Surgery results review process . Patients to be booked early into specific results review clinics following diagnostic testing under Gastroenterology. This cohort of patients represents the highest number of long waiting patients on the Trust Patient Tracking List (PTL).
- Daily reporting on patients waiting list over 18 weeks for first outpatient appointment.

Referral to Treatment

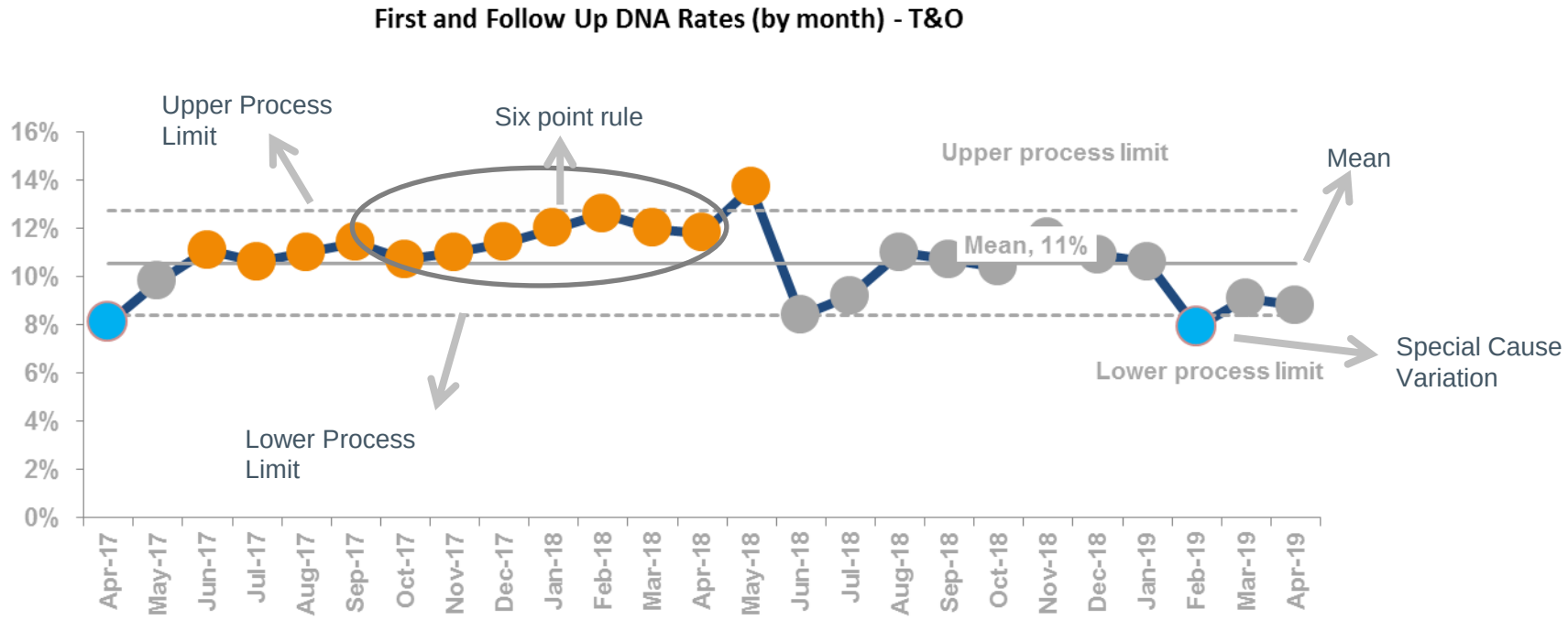
Specialty	Admitted		Non Admitted		Incomplete Pathway					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
General Surgery	246	50.8%	984	81.1%	923	307	1,230	75.0%	44	0
Urology	264	52.7%	1,571	92.7%	1,596	239	1,835	87.0%	5	0
Trauma & Orthopaedics	152	51.3%	2,354	86.0%	2,103	403	2,506	83.9%	0	0
Ear, Nose & Throat (ENT)	500	38.2%	2,649	86.1%	2,472	677	3,149	78.5%	14	0
Ophthalmology	0	-	435	94.9%	413	22	435	94.9%	0	0
Oral Surgery	6	33.3%	581	90.5%	528	59	587	89.9%	1	0
Neurosurgery	139	63.3%	2,135	81.7%	1,832	442	2,274	80.6%	17	0
Plastic Surgery	592	55.7%	1,007	87.6%	1,212	387	1,599	75.8%	18	1
Cardiothoracic Surgery	0	-	0	-	0	0	0		0	0
General Medicine	0	-	53	90.6%	48	5	53	90.6%	0	0
Gastroenterology	607	91.1%	2,409	88.3%	2,681	335	3,016	88.9%	7	0
Cardiology	882	73.4%	3,286	85.9%	3,470	698	4,168	83.3%	5	0
Dermatology	5	60.0%	3,637	89.6%	3,260	382	3,642	89.5%	3	0
Thoracic Medicine	12	100.0%	1,883	85.7%	1,626	269	1,895	85.8%	0	0
Neurology	29	86.2%	3,004	89.3%	2,708	325	3,033	89.3%	3	0
Rheumatology	0	-	1,153	83.7%	965	188	1,153	83.7%	1	0
Geriatric Medicine	0	-	115	97.4%	112	3	115	97.4%	0	0
Gynaecology	316	59.2%	2,591	91.0%	2,546	361	2,907	87.6%	11	0
Other (next slide)	1,103	71.4%	14,795	86.9%	13,647	2,251	15,898	85.8%	50	0
Total	**4,853**	**65.3%**	**44,642**	**87.3%**	**42,142**	**7,353**	**49,495**	**85.1%**	**179**	**1**

- 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 one 52 week breach patient reported was within Plastic Surgery. Trajectory was zero.

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

Maternity

Definitions	Format	Target	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Total number of women giving birth (per calendar day)	Number	14 per day	14.1	13.3	13.6	13.1	12.9	13.6	14.0	13.6	13.2	12.6	13.4	14.4	12.4
Caesarean sections (Total Emergency and Elective by Delivery date)	%	<28%	27.5%	23.7%	29.2%	28.5%	31.4%	30.4%	25.9%	25.9%	25.9%	25.6%	27.4%	25.7%	25.3%
% deliveries with Emergency C Section (including no Labour)	%	<8%	3.1%	1.9%	4.5%	4.6%	3.7%	4.7%	2.8%	3.2%	3.9%	2.6%	5.2%	4.5%	1.6%
% 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%	19.4%	
% of all births in which woman sustained a 3rd or 4th degree tear	%	<5%	3.6%	1.5%	2.1%	1.4%	2.0%	1.5%	2.8%	1.2%	1.5%	3.3%	3.5%	4.1%	2.7%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	%	<4%	2.6%	2.7%	2.6%	1.9%	3.0%	2.7%	1.8%	2.0%	3.4%	2.1%	2.0%	2.3%	3.5%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit	Number		9	10	12	6	8	10	9	12	7	6	9	5	12
Supernumerary Midwife in Labour Ward	%	>95%	98.3%	100.0%	98.4%	96.4%	95.2%	96.7%	98.4%	98.3%	100.0%	96.8%	96.7%	96.8%	96.7%
% women booked by 12 weeks and 6 days	%	90%	84.4%	86.2%	84.7%	86.6%	87.3%	83.3%	86.6%	88.4%	85.3%	84.9%	81.5%	81.7%	84.1%

Emergency Flow

Indicator Description	Target	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
4 Hour Operating Standard	95%	85.5%	85.6%	84.2%	82.2%	83.1%	85.4%	86.5%	87.0%	86.4%	83.3%	82.3%	83.2%	79.4%
Patients Waiting in ED for over 12 hours following DTA	0	1	2	0	0	1	1	0	1	2	3	1	4	9
Admitted patients with a length of stay 7 Days or Greater		294	291	315	321	315	298	301	290	314	302	315	320	336
Ambulance Handover - % under 15 minutes	100%	37.4%	37.0%	33.9%	33.0%	33.0%	35.1%	35.2%	36.0%	32.9%	32.4%	31.1%	31.3%	
Ambulance Handover - % under 15 minutes (London Average)	100%	46.5%	44.7%	41.6%	43.1%	45.4%	43.5%	44.4%	42.3%	43.9%	45.0%	44.7%	41.7%	
Ambulance Handover - number of patients not handed over within 30 minutes	0	138	135	145	87	94	76	112	119	134	171	163	176	
Ambulance Handover - % under 30 minutes	100%	93.0%	93.6%	92.3%	95.1%	93.6%	95.5%	94.3%	93.5%	92.9%	90.8%	90.8%	90.2%	
Ambulance Handover - % under 30 minutes (London Average)	100%	91.5%	90.5%	88.2%	90.3%	92.7%	91.7%	92.2%	90.6%	92.4%	92.3%	92.0%	89.6%	
Ambulance Handover - number over 60 minutes	0	3	1	13	6	8	6	0	4	2	1	4	11	

Cancer

Indicator Description	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	No of Patients
Cancer 14 Day Standard	93%	96.3%	95.9%	96.6%	94.4%	93.3%	94.4%	92.4%	90.2%	92.5%	95.6%	95.4%	93.8%	94.3%	1,598
Cancer 14 Day Standard Breast Symptomatic	93%	97.1%	95.4%	96.9%	97.4%	94.6%	94.7%	94.4%	94.9%	93.2%	94.9%	93.0%	94.3%	98.4%	244
Cancer 31 Day Diagnosis to Treatment	96%	99.1%	96.5%	98.2%	97.4%	98.4%	98.1%	96.2%	96.9%	96.0%	97.0%	98.5%	97.4%	96.9%	224
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	96.9%	96.6%	94.6%	97.9%	94.4%	96.2%	100.0%	95.7%	96.7%	100.0%	100.0%	100.0%	97.1%	34
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	107
Cancer 62 Day Referral to Treatment Standard	85%	87.8%	88.1%	94.8%	86.2%	77.8%	85.0%	75.6%	71.4%	85.8%	92.7%	87.1%	87.6%	89.0%	73
Cancer 62 Day Referral to Treatment Screening	90%	91.8%	93.2%	82.0%	88.7%	70.5%	76.6%	87.7%	96.5%	93.8%	97.4%	100.0%	100.0%	94.9%	19.5

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St George's University Hospitals NHS Foundation Trust

2.3

Meeting Title:	Trust Board		
Date:	19 December 2019	**Agenda No**	2.3
Report Title:	Emergency Care Update		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Lisa Foweather, General Manager, Emergency Department		
Presented for:	Assure		
Executive Summary:	The Trust continues to experience significant pressure in its performance against the emergency care four hour standard in November (the reporting month for this meeting) and into December to date. Of note is that the Trust continues to report an 8% gap between its November performance trajectory of 87.50% and its delivered performance of 79.44%. This paper provides an update to TEC and then to FIC on specific actions that the Trust's internal Emergency Care Delivery Board (ECDB) is doing right now to try and improve performance against the National Emergency Performance targets. This paper focuses on key, priority actions that support emergency care flow in the short term and follows on from the Trust Board discussion in November.		
Recommendation:	The Board is asked to note this report and the priority actions of the Emergency Care Delivery Board to deliver the Trust's four hour internal trajectory for December 2019.		
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:	Finance and Investment Committee	**Date**	12.12.19
Appendices:	N/A		

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2.3

Emergency Care Update

1.0 PURPOSE

1.1 This paper provides an update to TEC and then onto FIC on specific actions that the Trust's internal Emergency Care Delivery Board (ECDB) is doing right now to try and improve performance against the National Emergency Performance target.

2.0 CONTEXT

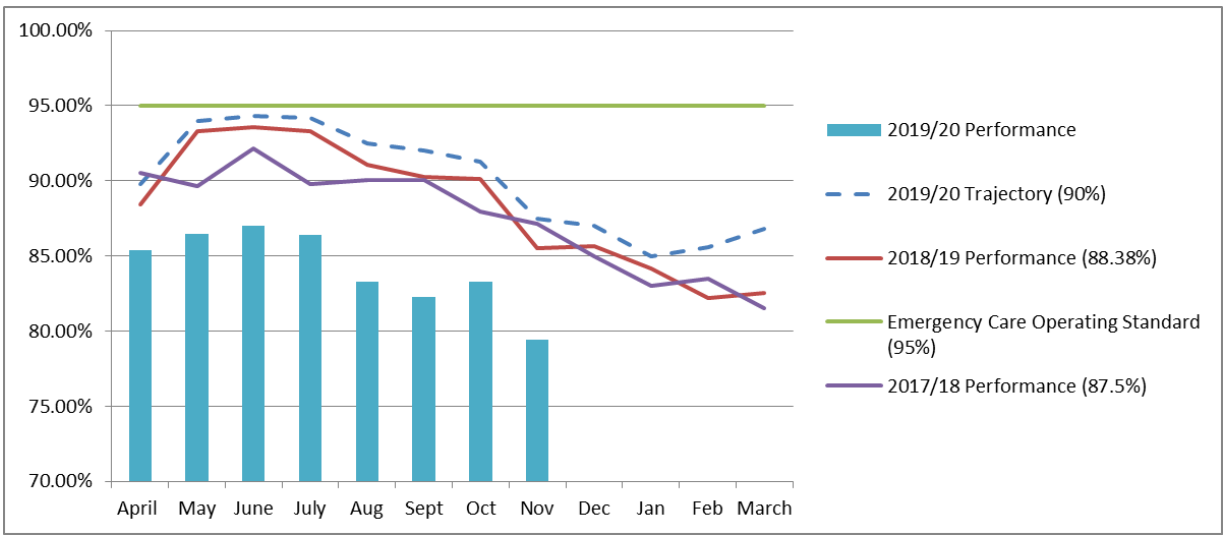
2.1 The Trust continues to experience significant pressure in its performance against the emergency care four hour standard in November (the reporting month for this meeting) and into December to date. Of note is that the Trust continues to report an 8% gap between its November performance trajectory of 87.50% and its delivered performance of 79.44%.

2.2 Performance for 2019/20 year to date is at 83.98% (as of the 13th December 2019). For the month of November 2019 there was a decline of 5% in the admitted performance and >1% in the non-admitted performance

- Admitted performance is running at circa 52%, in comparison to circa 57% at the end of October 2019. The trust trajectory for the year is 80%
- Non-admitted performance is running at circa 87% against the Trust trajectory (and national requirement) of 98% year to date.

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

Fig 1. Emergency Care Performance against Trust Trajectory for the Four Hour Emergency Care Standard 2019/20.



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%	83.25%	79.44%				
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%	50.48%	43.13%				
Non-Admitted Performance	88.98%	88.51%	90.71%	89.50%	87.08%	85.43%	86.94%	83.50%				
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%

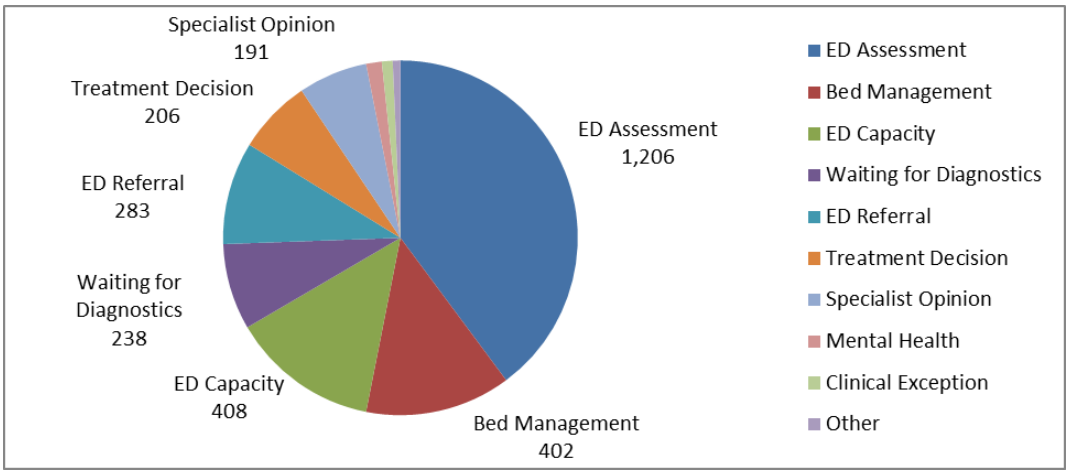
3.0 ACTIONS

3.1 The first objective is to close the gap on current levels of four hour operating performance versus the agreed Trust trajectory. For December 2019 this equates to a 7.56% improvement in performance (working on the current baseline of 79.44%) to a figure of 87%.

3.2 In order to understand the requirement and provide targeted actions to deliver the necessary improvement in performance, the chart below outlines the breach reason categories. The top 3 breach reasons are:

- ED Assessment (39.83%)
- Bed Management (13.28%)
- ED Capacity (13.47%)

Fig 2. November 2019 Breach Analysis



Breach reason	No.	%
ED Assessment	1,206	39.83%
Bed Management	402	13.28%
ED Capacity	408	13.47%
Waiting for Diagnostics	238	7.86%
ED Referral	283	9.35%
Treatment Decision	206	6.80%
Specialist Opinion	191	6.31%
Mental Health	43	1.42%
Clinical Exception	30	0.99%
Other	21	0.69%
Total	3,028	100.00%

3.3 To achieve the 7.56% improvement in performance in December 2019 there is a requirement to reduce the number of breaches against the projected number of ED attendances by circa 1135 to a total of 1893.

3.4 The overview of priority, targeted actions from the work of the weekly St George's ECDB to deliver this improvement in the Trust trajectory are listed below. This is not the exhaustive list of the work underway – it is written to draw the TEC and FIC's attention to the key actions only that can make an impact in the short term. Where appropriate, please also note that each action is consistent with the highest priority recommendations from the recent ECIST.

- **Emergency Care Processes**

  Objective: At this stage in the December month, the Trust needs to target a 6% improvement in its emergency care processes to reduce the ED assessment and ED capacity breaches. Actions underway (two high impact change examples only):

  1. Rapid Assessment Zone (RAZ). Start date of Monday 2nd December 2019
     The RAZ assessment team consist of a doctor, nurse and MA who operate from the previous CDU 2 area. (The displaced patients from CDU2 have been moved to a seated area within CDU) The aims of RAZ are:
     a) Identify patients that are appropriate for an ambulatory (non-admitted) pathway and those that are better suited for majors due to complexity of likelihood of admission
     b) Provide early assessment by a senior clinician
     c) Instigate early investigations and treatment
     d) Provide an opportunity for early discharge and early referrals where appropriate
     e) Maintain a sustainable working environment for the RAZ team and patient dignity
     f) Operate flexibly depending on staffing skill mix and occupancy

  This RAZ model was deployed within 4 days of permission to proceed from the ECDB. From the week commencing 9th December, the ECDB will assess its impact on non-admitted performance in particular through the ED department. The Chief Operating Officer will provide a verbal update against this objective at both TEC and FIC on the 11th and 12th December as it will effectively be the mid-point in the month.

2. Reducing Crowding in ED
   The Emergency Department Capacity Policy provides escalation measures to deal with surges in demand. The capacity plan provides supportive interventions to respond and recover from any surge activity, overcrossing to ensure patients safety and responsiveness. The plan identifies:
   a) The internal ED escalation states (Green, Amber, Red and Black) and how these contribute to the organisational OPEL status
   b) The threshold triggers for moving from one escalation level to another
   c) Action cards, for key individuals across the organisation to follow which detail what needs to be done, by whom and in what time frame, to address the situation.

Impact assessment will be measured in the week commencing the 9th December through the ECDB and the Chief Operating Officer will provide a verbal update against this objective at both TEC and FIC on the 11th and 12th December as it will effectively be the mid-point in the month.

- **Bed Management**

  Objective: Target of 1.56% improvement in the December 2019 Four Hour Operating Performance standard through the implementation of the Medicine and Cardiovascular Divisional Processes.

1. Medicine and Cardiovascular Divisional Processes
   When Opel3 is declared by GOLD or if the pressure is heightened within the division to prevent the organisation stepping into a higher OPEL status Silver Divisional Lead for the day will enact the 'Huddle' process
   a) Senior Managers will act as a Ward Liaison Manager
      a. Working with the Nurse In Charge to assist with any flow, diagnostic and discharge issues that the teams cannot push through
      b. Attend Board review meetings
      c. Attend Hub meetings as directed in the DDO's office to discuss/escalate issues with DDO and DDNG
   b) Confirm all patients have been seen by a consultant and have a documented clear management plan
   c) Confirm ward is working to a SAFER model and all 'red day' patients have plans
   d) Confirm pre 11am discharges for the today and the next day.

   The overall Trust objective is to reduce the number of patients over 21 days length of stay to 100 (from a current baseline of circa 140) in December.

4.0 IMPLICATIONS

Risks

4.1 Performance against the Four Hour Operating standard is an established Trust risk.

Legal Regulatory

4.2 NHS constitutional standard.

Resources

4.3 N/A

Equality & Diversity

4.4 N/A

5.0 NEXT STEPS

5.1 The Trust Executive and Finance and Investment Committee to receive a report on progress with each of the ECIST recommendations in Q.4 2019/20.

6.0 RECOMMENDATION

6.1 To note this report and the priority actions of the ECDB to deliver the Trust's four hour internal trajectory for December 2019.

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2.4

Meeting Title:	Trust Board		
Date:	19 December 2019	**Agenda No**	**2.4**
Report Title:	Cardiac Surgery Service; Safety and governance overview		
Lead Director/ Manager:	Richard Jennings, Chief Medical Officer		
Report Author:	Steve Livesey, Care Group Lead/Associate Medical Director – Cardiac Surgery Mark O'Donnell, Lead Cardiac Nurse – Governance & Mortality – Cardiac Surgery Kelly Davies, Head of Nursing - Cardiac, Vascular and Thoracic Surgery & Cardiology Clinical Academic Group		
Presented for:	Assurance		
Executive Summary:	This paper provides a comprehensive overview of the actions taken by the Trust to improve the safety, governance and culture of the cardiac surgery service, following the mortality alerts issued by NICOR in May 2017 and April 2018. It focuses in particular on the actions taken by the Trust over the last twelve months in cardiac surgery since the receipt of the CQC report and since the Trust appointed an external Care Group Lead / Associate Medical Director for the cardiac surgery service.		
Recommendation:	The Trust Board is asked to note the report and take assurance from the overview provided in this paper of the safety of the service and the progress achieved in strengthening the safety, governance and culture in cardiac surgery.		
Supports			
Trust Strategic Objective:	• Treat the patient, treat the person • Right care, right place, right time • Champion Team St George's		
CQC Theme:	• Safe, Well led		
Single Oversight Framework Theme:	• Quality of Care, Leadership and Improvement Capability		
Implications			
Risk:	As set out in the paper.		
Legal/Regulatory:	The paper details the Trust's engagement with regulators on this issue.		
Resources:	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**	11/12/19 12/12/19
Appendices:	None		

CARDIAC SURGERY SERVICE UPDATE

1.0 PURPOSE

1.1 This paper provides a comprehensive overview of the actions taken by the Trust to improve the safety, governance and culture of the cardiac surgery service, following the mortality alerts issued by NICOR in May 2017 and April 2018, the findings of the independent review by Professor Mike Bewick in July 2018, and the outcomes of the CQC inspection published in December 2018. It focuses in particular on the actions taken by the Trust over the last twelve months in cardiac surgery since the receipt of the CQC report and since the Trust appointed a new external leader for the cardiac surgery service.

2.0 BACKGROUND

2.1 In May 2017, the National Institute for Cardiovascular Outcomes Research (NICOR) issued an alert to St George's highlighting that the mortality rate for patients who had undergone cardiac surgery at the Trust between April 2013 and March 2016 was higher than expected. Of 2,505 cases in the period between 1 April 2013 and 31 March 2016, the risk-adjusted survival rate for cardiac surgery patients at St George's was 96.8% compared with a predicted survival rate of 98.3%. A NICOR alert is defined by the Society of Cardiothoracic Surgeons of Great Britain and Ireland as "*an early warning system to allow hospitals to review outcomes for their patients and if necessary take steps to correct any deterioration in the performance of the service*". A NICOR alert is triggered when a unit's mortality exceeds the national mean by 2 Standard Deviations (SDs) or more. A NICOR 'alert' differs from a NICOR 'alarm', which is a sign of definitive concern. A NICOR alarm is triggered when a unit's mortality exceeds the national mean by 3SDs or more. This Trust has never had a NICOR alarm for cardiac surgery. A second NICOR alert was issued to St George's in April 2018 covering the period 1 April 2014 to 31 March 2017.

2.2 Following receipt of the first NICOR alert in May 2017, the Trust established a cardiac surgery task force chaired by the Acting Medical Director and Chief Nurse, the purpose of which was to address the concerns that had arisen, monitor and improve the safety of the service, and provide assurance to the Trust's Quality and Safety Committee and Board of Directors. Meeting weekly, the task force focused on making improvements to the governance and operations of the service, team working and culture, training and education, and the development of plans for conducting an independent external review of the service. During 2017, the Board's Quality and Safety Committee and the Trust Executive closely scrutinised the safety of the service and the factors that had led to the NICOR alert. This included reviewing the NICOR outcomes, an internal review of mortality during the period of the NICOR alert, benchmarking against other Trusts, and triangulation of a wide range of quality and safety metrics relating to the service, including serious incidents, inflection control, hand hygiene, complaints and referral-to-treatment time data. To address concerns about poor behaviours within the service and the culture of the unit, the Trust arranged external mediation to improve team dynamics.

2.3 In order to provide assurance that the steps being taken by the Trust were delivering the necessary improvements to the safety of the service with the necessary pace, in May 2018 the Trust commissioned Professor Mike Bewick, former Deputy Medical Director at NHS England, to undertake an independent review of the cardiac surgery service. Professor Bewick's independent report was received by the Trust in July 2018. It highlighted areas where the Trust had made progress and identified further actions that were needed to improve the service. The Board accepted Professor Bewick's recommendations in full and put in place a clear set of actions to deliver them.

2.4 To support it in this, in August 2018 the Trust sought support from its regulator, NHS Improvement, to oversee the work it was doing to improve the service. Alongside this, in September 2018 the Trust decided to temporarily transfer the operations of a small number of patients requiring the most

complex cardiac surgery to other London Trusts in order to give the cardiac surgery service the space to make the necessary improvements.

2.5 In the weeks and months following Bewick report, the Trust made a series of fundamental changes to the leadership and governance of the service. This included the appointment of Mr Steven Livesey (an experienced internationally respected cardiac surgery from outside the Trust) as the new Care Group Lead/Associate Medical Director for Cardiac Surgery in December 2018. Having joined on a fixed-term basis, Mr Livesey has since been appointed substantively. Governance within the service has been significantly enhanced, with the introduction of a new system to capture clinical information and outcomes relating to cardiac surgery mortality, and the implementation of a range of standard operating procedures to enhance safety within the service. These have included the introduction of a new 'consultant of the week' model, and fundamental changes to the mortality and morbidity meetings and multi-disciplinary team meetings. All deaths following cardiac surgery are routinely reviewed by a serious incident panel with independent external input. Outcome data is reviewed at a weekly meeting chaired by Mr Livesey, and every patient requiring cardiac surgery is discussed at an MDT. To provide further assurance on the safety of the service, the Chief Medical Officer and Chief Nurse continue to review a regular dashboard of safety, quality and performance and metrics to ensure Board-level oversight of the safety and operation of the service.

2.6 Throughout the period since the receipt of the first NICOR alert in May 2017, the Board and the Executive Team have closely scrutinised the safety and performance of the cardiac surgery service, and the improvements being implemented to address the mortality concerns highlighted through the NICOR alert and the wider governance and cultural issues identified by Professor Bewick and the CQC in December 2018 following its inspection of the service in August and September that year. The Board, the Quality and Safety Committee and the Trust Executive Committee have received regular reports on the service, including monthly reports since the completion of the independent Bewick report. Improvements continue to be made to the service and, at this time, the temporary changes to the service introduced in September 2018 remain in place. The Board reviewed the progress of actions arising from the Bewick Report recommendations in detail in November 2019.

3.0 UPDATE ON PATIENT SAFETY INDICATORS

This section of this paper provides an overview of the different sources of assurance concerning the safety and quality of the cardiac surgery service at St George's. This assurance comprises external assurances (for instance, from National Institute for Cardiovascular Outcomes Research) and the Care Quality Commission (CQC), and internal assurance provided through the Trust's own internal safety governance mechanisms. This paper includes an overview of the outcomes of cardiac surgery over the past twelve months, including post-operative survival, post-operative deaths, complications, safety incidents, complaints and inquests.

3.1 External assurance; Update from NICOR

In the public Trust Board paper in October 2019 it was reported that the Society for Cardiothoracic Surgery (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.

The information on the SCTS website confirms that the mortality for the period April 2015 to March 2018 is within *3* standard deviations of the national mean, but independent confirmation has also been obtained from SCTS that the mortality for this period is within *2* standard deviations from the mean, and that the Trust is therefore no longer 'in alert'.

3.2 External assurance; CQC

December 2018 CQC report: As noted in the previous report to Quality and Safety Committee in November 2019, 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**.** The report also identified a number of areas where the Trust needed to take action to improve the service and over the past year, substantial work has been undertaken to address each of the "must do" and "should do" actions identified by the CQC in December 2018 and these are set out in Section 4.0 below.

December 2019 CQC report: The CQC carried out an inspection of core services of the Trust between July and September 2019 and this inspection included cardiac surgery. The CQC's report, published on 18 December 2019, recognises the improvements that have been made to the service. Among its observations, the CQC concludes that "on this inspection, we found there had been significant improvements to the leadership of the service". The CQC observes that "the service had improved learning from incidents" and had made further improvements in governance, particularly in relation to mortality and morbidity meetings. It also finds that "following several years of cultural challenges in cardiac surgery, we noted that the situation was much improved" and that "there was a strong clinical governance lead, who was making a positive difference". It reports that the Trust had "taken action to improve all aspects of the leadership and culture of the cardiac surgery service". In addition, it observes that "the Trust provided us [CQC] with evidence to demonstrate the actions taken and planned as a result of previous reviews and the on-going review". The report notes that "staff commented that leaders had grasped difficult issues and demonstrated commitment to dealing with the root cause of the problems" and that "service leaders told us [CQC] that they had received strong support from the executive team to resolve the issues in cardiac surgery". The CQC concludes that "the senior management team had worked consistently in collaboration with external partners to address the on-going concerns of safety, culture and leadership within the service, and we saw evidence of this through our engagement with the Trust" and that "overall, this meant that we are now assured that there was credible and effective leadership in the cardiac surgery service".

3.3 Internal assurance; cardiac surgery monthly dashboard summary

Key patient safety metrics are reported on the cardiac surgery monthly dashboard and reviewed within the department and at the Cardiac Surgery Steering Group, which is chaired by the Chief Medical Officer and meets monthly. 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. It is worth noting that the CQC's inspection report of 18 December 2019 finds concludes that the cardiac surgery weekly dashboard "provided a comprehensive view of quality and safety in the specialty". The sections below set out how the Board can take assurance from the metrics considered on the cardiac surgery dashboard.

3.4 Post-operative survival and post-operative deaths

The unadjusted mortality rate following cardiac surgery in calendar year 2019 was 2.5%. NICOR excludes some cases from its analysis (for example, high risk emergencies and some rarer cases which are difficult to assign an accurate risk to) and so the mortality noted by NICOR will be lower after their analysis, and the Trust's internal monitoring shows the unit to be in the "as expected" range. In accordance with the Trust's Standard Operating Procedure for post-operative deaths in cardiac surgery all of these deaths are being 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.

3.5 Complications

The individual cardiac surgery dashboards and dashboard reports are not replicated in this paper because they contain patient level detail that could make individual patients identifiable. For this reason, the cumulative data for the most recent calendar year is shown instead. The last time that cardiac surgery post-operative complication rates were published nationally was 2008 (see section

14, references, 3rd reference). Table 1 below shows the complication rate in the Trust's cardiac surgery service for the period January – November 2019, and where this is relevant, this data is presented alongside the national rates in 2008.

Table 1: Complication rates in cardiac surgery January – November 2019

	SGUH (January 2019 – November 2019)	UK 2008
Post-operative stroke	1.5%	1%
Post-operative renal failure dialysis or filtration	2.3%	3.6%
Deep sternal wound infection	0.0%	0.5%
Resternotomy for bleeding	3.9%	3.4%
MRSA	0.0%	n/a
C *Difficile*	0.6%	n/a
Pressure ulcers grade 3	0.0%	n/a
Pressure ulcers grade 4	0.0%	n/a
Nursing alerts	0.9%	n/a
Complaints	2.3%	n/a

3.6 Learning from cardiac surgery serious incident (SI) and adverse incident (AI) investigations

From January – November 2019 inclusive there have been four Serious Incident (SI) declarations and two Adverse Incidents (AI) investigations, all of which were fully investigated. In each case, the investigations provided learning and led to specific recommendations and agreed actions. In its report on its inspection of the Trust's core services, the CQC report of December 2019 found that the Trust had taken action to strengthen its processes for learning from incidents. It commented that leaders and staff had told the CQC that they were reporting incidents more frequently and that staff described M&M meetings as "structured, open and well attended, and they included constructive debate on improving issues or outliers".

This paper does not attempt to summarise the learning or the changes arising from each of these investigations, but two examples are provided below to illustrate the process of learning and change that has taken place.

In the first example, an investigation recommended that the cardiac surgery service should ensure there is clear identification of who the consultant responsible is for any particular inpatient at any particular time, together with an agreement of who will present this patient at the MDT. In response to this recommendation, an action was taken to ensure that all inter-hospital transfers awaiting surgery are now under the cardiac surgery care group Consultant of the Week. This has removed any potential ambiguity on this important issue.

In the second example, an investigation recommended that the cardiac surgery service should establish a clear process and venue for daily TOE guided cardioversion, documented in a Standard Operating Procedure (SOP) for cardiology and cardiac surgery. In response, an action was taken to ensure that when a TOE guided cardioversion is required, the on-call non-interventional cardiologist will be contacted and this will be arranged in a timely manner.

3.7 Complaints

Since January 2019 there have been a total of 12 complaints received by the cardiac surgery care group, with no new complaints received by the service since August 2019. There has been 1 complaint that has been reopened and resolution for this complaint is underway. To date no complaints have been taken forward to the complaint ombudsman.

A theme in complaints was communication. The introduction of Consultant of the Week and twice daily Consultant led ward rounds have supported the delivery of this significant improvements in communications with patients and their families throughout their time at the Trust.

3.8 Inquests

There have been three cardiac surgery related inquests in the calendar year 2019. The outcomes for each were:

1 Complications of essential surgical treatment in combination with natural disease.
2 Recognised complications of essential surgical treatment
3 Natural Causes

We have not had a Prevention of Future Deaths Report (Coroner's Regulation 28 Reports) in relation to cardiac surgery inquests.

4.0 The Trust response to the CQC inspection in August 2018

The CQC undertook a focused inspection of the cardiac surgery unit on 23 August, 13 and 14 September 2018. The purpose of the inspection was to follow up on concerns from the Bewick Report.

The published report included areas for improvement split into action that the Trust 'must take' and action that the Trust 'should take'; these are outlined in the table below.

Action the hospital MUST take to improve	**Action the hospital SHOULD take to improve**
Review and improve governance systems and processes for the unit.	Review the multiple patient record systems in use, because there was a risk of information not being accessible or not being handed over adequately.
Review the quality of mortality and morbidity meetings and include evidence of learning and how this is shared.	Ensure all medical staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally, where appropriate.
Improve learning from incidents, mortality and morbidity amongst consultants.	Ensure all staff understand and apply the Duty of candour procedure, when it is clearly indicated.
Resolve issues relating to leadership structure and cohesion to support the service to change and improve.	Support staff working in the unit, to improve morale and well-being.
Address cultural issues within the service, to improve multi-disciplinary working and effective governance systems.	

Actions taken to improve the governance systems and processes for the Cardiac Surgery Unit;

- A new Care Group Lead/Associate Medical Director (AMD) for Cardiac Surgery was recruited to lead the service and appointed to the role of Care Group Lead (lead cardiac surgeon).

- From January 2019 the AMD/Care Group Lead has chaired monthly Care Group Meetings, with a clear agenda, minutes and rolling action log, where formal internal governance of the service is undertaken.
- In November 2019 the service appointed a permanent, dedicated Service Manager (a post previously shared with thoracic surgery), to administer the day to day governance and operational running of the service.
- Clinical governance of surgical activity has been strengthened through the introduction of new clinical audit software (Dendrite) which was implemented on 28 November 2018. This is used to provide outcome data on the activity taken by the unit as a whole as well as by individual surgeons. This outcome data is now openly shared and discussed among the cardiac surgeons under the chairmanship of the Care Group Lead/Associate Medical Director, who facilitates a safe learning environment for this data to be constructively learned from.
- From September 2018 there has been a daily cardiac multi-disciplinary team meeting (MDT), which is central to the good governance of clinical decision-making.
- From October 2018 a Consultant of the Week model was introduced to improve the quality and consistency of care for ward inpatients. This provides a clinical continuity for these patients which are an important and recognised component of patient safety.
- From September 2018 the service has produced a daily monitoring dashboard, which details all activity and quality information including the number of procedures undertaken, clinical incidents, deaths, RTT position and quality data including FFT reports. The monitoring dashboard is sent to all clinical and operational leads for the service on a daily basis. A summation of governance information is provided to the monthly Mortality and Morbidity meeting, the Care Group meeting and to the Cardiac Surgery Steering Group. Any deviation from expected norms is addressed by the Care Group Lead/Associate Medical Director in the first instance through normal governance processes.
- Standard Operating Procedures within the Cardiac Surgery care group have been developed, approved and ratified for all operational and governance aspects of the service.
- All the changes described above have been overseen by a dedicated steering group, chaired by the Trust's Medical Director/Chief Medical Officer, which has met on a fortnightly basis to oversee progress and review evidence. The steering group has clear terms of reference, and reports into the Board's Quality and Safety Committee.
- Any significant safety concerns about individual consultant performance are escalated to the Chief Medical Officer (CMO).

Actions taken to improve the quality of mortality and morbidity meetings, and the identifying and sharing of learning from M&M meetings;

In addition to actions already described, the following have also been completed:

- From January 2019 the Cardiac Surgery Care group has identified and disseminated a "Lesson of the Month", which is taken from the most important learning derived from any incidents or complications or patient complaints or feedback.
- The Care Group Lead/Associate Medical Director ensures that learning points relevant to individual surgeons (in regard to individual practice) are discussed, and appropriate actions agreed as required. These discussions are documented through individual 1:1 notes, and followed up through on-going clinical supervision to ensure adherence.
- To ensure that learning is shared across wards, theatres, Cardiac ITU and the division, the Clinical Governance Lead provides a summary of the learning identified to the Divisional Governance Board.
- To ensure that more widely applicable learning is shared more broadly, on a quarterly basis the Clinical Governance Lead provides a Trust-wide communication to highlight the key learning points.
- To further ensure that identified widely applicable learning is shared across the Trust a programme of work has been included in the Trust's Quality Improvement Programme for delivery in 2019-20.

Actions taken to improve the culture of learning from incidents, mortality and morbidity amongst consultants;

In addition to actions already described, the following have also been completed:

- To ensure that consultants develop a culture of learning from incidents, mortality and morbidity there is a weekly consultants meeting, chaired by the Care Group Lead/Associate Medical Director, where incidents, mortality and morbidity are discussed in a forum consisting only of the consultants themselves. This meeting is a forum for discussion and is not minuted. This has been put in place to create a more supportive and collaborative learning environment.

Actions taken to improve the leadership structure;

In addition to actions already described, the following have also been completed:

- The core business of cardiac surgery is run through the monthly Care Group meeting, which sets the direction of the service and ensures that the business plans and core service requirements are met.
- Weekly cardiac surgeons meetings ensure that clear direction is given within the service by the AMD and Care Group Lead to the surgical workforce.

Actions taken to improve the cultural issues within the service that limited effective multi-disciplinary working and effective governance systems;

In addition to actions already described, the following have also been completed:

- The cardiac surgery service is underpinned by a set of comprehensive SOPs, which sets out the governance structure of the service. These were approved and ratified by the Cardiac Surgery Steering Group and an audit programme for the SOPs is underway.

  The CQC's inspection report, published on 18 December 2019 (referenced above), recognises many of these improvements to the safety, quality and culture of the cardiac surgery service.

5.0 INTERNAL AUDIT ASSURANCE THAT IMPROVEMENTS HAVE BEEN EMBEDDED

An important part of the cardiac surgery improvement process has been the establishment of a number of Standard Operating Procedures (SOPs) to ensure good practice in key areas.

To assess the success of these SOPs, an audit programme has been devised whereby certain elements of a SOP are assessed and then presented at the monthly open cardiac surgery Integrated Governance and Mortality & Morbidity Meeting. Each month a different SOP is audited and to date the SOPs relating to the management of Multi-Disciplinary Meetings, the role of the Consultant of the Week and the SOP relating to patients requiring cardiac surgery have been audited.

5.1 MDT audit

This SOP relates to the Monday-Friday Multi-Disciplinary Meetings where the treatment plans for all patients awaiting cardiac surgery are discussed by consultant surgeons, cardiologists, intensive care/anaesthetic consultants and the Pre-Operative Care Team of specialist nurses. This SOP has been audited twice. An audit in February 2019 looked at the make-up of people attending the MDT meeting to ensure that the right mix of expertise was present when deciding on the best care for each patient. It also assessed whether key information was presented to help clinicians make an appropriate plan. The audit showed that at a minority of MDT meetings some groups were under-

represented and so a plan was made to drawer up an attendance rota. Should the necessary expertise be lacking at the MDT meeting, the case should be reviewed with the appropriate clinicians outside the meeting. The audit also showed that the EuroSCORE II (an assessment of how risky cardiac surgery may be for an individual patient) was not always quoted and this was highlighted for future inclusion.

The MDT meetings were re-audited in July 2019 in terms of who was attending and the availability of the MDT outcomes in the electronic patient record. This audit showed good attendance by cardiac surgeons but an occasional under representation of cardiologists. This will now be addressed in the cardiology consultants' job planning to ensure better attendance. All MDT outcomes had been signed by the meeting chair and were available for viewing in each patient's electronic medical notes.

These audits have demonstrated that in the majority of cases a satisfactory clinical skill mix was involved in exploring each patient's treatment options and that the reasoning and decisions were accessible in the patient's record. A future audit could look at any cases where the skill mix is deficient to ensure that appropriate decision making occurs outside of the MDT meeting or the patient is re-discussed at a later MDT.

5.2 Consultant of the Week

The Consultant of the Week (CoW) SOP introduced a new practice to the Service whereby each week a named cardiac surgery Consultant is responsible, among other things, for seeing all inpatients on a ward round twice a day (Monday to Friday) to promote continuity of care and timely decision making, overseeing the transfer of patients awaiting urgent cardiac surgery from other hospitals, reviewing all new urgent patients within 14 hours of arrival and helping with emergency surgery as it arises.

The audit from August 2019 showed that at least 90% of the ward rounds were conducted by a Consultant of the Week (CoW) and the remaining 10% may have also been done by the CoW, although this was not recorded in the documentation – highlighting the importance of accurate documentation. Furthermore, the audit highlighted a known discrepancy between the SOP and current agreed practice relating to CoW ward rounds on the Cardiothoracic Intensive Care Unit – the SOP included twice daily ward rounds by the cardiac surgeon at week-ends but current agreed practice is to perform only one, the other being undertaken by an ITU consultant.

All new non-elective patients were reviewed by the CoW within the 14 hours of admission in accordance with the national standard.

In terms of continuity of care it was noted that the CoW sometimes varied within a single week. This was to allow the surgeon to undertake their planned operating lists and sometimes their outpatient clinics.

The audit has shown that the introduction of a Consultant of the Week is ensuring regular, prompt, senior level clinic review and decision making. Further work is underway to achieve greater continuity of care and to assess how the consultant will balance their CoW duties with other activities such as operating lists and outpatient clinics as activity levels increase.

5.3 Patients requiring cardiac surgery

A number of audits have been performed to ensure that the patients being presented to St George's for cardiac surgery are appropriate in terms of the surgery the service can currently offer at this centre. Work has also been done looking at how the risks quoted to patients when they consent to procedures match EuroSCORE II risk calculations. The service has also looked at the reasons why patients may have to return to theatre due to complications following their initial surgery.

Two emergency cases were operated on in accordance with the SOP and both survived. No patients required referral to another cardiac centre for their surgery.

An audit from 7-11th January 2019 looked at the risk quoted to patients when they were consented for their operations. It is important to quote a risk that is as accurate and evidence-based as possible so that patients can make an informed consent to the procedures. All of the 17 elective and urgent operations were found to have an appropriate risk quoted to the patients when compared to EuroSCORE II risk calculations. Since the audit was completed it has become standard practice to quote the EuroSCORE II on the consent form.

A further audit looked at the circumstances around the 4 patients who had to return to theatre due to complications following initial cardiac surgery in February 2019. The audit showed that the complications had been identified in a timely fashion, were appropriately escalated to senior clinicians and taken back to theatre without undue delay. The need for returning to theatre was explained to each patient and documented in the electronic patient record.

These audits demonstrate that patients' individual risks when having cardiac surgery are being accurately quoted and that the service is managing High Risk and Emergency patients appropriately and within the limitations currently in place on the Service.

5.4 Future audits

The remaining SOPs are due to be audited over the next five months and the cycle will then start again, with other elements of each SOP being audited. This cycle of audits allows us to identify shortcomings in our practice or the SOPs themselves and we are already aware that some SOPs are due to be updated, which Mr Livesey is currently addressing.

6.0 QUALITY IMPROVEMENT INITIATIVES

The November Cardiac Surgery Update report there was a full review of the actions taken in response to the Bewick Report recommendations.

The Bewick report made many recommendations.

Several concerned the Consultant staffing of the unit**.** The current consultant staff meet the criteria in the Bewick Report, as follows:

- Mr Steve Livesey appointed as Care Group Lead/Associate Medical Director for Cardiac Surgery and Consultant Cardiac Surgeon
- Six full- time consultant cardiac surgeons
- One locum consultant cardiac surgeon

The current consultant staff provide sufficient cover to run a "Consultant of the Week" system, an appropriate on-call rota and give all surgeons adequate access to theatre. It also allows for sub-specialisation. There are two mitral surgeons and two surgeons doing major aortic surgery.

The Bewick report also recommended focussed practice. Subspecialisation has been achieved (see above); the unit is working with Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust to develop a South London Cardiac Surgery network. This will oversee the further development of specialist cardiac surgery.

The Bewick Report highlighted a concern over data entry and outcome monitoring. The Dendrite software system is in use now, as recommended and outcomes are reviewed at the monthly Cardiac Surgery Integrated Governance meeting. In addition, a Case Management Team has been appointed. This is a nurse-led team who have streamlined the pre-assessment and admission

process for both elective and non-elective patients.

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.

7.0 Organisational Development Interventions

In addition to addressing some of the key leadership requirement, the Trust has put into place a number of organisational development (OD) interventions designed to address the some of the previously poorly-working relationships within the team, which has included intensive (external) team mediation.

We have also engaged the services of an OD consultant to continue to work with the team, under the leadership of Mr Steve Livesey, building upon the earlier mediation recommendations.

8.0 EXTERNAL GOVERNANCE; UPDATE

The Trust continues to meet regularly with NHSE/I and the CQC and other regional and local stakeholders to provide assurance on the safety of the service and the improvements being made.

9.0 EXTERNAL MORTALITY REVIEW

In December 2018, NHS Improvement commissioned an independent review of cardiac surgery mortality at St George's during the period April 2013 to December 2018. The review, led by Mr Mike Lewis, an experienced cardiac surgeon, has been examining all deaths following cardiac surgery at St George's in this period.

The Trust has worked closely with the independent panel leading the review to ensure it has access to all of the information it needs to conduct its work. The independent panel continues to draft its report.

The Trust has ensured that the families of patients who died following cardiac surgery during the period under review by the panel have been kept up to date on the progress of the review. Once the panel has completed its work, the Trust will write to the families of all patients whose care has been examined by the panel to let them know the conclusions the panel has reached and to offer them the opportunity to discuss the findings with the chair of the panel and with the new Care Group Lead/Associate Medical Director for Cardiac Surgery and the Trust's Chief Medical Officer.

10.0 CARDIAC SURGERY RISK REGISTER; UPDATE

There are 5 risks related to cardiac surgery, these are;

CVT-1608	Loss of Income in cardiac surgery	Moderate (8)
CVT-1642	Reputational impact of service challenges within cardiac surgery unit at St Georges	Extreme (15)
CVT-1660	Risk to patient safety within cardiac surgery	High (12)
CVT -1661	Strategic loss of cardiac surgery service	High (12)
CVT – 1894	Service continuity after external mortality report is published	Moderate (8)

These risks are update monthly and whenever significant changes occur within the service. Any changes to the cardiac surgery risk register are discussed at service level, the Cardiac Surgery

Steering Group and are reviewed at the Risk Management Executive (RME).

Over the course of the year there have been some changes to the risk scores;

CVT-1608 (loss of income in cardiac surgery) – In August 2019 it was agreed at RME that this risk had been appropriately reduced to moderate. This was based on the cardiac surgery service meeting the block contract. Close oversight will continue and the Trust will continue to engage with referring hospitals and local partners on referrals to the Trust following the improvements that have been made to the safety, quality and governance of the service.

With the reduction in complex work the Trust saw a reduction in income related to cardiac surgery in 2018/19. This was the material factor in Cardiac Surgery reporting an adverse variance of £9.7m in its financial performance in that year, and the main contributory factor in the Trust missing its overall financial control in 2018/19. The risk was reduced in August 2019 to reflect the fact the financial plan for 2019/20 was based on the lower income value.

CVT-1660 (risk to patient safety within cardiac surgery) – This risk was added to the risk register following the concerns identified about mortality in the service. It is important to note that this risk around patient safety is being very thoroughly and extensively mitigated by all the safety and governance measures and quality improvements described in the rest of this paper. This risk was reduced in February 2019 from an extreme to a high risk following review at RME. This decision was based upon the data for the cardiac surgery survival rate. As set out above, the Trust has taken robust action to improve all aspects of safety, quality and governance of the cardiac surgery service. The latest outcomes data from NICOR demonstrates that the Trust was no longer an outlier for mortality in the period April 2015 to March 2018, and the CQC in its report published on 18 December 2019 recognises the many improvements made to the service since its last inspection in August and September 2018. Given there is an ongoing external review of mortality in the service in the period between April 2013 to December 2018, it is appropriate to maintain the risk as stated until the outcomes of this review are known and any actions required are fully implemented.

CVT-1894 (service continuity after external mortality report is published) – This new risk was added to the risk register in July 2019 and describes the potential risk to service provision following the publication of the external mortality review. While the Trust does not anticipate any disruption in service provision, it is appropriate to plan for the possibility and there are a range of controls that the Trust have developed in preparation should they be required.

11.0 ACTIVITY

Since the publication of the Bewick Report, referral rates have fallen from previous levels (having previously operated on some 90 cases per month, the service now operates on approximately 60 cases per month). The rate of referral is currently stable but is below our current potential capacity. The fall in activity is greater for elective than emergency cases. The Trust continues to work with partners on referrals to the service following the improvements that have been made to the safety, quality and governance of the service.

12.0 NETWORKING CARDIAC SURGERY IN SOUTH WEST LONDON

The three Trusts in South London that provide a cardiac surgery service (SGUH, GSST and KCH) are in the early stages of discussion about ways in which they may work more closely together in the future. The potential for common protocols and processes, where appropriate, are being discussed across all three Trusts to facilitate closer working.

13.0 RECOMMENDATIONS

The Trust Board is asked to note the report and take assurance from the overview provided in this paper of the safety of the service and the progress achieved in strengthening the safety, governance and culture in cardiac surgery.

14.0 REFERENCES

1 National Institute for Cardiovascular Outcomes Research https://www.nicor.org.uk/
2 Society for Cardiothoracic Surgery (SCTS) in Great Britain and Ireland https://scts.org/
3 Demonstrating Quality – 6th National Cardiac Surgery Database Report (SCTS, 2008), available from https://scts.org/_userfiles/resources/SixthNACSDreport2008withcovers.pdf

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St George's University Hospitals NHS Foundation Trust

2.5

Meeting Title:	**Trust Board**		
Date:	19 December 2019	**Agenda No**	**2.5**
Report Title:	External Clinical Governance Reviews (Part 1 April 2019 & Part 2 June 2019); Update of progress against the recommendation		
Lead Director/ Manager:	Richard Jennings, Chief Medical Officer Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Ashleigh Soan – Medical Directorate Business Manager Alison Benincasa – Director Quality Governance		
Presented for:	Discussion		
Executive Summary:	Strengthening the Trust's clinical and quality governance structures and processes was approved as one of the Trust's four quality priorities by the Board in March 2019. Since then, the Board has received the findings of an initial, external clinical governance review in June 2019. This highlighted areas for development in the Trust's approach to learning from deaths, and particularly the variability of Mortality and Morbidity meetings. At the July 2019 Board meeting, Board members were made aware of a second review was being commissioned from the same external clinical governance professionals. This second Review looked at the capacity and resilience of the teams under the Chief Medical Officer (CMO) and Chief Nurse (CN) and divisions, as well as the legal services function under the Chief Corporate Affairs Officer (CCAO). This was initiated in June 2019 and the findings are now shared with the Board for the first time. A third phase clinical governance review will commence in Q4 2019/20 and will examine ward to Board quality and safety reporting. This paper details the restructuring of the CMO and CN directorates, additional clinical governance support within the divisions, administrative support for Mortality and Morbidity Meetings and additional support and resources for the legal services team in the Corporate Affairs directorate. The investment will strengthen clinical governance throughout the trust with a particular focus on risk management and patient safety. Since the completion of the first review, a weekly oversight meeting chaired by the CMO and CN was established. Progress has been made against the recommendations of the first and second reviews and the detail is provided combined action plan in appendix 2. This paper describes the steps that have been agreed by the Executive Team, in response to the first and second external clinical governance reviews that are required to appropriately strengthen the governance capacity of the Care Groups, Divisions and Medical and Nursing Directorates to deliver safe patient care across the organisation.		

	The priorities for Q4 2019/20 include: • Prioritising recruitment for administrative support for M&M and MDTs with the clinicians concerned. • Standardising guidance for M&M and MDTs. • Producing new role descriptions and clearer responsibilities for key posts. • At least partially filling the new structures approved in the Medical, Corporate Nursing, Corporate Affairs and Divisional governance teams. • Completing recruitment for the trust Learning from Deaths Lead (January 2020).		
Recommendation:	**1.** The Board is asked to note the findings of the second governance review (June 2019). **2.** The Board is asked to note the actions being taken to strengthen the Medical and Nursing Directorates in response to the recommendations of the second governance review (June 2019). **3.** The Board is asked to note the progress as described in the combined action plan (appendix 2) against the recommendations of both governance reviews (April 2019 and June 2019).		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Safe, Effective, Caring & Well led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	None		
Legal/Regulatory:	Enforcement undertakings applicable to SGUH Compliance with the Health & Social care Act 2008 (Regulations 2014) and CQC Registration Regulations		
Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	Trust Executive Committee Quality and Safety Committee	**Date**	11.12.19 12.12.19
Appendices:	Appendix 1: 'Governance review: capacity and resilience of the corporate and divisional support for clinical governance' (June 2019). Appendix 2: Action plan for '*Governance review: mortality and morbidity and multidisciplinary team meetings*' (April 2019) and 'Governance review: capacity and resilience of the corporate and divisional support for clinical governance' (June 2019).		

CLINICAL GOVERNANCE REVIEW (Part 1 & 2) PROGRESS UPDATE

1. BACKGROUND

As part of the Trust's approach to strengthening safety governance throughout the organisation, with the approval of the Board, an initial clinical governance review was commissioned in January 2019. This first review focused on the safety governance and culture of Morbidity and Mortality (M&M) and Multidisciplinary Team (MDT) meetings at a care group level, identifying areas of good practice and highlighting any areas for improvement.

The review was commissioned by the Chief Medical Officer and led by three independent governance professionals. Their report was received in April 2019 and was presented to Trust Board in June 2019. It was agreed that the Board would receive a report to provide assurance on progress before the end of Quarter 3 2019.

An interim report from the review team was shared with the Chief Medical Officer and Chief Nurse in February 2019. This started to identify constraints in the Trust's governance infrastructure, including the capacity available, role boundaries, the grading structure and the integration of corporate and divisional governance expertise. It was agreed that, once the first review was complete, a second to examine the capacity and resilience of the corporate and divisional support for clinical governance would follow.

This second review was conducted by two of the three governance professionals who conducted the first review, to make use of their existing knowledge of the Trust. The review started in May 2019 and was completed in June 2019. This review identified the need for significant changes to strengthen the capacity of the Medical Directorate and Nursing directorates to deliver high quality safety governance in the organisation. The report of the second governance review is being shared with the Board for the first time in this paper. This paper also describes the changes to the structure of the Nursing and Medical Directorates that have been agreed by the Executive Team to strengthen quality and safety governance, in response to this second governance review.

This paper also includes the combined action plan formulated in a response to the recommendations of the first and second governance reviews.

A third external review to map the system of ward to board quality and safety reporting, and to suggest improvements, is planned for Quarter 4 2019/20.

2. GOVERNANCE REVIEW: M&M AND MDT MEETINGS (PART 1 APRIL 2019)

The purpose of the first clinical governance review was twofold:

- To scrutinise how the trust was applying the principles and standards in the national Learning from Deaths (LfD) Framework. This included examining how intelligence from the learning from deaths process linked into the wider quality governance systems within the trust, such as the Serious Incident process.
- To develop a more in depth understanding of how quality governance was working at care group level, specifically Mortality and Morbidity (M&M) meetings and Multidisciplinary Team meetings (MDTs).

The review team made two principal observations:

- The Trust framework for Mortality and Learning from Deaths needed a refresh to bring it in line with national 2017 guidance. This included a requirement to consider how Learning from Deaths fitted with the wider clinical governance structures in the Trust.

- That there was a lack of consistency in the way that the M&M meetings were organised and conducted, because of a lack of standardized guidance and tools. In addition, the outputs (learning points and actions) from meetings varied dependent on the level of administrative support available. A key recommendation focused on additional resource and support for M&M and MDTs where required meetings.

3. CLINICAL GOVERNANCE REVIEW: CAPACITY AND RESILIENCE (PART 2 JUNE 2019)

The terms of reference for the second external review were as follows:

- To examine the overall capacity and distribution of resource for clinical governance across the Corporate Nursing Team, Medical Directorate and Divisional teams, setting out the current roles and responsibilities expected of each component part.
- To evaluate whether the capacity and experience in the team is sufficient for a Trust of St George's size and complexity. This included benchmarking the level of resourcing against other, comparable trusts.
- To review current leadership and succession planning arrangements and the overall resilience of the clinical governance function centrally and at divisional level.
- To assess the training, development and support needs of members of the three teams.
- To make practical recommendations to improve the current model, including costed options for future structures for consideration.

The review concluded that the infrastructure for clinical governance at St George's was light, particularly when compared with other large teaching trusts. It also noted that the way the current resource was distributed impacted on the effectiveness of the function. The key findings included:

- The seven Associate Medical Directors have very specific remits, limiting the ability to deputise for the Chief Medical Officer across the whole portfolio and limiting effective succession planning.

- The structures under the Chief Nurse lacked capacity and seniority in some areas, particularly patient safety, risk management, clinical audit and effectiveness

- Divisions had differing levels of clinical governance support and variation in how roles such as consultant clinical governance leads were described and discharged.

- The capacity and resilience of the legal services team, which sits under the Chief Corporate Affairs Officer, required strengthening.

- A full version of the report is contained in appendix 1.

4. CLINICAL GOVERNANCE REVIEWS RECOMMENDATIONS, ACTION PLAN AND RESOURCE

A combined action plan for both clinical governance reviews is being shared the Board for the first time and is attached in appendix 2. The financial implications of the changes recommended by the

reviews have been discussed and agreed by the executive directors. The key changes are divided between five key areas:

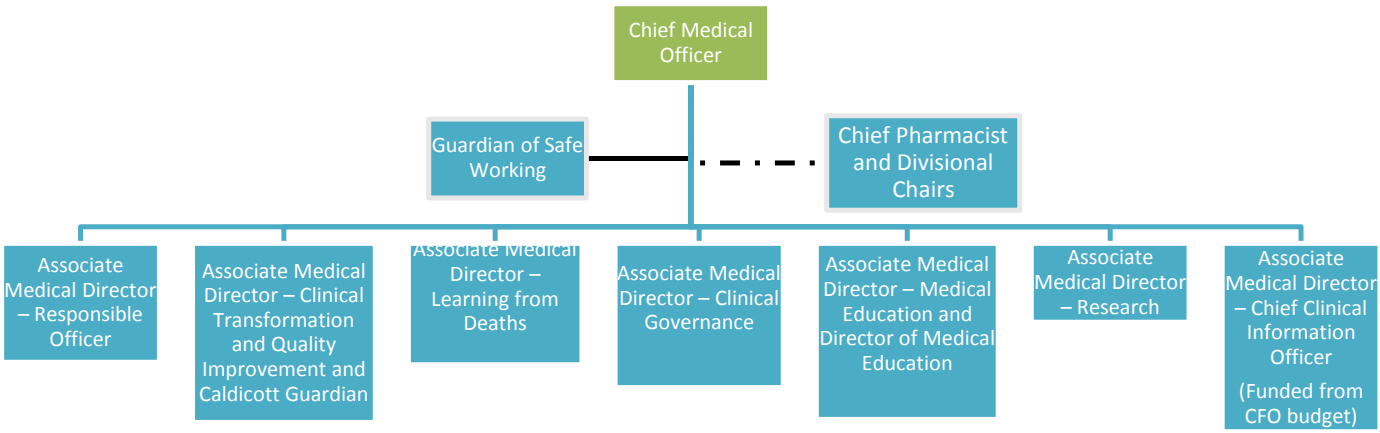
1. Medical Directorate - The aim of the change is to increase the resilience in the medical directorate by concentrating resource into three posts with broader remits, better able to deputise for the Chief Medical Officer, providing Trust-level leadership for their respective portfolios, and managing and supporting their direct reports.
2. Corporate quality governance (Nursing Directorate) – The aim of the changes is to improve the capacity and seniority of resource to support risk management and compliance (areas identified as in need of development in the latest CQC inspection) and improve the capacity and seniority of resource to support clinical effectiveness, as identified by the second clinical governance review. The Quality and Safety Committee has also recognised NICE compliance and clinical audit as areas in need of development. It is also intended to improve patient safety senior support to oversee and support the team and implement any national changes to the serious incident framework.
3. Legal Services – The aim of the changes is to strengthen the capacity and resilience of Legal Services to manage the very significant rise in the number and complexity of clinical claims and inquests., These changes will provide capacity for analysing claims and inquests to identify and distil learning, and to triangulate and disseminate learning across the Trust in line with the requirements and vision of the new NHS Patient Safety Strategy. The changes will also strengthen corporate reporting of legal issues, and ensure there is greater resilience and succession planning.
4. Divisional governance – The aim of the changes is to level the allocation of resource within the Divisions and to ensure that services own and drive the quality governance agenda.
5. Support for morbidity and mortality meetings within the Trust – The aim of the changes is to ensure consistent and appropriate support across the Trust for M&M meetings.

a) Medical Directorate

Current Medical Directorate structure

The current Medical Directorate structure (Chart 1) consists of seven Associate Medical Director (AMD) posts, which cover different portfolios of work. These are; medical workforce (including the Responsible Officer role), research, medical education, learning from deaths, quality improvement & clinical transformation, governance & patient safety and chief clinical information officer.

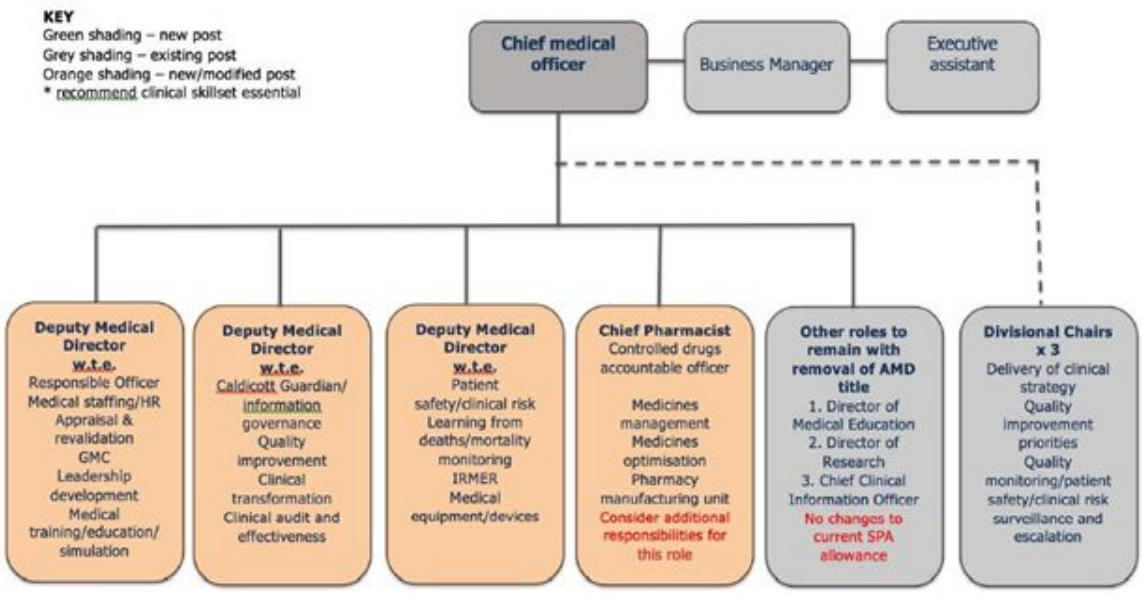
Chart 1: Organogram outlining the existing structure of the Medical Directorate



Two AMDs have stepped down to pursue other leadership roles and two of the current AMDs will be stepping down in 2020; this provides the Trust with a natural opportunity to review the requirements of the Medical Directorate and the impact any changes would have on the structure within the directorate.

The second clinical governance review recommended a change to a structure with three whole-time equivalent Deputy Medical Directors (30 Programmed Activities) (see chart 2).

Chart 2: Medical Directorate structure proposed by external governance review (June 2019)

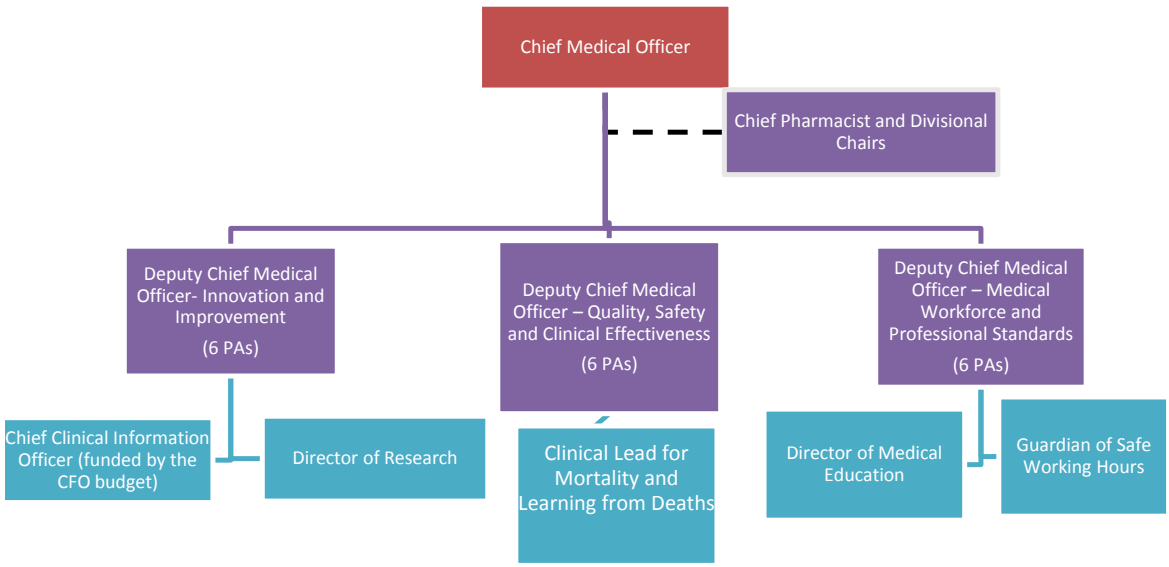


Proposed structure

Although it represents a lowered increase in capacity than that recommended by the external governance report, the proposed structure (Chart 3) would provide the clarity of roles and capacity required to continue to drive quality and patient safety initiatives within the Trust. This proposed structure would also provide a similar level of support for the Chief Medical Officer as the Chief Nursing Officer has within her deputy structure. The proposal reorganises the structure to have three Deputy Chief Medical Officers.

Deputy CMO title	Brief description of the role
Deputy Chief Medical Officer - Medical Workforce and Professional Standards	To lead on the critical people aspects of the directorate's portfolio, ensuring that trainee, trust grade and consultant staff are recruited, appraised, supported and developed ; are held account for their adherence to trust values and maintain high standards of clinical care.
Deputy Chief Medical Officer – Quality, Safety and Clinical Effectiveness	To provide senior medical leadership for development and implementation of the trust's quality strategy. They are key in fostering a culture of patient safety improvement within the organisation. The post-holder will work closely with the Chief Nurse's team to identify and investigate opportunities to improve patient safety and patient experience; and will support implementation of annual plans to address key causes of repeat harm or poor patient experience and will oversee and provide assurance on the trust's adherence to national clinical practice guidelines though the clinical audit programme.
Deputy Chief Medical Officer – Innovation and Improvement	To play a key role in fostering a culture of innovation and continuous quality improvement and oversee the Trust's compliance with Caldicott requirements via the Caldicott Guardian. To provide senior clinical input into shaping and delivering the Trust's strategy and vision for the organisation within the South West London sector.

Chart 3: Proposed Medical Directorate structure



b) Corporate Clinical Governance

The current structure based under the Chief Nurse has five sub-teams – the new Medical Examiner Office, Patient Experience, Patient Safety, Audit and Effectiveness and Risk. Investment was enhanced in the Patient Experience team, a new ME and ME Officer earlier this year. However, the amount in the latter three areas remains comparatively thin and the banding structure offers very limited opportunity for internal career development. Given the CQC's concerns about the maturity of risk management in the Trust, the resource attached to this part of the structure is particularly in need of strengthening.

The Director of Quality Governance stepped down in summer 2019 and the Clinical Audit Manager moved across into the ME Officer role. This had prompted some reconsideration of the resourcing of each sub-team and role bandings prior to the second governance review reporting.

Chart 4: Current structure of Corporate Clinical Governance (sits within the Corporate Nursing Directorate)

Chart 5: Structure proposed by the governance review (June 2019)

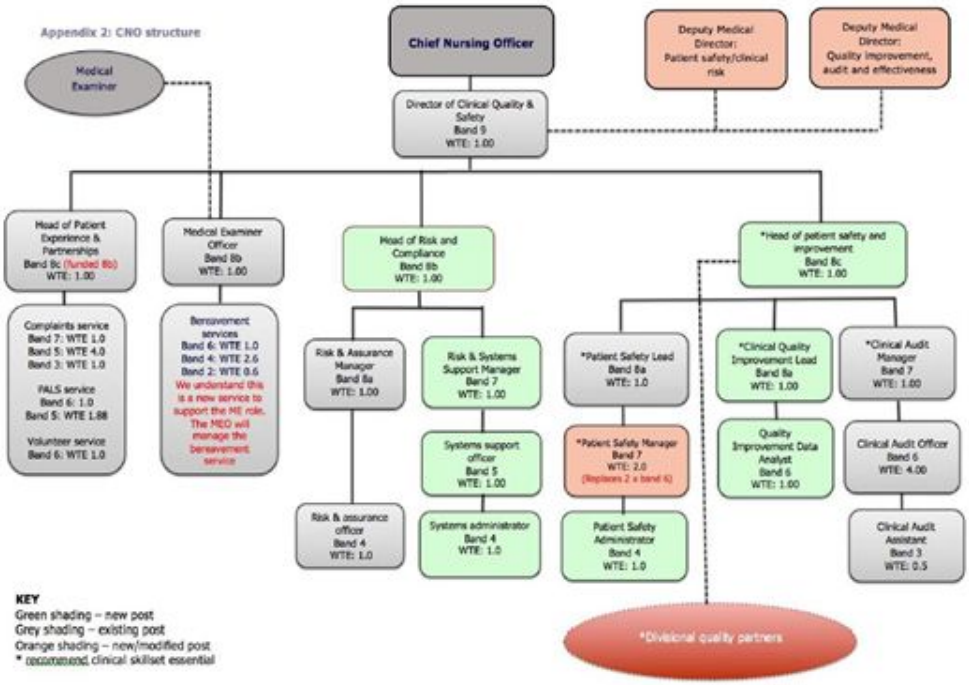
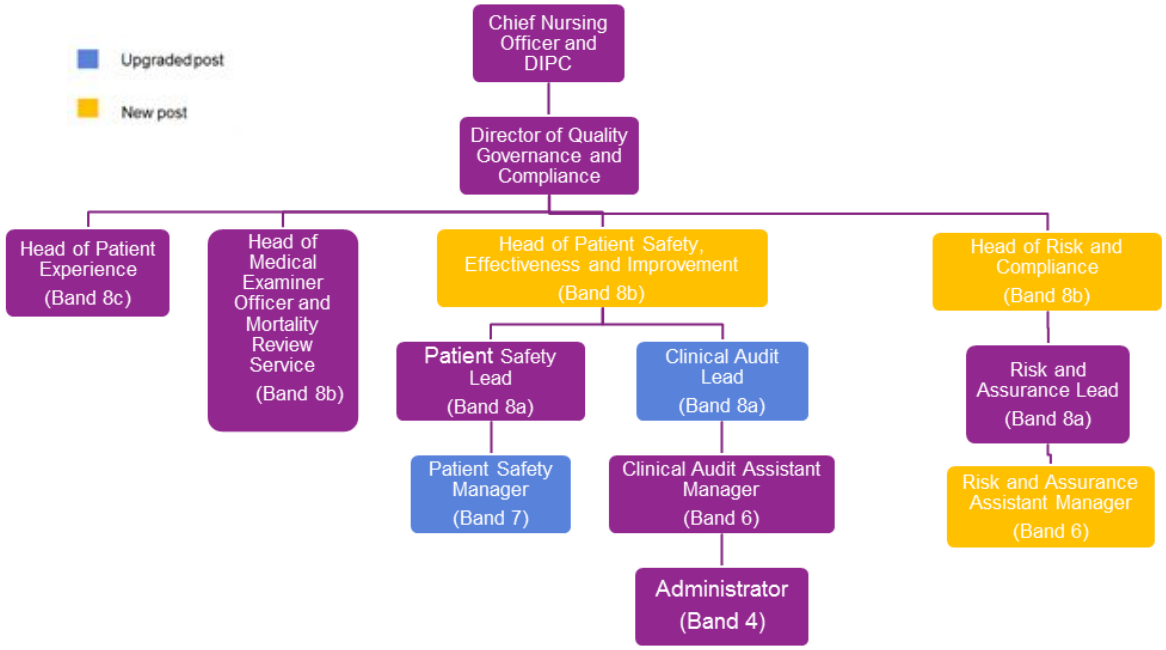


Chart 6: <u>Proposed</u> structure for Corporate Clinical Governance following the recommendations made by the governance review (June 2019)



The structure under the Chief Nurse has adhered to the principles of the review's recommendations but made a number of changes to the proposed bandings and portfolios. It has created a tier of 4 Band 8b/c managers to oversee the five sub-teams. This offers both more seniority of support, but also creates opportunities for career progression. Both Clinical Audit and patient safety have had an uplift in the bandings in each team. This will help to address Quality and Safety Committee concerns about NICE guidance and Clinical Audit. The majority of additional resource has been put into the risk and compliance arm. This should allow the team more time to build capacity and capability in divisional and corporate functions as well as managing processes such as the Corporate and divisional risk registers.

c) Legal Services

The governance review (June 2019) highlighted that the resilience and capacity of Legal Services was a concern, alongside a lack of capacity to enable effective and systematic learning from claims and inquests, and to triangulate this with other metrics such as complaints and compliments. Although the review team noted that the service was well managed, there was a concern highlighted that the current departmental structure did not allow for appropriate contingency or succession planning. In the past 10 years, the number of claims and inquests has grown exponentially. In 2008, the legal services team supported the Trust in dealing with a total of 40 new inquests. In 2018, this had risen to a total of 225 new inquests in a single year. In 2019, this had risen further to 265 new inquests. There has been a similar pattern in terms of the number of claims. Whereas in 2008 the legal services team handled 55 new claims, in 2018 the team managed a total of 160 new claims. At any one time, the team is dealing with several hundred claims, at various stages of development. At present, the team is managing a total of more than 700 claims. Alongside the increase in the volume of claims, the complexity of both claims and inquests has also grown. Effective planning and preparation for inquests, particularly sensitive and complex inquests, has helped the Trust, over time, to avoid a number of potential Prevention of Future Deaths notices, as well as to ensure the Trust

has strong and effective relationships with the coroners. The principal benefits of increased capacity in the legal services team is threefold: (i) Increased ability to extract and disseminate learning from claims and inquests and develop a comprehensive Trust-wide programme of learning at both service and divisional level in line with the vision set out in the new NHS Patient Safety Strategy; (ii) Strengthened corporate governance reporting to the Trust Executive and Board on legal issues, including through the development of a quarterly litigation report, covering claims and inquests, as well as rapid communication of high profile legal issues affecting the Trust; and (iii) Increased resilience of the legal services team.

Chart 7: <u>Current</u> Structure of Legal Services

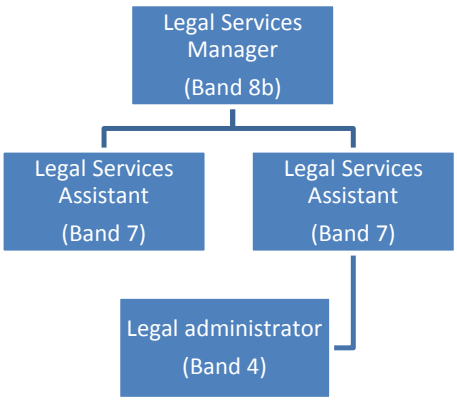
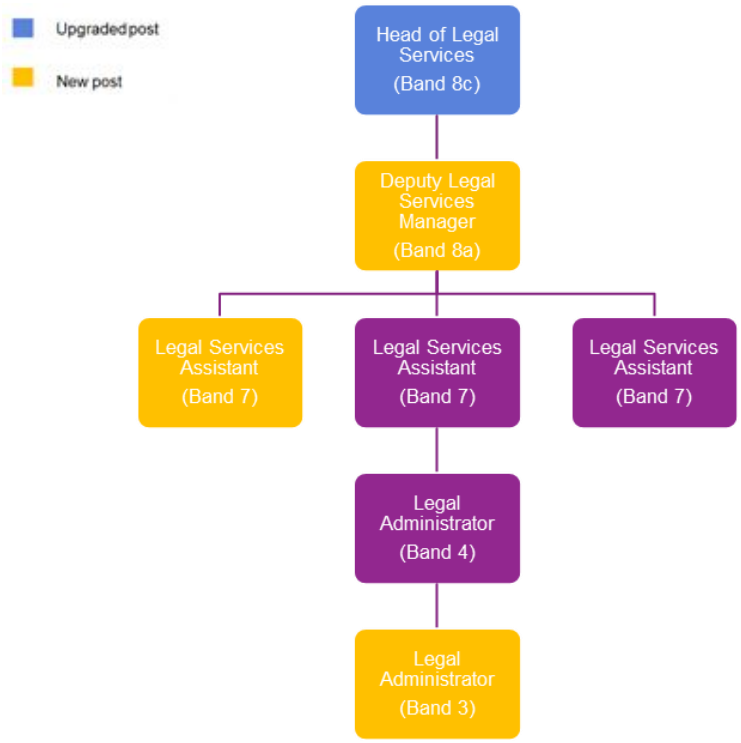


Chart 8: <u>Proposed</u> structure for Legal Services



d) Divisional governance

Chart 9: Current Divisional governance structures highlight the disparity in the amount of resource available to each division and the gradings of the postholders. The external review team noted that, particularly in the leaner structures, governance support tended to be focused at managing the responses to incidents, with less time available to either develop the expertise of other divisional staff or to improve identification, escalation and management of risk.

Chart 9: Current Divisional governance structures

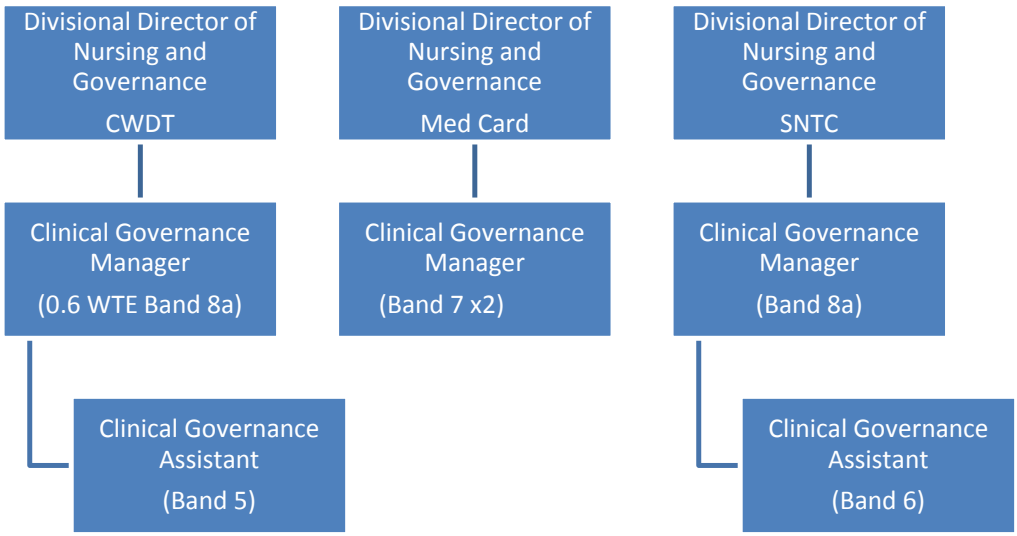


Chart 10: Divisional governance structure proposed by governance review (June 2019)

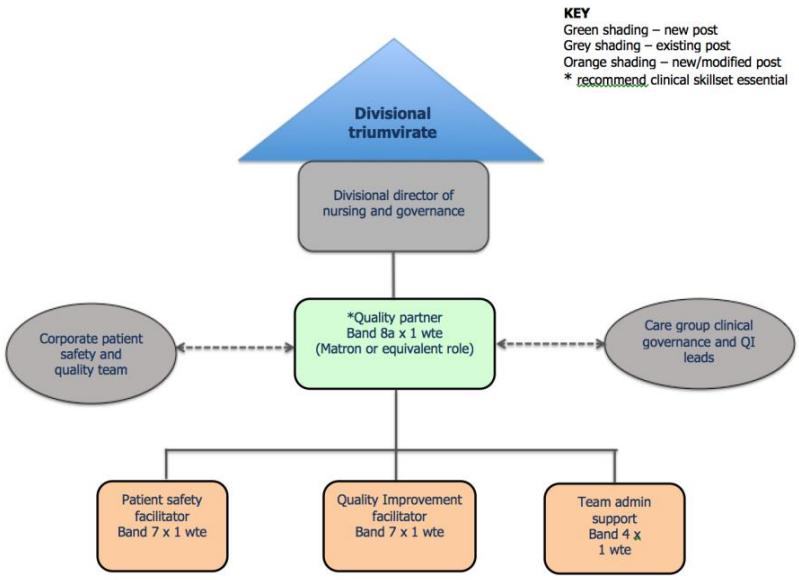
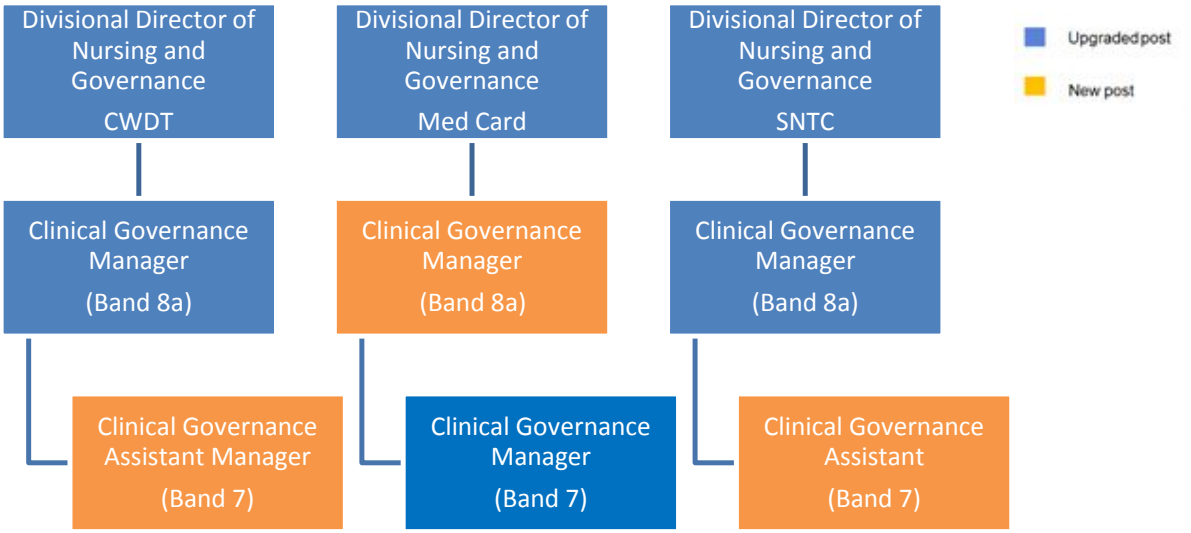


Chart 11: Proposed Divisional governance structure



The proposed support for divisions does ensure that there is a senior Band 8a and 7 in place in each division. The review team's suggestion of a second Band 7 was based on the assumption that post would have a remit to promote use of quality improvement techniques in improving safety, patient experience or effectiveness. As the QI academy has attached a QI business partner to each division this was not felt to be necessary.

e) Support for morbidity and mortality (M&M) meetings

In response to the recommendation (in the first external clinical governance review (April 2019)) to support M&M meetings to ensure consistency in approach and administrational resource, it is intended that the Trust have a central function that sits in the corporate team, with dotted lines to the divisions. This will enable cross-cover and ensure that the post-holders are focussed on providing resource to all M&M meetings, regardless of Division. Reviewing the number of meetings across the Trust and the time required to ensure the each is supported appropriately, it is intended that six Band 5 posts be developed and appointed to.

5. CLINICAL GOVERNANCE REVIEWS RECOMMENDATIONS RISK LOG

The combined action plan has been reviewed to ensure that the deadlines against the actions are realistic. However, there are accepted risks that may hinder the progress of these actions. For each of these accepted risks, the log below gives details of the mitigations in place or planned.

Risk	Mitigations	Status	Responsible Lead
Interventions fail to achieve traction at Care Group and Divisional Level	• Re-audit M&M and MDT meetings in Q3 2020 to identify how far guidance and support has been embedded and identify further actions needed	To be commissioned from Internal Audit	Chief Medical Officer

Risk	Mitigations	Status	Responsible Lead
	• Prioritise investment in administrative support for M&M and MDT meetings • Establish communities of practice to enhance peer support and challenge, using expertise from the Health Innovation Network • Commission external review by NHSEI Governance lead to test how risks are identified, mitigated and escalated at Care Group and Divisional level	Complete In progress In progress	Chief Nurse
Slippage in recruitment to new posts	• Maximise opportunities to enhance the structures through re-banding • Have job descriptions ready and banded to enable consultation and recruitment to proceed at pace • Identify and encourage suitable internal and external candidates to apply	Complete In progress In progress	Chief Nurse Chief Medical Officer Chief Corporate Affairs Officer (for legal team)
Requirement for Executive time to focus on other priorities in Quarter 4 2019/20 reduces the ability to progress actions and oversee progress	• Empower Deputy Chief Nurse, Director of Quality Governance and Compliance, Divisional Chairs, Associate Medical Directors and CMO Business Manager to take action • Identify additional internal and external options for CMO support in Q4 • Focus time of NHSEI Improvement Director on governance support	In progress To be identified In progress	Chief Medical Officer
St George's practice fails to keep pace with national standards of good practice	• Maximise national links to mortality and learning from deaths expertise through NHSEI medical directorate, the AHSN, HEE and National Medical Examiner's Office • Support key leads to participate in training and development opportunities • Offer governance managers the opportunity to join the NHSEI community of practice	In progress To be commenced To be commenced	Chief Medical Officer Chief Nurse

6. References

- Royal College of Surgeons: Morbidity and Mortality Meetings: a guide to good practice (2015)
- Care Quality Commission - Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England (2016)
- National Guidance on Learning from Deaths, a framework for NHS Trusts and NHS Foundation Trusts for identifying, reporting, investigating and learning from deaths in care (2017)
- National Quality Board Learning from deaths: guidance for NHS trusts on working with bereaved families and carers (2018)
- Care Quality Commission - Learning from deaths: a review of the first year of NHS trusts implementing the national guidance (2019)
- Royal College of Physicians Mortality Toolkit: Implementing Structured Judgement Reviews for improvement, v1.3 (2018)
- Paper 2.3 - Clinical Governance Review, published as part of St George's University Hospitals NHS Foundation Trust public Trust Board papers for June 2019, available from https://www.stgeorges.nhs.uk/wp-content/uploads/2019/06/Trust-Board-Meeting-Agenda-June-2019.pdf

St George's University Hospital NHS Foundation Trust

Governance review:
Capacity and resilience of the corporate and divisional support for clinical governance

June 2019

Contents

1.0 Introduction

In January 2019 the trust commissioned an independent review of its governance surrounding mortality and morbidity and multidisciplinary meetings. The report from this review made seven recommendations about the trust's quality governance, three of which are the main focus of this report:

- **Recommendation 9:** Consider what changes are required to provide support and resources to the chief medical officer in concert with the chief nursing officer, reflecting their need for an integrated approach to quality governance
- **Recommendation 11:** Review the corporate quality governance leadership and capacity so that the divisions are supported to provide a consistent and uniform approach in their delivery of the trust's quality governance arrangements
- **Recommendation 13:** Consider reviewing the roles of divisional chair, clinical director, care group lead, and clinical governance lead, to ensure that these role expectations and responsibilities are consistent, clear, well understood, and properly resourced in terms of protected time, support, and development to enable staff to deliver them in line with trust expectations

The independent review team (Elizabeth Seale and Geraldine Lavery) were further commissioned to undertake this review.

2.0 Review approach and methodology

Terms of reference for the review were established and agreed with the chief medical officer and the chief nursing officer. These were shared with the leadership teams in the trust's three clinical divisions (SNCT, Medcard & CWDTOCC) and with individuals who met with the review team.

The review team had access to and examined a number of documents, which included:

- relevant job descriptions
- corporate and divisional structures
- policies
- terms of reference for divisional meetings

From 4-7 June the review team met with 29 key individuals to obtain both a corporate and divisional perspective of the trust's quality governance arrangements. A further seven meetings took place on June 20 and two additional meetings took place via teleconference. These meetings took the form of conversations and assisted the review team in gaining a clearer picture of the trust's approach to quality governance and the challenges that teams and individuals are facing.

3.0 Acknowledgement

The review team would like to thank everyone who engaged in the review process and gave their time to meet or speak with them. They would also like to express their appreciation to Wanda Lamey for organising the meeting schedule and venues.

4.0 Background

The trust operates a clinical divisional structure, headed up by a divisional chair supported by a director of operations and a divisional director of nursing and governance. This model has been in operation for a number of years and its leadership team members, although working collaboratively, are in a hierarchical structure. Divisional chairs are overall accountable for each aspect of divisional performance: quality, finance, and operational performance, and report to the chief operating officer. The clinical structure below the triumvirate operates at a directorate and then care group level with each level replicating the divisional management structure of a clinical lead (clinical director or care group lead) supported by an operational or service manager, and a senior nurse (head of nursing or matron).

Appointment of a divisional chair is currently made for a three-year term and a formal process is in place to appoint clinical directors and care group leads. Traditionally, divisional chairs return to full-time clinical roles having completed their term. Divisional chairs have to date been drawn from the medical consultant body within the trust.

A fully devolved divisional governance structure is in place and a business partner model supports the leadership team for human resources and finance. There are variations in the size and complexity of each division with expenditure budgets ranging from £17.2 million in CWDTOCC, £38.5 million in SNCT to £89.3 million in Medcard.

5.0 Context

Clinical governance is a well defined terminology in healthcare: '*a system through which (NHS) organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'* (Scally and Donaldson 1998, p.61).

Clinical governance is an umbrella term describing a systematic approach. It covers activities that help sustain and improve high standards of care and encompasses such areas as quality assurance, quality improvement, incident management and clinical risk; this requires a continuous and dynamic process for identifying and judging risk, and subsequently making plans to mitigate or eliminate the risk.

In Lord Darzi's report *(High quality care for all: NHS Next State Review final report. Department of Health. 2008, p. 47)*, the focus moved to quality and the importance of this being understood from the patient perspective, building on the cornerstone of pre-existing local clinical governance.

Darzi said that care provided by the NHS would be of high quality if it were:

- **Safe**
- **Effective**
- **With positive patient experience**

With equal importance being placed on each element.

6.0 Quality governance

Since 2008 the term 'quality governance' has superseded 'clinical governance', reflecting that the governance of treatment and care within the NHS has now widened beyond clinical care and needs to encompass the values and behaviours of individuals and organisations as well as the structures, systems and processes. Monitor developed a quality governance framework in 2010 as part of the guidance for aspiring foundation trusts, based on the concept of continuous improvement. This continues to form the basis of the CQC well-led framework currently used to assess governance in healthcare trusts.

7.0 Key findings

The review team met with many enthusiastic and competent individuals in the trust who were committed to providing high quality safe care and services. The capacity and resilience

issues within the corporate quality team and the divisional governance teams are acknowledged, and some actions are already being taken to resolve these. For example the chief medical officer has recently appointed a business manager to support his function. The chief nursing officer has undertaken a consultation within the patient experience staff group, and recently appointed a band 8c to lead this reorganised team. The chief nursing officer's portfolio will also include the medical examiner officer who will provide support to the new independent medical examiner role once this has been implemented. Some reorganisation of services and functions to support this development has already been decided with planned changes in place. Two of the posts directly reporting to the chief nursing officer are also soon to become vacant and she has therefore already begun to consider different ways to structure and re-focus the functions within her portfolio. The three divisional directors of nursing and governance have also been considering how to further strengthen their governance function. Some of the findings below have already been identified, and recommendations to support and strengthen the resilience and capacity within the trust for quality and patient safety have taken account of these developments.

7.1 Divisions

As previously explained, the trust operates a devolved structure with each of the three divisions having some level of autonomy and accountability. The divisional chairs, although overall responsible for the effective performance of their services and efficient use of resources, still retain considerable clinical commitments; much of the leadership role and operational activity is therefore delegated to the divisional directors of operations and the divisional directors of nursing and governance. This leads to a view held by some that although St George's is clinically dominated it is not clinically led. The divisional chairs report to the Chief Operating Officer and maintain a professional line of accountability to the chief medical officer.

Divisions do not operate under close corporate direction and have a tendency to work in isolation from one another. They have each, over time, developed their own governance arrangements. Key committees consistent across divisions are the divisional board and divisional governance boards, both of which are held monthly according to agreed terms of reference.

The trust shared with the review team the work they are conducting with regard to refreshing its accountability framework. This work was described as designed to *'re-set how everything works'*. The review team were told that the trust executive team recognise that this is something that is needed urgently, given that St George's remains in double special measures. The documents reviewed demonstrate recognition by both clinical divisions and the executive team that the current arrangement regarding divisional accountability, autonomy and corporate intervention, is not effective. There is considered to be a lack of consistency or standardised approach in both leadership and how each division functions. The review team also learnt that the Chief Executive's aim in strengthening accountability is to achieve a 'clinically led organisation' with clinicians playing a lead role in the key decisions about all aspects of the operation of the trust: quality; performance; workforce and finances. In this, she recognises that this can only be achieved by clear targets and delegated responsibility, empowering leaders to act and deliver, and engendering divisional ownership.

7.2 Divisional chairs

Divisional chairs are seen as the trust's most senior leaders after the members of the executive team and are accountable for the management of their division. They are responsible for the effective performance of the division's services and efficient use of resources. Each division is a complex entity with a wide range of clinical specialities, comparable in size to a district general hospital. Each divisional chair is currently paid additional sessions to undertake this role – currently 4 SPAs. As mentioned previously many of the leadership and operational functions are either delegated to the divisional director of operations or the deputy director of nursing and governance. The review team did not establish to what extent each of the current chairs is committing more or less of the allocated amount of time to their role.

The current divisional chairs are all senior medical consultants and undertake these roles on a three-year basis, alongside a continued clinical commitment. Reviewers were told that there is currently no real competition for the role of divisional chair and the appointment process is not considered as robust. There has been little in the way of formal professional development for these roles in terms of preparation for leadership, operational and financial management, or how these map to a holistic plan for senior consultants wishing to progress their careers in a direction other than clinical. Two of the current post holders are about to step down from these roles and this provides the trust with an opportunity to review these

positions and consider how they could function in the future. This work is already underway as referred to in the previous section of this report. The reviewers were told that the trust executives have listened to the feedback from those in clinical leadership roles and have concluded that the remuneration offered, and the lack of formal training and professional development, is not commensurate with the time and commitment required, and is not sufficient to make the roles attractive to clinicians. This feedback is not limited to divisional chairs however, and extends to clinical directors and care group leads.

Consideration is being given to broadening these roles beyond the medical fraternity, encouraging applications from a wider clinical professional group, with a view to attracting those who are seeking careers in clinical leadership at regional or national level or as a move towards an executive leadership position. Supporting these roles with a good development and training programme would facilitate such development.

It is important that the trust invests in its leaders to ensure that there is clear accountability, and that it creates opportunities for career progression to valuable employees, together with succession planning to support its development as a learning organisation. The actions proposed by the trust as part of the development of these roles and the wider accountability framework aligns with the review team's view in terms of:

- Defining responsibilities of key clinical roles
- Confirming the amount of time that should be devoted to them
- Agreeing a method of remuneration
- Confirming what management support is required
- Making training available to clinical leaders and managers and devising an organisational development plan to support this.

The proposed performance framework sets out the expectations of this role going forward but does not, at this stage, clarify how the trust plans to transition from the current role to that envisaged. Due to the work underway with regard to the proposed changes the review team have not made any more detailed recommendations within this review.

7.3 Divisional directors of nursing and governance (DDNG)

Because of the current line management reporting arrangements, whereby the divisional

directors of nursing report to the divisional chair via the divisional director of operations, it could be considered that there is a lack of parity within the divisional triumvirate team. Although the three members work collaboratively, the divisional director of nursing and governance could be seen as the junior member rather than having equal status within the team. It was explained that this was seen as an effective model currently with each senior role in the divisional triumvirate having equal responsibility for quality. A number of other people, however, told the reviewers that this team structure and reporting arrangement reinforces the perception that quality, and in particular quality governance, is seen as being the nurse's job. The proposal for a new accountability framework is ambiguous as to whether this situation is likely to change although reviewers heard that the expectations of this role have not yet matured. There is a view held by some that DDNGs do not really work within the triumvirate but report directly to the chief nursing officer and are therefore de facto deputy CNOs rather than divisional directors of nursing. The new framework may give an opportunity to better clarify the expectations of this role.

An example of this lack of parity for quality in the team is the complaints policy, which states that:

'…divisional directors of nursing and governance are responsible for overseeing the complaints process in their areas and providing direct oversight of the investigation and response when the complaints concern nursing issues. They are also expected to monitor the response rate in each care group and set improvement trajectories where performance falls short of expected standards. They are responsible for ensuring that strong local processes are in place to ensure review and learning from complaints within clinical areas/teams and that these actions are clearly recorded and monitored'.

Directors of operations are only required to have oversight in the absence of the DDNGs. The investigation of complaints within specific areas is the responsibility of general/service managers and heads of nursing. Whilst parts of the investigation may be delegated to an appropriate person in that area or service, accountability for the timeliness and quality of the investigation and complaints response remains with the general managers/heads of nursing under the direction of the DDNGs. The review team was told that some of the DDNGs spend a large amount of their time (often out of normal working hours) managing the complaints process and quality assuring responses.

Senior medical colleagues are responsible for overseeing investigations and responses when

the complaints contain medical/surgical issues. But again the DDNG takes a coordinating and oversight role.

There is no specific role described in the trust's serious incident policy for DDNGs. Their responsibilities are set out in a generic section that refers to the expectations of clinical directors, divisional directors of operations, divisional directors of nursing, and senior managers. The policy references the divisional chair as being the responsible divisional lead. Responsibility of administration of the process within the divisions is in practice delegated to the DDNG, supported by their divisional governance manager. The serious incident investigation process however appears to be much more clinically biased when compared to that for complaints. For example, the executive-chaired serious incident declaration meeting (SIDM) does not include either DDNGs or divisional governance managers in its core membership or as attendees. Information and decisions arising from this meeting are communicated to the relevant DDNG or divisional governance manager by the corporate quality governance team, not always in a timely manner due to the resource capacity of this team, and depending on the nature of the serious incident. This is at odds with the practical expectations of the DDNG in coordinating the overall process within divisions and with the trust policy as it stands.

Divisional governance managers are described in the policy as having a role in supporting the DDNG and working closely with the corporate risk and assurance department in relation to serious incidents. Divisional governance managers have not however been offered the opportunity to attend SIDM and stated to the review team that they did not believe it was a meeting for them. It was described as 'too clinical' with medical staff often presenting findings from an investigation or a 72-hour review. Although a large part of their role is focused on supporting serious incident investigations and action plan management, the fact that they believe there is nothing they can contribute to the meeting seems to indicate a lack of cohesion between the corporate quality governance function and that within divisions.

This is not however the view of the DDNGs who consider that there would be considerable value in them attending and participating in this meeting. Reviewers were told that the 72-hour report is often considered at the meeting without any input from the DDNGs or the division's governance team, and therefore may not represent all the facts, or the context of the situation. The DDNGs would in many cases be able to provide the wider

context and perspective of the incident that would then inform the conversations and decision-making process at the SIDM meeting. An example was provided where a serious incident was declared on insufficient/inaccurate evidence in the 72-hour report; if the SIDM had the full context it may have resulted in the decision not to declare the incident as a serious incident. Once declared to commissioners and reported on STEIS, the ability to downgrade the incident is administratively complex and time-consuming. The review team was told that for a DDNG to attend this meeting *'would be the best hour's investment in the week'*.

The DDNGs, supported by the divisional governance managers, are responsible for the management and coordination of their division's investigations of serious incidents; they also monitor and record delivery of subsequent actions. Because the DDNGs are not fully involved in the overall serious incident process, the organisation is not benefiting as much as it could from their expertise and advice, and detailed knowledge of their division.

The review team noted that the policy relating to serious incident investigations was approved in April 2016 with a review date of March 2017. This does not appear to have been completed and some of the titles used within the policy do not reflect the current structure. For example, the Head of Risk Management is responsible operationally for implementation of the policy, a position that no long exists. There is no reference to the director of quality governance. The policy is also light on its reference to the Duty of Candour with no reference to quality improvement or the Learning from Deaths local or national framework. Reviewers are however aware that the trust is working closely with NHSI in their preparation for the introduction of the Patient Safety Incident Response Framework, due to be implemented over an 18-month period from September 2019. This would be an opportunity to review and substantially update the policy.

7.4 Medicines management

Currently the chief pharmacist sits in the CWDTOCC division. He is accountable to the divisional chair through the division's director of operations, with professional accountability to the chief medical officer. The chief pharmacist is the trust's controlled drugs accountable officer (CDAO). At St George's, this is a role delegated by the chief medical officer. Along with the normal medicines management function, the chief pharmacist is also responsible for the licenced medicines manufacturing unit, which is regulated by the MHRA, and manufactures and supplies bespoke medicines to fee-paying clients external to the trust.

Medicines management expenditure accounts for 9.2% of the trust's total expenditure budget for 2019/20, with £5.2 million income from the pharmacy manufacturing unit as well as other income streams. Although the highest spend on medicines will be within the Medcard division, every patient who comes through the organisation will need some kind of medication intervention. This means that the chief pharmacist is accountable for a significant proportion of the trust's overall budget and the review team questions whether this is fully recognised in terms of where this role currently sits within a division.

The chief pharmacist holds a key clinical role across the entire organisation, leading on the hospital-wide pharmacy transformation programme quality improvement plan and may be professionally isolated in the current situation. This may restrict the post holder's capacity to influence clinical decision-making and reduce the ability to provide trust-wide leadership to mitigate medicines management risks.

7.5 Clinical governance leads

The specific role of clinical governance lead does not appear in all care groups. In the smaller groups, the care group lead incorporates the expectations of this role. In larger care groups however, the role of clinical governance lead is given to another member of staff. To the review team's knowledge, all care group and clinical governance leads are drawn from the medical workforce. Reviewers were told that whilst the divisional chair, clinical director, and care group lead roles were now formalised with a job description and a recruitment and selection process, care group leads were expected in turn to appoint clinical governance leads, for which there is no clear process. Some individuals carrying out this role spoke of having a job description that sets out the role expectations whilst others spoke of a less formal arrangement. The job plans for these post holders varied between 0.5 and 2 SPAs. The review team noted that this role was not referenced in the trust's plans to strengthen its accountability arrangements.

The review team spoke to a number of medical staff that have this role and remit at care group level. It was apparent from these conversations that the role had not been clearly defined and agreed, and that individuals were interpreting what was expected of them in different ways. For example, some were very process and task focused, producing information and data from the incident management system (Datix). This has a high level of

administrative content. There appears to be very little focus on analysis in terms of drawing intelligence from raw data, or the application of quality improvement (QI) tools and techniques to support a regime of continuous learning and improvement. This is similar to the focus of the work of the divisional governance managers.

In contrast, others were QI trained and interpreted their role as being quality improvement catalysts within their speciality. In one case, the care group had appointed a clinical governance lead and a quality improvement lead, which had led to some confusion. The clinical governance lead in this case believed that quality improvement was at the core of her role.

The review team heard, as was reported in the previous review, that there was insufficient administrative support to deliver this role effectively. The general lack of administrative support was a theme the reviewers heard throughout this review. This leads to clinical professionals and others having to undertake low-level administrative tasks that they are neither trained for, nor should they be spending time doing, as it reduces their capacity to perform their tasks in an efficient way. Reviewers were told that there is an expectation that doctors operate at the 'top of their grade'. To support them to do this however will imply investment to relieve them of tasks that could be more efficiently and economically done by other staff.

The review team observed that there was no corporate or overt local direction on what was expected of these roles. Neither the corporate quality governance team nor the divisional governance managers have the capacity to support these posts effectively. This will contribute to the lack of consistency and direction for these post holders observed during the review. Collectively, this cohort of staff could have a significant impact on quality improvement across the organisation.

The review team were told that there is no sense of succession planning for the clinical roles defined within the divisional management structure.

7.6 Divisional governance teams

Currently, each division has a slightly different configuration of staff in these roles, although there are believed to be plans to align these. The configuration at present is:

- Medcard: 2 x band 7 divisional governance managers
- SNCT: 1 x band 8a divisional governance manager with a band 6 assistant
- CWDTOCC: 1 x band 8a divisional governance manager
- Maternity and obstetrics (part of CWDTOCC): lead midwife clinical governance; risk and governance midwife; QI assistant; IT data manager; secretary; consultant midwife who heads up a practice support team and clinical placement facilitators. Whole time equivalent information was not provided.

The work undertaken by the divisional governance manager in the Medcard, SNCT and CWDTOCC divisions tends to be task and process oriented, providing information to various meetings and helping to meet deadlines for complaints, incidents and serious incidents and producing reports for corporate meetings. Reviewers were told this is a very 'spreadsheet driven' style of reporting upward with regard to clinical governance. Clinical audit and effectiveness is given very little attention within divisions with more focus on complaints and incidents. There is little attention given to analysing clinical or non-clinical risk, themes and trends, or quality improvement or continuous learning. A lot of data appears to be gathered that does not result in the provision of useful intelligence. The role would be better described as facilitation rather than a management function. With the exception of the CWDTOCC division and the maternity governance team, these staff are not from a clinical background.

The exception to this was within maternity and obstetrics where, due to the historic arrangements around compliance with CNST, there is a much stronger focus on clinical quality and patient safety, with the resource to enable this. Both the director of midwifery and the clinical director lead on quality governance, providing a collaborative an integrated medical and nursing leadership approach to governance. This is a well-resourced governance team that has fully integrated patient safety, quality improvement and practice change functions, setting out expectations for and supporting an environment in which continuous learning can flourish. There is much the rest of the trust could learn from this model and how a patient safety and quality improvement approach can work cohesively to improve the patient's experience.

Reviewers were told of a lack of connection between divisional and corporate quality governance teams. The present devolved structure has led to much inconsistency and lack of direction across the organisation, with an uncoordinated sharing of responsibilities and tasks. The reviewers were told that this way of working does not support continuous learning and is viewed as a barrier to quality improvement.

With better direction, connection and support from corporate subject matter experts the functions and role of the divisional governance manager could be key in developing a patient safety and quality improvement culture within the organisation. However, to do so will require a culture change and appropriate resources, with a clear operating framework and expected quality standards. Strengthening and clarifying the connection and professional accountability between the corporate and divisional governance teams will be essential in achieving this.

8.0 CORPORATE

8.1 Legal Services

Legal services are positioned within the office of the director of corporate affairs. The head of legal services has been in post for a number of years and manages a small team. This is a well-regarded service and has established a positive working relationship with the coroner. The head of service is responsible for the management of the clinical negligence scheme, and overseeing arrangements for inquests, preparing staff and managing the interface with the coroner's service. Inquests have increased exponentially for the trust in recent years, reaching a total of around 200 last year with a predicted similar volume for 2019/20. This increase has not been matched by increased capacity within the team. The review team were also told of insufficient capacity in the claims team to support any learning from claims.

This important service for the trust is being well managed by a competent and committed individual. However, the previous review highlighted the risks to the trust where competent individuals were performing their role very well but in an isolated situation without effective contingency arrangements or succession planning in place.

8.2 Corporate quality governance team – chief nursing officer portfolio

There is a recognised lack of capacity within the corporate quality governance team at St George's. As stated above, the current director of quality governance left the trust at the

end of June and the chief nursing officer is considering the impact of this on her current structure.

Because of the limited capacity within the corporate team, the focus of their work has been on following process and completion of tasks: producing reports for various governance and assurance forums, and ensuring key deadlines, such as for serious incidents and complaints are met. This has led to little opportunity to provide analysis, to identify themes and trends and for the development/support for quality improvement and learning.

There is a lack of an integrated perspective on high quality governance that is focused on continuous learning and quality improvement at both the corporate and divisional levels. There is a sense that medical staff are responsible for certain aspects of clinical governance and nurses for others.

8.3 Patient Safety (Clinical risk)

There is currently no senior clinical role in the corporate quality governance team that leads on patient safety. Clinical risk is managed at a middle management level and a transactional approach to governance is particularly evident within this team. The main purpose of this function currently is the oversight of the serious incident investigation and reporting function, supporting weekly meetings of the serious incident decision meeting (SIDM), and chasing outstanding actions. Concentration appears to be on coordinating the various elements of the process in order to meet the timelines set. There is limited capacity within the current structure to focus on and support learning and improvement.

This small team also administers the CAS (central alerting system) patient safety alert process and deliver root cause analysis training on an ad hoc basis.

The associate medical director (AMD) for governance leads on serious incidents and and co-chairs the SIDM with the chief nursing officer and shares learning from serious incidents across the trust using various media. This role is under review following the intended alteration in direction by the current post holder, which could offer an opportunity for change, particularly in light of the upcoming implementation of a new national framework.

8.4 Clinical audit and effectiveness

The head of clinical audit and effectiveness also provides support to the AMD for learning from deaths. This aspect of the role has increased over recent time and now dominates the attention of the post holder, with oversight only of the clinical audit and effectiveness team. There are now plans for this post to move to a new role, supporting the medical examiner function once this has been established. The review team understands that the role will also involve line managing the bereavement office function, which may be further extended to include the mortuary in the future. The remainder of the clinical audit and effectiveness team who are led by a band 7 clinical audit manager will need to move to an alternative line of reporting when this move takes place.

The clinical audit and effectiveness team have not historically had a high profile in the organisation; their approach has tended to be functional, rather than acting as an integral and effective part of the quality improvement cycle. The department is largely focused on the coordination of nationally mandated audits, distribution of NICE guidelines and monitoring of returns. The audit manager drafts the annual internal clinical audit plan for discussion at a divisional level, but receives very little feedback. This appears to be a part of the general perception in the rest of the organisation that audit and effectiveness has a relatively minor role to play, and has little status or impact; further indications of this are:

- Although represented at PSQG the very wide remit of this group means they only have a 'small voice' and little influence
- Responses from divisions on clinical audits and NICE guidelines generally indicate a lack of engagement with how they are intending to respond, or to update procedures in order to achieve current compliance
- Audits being undertaken but not centrally registered
- Audit and effectiveness appears to have a low profile within the divisions
- No clinical champion for audit and effectiveness at a senior level within the medical leadership
- No corporate leadership and clinical oversight of NICE guidance and audit
- There appears to be to no overarching corporate control of or oversight on the development and/or updating of clinical guidelines, policies and standing operating procedure. This represents a risk to the trust.

The removal of the band 8a from this function will only serve to further diminish the profile and effectiveness of this team unless it is incorporated into the corporate structure in such a way to address this.

This is a reasonably well-resourced team, with a capable audit manager who is ambitious to develop a more dynamic service, and to establish stronger links with the divisions and the quality improvement agenda.

There is variation in the approach by the clinical governance leads at care group level to clinical audit and effectiveness, and this may have a negative impact on opportunities for clinicians to learn and improve their service or individual practice. It does not appear to be recognised as an integral part of the quality governance agenda.

As mentioned previously in this report, none of the seven AMDs currently has a lead role for clinical audit and effectiveness. Reassessing these AMD roles to include this function would facilitate the corporate and cooperative approach that is lacking at present and provide a strong link with quality improvement. The clinical audit manager also described some good quality improvement work being undertaken within the trust, but that it is happening in silos.

The review team noted that the central record of clinical audits is kept using an Excel spreadsheet. The trust has not looked to develop the Datix system to incorporate clinical audit. Whilst Datix does not have a dedicated module to support this, other trusts have developed the PALs module to good effect. Doing this may reduce the data collection burden for clinical auditors, allowing them to concentrate on supporting quality improvement projects.

8.5 Non-clinical risk

The reviewers were unable to obtain a copy of the trust's risk management strategy document. The current risk management policy was due for review in July 2018. The policy states that the director of quality governance is the lead for the risk management process across the trust and is responsible to:

> … *implement and maintain an effective system of risk management. The Director of Quality*

Governance is responsible for risk management policy development, developing and communicating the Board's appetite for taking risk, establishing mechanisms for scanning the horizon for emergent threats and keeping the Board sighted on these, and monitoring the management of risk across divisions…

The imminent departure of the director of quality governance will leave a gap in the strategic management of risk and support in this area to the trust board. Below the director role a band 8a member of staff manages non-clinical risk and assurance. This individual currently maintains both the corporate risk register and the board assurance framework (BAF). It is understood that responsibility for the latter is shortly to move to the director of corporate affairs, reflecting its relationship with the trust board. The review team would support this change.

This gap in the strategic leadership of non-clinical risk raises questions about who will guide the board on effective management of risk, such as the development of the BAF in line with the recently agreed strategy, horizon scanning for emerging risks (external and internal), establishing and revisiting the board's risk appetite, and the effective use of risk escalation and de-escalation.

The policy also refers to a Head of Governance, which is no longer a recognised role within the trust. This therefore questions how the responsibilities of that role are being effectively discharged across the organisation for example in areas such as:

…oversight of risk exposures facing the business
…support to Divisions,
…and the maintenance of the corporate risk/safety management plan.
…carry out sufficient checks within and across Divisions to monitor the management of risk alongside the Board's appetite for taking risk.
…The Head of Governance shall take the lead in triangulating lessons for learning ensuring defects; alerts or changes in practice are conveyed to front line teams promptly.

The reviewers heard a number of times that the executive team is not fully sighted on risks and risks are not always escalated appropriately or in a timely manner. The trust is in the lowest quartile nationally for incident reporting according to the national reporting and

learning system (NRLS), which could indicate a lack of an incident reporting culture. This is a further risk to the trust if there is not a strong culture of reporting and escalating incidents or risks. The review team also heard that due to the limited resource within the corporate team, the only training provided to staff was on an ad hoc and bespoke basis and does not get reinforced to all staff at the point of corporate induction.

8.6 Datix system

Support for and administration of the trust's chosen integrated risk management system (Datix) is provided within the quality governance team. There has been insufficient capacity within the central risk team to keep up to date with version developments. This may be inhibiting its functionality and the quality of information available to end-users. This lack of capacity will also have restricted opportunities to introduce additional modules, as they are developed, such as mortality review and moving complaints to a web-based platform, as well as supporting clinical audit as referenced earlier in this report. The same small team of staff are also responsible for delivering training to staff across the trust. Aside from the increase in resource needed to effectively support and develop this system, a separate piece of work to externally review the Datix system may be helpful.

8.7 Quality improvement and learning

There is a lack of clarity or cohesion in terms of leadership and corporate approach to quality improvement. The review team observed:

- **Director of quality improvement** (reporting to the chief nursing officer) – this role does not have responsibility for leading on QI but is concentrated on CQC compliance and assurance.
- **AMD for quality improvement** (reporting to the chief medical officer but with links to the director of quality improvement methodology role) – the focus of this role is quality improvement (QI) and coordinating the St George's QI academy. There is a view however that this promotes an academic and theoretical approach which is not suited to being widely adopted for groups of staff wishing to implement change in practice. Currently in excess of 90 staff have been externally trained in QI techniques, which represent a considerable potential resource, spread across the trust. However, as a resource, it is important that there is a coordinated effort to

support and direct them to put theory into practice, and demystify the QI approach so that this investment results in tangible improvements for patients and that QI becomes *'the way we do it at St George's'*.

- **Director of quality improvement methodology** (reporting to the Director of delivery, efficiency and transformation) – the focus of this role is to oversee transformation projects, some of which link to quality initiatives. The team is described as the 'PMO' (project management office). Some individuals referred to this individual as the person they reach out to support with QI; however, others described this function as very project-driven and not an approach that is conducive to improving quality.

Each of the post holders is aware of the others' involvement in quality improvement, but having three roles, sitting in three executive portfolios, each with a different perspective on delivering QI, presents a confusing picture to staff. These may be barriers to a trust-wide collective vision for applying QI techniques to areas identified for improvement and the central harnessing of talent in this area that the trust has invested in.

From feedback as part of the consultation on the new Patient Safety Incident Response Framework the national development team has identified a need to introduce a more QI and human factors approach to serious incidents. It is believed that this would have a positive impact on the ability of those involved in incidents to come up with different, creative solutions to reduce the risk of such incidents recurring.

8.8 Complaints and patient engagement

The trust has recently appointed an 8c head of patient partnership experience. A consultation is almost complete for the planned changes to the functions that sit under this role (complaints, PALS and patient engagement and partnership). The review team understand that a caseworker approach is to be implemented for management of complaints, liaising with patients and relatives, and providing a single point of contact. The review team understand that the intention of this change is to provide a more supportive and robust service to assist the divisions in the management of complaints.

8.9 Chief medical officer's portfolio

The chief medical officer has been in post for some six months. This is an ideal position from which to see the organisation from a new perspective; review and challenge the current ways of working which are seen as the norm. It is also a very important leadership role with a large strategic and outward facing element to it. The executive leadership for clinical governance is shared between the chief nurse and chief medical officer. It is important to ensure that the CMO's office is appropriately resourced to support this role and the development of a more integrated governance system. Some of this has already commenced with the appointment of a band 8 business manager post. The CMO is very keen to ensure that there is a more equitable and integrated leadership approach between the medical, nursing and allied health professional fraternity.

The CMO inherited the support structure of his predecessor. This consists of seven associate medical directors, who have a particular interest or focus in areas such as:

- Medical HR (including the responsible medical officer role)
- Research
- Medical education
- Learning from deaths
- Quality improvement and clinical transformation
- Governance and patient safety
- Chief clinical information officer

AMDs have different SPAs in their job plans to support this work and reviewers were told that effective delivery in most cases required a significant element of discretionary effort, beyond the job planned element. With the exception of the AMD for HR, all undertake clinical commitments. The review team were told each of these post holders has been recruited internally, not always through a formal process, with the AMD role described as 'nebulous'. This may well have led to a lack of formal direction and performance outputs for these roles, leaving the individuals to find the best way of working or focussing on their own areas of interest. The reviewers were told that the AMDs currently don't have regular opportunities to come together as a team to share their work; this may limit opportunities to develop a collective approach and lead to silo working. The reviewers did not have the opportunity to speak to all the AMDs and focused their efforts on speaking to those that

had a specific role in clinical governance, quality and HR. It is also important to note as stated above there is no senior leadership role that encompasses audit and effectiveness.

Two of the current AMDs are stepping down (or have stepped down) from their roles, and this may provide an opportunity to review the office of the CMO and how that support is provided. This could take into consideration succession planning, talent mapping and development opportunities for those who wish to develop a clinical leadership career. There are also some roles in the trust, such as chief pharmacist, that provide trust-wide services that would benefit from closer alignment to the CMO and his team. This would provide clinical oversight and direction and ensure individuals are not professionally isolated, and are able to influence clinical decision-making and quality improvement.

As part of the review the team did not speak with any of the allied health professionals; it was noticeable that this staff group, which include the physicians' assistants, do not appear to feature very prominently within the organisation. It was unclear who was the voice at an executive level for this very important group of clinical professionals. The CMO may wish to consider whether this is a role that would sit well in his remit, and therefore initiate a process that would help bring parity of esteem and effectiveness to all clinical professions.

9.0 Conclusion

Over the past decade continuous quality improvement (QI) has become a key approach used in clinical and corporate services within the NHS. Strategic partnerships with organisations such as the Institute for Healthcare Improvement (IHI) and the King's Fund have helped support this development. In its publication *Embedding a culture of quality improvement (Kings Fund, November 2017)* the key enablers for embedding a culture of quality improvement were described as:

- developing and maintaining a new approach to leadership
- allocating adequate time and resources
- ensuring there is effective patient engagement and co-production
- maintaining staff engagement.

The publication goes on to say that fidelity to a chosen approach is critical to sustaining and embedding quality improvement in an organisation's culture. The report found that NHS

leaders needed to engage with staff to empower frontline teams to develop solutions, and ensure that there is an appropriate infrastructure in place to support staff and spread learning. This is seen as of even greater importance at a time of severe financial restraint, rising demand for services and significant workforce pressures as it offers opportunities to improve the quality of care at the same time as increasing productivity by removing the barriers to getting it right first time.

It is in the context of the advance in healthcare from a didactic approach to clinical governance, to one of enabling and empowering sustainable quality improvement from grass roots level that this report is written.

St George's is facing challenging times and is under considerable scrutiny from the regulators. Over recent years there has been insufficient investment in the resources to provide effective governance systems that support functions such as patient safety, risk and quality improvement at both a corporate and divisional level. Financial constraints have led to reductions in the resource available to senior staff with the energy and passion to lead on improving the quality and safety of patient services.

From this review it was evident that capacity within both the divisional and corporate teams is not sufficient to enable them to function effectively. Although there is evidence of some pockets of individuals and groups who are focusing on QI, and a reasonable resource who have attended IHI QI training, the majority of the organisation tends to adopt a more bureaucratic approach to clinical governance; the quality improvement aspects tend to be less of a priority. There is a tendency to focus on collating data and information, rather than using them to inform how the organisation can improve practice and learn, in order to improve outcomes and experience for patients. This may well be a consequence of the lack of resources invested to facilitate this process – particularly in the corporate teams – or it may be indicative of a culture that lacks maturity in its empowerment of staff to flourish.

Because of the lack of capacity, expertise and focus on QI in the corporate team there is limited connection with the divisions and lack of direction to embed a culture of learning. The review team heard however that there has been a step change in the approach to governance and quality under the new chief medical officer. This has had an impact on the

work of the board with board members starting to think more deeply about how patients are being looked after, and conversations at this level have improved.

The next section sets out some options for the trust to consider that would strengthen the three components: chief nursing officer (corporate team), chief medical officer, and divisional teams.

10.0 Options and recommendations

The options for change proposed for the chief medical officer, chief nursing officer, and divisional structures are designed to bring St George's in line with other, similar trusts. In terms of scale, the closest comparison has been made with Cambridge University Hospitals NHS Trust (Addenbrookes), which has invested in its quality governance over time in order to address its quality and regulatory challenges. The amount of investment recommended at St George's is not inconsiderable, however the trust may consider justifying this in terms of:

- Potential reductions in litigation and claims
- Improvement in reputation – public, patient and other stakeholders
- CQUIN income secured and available to pump prime training and service improvement

The options would also support the issues identified in the discussion document presented at the trust TEC in April 2019 (*Aligning priorities, accountabilities and a performance framework*). This paper outlined the proposal for the development of a single improvement programme. The programme includes core elements such as: culture, governance, management capacity and capability (led by the chief executive officer) and a safety culture (led jointly by the chief medical and chief nursing officers).

10.1 Chief medical officer structure (Appendix 3)

The proposal to strengthen the office of the chief medical officer is to move away from the current associate medical director model and replace it with three full-time equivalent deputy chief medical officers or medical directors, expanding the current total capacity of the seven associates of 20 SPAs to a 30 SPA resource. As well as increasing capacity, this would consolidate the current arrangement, which presents a fragmented picture. It would also provide career progression opportunities to senior consultants aspiring to a chief

medical officer role or work at a similar level in the healthcare sector. This would also provide a similar level of support for the chief medical officer as the chief nursing officer has with her deputy structure. There are three discreet roles that do not fit into this model and will therefore need a different approach. The roles are:

- Director of medical education
- Director of research
- Chief clinical information officer

It is possible that removing the title of association medical director from these roles will be perceived as disempowering and a reduction in status for the current post holders. To mitigate against this, the chief medical officer may wish to consider modifying the current titles. It is proposed that the SPAs associated with these roles remain as they are.

The 2019/20 budget for the current model is £325,998 which includes funding for the three discreet roles referred to above. The budget is currently underspent due to vacancies in this staff group. The option proposed in appendix 3 has not been costed by the review team due to the potential for variance in the level of remuneration sought by potential post holders, and the lack of clarity in the current budgetary arrangements. Reviewers are also not sighted on the funding of the new medical examiner role when introduced, and the impact this might have on the current budget. The proposal however will imply an increased financial commitment by the trust.

10.2 Chief nursing officer structure (Appendix 2)

The proposal is to restructure and invest in the current corporate quality governance team from 25.58 wte staff to 33.58 wte, with an increase in high qualified (subject matter experts) and banded posts and providing a clear clinical leadership role to patient safety.

Key new roles being proposed, with the greatest impact on strengthening and improving the trust's governance of quality and safety are:

- Head of risk and compliance
- Head of patient safety and improvement
- Clinical quality improvement lead

The current staffing budget provided to the reviewers for this team is £1,328,506. The cost of the recommended option is £1,791,256 (uplift of £462,750 full year effect). This uplift can however be mitigated to some extent by the proposed transfer of the director of quality improvement to the vacant post of director of quality governance. The former post would then be disestablished with an annual saving of £127,774. This mitigation would therefore reduce the full year effect of the uplift to £334,976 recurring revenue cost.

Where posts are vacant, new or modified, the mid-point of the AfC scale has been used. The review team noted that the new head of patient experience and engagement role has been appointed to at 8c but is funded at AfC 8b. Reviewers believe this is to be mitigated by other staffing changes within the chief nursing officer's budget and outside the element reviewed.

10.3 Divisional structure – quality governance (Appendix 4)

This option proposes creating a quality partner role within each division at a band 8a, reporting professionally to the (newly created) role of head of patient safety and improvement and to divisional deputy directors of nursing and governance operationally. It is suggested that these roles will be recruited from the matron/AHP population within divisions. Divisions may wish to consider if this could be achieved therefore on a cost neutral basis. Quality partners will be responsible for:

- Ensuring divisional staff are trained and supported in performing key clinical risk processes such as incident reporting, investigation, complaints, discharging the duty of candour
- Supporting and coordinating the work of care group level quality governance leads
- Coordinating serious incident investigation in line with the new national framework, including a quality improvement, human factors and listening in action approach
- Compiling reports for divisional governance meetings
- Compiling evidence for assurance on quality and safety matters, including clinical audit, CQUINs and CQC compliance
- Facilitating the analysis of divisional data for the benefit of quality improvement
- Promoting and helping enable learning from incidents, complaints, and other sources within and across divisions

- Supporting care group-level risk management and maintaining divisional risk register, ensuring the agreed risk escalation framework is adhered to

To support this, each quality partner will have a team of the following:
2 x band 7 wte quality facilitators (already funded)
1 x band 4 wte quality administrator (already funded)

10.4 Divisional chair role

As previously mentioned, as part of the work underway to strengthen accountability and the trust's performance structure, the role of the divisional chair going forward is being discussed. In this context, the review has not attempted to redefine the role in its entirety. There are some expectations, in terms of providing support to the chief medical officer, which should be taken into account. There should be an expectation that the divisional chair provides leadership and is accountable for ensuring that there is an adequate structure, systems and processes in place throughout the division to enable the early identification and escalation of upcoming risks, particularly those relating to patient safety. In order to do this, divisional chairs should be held to account by the chief medical officer to deliver the trust's clinical strategy, including all strands of quality governance, quality performance and quality improvement. For example, divisional chairs should be able to:

- define, with their teams, key priorities for quality improvement in the context of the trust's clinical strategy
- be prepared to act on the findings from recent reviews into the trust's governance arrangements and ensure that they have mechanisms in place to define and measure against their division's service-specific key performance indicators. Particularly, the recent review of mortality and morbidity, and MDT governance, and recent issues relating to cardiac surgery.
- know when any of their services and specialties are failing to achieve the required quality performance and put in place the resource required to correct the situation, including the use of the QI approach to support change.

Divisional chairs should also have a responsibility to contribute to the work of the chief medical officer by liaising closely with the deputy chief medical officer roles

10.5 Care group governance lead role

The governance review referred to earlier in this section of the report recommended that this role be reviewed along with those of divisional chair, clinical director, and care group lead. The accountability framework discussion document however does not reference this important role. This represents a significant and influential resource across the trust. The review team therefore recommend that the principles applied to developing other key clinical roles in each division is applied to this role so that there is a corporate shared understanding of expectations and responsibilities. All identified leads should have a generic job description that aligns with the chief medical officer's expectations; they should also be given comparable SPA time to deliver their role, as well as administrative resource. They should work closely with the team of the quality partner within each division.

10.6 Divisional director of nursing and governance role

The review team believe this role should be recognised within the divisional triumvirate as an equal partner, and report directly to the divisional chair rather than through the divisional director of operations as is currently the case. The current structure reinforces the belief that:

- nurses are junior to doctors and managers
- governance and quality can be delegated
- the primary clinical relationship (for this role) is with the chief nursing officer rather than the divisional chair

The review team advise that this alteration to the current arrangement would have an impact on both how the DDNG's perceive their contribution to the divisional leadership and in turn, how other staff see their role. One example of this would be to invite them to attend the serious incident decision meeting whenever incidents/potential serious incidents are being discussed.

10.7 Clinical audit and effectiveness

The trust does not currently have senior clinical leadership for clinical audit and effectiveness. The trust should consider how it elevates the profile of clinical audit and effectiveness as a valuable element underpinning continuous quality improvement. Whilst national audit methodology is prescriptive for the most part, local audits and the utilisation

of junior doctors and nurses can be directed so that this work is contributing to cycles of improvement and learning. Including leadership responsibility for this in one of the recommended deputy chief medical officer roles is key to providing corporate direction for doctors and nurses, as well as the corporate clinical audit and effectiveness team.

10.8 Legal services

Consideration should be given to the capacity and resilience within this team given the current structure, and the potential impact on the lack of opportunity to learn from claims alongside other sources of intelligence. The trust should ensure that it considers contingency arrangements and succession planning and development opportunities within this team.

10.9 Summary

The trust is in the process of developing a governance environment that supports its journey towards excellence. The proposals outlined above should assist in enabling the trust in this ambition.

St George's University Hospital NHS Foundation Trust

Governance review:
Capacity and resilience of the corporate and divisional support for clinical governance

Report appendices

June 2019

Appendix 1: Terms of reference

Clinical Governance Capacity and Resilience Review
Terms of Reference
May 2019

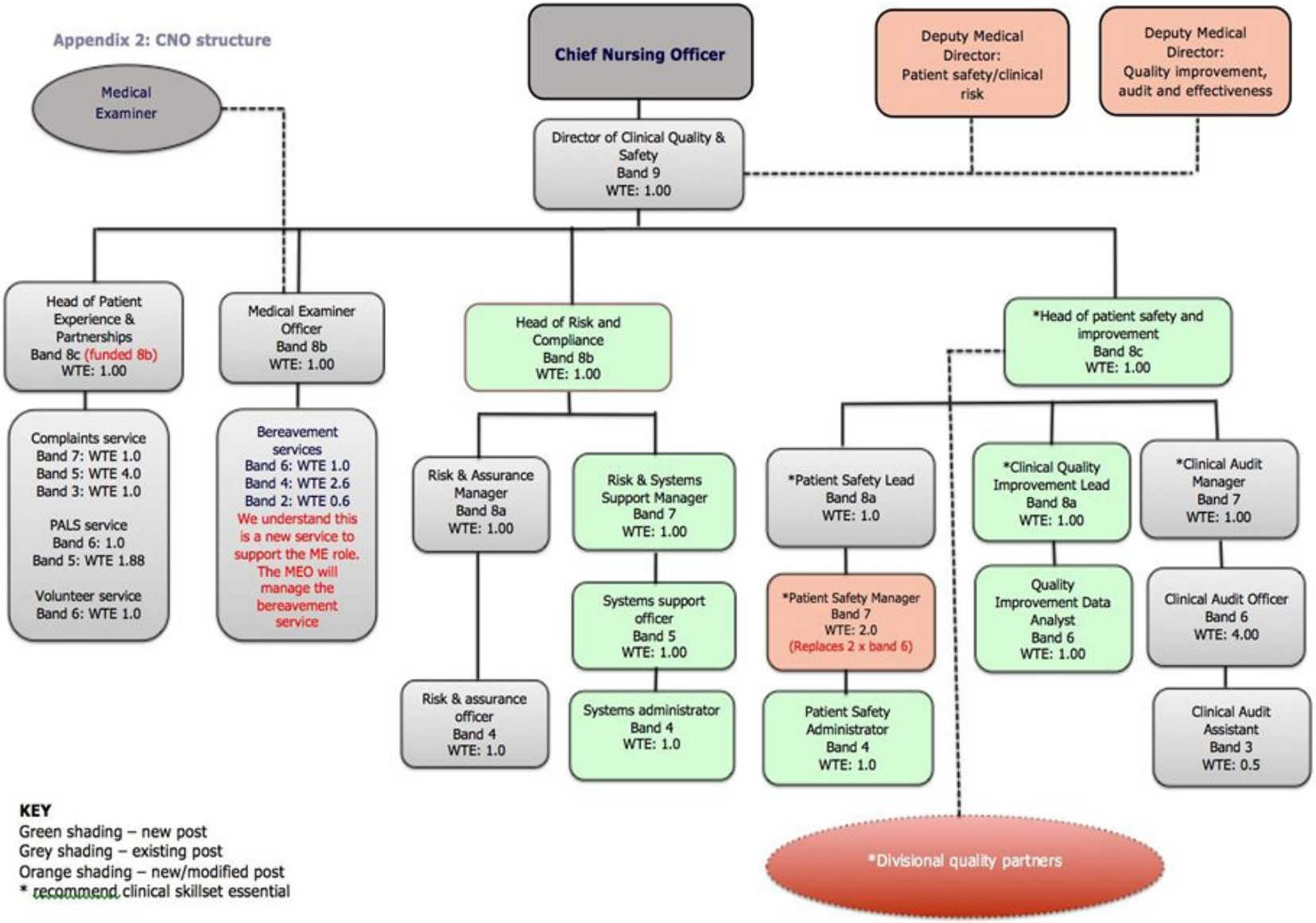
In January 2019, the trust commissioned an independent review of mortality and morbidity, and multidisciplinary team meetings. The review identified the need to provide a more structured framework of standards and support to promote more consistency in both meetings. It also suggested the trust undertake a review of the central and divisional support provided for clinical governance.

Currently, executive leadership for clinical governance is shared between the chief nurse and chief medical officer. Each executive director has some dedicated resource within his or her structure. In addition, each division has a divisional director nursing and governance, one or more divisional governance managers/risk specialists and a network of care group level consultant clinical governance leads.

The purpose of the review is to:

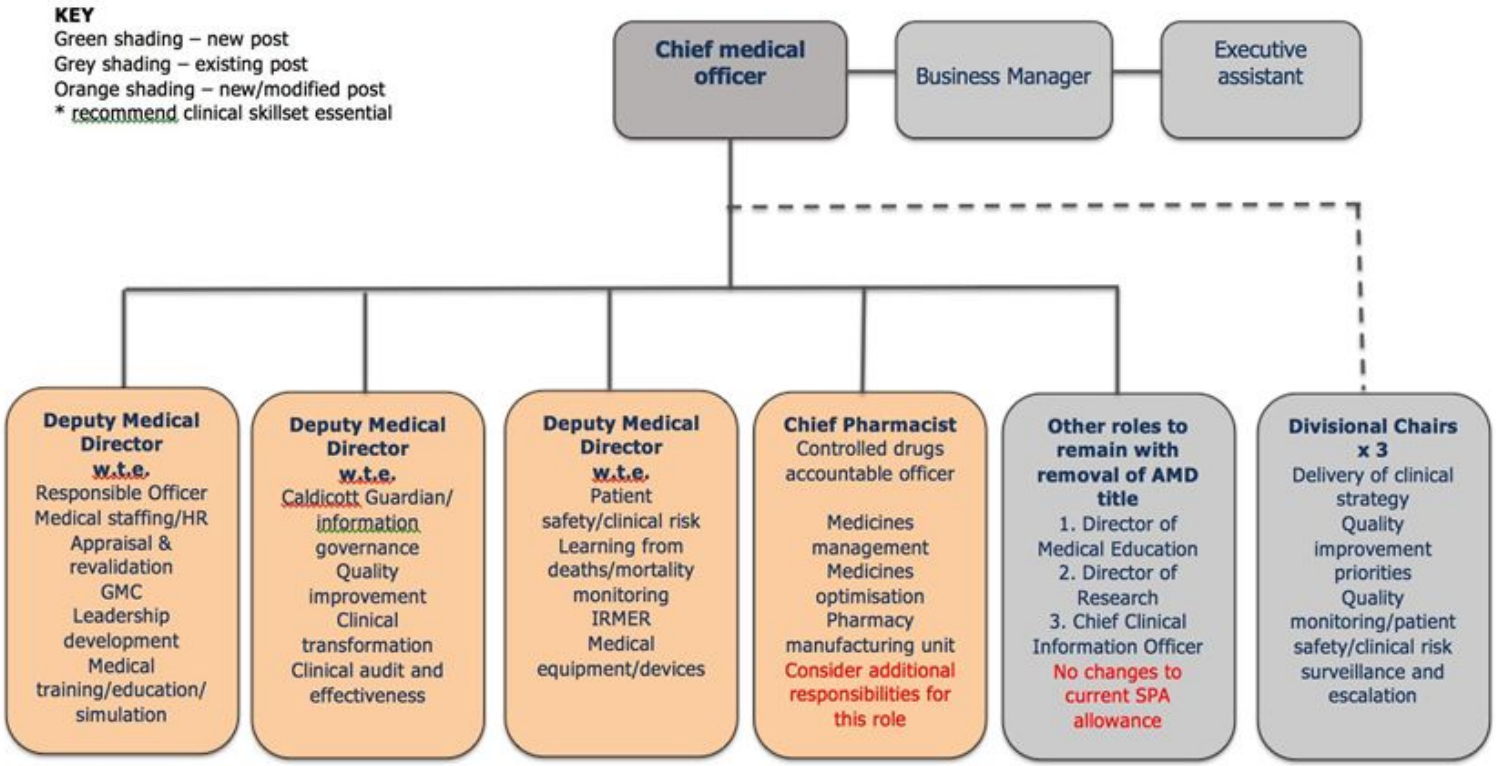
- Examine the overall capacity and distribution of resource for clinical governance across the three components of chief nurse, chief medical officer and divisional teams, setting out the current roles and responsibilities expected of each component part. This should include consideration of how the new, independent medical examiner role fits into the structure.
- Evaluate whether the capacity and experience in the team is sufficient for a trust of St George's size and complexity. This includes benchmarking the level of resourcing against other, comparable trusts.
- Assess to what degree the central and divisional teams work collectively to deliver the clinical governance agenda, highlighting any gaps.
- Review current leadership and succession planning arrangements and the overall resilience of the clinical governance function centrally and at divisional level.
- Identify potential benefits of moving to a clinical governance structure that integrates the work of the three components.
- Assess the training, development and support needs of members of the three teams (training needs analysis to be delivered separately)
- Make practical recommendations to improve the current model, including costed options for future structures.

Appendix 2: CNO structure

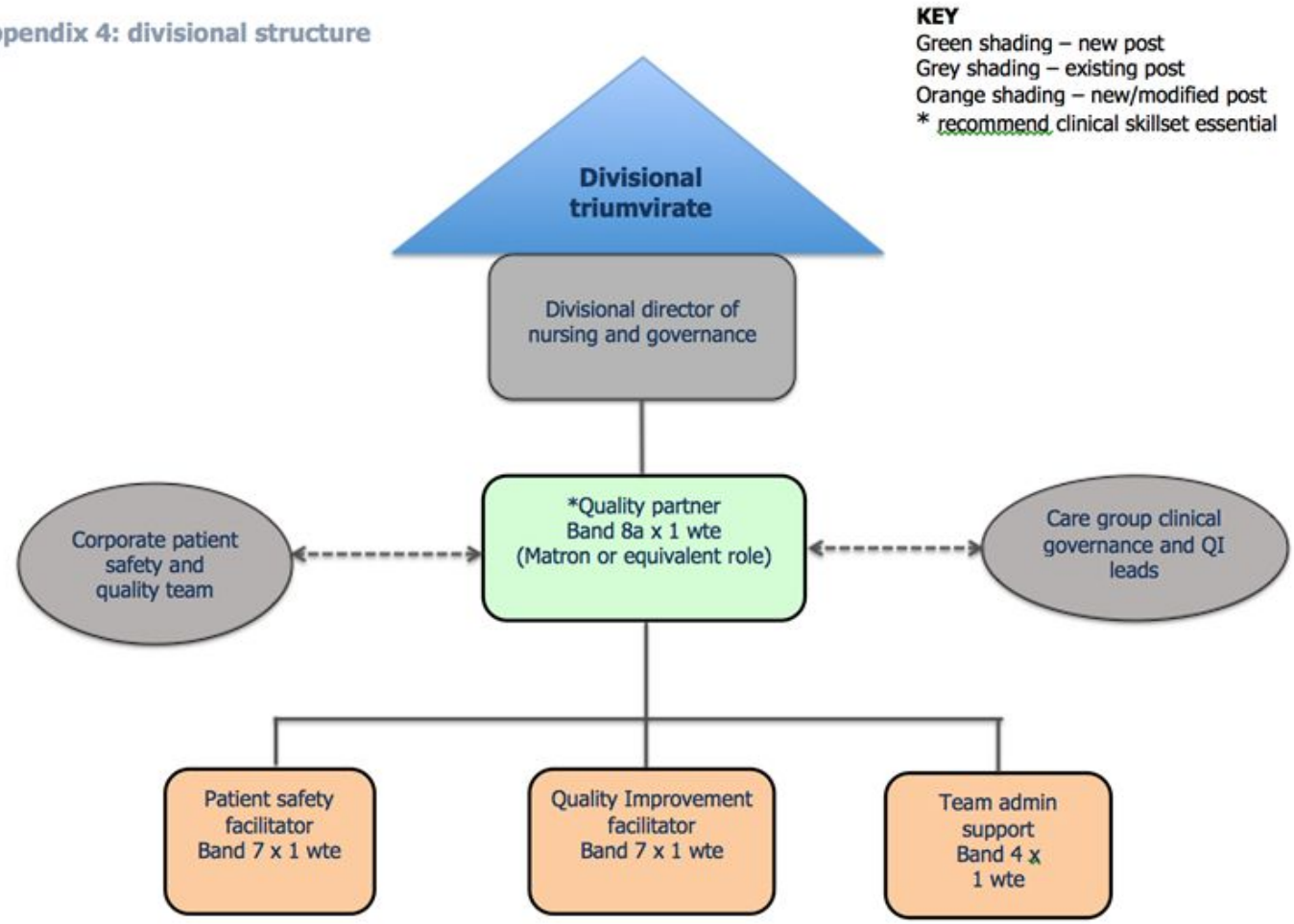


KEY
Green shading – new post
Grey shading – existing post
Orange shading – new/modified post
* recommend clinical skillset essential

Appendix 3: CMO structure



Appendix 4: divisional structure



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Trust action plan: combining actions from: 1. MM & MDT review (April 2019) 2. Clinical Governance review (June 2019)

1. MM and MDT review

External governance review part I recommendation no. and page no.	Trust ref	Recommendation	Trust actions recommended	Senior Responsible Owner	Action owner	Expected Completion Date	Delivery Status (RAG)	Progress / Comments	Evidence required to close action	Closed Date	Financial implications
Recommendation 1, page 6	1.1	A mortality strategy should be developed that incorporates all the various strands of the learning from deaths framework, with a clear focus on improving the quality of clinical care and preventing avoidable patient death	1.1.1 Recruit to the lead role for Learning from Deaths (see action 2.1 below) 1.1.2 Develop mortality strategy with assurance process for implementation including approval by Quality and Safety Committee 1.1.3 Upload Mortality Strategy to intranet and internet supported by appropriate communications strategy	CMO	Lead for Learning from Deaths (LfD)	29.02.2020		The LfD lead JD is complete and has been advertised. Interviews will take place in January 2020. As the Trust is developing its Quality Strategy for December Board, the option to incorporate LfD within that rather than having a separate strategy is being considered.	Lead for Learning from Deaths in post with development plan approved. Approved Mortality Strategy document. Link to assurance reporting (quarterly) on implementation of LfD. Plan in place to implement and monitor the strategy.		See 2.1 below
Recommendation 2, page 6	1.2	The CMO should consider how the interface between the new medical examiner system (when implemented) and the learning from deaths framework will operate at St George's to ensure independence of the medical examiner's role is maintained as intended within the latest guidance	1.2.1 Recruit to the lead role for Learning from Deaths (see action 2.1 below) 1.2.2 Lead Medical Examiner (ME) and lead for LfD to develop a standard operating policy to describe how the medical examiner system and the LfD framework will operate at the Trust 1.2.3 SOP to be ratified at MMC meeting prior to implementation. 1.2.4 Monitor the effectiveness of the SOP through an audit to be presented to MMC in Q3 20/21.	CMO	Medical Examiner and lead for LfD	30.04.2020; with audit of the SOP implemetned at 6-9 months in Q3 20/21		Development of SOP requires input from the LfD Lead, Lead ME, MMC and local clinical governance leads/M&M Chairs. Discussion about the link between ME and the role that M&M play in learning from deaths at the organisation is on the agenda at the Clincal Governance Lead meeting (18.12.2019). Further national guidance will be produced by NHSEI in 2020	Lead for Learning from Deaths in post Standard Operating Policy agreed that reflects the latest NHSEI guidance		
Recommendation 3, page 6-7	1.3	The forthcoming review of the learning from deaths policy should ensure that it encompasses all relevant new national guidance	1.3.1 Review and revise LfD policy taking specific account of the NHSI *Template Learning from Deaths policy, September 2017* and the *Implementing the Learning from Deaths framework: key requirements for trust boards, July 2017* and considering how a patient reference group is involved in the development of this policy 1.3.2 Ensure the mechanism for monitoring and providing periodic assurance to the board that the intentions of the policy are being met is included 1.3.3 Ensure how bereaved families are engaged and supported is described within the policy 1.3.4 Utilise the Patient Partnership and Experience Group to discuss and agree the expectations and content of the LfD policy	CMO	Lead for LfD in consultation with divisional chairs	30.04.2020		LfD policies have been sourced from Addenbrookes and Portsmouth and will be used to update the SGH version. This will include setting out the assurance process to Board and include guidance on bereaved families engagement. The PPE lead has approached PPEG members on 19th November to identify whether there are any members interested in joining MMC. Two members have expressed an interest and this is being progressed.	Monitoring against 70% standard, with explicit reporting on completed SJRs for LD. Include in integrated thematic reviews to Q&S Committee: quarterly Bereavement services survey results reported to PEG. Healthwatch commissioned feedback		

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Trust action plan: combining actions from: 1. MM & MDT review (April 2019) 2. Clinical Governance review (June 2019)

Recommendation 3, page 6-7	1.4	Strengthening the role of the mortality monitoring committee in delivering its aim to support clinical teams in their local mortality and morbidity governance processes	1.4.1 Review and revise terms of reference of the mortality monitoring committee to include membership, strengthening links to local M&Ms, and chair responsibility.	CMO	Head of ME Office and Mortality Rrview Service and Lead for LfD	30.04.2020		The CMO has now taken over chairing the Mortality Monitoring Committee (MMC). The newly appointed LfD will be involved in the review and revision of the MMC terms of reference.	Revised terms of reference for Mortality Monitoring Committee. Terms of reference for local mortality monitoring meetings. Effectiveness tool. Results of Mortality Monitoring Committee effectiveness review and resultant action plan		
Section 7.1.5, page 19	1.5	Conduct a retrospective Structured Judgment (SJR) Review of learning disability deaths from 2017/18 to date, with findings reported to Quality & Safety Committee before calendar year end.	1.5.1 Complete SJR review of learning disability deaths from 2017/18 to date 1.5.2 Report to PSQG, MMC and QSC 1.5.3 Implement and monitor resultant actions	CMO	Review by external person/team	31.12.2019		07.10.2019 - Recommended for Blue. This is completed and CMO business manager has obtained the agenda and minutes of QSC meeting where annual LD report was discussed and the report is logged in the evidence folder. 25.09.2019 - All Learning Disability deaths in the Trust are subject to a Structured Judgement Review and reported to the national Learning Disabilities Mortality Review Programme (LeDeR). It has been agreed with the Local Area Contact for the Trust that we will receive redacted copies of all completed LeDeR reviews for our learning disability patients so that we are able to review them and identify any actions required	Mortality Monitoring report to MMC, PSQG and Q&S committee including findings of Structured Judgement Reviews for learning disability patients		
Recommendation 4, page 7	1.6	Revise the role of the mortality monitoring committee so that it has a higher profile within the trust corporate quality governance structure. This should include consideration of how this committee can best deliver the trust's mortality strategy when developed.	1.6.1 Review the Trust accountability framework and reporting to Trust Executive Committee with a view to including a report of the proceedings of the committee in the TEC forward planner	CMO	Head of ME Office and Mortality Rrview Service and Lead for LfD	30.06.2020		MMC will report into QSC, and through QSC into Trust Board. Key safety issues identified by MMC will also be discussed at PSQG.	Monthly report of committee proceedings to TEC. Quarterly mortality monitoring reports to PSQG, QSC and Trust Board.		
Recommendation 5, page 7	1.7	Develop an overarching trust wide framework for conducting care group level mortality review meetings based on the latest best practice guidance. This will provide a model framework for divisions and care groups to consider best practice in holding such meetings, and how learning opportunities are shared that influence changes in practice. the framework should be included in the Learning from Deaths Policy	1.7.1 Develop a care group level mortality review meeting framework (integrated in to the Learning from Deaths policy) specifically using the Mortality Toolkit: Implementing Structured Judgement Reviews for improvement, v1.3 June 2018. As a minimum, this should include: • how to chair an M&M meeting • involvement of junior doctors, nurses, AHPs and other relevant staff groups • review of Dr Foster data • standardised method of presentation and grading classification • focus on learning and quality improvement opportunities • peer review • audit process including annual audit as part of the Trust's clinical audit cycle • clinical governance reporting arrangements 1.7.2 Ensure that a mechanism is in place that enables clinicians to refer cases as potential serious incidents for consideration by SIDM	CMO	Medical Examiner and Lead for LfD	30.06.2020		An event for M&M leads is being held on 18/12/2019. This will includeinternal speakers and discussion tables. In parallel the contents of a resource pack is being finalised. This will draw on the Royal College of Surgeons mortality toolkit and other good practice guidance. It will include clarification of how to refer cases to SIDM. It is intended that M&M leads will meet with the CMO, and other Executive Directors as appropriate, quarterly, and will also have their own discussion and learning forum. The CMO is meeting with Health Innovation Network to see whether their expertise of developing Communities of Practice can provide useful guidance for this Trust.	Peer review arrangements, quarterly reporting to PQSG Annual clinical audit results and action plan		

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Trust action plan: combining actions from: 1. MM & MDT review (April 2019) 2. Clinical Governance review (June 2019)

Recommendation 6, page 7	1.8	Develop an overarching trust wide policy for conducting care group level multidisciplinary meetings from which local standard operating procedures can be developed based on the latest best practice guidance. The policy should incorporate how each MDT will assess (at least annually) its own effectiveness/performance and benchmark itself against similar MDTs, making use of peer review and other national tools as they become available. The policy should include how the board receives assurance – positive and negative – on the effectiveness of its MDTs.	1.8.1 Develop a policy for conducting MDT meetings. This should include as a minimum: • the constitution of the multidisciplinary team • meetings attendance • teamwork and culture • patient-centred clinical decision-making • infrastructure for meetings • clinical governance mechanisms and monitoring • peer review • audit process • organisational support 1.8.2 Approve policy at PSQG and upload on to trust policy hub 1.8.3 Develop and implement a tool to measure the effectiveness of MDT meetings 1.8.4 Ensure a mechanism is in place to effectively share the learning 1.8.5 Ensure that a mechanism is in place that enables clinicians to refer cases as potential serious incidents for consideration by SIDM	CMO	CMO Business Manager in conjunction with Care Group Leads and Clinical Governance Leads	30.06.2020		In the review, a number of tumour group MDTs, perinatal and cardiac surgery were identifed as having good processes and practice, Clinicians within the exemplars will be approached to develop a common set of guidance, drawing on national cancer guidance and their own local strengths. This will be discussed as part of the Clinical Governance M&M forum being held on 18/12/2019.	Peer review arrangements reported quarterly to PQSG Annual clinical audit results and action plan		
Recommendation 7, page 7	1.9	Design and implement a training needs analysis for those chairing and participating in local morbidity and mortality and multidisciplinary meetings	1.9.1 Obtain views of current meeting chairs and participants in terms of training needs. 1.9.2 Take into account: constitution of the MDT; meetings attendance - expectations and recording; teamwork and culture; patient-centred decision-making; clinical governance (e.g.. Peer review arrangements); and ensuring effective shared learning. 1.9.3 Review training needs analysis against current training provision	CMO	Associate Director for Education and Workforce	30.06.2020		An initial training needs analysis was completed by the external consultants undertaking governance review 2. This will be sense checked with M&M leads first at the December event. Discussions are also commencing with the S London Health Innovation Network where there is an interest in creating a network for learning from deaths.	Training reports to Workforce and Education Committee		
Recommendation 7, page 7	1.10.	Establish a community of practice approach with those who chair mortality and morbidity and MDT meetings, involving executive leadership to build relationships and share learning through discussion and activities	1.10.1 Establish two communities of practice for MDT and M&M chairs. This should include: • a virtual community for sharing information and learning • quarterly joint meeting which include opportunities to meet with executive leaders • define and establishing KPI's to monitor performance against policy • establish a central repository and system for reporting quality assurance to CMO/CNO • consider introducing an accreditation system • establish a peer review and audit process	CMO	CMO Business Manager in conjunction with Clinical Governance Leads	30.06.2020		An event for M&M leads is scheduled for December and the timetable and plan for achieving this action will be considered in this meeting.	Annual assurance report to the Quality & Safety Committee		
Recommendation 8, page 7	1.11	Part of the protocol for developing and approving new clinical services should give consideration to the impact a new service will have on clinical support services, particularly in the resource requirement required to attend multidisciplinary team meetings.	1.11.1 All business cases linked to the development of new clinical services presented to the Business Case Development Group to have the section completed in full re the consideration to the impact on clinical support services particularly in the resource required to attend MDTs. Business cases will not be recommended to the Trust Investment/Disinvestment Group (IDDG) or considered by IDDG without this information	CMO	Deputy CFO	31.01.2020		07.10.2019 - Emphasis made on ensuring that sufficient PAs for clinicians to attend MDTs and M&M meetings are factored in to all business cases 03.10.2019 - Discussion with Chief Strategy Officer, member of IDDG. Confirmation that business case template contains relevant information. Action required is for the committee to reinforce that no business case to be considered without the information being completed in full	Business cases - with information fully completed		
Recommendation 9, page 8	1.12	Consider what changes are required to provide support and resource to the chief medical officer in concern with the chief nursing officer, reflecting their need for an integrated approach to quality governance.	See actions 2.1 and 2.2 below								

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Recommendation 10, page 8	1.13	Reflect on the organisation's ward to board reporting framework of meetings to ensure that the board continues to receive reliable assurance on the quality (safety, effectiveness and experience) of the services it offers, and that it meets its statutory responsibilities in this regard.	This recommendation is being addressed through the commissioning of a third external clinical governance review, which will report in due course.								
Recommendation 11, page 8	1.14	Review the corporate quality governance leadership and capacity so that the divisions are supported to provide a consistent and uniform approach in their delivery of the trust's quality governance arrangements.	See action 2.2 below								
Recommendation 12, page 8	1.15	Develop a programme for the divisional senior leadership team to provide greater understanding and good practice in governance systems and process particularly seeking and receiving assurance as part of the trust's risk management arrangements.	1.18.1 Include good practice in governance systems and process in the executive and divisional triumvirate development programme	CNO	QI Director	31.03.2020		A review of how risk is managed in the divisions will be undertaken by NHSEI and TIAA. Thie findings will be important for shaping the content of the training recommended by the review. It is therefore proposed that the training programme waits until that work has completed.	Development programme outline. Workshop/ seminar.		
Recommendation 13, page 8	1.16	Consider reviewing the roles of divisional chair, clinical director, care group lead, and clinical governance, to ensure that these role expectations and responsibilities are consistent, clear, well understood, and properly resourced in terms of protected time, support, and development to enable staff to deliver them in line with trust expectations.	See actions 2.3, 2.4, 2.5 and 2.6 below								
Recommendation 14, page 8	1.17	Consider conducting a medical engagement programme across the trust's consultant body. This will establish a baseline to inform the chief medical officer to consider what other mechanisms might be necessary to ensure the most senior leaders keep in touch with their medical workforce.	1.20.1 Commission MES and launch Trust wide 1.20.2 Develop an action plan in response to findings 1.20.3 Monitor delivery of actions and report progress through People Management Group and Workforce and Education Committee	CMO	Head of Medical Workforce	31.10.2019		The Medical Engagement Survey has completed and the report has been received. It suggests some improvement from the last 2017 review. It is planned to circulate the survey results to consultants before Christmas. A discussion with the Faculty of Medical Leadership and Management has been arranged for 18/12/19 to discuss whether a series of facilitated workshops would be helpful to formulate a response. Funding is being sought from NHSEI.	Trust board approved action plan by 31.03.2020		
Recommendation 15, page 8	1.18	Reflect on the perception that the culture is medically dominated, and consider how the Trust can achieve parity of esteem across all professions delivering clinical services to patients.	1.21.1 Include in the rollout of high performing teams programme as part of the QI Academy 1.22 Develop the AHP voice within the organisation and review the Chief AHP role 1.23 Ensure that the framework for M&M and MDTs stresses inclusivity 1.24 Adopt the NHSI Culture and Leadership toolkit	CMO	CNO; AMD for QI	30.06.2020		Additional posts are due to be recruited to support the roll out of HPT. An initial AHP workshop was held on 14.10 and it was agreed to hold a follow up event.The Chief Strategy Officer has agreed to be the AHP voice at Board. The JD for the Chief AHP is under review. The Trust has joined the NHSI Culture and Leadership Programme and is in the process of recruiting the internal change team which drives a bottom up approach. The change team will be multidisciplinary.	Trust board quarterly report commencing 31.03.20		

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Red = Deadline missed with no mitigation plan in place

Trust action plan: combining actions from: 1. MM & MDT review (April 2019) 2. Clinical Governance review (June 2019)

Not a specific recommendation, but required to maintain Appendix 5, pages 49 - 54 as a live document	1.19	Establish a mechanism for maintaining an up to date record of all MDT and M&M meetings across the Trust	1.22.1 Divisions to establish and maintain a process for ensuring up to date records of all MDT and M&M meetings is in place. 1.22.2 Include a system for ensuring quarterly reporting to the CMO/CNO at PSQG	CMO	CMO Business Manager in conjunction with Care Group Leads and Clinical Governance Leads	30.06.2020		An SOP has been agreed which will require a quarterly update to the CMOs office. Review and report to ensure accuracy of record required on a quarterly basis to MMC.	Central repository Quarterly reporting to CMO/CNO		
2. Clinical Governance Review											
External governance review part II recommendation no. and page no.	**Ref**	**Recommendation**	**Trust Actions**	**SRO**	**Action owner**	**Expected Completion Date**	**Delivery Status (RAG)**	**Progress / Comments**	**Evidence**	**Closed Date**	**Financial implications**
10.1, page 28	2.1	**Chief Medical Officer Structure:** Strengthen to office of the Chief Medical Officer to move away from current associate medical director model and replace it with 3 wtes deputy chief medical officers/ medical directors, expanding the current total capacity of the 7 associates 20 PAs to a 30 PA resource. Retain x3 associate medical directors for medical education, research and clinical information officer role	2.1.1 Review and agree final team structure 2.1.2 Develop a business case for investment and take through IDDG 2.1.3 Develop a generic job description for deputy chief medical officer/ medical director 2.1.4 Agree changes required to title of the 3 AMD roles, consult with affected staff and implement agreed changes 2.1.5 Develop and implement recruitment strategy for the new posts	CMO	CMO Business Manager	31.03.2020		The structure has been completed, job descriptions written and net investment needs identified. The structure will move from 7 AMDs to three deputy CMOs - innovation and improvement ; safety quality and effectiveness ; medical workforce and professional standards, supported by the CCIO, Learning from deaths lead, director of research and director of education and guardian of safe working hours. The business case will be considered at December IDG.	New and revised job descriptions Costings finalised Business case People in post		TBC: IDDG business case value TBC
10.2, page 28	2.2	**Corporate Quality Governance:** Restructure and invest in the current corporate quality governance team from 25.58 wte to 33.58 wte, with an increase in high qualified (subject matter experts) and banded posts and providing a clear clinical leadership role to patient safety	2.2.1 Review and agree final team structure 2.2.2 Develop a business case for investment and take through IDDG 2.2.3 Develop job descriptions for Head of Risk and Compliance, Head of Patient Safety and Improvement and take to AfC panel for banding (8b) 2.2.4 Develop and implement recruitment strategy for the new posts including application of organisational change policy as appropriate	CNO	Director of Quality Governance and Compliance	31.03.2020		14.11.19 The structure has been finalised and costed, All job descriptions have been written. The team will be headed by a Direcror of Quality Governance and Compliance (interviews 22/11) and Band 8 leads leading small teams on safety and effectiveness, risk and compliance, patientand public experience. Divisional support will be enhanced. The business case will be considered at December IDG.	New and revised job descriptions Costings finalised Business case People in post		TBC: IDDG business case value TBC
10.3, page 29	2.3	**Divisional Structure - Quality Governance:** Create a quality partner role within each division at a band 8a, reporting professionally to the (newly created) role of head of patient safety and improvement and to divisional directors of nursing and governance operationally. These roles will be recruited from the matron/AHP population within divisions. Divisions to consider if this could be achieved on a cost neutral basis. Each quality partner will have a team of the following: 2 x band 7 wte quality facilitators (already funded) and 1 x band 4 wte quality administrator (already funded)	2.3.1 Develop role description for Quality Partner Role (for inclusion in the successful candidates current job description) 2.2.3 Develop and implement recruitment strategy for the new posts	CNO	Director of Quality Governance and Compliance	31.03.2020		14.11.19 The structure has been finalised and 2 job descriptions need to be written. The aim is to enhance the support embedded in divisions. The business case will be considered at December IDG.	Role description Quality Partners in place		Cost neutral

17/12/2019

Delivery RAG key

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual
Green = On target with evidence of progress supplied
Amber = Deadline missed/ or likely to be missed with mitigation for delivery in place and with evidence of progress supplied
Red = Deadline missed with no mitigation plan in place

Trust action plan: combining actions from: 1. MM & MDT review (April 2019) 2. Clinical Governance review (June 2019)

10.4, page 30	2.4	**Divisional Chair Role:** Clarify the expectations of the role of the divisional chair including the provision of support to the chief medical officer. There should be an expectation that the divisional chair provides leadership and is accountable for ensuring that there is an adequate structure, systems and processes in place throughout the division to enable the early identification and escalation of upcoming risks, particularly those relating to patient safety. In order to do this, divisional chairs should be held to account by the chief medical officer to deliver the trust's clinical strategy, including all strands of quality governance, quality performance and quality improvement. Divisional chairs should also have a responsibility to contribute to the work of the chief medical officer by liaising closely with the deputy chief medical officer roles	2.4.1 Develop a role description for divisional chair 2.4.2 Establish monthly 1:1 cycle with CMO 2.4.3 Develop a set of agreed annual objectives with CMO and schedule 6 monthly review 2.4.4 Implement the revised structure, systems and processes throughout the division to enable the early identification and escalation of upcoming risks, particularly those relating to patient safety	COO	COO	31.03.2020		Appointments have been made and the new post-holders will start in the New Year.	Divisional chair role description 1:1 schedule in diaries Annual objectives Revised terms of reference Standardised agenda		Cost neutral
10.5, page 31	2.5	**Care Group Governance Lead Role:** All care group governance leads to have a generic job description that aligns with the chief medical officer's expectations and they are expected to have a clear understanding of their role and its contribution to the quality and safety of patient care. In recognition of these expectations, they should be given comparable SPA time to deliver their role, as well as administrative resource. They should all be capable of and expected to influence quality improvement within their care group, and should be considered a priority for the spread of QI tools and techniques by the QI academy. They should work closely with the team of the quality partner within each division and should also have the opportunity to come together periodically to share learning and good practice.	2.5.1 Develop a role description for care group governance lead 2.5.2 Establish monthly 1:1 cycle with Divisional Chair 2.5.3 Develop a set of agreed annual objectives with DC and schedule 6 monthly review including to undertake specific training in QI methodology 2.5.4 Establish a monthly care groups lead forum in addition to the regular care group lead development days	CMO	CMO Business Manager	31.01.2020		A draft clinical governance lead JD has been developed and will be shared with clinical governance leads in December 2019.	Generic job description 1:1 schedule in diaries Annual objectives Training records Revised terms of reference Standardised agenda		Cost neutral
10.6, page 32	2.6	**Divisional Director of Nursing and Governance Role:** The review team strongly recommends that the DDNG role should be recognised within the divisional triumvirate as an equal partner, and report directly to the divisional chair rather than through the divisional director of operations	2.6.1 Consider a revised reporting structure of DDO and DDNG to the divisional chair 2.6.2 Consider extending SIDM to include DDNGs	COO	Divisional Chairs/ SIDM panel	31.01.2020		Initial discussions commenced at Commcell with senior leaders providing views re divisional triumvirates and the accountability framework. Further discussion has been held to agree actions with the COO and Director of Quality Governance and Compliance.	Revised reporting structure in place. Revised membership of SIDM in place.		
10.7, page 32	2.7	**Clinical Effectiveness and Audit:** The trust should consider how it elevates the profile of clinical audit and effectiveness as a valuable element underpinning continuous quality improvement. Whilst national audit methodology is prescriptive for the most part, local audits and the utilisation of junior doctors and nurses can be directed so that this work is contributing to cycles of improvement and learning. Including clinical leadership responsibility for this in one of the recommended deputy chief medical officer roles is key to providing corporate direction for doctors and nurses, as well as the corporate clinical audit and effectiveness team	2.7.1 Identify a clinical leader for clinical governance and effectiveness - as part of one of the deputy CMO roles 2.7.2 Develop a targeted approach for local audits for inclusion in the clinical audit annual plan to utilise junior doctors and nurses 2.7.3 Initiate quarterly reports to PSQG re NICE guidance compliance 2.7.4 Re-establish the clinical effectiveness committee with the clinical lead as Chair to drive the development of the annual Clinical Audit Plan	CMO	Director of Quality Governance and Compliance	31.01.2020		A job description for a Deputy CMO with clinical effectiveness in their remit is complete. The clinical audit team under the Chief Nurse has been redesigned and will be headed by a Band 8a clinical audit lead. The JD has been written. 25.09.2019 - The Clinical Audit Manager is now part of the Quality Improvement Academy meeting with QIA colleagues on a weekly basis			
10.8, page 32	2.8	**Legal Services:** The trust should increase the capacity within this team by appointing a minimum of 1 wte . This role should be sufficiently senior to operate as a deputy to the head of legal services, and therefore should be within the band 8 senior manager pay scales. This would expand the capacity and resilience of the service and provide an opportunity for succession planning within this team.	2.8.1 Review and agree final structure 2.8.2 Develop a business case for investment and take through IDDG 2.8.3 Develop job description for deputy head of legal services 2.8.4 Develop and implement recruitment strategy for the new posts including application of organisational change policy as appropriate	CCAO	Legal Services Manager	31.03.2020		The proposal made in the public Trust Board paper (December 2018) will strengthen and increase capacity within legal services, and will ensure the team is resouced to be able to respond to the exponential rise in the number and complexity of claims and inquests in recent years and to implement the vision for learning from claims and inquests set outt in the July 2019 Patient Safety Strategy. Relevant job descriptions are in development.			TBC: IDDG business case value TBC

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2.6

Meeting Title:	**Trust Board**		
Date:	19 December 2019	**Agenda No**	2.6
Report Title:	RTT Clinical Harm Impact Review Closure Report		
Lead Director:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Dr Renate Wendler, Trust Clinical Incident Lead Matthew Davenport, Deputy Director – Elective Care		
Presented for:	Assurance		
Executive Summary:	In April 2016 the Trust identified a significant data quality issue in relation to recording accurate Referral to Treatment (RTT) data. This was identified through the investigation of a Serious Incident (SI) in relation to a patient who not followed up appropriately in an outpatient clinic. The Trust commissioned MBI Health Group to undertake an independent external assessment on the Trust's RTT data quality. The external assessment commenced in May 2016 and the finding was presented in a report to the Trust Board held in June 2016. The Trust Board took the decision to suspend national RTT reporting with immediate effect as a result of the finding of the external assessment and subsequent discussion. In response to this the Trust set up an Elective Care Recovery Programme (ECRP) and appointed an RTT Programme Director in October 2016. The ECRP was focused on validation of pathways and establishing a Clinical Harm Review Programme (CHRP). This process took just over two years. Following discussion at the Trust Board held in December 2018, the Trust initiated a further external assessment in January 2019 and the decision was made to resume reporting nationally on RTT and performance from end of January 2019. In September 2019 the Trust resumed reporting nationally on RTT and performance at the Queen Mary Hospital site Internal and independent assessments of our waiting lists confirm that the systems and processes for managing patient pathways are safe and robust. Since the Trust has resumed reporting nationally on RTT and performance there have been no Serious Incidents declared as a result of the patient being lost to follow-up (e.g. not completing treatment or being discharged or referred elsewhere appropriately). As of 13th November 2019, the ECRP has now been concluded. This report outlines the methodology and outcomes of the CHRP and actions taken in response.		
Recommendation:	The Board is asked to consider the assurance provided in this closure report that the learning from the RTT Clinical Harm Impact Review has been robustly acted upon, and that the Clinical Harm Impact Assessment has fully identified any harm that arose, and that statutory Duty of Candour has been discharged.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person Right care, right place, right time		

CQC Theme:	Safe, Effective and Well Led		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee Quality and Safety Committee	**Date**	11.12.19 12.12.19

RTT CLINICAL HARM IMPACT REVIEW CLOSURE REPORT – DECEMBER 2019

1.0 PURPOSE

This report provides assurance that the learning from the RTT Clinical Harm Impact Review has been robustly acted upon, and that the Clinical Harm Impact Assessment has fully identified any harm that arose, and that statutory Duty of Candour has been discharged.

2.0 BACKGROUND

In April 2016 the Trust identified a significant data quality issue in relation to recording accurate Referral to Treatment (RTT) data. This was identified through the investigation of a Serious Incident (SI) in relation to a patient who not followed up appropriately in an outpatient clinic.

The Trust commissioned MBI Health Group to undertake an independent external assessment on the Trust's RTT data quality. The external assessment commenced in May 2016 and the finding was presented in a report to the Trust Board held in June 2016. The Trust Board took the decision to suspend national RTT reporting with immediate effect as a result of the finding of the external assessment and subsequent discussion.

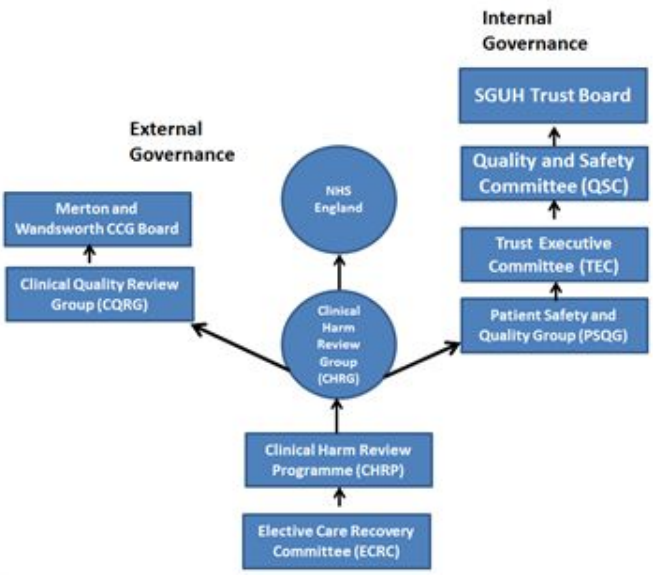
In response to this the Trust set up an Elective Care Recovery Programme (ECRP) and appointed an RTT Programme Director in October 2016. The ECRP was focused on validation of pathways and establishing a Clinical Harm Review Programme (CHRP). This process took just over two years.

3.0 THE CLINICAL HARM REVIEW PROGRAMME (CHRP)

Following the appointment of the RTT Programme Director in October 2016, the Elective Care Recovery Programme (ECRP) was set up with the initial agenda to validate and correct historic patient records, assess patients with excessive waits for clinical harm and expedite patient treatment where appropriate, and ensuring data capture was accurate and complete.

3.1 GOVERNANCE OF THE CLINICAL HARM REIVEW PROGRAMME (CHRP)

Chart 1: External and Internal Governance of CHRP



The Clinical Harm Reviews were performed by a number of independent GPs who reviewed individual cases of patients identified as requiring a clinical harm review (either lost to follow-up or excess waits) and reported the level of harm the patient may have experienced.

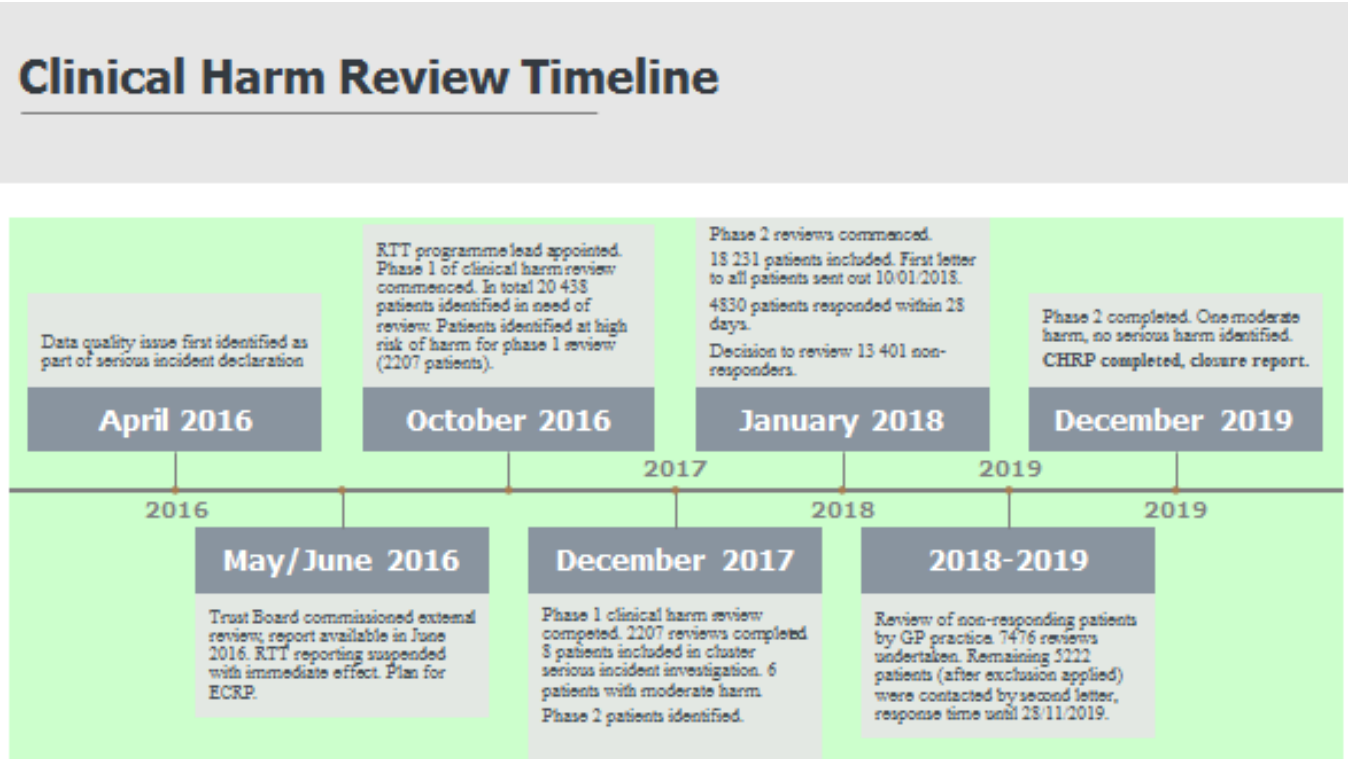
The CHRP was managed and governed internally through Patient Safety and Quality Group (PQSG) which received a monthly update on the latest available position. PSQG is chaired by the Trust's Chief Medical Officer and Chief Nursing Officer and is attended by Merton and Wandsworth CCG.

CHRP also reported monthly into the Elective Care Recovery Committee (ECRC). The ECRC was formed as part of the ECRP and was chaired by the Trust's Chief Executive Officer (CEO) and attended by key stakeholders from Merton and Wandsworth CCG and NHS Improvement (NHSI).

The CHRP was reported to NHS England through the Clinical Harm Review Group (CHRG). The membership of the CHRG included the Trust's Chief Medical Officer, Director of Quality and Governance, Deputy Director of Elective Care, Divisional Clinical Chairs and was chaired by the Director of Nursing for South London.

3.2 TIMELINE OF THE CHRP

Chart 2: Timeline of the Clinical Harm Review Programme



3.3 METHODOLOGY OF THE CHRP

Phase 1

The CHRP reviewed 20 438 pathways where it was unclear if patients had come to any clinical harm. There was two phases to this work (Phase 1 and Phase 2).

Phase 1 reviewed pathways where there was a higher risk of clinical harm to patients. The criteria for review in Phase 1 are given below:

- Patients who had waited over 52 weeks where treatment had not been recorded (52 week breach)
- Patients who had started on a cancer 2 week wait pathway and appeared to have been lost to follow up
- Patients who had appeared to be on a cancer pathway for over 104 days
- Paediatric patients who had appeared to have been lost to follow up
- Overdue planned patients (minimum of six weeks past due date)
- Complaints from patients in relation to their waiting times
- A cohort of incident reports reported on the Trust's incident reporting system which suggested a delay in patients receiving treatment
- Primary Care Alert from GP's highlighting concerns related to individual patient pathways

Using the above criteria, a total of 2207 patients identified as requiring review in Phase 1. The RTT Programme Director in conjunction with the Trust's Lead Commissioners Merton and Wandsworth CCG identified six external independent GP's to review the identified Phase 1 patients. To complete the reviews, the GPs worked on-site at St George's Hospital, Tooting. Phase 1 was completed in December 2017, nine months after the work commenced.

Phase 2

Between October 2017 and December 2017, a second cohort of patients was identified through the ECRP. These patients were understood to be significantly lower risk than those identified in Phase 1. A total number of 18 231 patient pathways were identified and highlighted as Phase 2 of the CHRP. The approach taken to manage this volume of patients was to contact all 18 231 patients by letter using an external mailing organisation. On 10th January 2018 the Trust sent out letters to all of these patients asking them to contact the Trust if they had been seen, required to be seen or no longer wanted to be seen, as it was unclear from the Trusts records. Patients were given 28 days to respond to the letter, in which time a total of 4830 patients responded. All the patients who responded to this letter were contacted by the appropriate service and either discharged or received a follow-up via telephone or appointment. Of the patients who responded to the letter there was zero harm identified.

A total of 13401 patients didn't respond to the letter within the 28 days and a decision was made that all of these patients should have their clinical pathway reviewed. The purpose of this review would be to identify whether the episodes of care were complete, or whether any further follow-up was required. The patient's referring GP practice were asked to review and report whether they suspected any clinical harm had occurred to any patient being lost to

follow-up by the end of April 2018. A total of 7476 reviews were undertaken. There were a further 5925 patients who had not received a review from the referring GP practice.

As agreed with Merton and Wandsworth CCG and at PSQG, a second letter was sent to these patients asking them to contact the Trust if they were still waiting to hear from the speciality they were referred to initially. It was agreed to apply the following exclusions:

- Deceased patients.
- Patients who had been seen since 2nd January 2018 on the same pathway (not necessarily the same specialty).
- Patients who had an appointment up to the 31st December 2019 on the same pathway (not necessarily the same specialty).
- Patients on the planned waiting list within the same speciality with a future due date to be seen.

After applying the exclusions to patients who did not receive a GP review, a total of 5222 patients had a second letter sent. A date of 8th November 2019 was given as the deadline for the response to the second letter. The CHRP has now been concluded. The position of the responses to the second letter is described in Table 1 below.

Table 1: Phase 2 response to second letter progress table (as of 13th November 2019)

	Total
Total Patients	**5,222**
Total Responses	**854**
Source Of Response Email	**79**
Source Of Response Post	**775**
Total Remaining	**4,386**
No I don't need an Appointment (Discharge)	**521**
No I don't need an Appointment (Patient is still on a Active Pathway)	**28**
Yes I need an Appointment	**169**
Service response received	**0**
Im not sure	**136**
Service response received	**0**

3.4 CHRP CATEGORIES OF HARM

The specification for the review of a patient's care by local GP practice was developed by Merton and Wandsworth CCG and the definition of harm was measured against four defined criteria, which were agreed with NHSE and the CCGT and are outlined below.

- No Harm: In the clinician's opinion, the patient has suffered inconvenience only.

- Low Harm: In the clinician's opinion, the patient has suffered inconvenience, e.g. prolonged discomfort, not leading to a need for significantly changes in treatment or causing physical harm.

- Moderate Harm: In the clinician's opinion, the patient has suffered moderate physical or psychological harm.

- Severe Harm: In the clinician's opinion, the patient has suffered significantly on a similar level to the triggering of a Serious Incident (SI).

3.5 OUTCOMES OF CHRP

Phase 1

In conclusion to Phase 1 of the CHRP (2207 patients initially reviewed by the group if independent GP's), there were a total of 2110 no harms, 76 low harms, 6 moderate harms, and 15 severe harms.

Within the CHRP any patient that was independently reviewed and graded as moderate or severe harm were sent to the speciality that the patient was being initially referred to for feedback on why the patient's care may have been delayed and whether clinicians would agree with the assessment of harm. In case of moderate or severe harm normal Trust governance processes would be deployed, e.g. submission of an incident report and subsequent discussion at the Serious Incident Declaration Meeting (SIDM) as appropriate and serious incident declaration as per NHS framework.

After further review by the speciality and discussion at SIDM, it was determined that the majority of severe harm cases that were initially identified by the CHRP did not meet the Serious Incident Criteria. The decision to not declare a serious incident was only taken if there was clear evidence provided that the delay to the patient's pathway did not contribute to any adverse outcome. All cases where serious incidents were declared were reviewed at the CHRG and the external board meetings with NHSI and Merton and Wandsworth CCG.

Of the cases identified as severe harm at initial review in Phase 1 (15), 8 were subsequently complied in a cluster SI to identify common themes. Four patients of the eight patients included in this cluster SI report have subsequently died.

To assess avoidability of the deaths, expert clinical oncologists were asked to provide an independent clinical assessment of the patient pathways and whether a delay in care contributed to the eventual outcome and to score each case to this regard:

Outcome 1: *Delay in care did not contribute to the death of the patient*

Outcome 2: *Delay in care may have contributed to the death of the patient*

Outcome 3: *Delay in care definitely contributed to the death of the patient*

Independent assessment concluded that in one case the delay in care did not contribute to the death of the patient as they died from a different pathology, where in the remaining three cases the delays may have contributed to the eventual outcome. The information from the above is being used to inform the referrals made to the Coroner for these four patients.

The other four patients where severe harm was found are being continually reviewed on a monthly basis. In all four cases, the diagnosis of cancer, or the appropriate initiation of treatment of cancer, was inappropriately delayed.

Phase 2

Of the 4830 patients who responded to the first letter, 4792 patients were discharged and 38 patients requested an appointment. All of these 38 patients were seen and no harm was

identified. Of the 7476 patients who did not respond to the initial letter and whose cases were reviewed by the patient's referring GP, 35 patients were identified as having suffered low harm as a result of the delay to their care pathway one patient was identified as having come to moderate harm and zero patients were identified as having suffered severe harm.

Table 2: Patients reviewed in Phase 2 by Borough

	Merton &Wandsworth	Croydon	Richmond	Kingston	Sutton	OUT	Total
Total Patients	7,447	723	1,269	682	414	2,866	**13,401**
Total Responses	5,584	638	719	355	180	0	7,476
Total Remaining	1,863	85	550	327	234	2,866	5,925
Total No Harm	5,158	573	643	321	156	0	6,851
Independent review confirmed Low Harm	25	4	2	3	1		35
Other (Dental referral, patient not regestered with GP, treated at other provider)	401	61	74	31	23	0	590
(GP) Total Harm Un-categorised	2	0	1	0	0	0	3
(GP) Total Low Harm	0	0	0	0	0	0	0
(GP) Total Moderate Harm	2	1	0	0	0	0	3
(GP) Total Severe Harm	2	0	0	0	0	0	2
Patients outstanding for Independent Review	0	0	0	0	0	0	0
Total Indpendent Reviews Completed to date	150	28	4	8	11	0	201
Indpendent Review Moderate Harm	2	1	0	0	0	0	3
Indpendent Review Severe Harm	2	0	0	0	0	0	2
Patients put forward for Internal Review	4	1	0	0	0	0	5
DATIX Raised	3	1	0	0	0	0	4
Patients confirmed Moderate Harm	1	0	0	0	0	0	1
Patients confirmed Severe Harm	0	0	0	0	0	0	0

4.0 DUTY OF CANDOUR

In line with NHS standards, duty of candour was discharged for all moderate and severe harm incidents and an apology provided to the patients and relatives of all those included in the report for providing a standard of care that fell short of high standards we would expect.

5.0 LESSONS LEARNED AND CHANGES IMPLEMENTED

The following lessons learnt and recommendations that appear below in italics are taken directly from the Cluster Serious Incident Investigation Report (August 2018).

5.1 OPERATIONAL AND PROCESS

1. *Operational/Process Systems – failure with services operating with paper-based systems that was open to human assumptions and errors*:

   As a result of the learning from the RTT problems, the Trust now has robust processes to track patients on all Patient Tracking Lists (PTL). This includes Referral To Treatment (RTT) PTL (split by first appointment PTL, Follow up/continuing PTL and admitted PTL), non-RTT PTL, Patients being actively monitored, Planned patients. These reports are refreshed daily and data quality monitored through a daily Data Quality (DQ) dashboard.

2. *Quality Assurance – variances in process and data collection systems across the Trust that are difficult to compile and/or audit patient information*:

   Validation and audits are undertaken monthly to ensure DQ is within acceptable margins. The Trust audit results and findings have now been externally reviewed on three separate occasions, all passing as fit for purpose.

3. *Processing of Patients Information/Documentation Within Department Offices – the exchange processes of patient's information or documentation between departments led to the loss of paper documents/faxes with email channel being the most reliable:*

Electronic referral systems have been introduced. This enables the Trust to track all patients on all PTLs. The Trust now tracks the outcomes of patients including those without a next event (unbooked) as part of the weekly governance structure for performance management. These reports are reviewed weekly in speciality level PTL meetings, weekly Access Meeting, Fortnightly Access Committee and DQ metrics tracked quarterly through Trust Executive Committee (TEC), Quality and Safety Committee and Trust Board.

5.2 COMMUNICATION

4. *Internal Communication – led to a loss of opportunities for service to service dialogue particularly with some diagnostic services. This led to suspicion of malignancy not emphasised or highlighted sufficiently. Breakdown in communication has also caused some procedural delays:*

The Trust now operates an electronic referral process which negates the use of paper referrals. Patients referred via a cancer Two Week Rule (TWR) are tracked daily by the Trust cancer team. All patients at every stage of their pathway are closely monitored from referral through to treatment. This is overseen by the General Manager for cancer. The Trust has for the last four months (July – October 2019) achieved all nine cancer performance metrics.

5. *Patient Factors – with a growing and aging population there appear to be an increase in the elderly with comorbidities; families do not appear to have been fully informed and the patients GP not utilised adequately. In addition other patient factors i.e. choice, communication, inaccurate contact details etc. can impact negatively on the patient's pathway timeline:*

This remains an external factor that will continue to impact patient pathways.

5.3 TRAINING

6. *Staff are the most valuable asset of the Trust and with changes to systems and personnel staff require the appropriate training to ensure they can operate effectively and efficiently to manage their patients:*

Comprehensive on-line training on RTT processes at Level 1, Level 2 and Level 3, has been added to the Trust's Mandatory and Statutory Training (MAST) Programme. This is required by appropriate members of staff from different professional groups, including nursing and midwifery, allied health professionals, medical and administration and management.

As part of the Elective Care Recovery Programme (ECRP) the Trust delivered a comprehensive training programme to ensure staff were equipped to undertake the role they were appointed to. More information can be found in the recommendations section.

6.0 RECOMMENDATIONS

1. *Implementation of a 'live' Patient Tracking List (PTL) that will track and manage all patients that are referred to the Trust for diagnosis and treatment:*

The Trust introduced a new live Patient Tracking List (PTL) in Feb 2017 called Patient Management Module (PMM). Whilst this PTL was live and refreshed daily it took until December 2018 to ensure its accuracy and fitness for purpose. The Trust was audited by the Intensive Support Team (IST) part of NHS Improvement (NHSI) along with an external data quality audit undertaken by MBI Health Group. Both organisations were in support of the Trust returning to report as a result of their findings.

2. *Provide mandatory Referral To Treatment (RTT) training and on-going RTT support to all clinical and non-clinical staff to ensure they can use the 'live' PTL and improve data quality:*

Training was mandated for all staff with access to iClip throughout the Elective Care Recovery Programme (ECRP). This included online RTT training designed by the IST, Clinical Decision Outcome Form (CDOF) training for clinicians as well as class room session for specific groups of staff tailored to job role. More recently targeted training has been provided following review of the data quality dashboard which was introduced ahead of returning to national RTT reporting in January 2019. As part of returning to national reporting the Trust has also committed to undertaking future external Data Quality (DQ) assessments the most recent of which took place in November 2019.

3. *Ensure the learning is cascaded through the Trust and included in existing ECRP and Outpatient Transformation action plans:*

Action plans have been developed for the continued management of all tracked data quality metrics. This highlights, where required, training needs and learning is shared throughout the governance structure of the Elective Care Programme.

Following discussion at the Trust Board held in December 2018, the Trust initiated a further external assessment in January 2019 and the decision was made to resume reporting nationally on RTT and performance from end of January 2019.

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3.1

Meeting Title:	Trust Board Meeting		
Date:	19 December 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 05 December 2019, including commenting on assurance to the Board on key risks allocated to the Committee.		
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		

1. Committee Chair's Overview

We had good attendance at the meeting although it was disappointing that representatives of MedCard and CWDT did not attend, or apologise for absence. The areas of focus at this month's meeting were: updates on staff engagement; update reports from both of our Guardians; and a detailed review of staffing levels and cost, against a background of increasing financial pressure within the Trust.

We received good assurance on the processes to identify the need to use additional resource via our flexible workforce of bank and agency staff, and looked at current trends. However, we remained concerned about the level of Trust-wide planning behind this. Those present at the meeting could not identify a single, agreed, forward-looking target or budget metric for WTE staff numbers or pay spend across the Trust, against which performance could be managed. In the absence of a definitive answer here, we agreed that this question would be progressed by the Finance and Investment Committee. The issue was raised at FIC and confirmation provided there that there is a clear plan. A follow-on briefing meeting is to be held to address this.

2. Key points:-

Board Assurance

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 these risks was discussed. The Committee concluded that it would recommend to the Board that risk ratings for these should remain as currently set, albeit that solid progress was being made in many areas to mitigate the risks.

Strategic Themes

Theme 1 - Engagement

Staff Survey – the NHS national staff survey had closed with a combined response rate from St George's and Queen Mary's staff of c57.6%, an improvement on last year's 54.6%. The results will expected be published in March next year.

Staff Engagement Plan 2019 - 21 – Liz Wood reported to us on a new initiative, to be personally led by the Trust CEO, to move forward the culture of the Trust, and wider organisational development. The delivery mechanism for this will include the Staff Engagement Plan, and whilst the actions and timescale in this remain unchanged, they will be absorbed into a wider programme of action. Whilst welcoming of this wider initiative, we want to retain focus on the engagement plan, and will therefore receive a detailed progress update on this, as originally planned, at our February meeting.

WRES - The Trust lead is now back at work and we look forward to the re-initiation of progress here. The interim support from Epsom and St Helier has made solid progress in the meantime, and we hope that this support can be continued for a while. We received a report on the progress being made on actions within the Diversity and Inclusion Strategy.

Pension Scheme – Lifetime and Annual Allowances - the Committee was briefed on an initiative from DHSC which would, if implemented, address a number of concerns raised by our Consultants and potentially remove an impediment to additional working hours. However, this would not address the position of other senior staff.

Partnership Forum – it was reported to us that this forum, involving staff-side liaison is being re-invigorated.

Theme 2 – Leadership and Progression

We received a report that the Trust has commenced a programme of work on changing the culture of the organisation and is inviting a cross section of staff to become culture champions, who will work as part of

[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.

a team being led by the CEO and who will be taught to use the NHSI/E culture tools to start to deliver sustainable culture change across the Trust.

Theme 3 - Workforce Planning and Strategy

The draft Workforce Strategy we had reviewed at an earlier meeting had been updated, and then approved by the Trust Board at its November meeting. The focus on three core areas (recruitment; retention; and new roles) was also approved by the Board, and we had a short update on how the strategy would be translated into a series of targeted initiatives. We endorsed the proposed approach and will, at our February meeting, review the 2020/21 Delivery Plan that is now being created.

We reviewed a number of **workforce statistics**. Sion Pennant-Williams summarised the differences between the two 'establishment' numbers the Trust maintains, and whilst these could be reconciled more closely, there remained a material variance. One result of this reconciliation has been to allow the Trust's vacancy rate to be recalculated, with a consequent reduction to 9.68%. The same report to the Committee noted that "…*it is clear that actual FTE plus bank and agency FTE are higher than the established FTE..*" .

This raised a question of whether the Trust was deploying more resource than planned. There was a helpful discussion on this, but the Committee noted with concern that there appeared to be no single, agreed forward-looking target or budget metric for WTE staff numbers across the Trust, against which performance could be managed. The long discussion on this ultimately did not yield a conclusion, and it was agreed that this would therefore be raised at the Finance and Investment Committee the following week.

Sickness levels across the Trust as a whole had risen slightly to 3.73% (but down from the 4% reported 12 months ago), but some areas had sickness levels well in excess of 7%. Given the cost to the Trust of staff sickness, the Committee will review current practice at its next meeting. MAST compliance continues to trend at c 90%. Staff turnover is up almost 1% on a year ago, at 17.78%. The flu vaccine uptake by staff was 81.7% at the time of the Committee meeting.

We received a detailed report from Justin Sharp (our Temporary Staffing Manager) on the Trust's use of flexible staff (via bank or agency). An extract is attached in Appendix 1. Justin summarised the current position, and some of the market challenges. Flexible staff currently represents circa 10% of our deployed WTEs and are therefore a critical part of our workforce on a continuing basis. The reality is that our use of such staff is not temporary, but rather a critical and continuing part of our total deployed workforce. Justin reminded us that a good proportion of our bank (3,800 or 62%) comprises staff with a substantive contract at the Trust choosing to work additional hours.

An increasing number (currently 2,300, representing 37% of bank staff) are choosing to work on a Full Bank (or bank-only) basis with the Trust. Justin set out how our rostering systems across the Trust engage with bank staff and ensure timely allocation of shifts, although a number of these are allocated within 24 hours of start time. For nursing bookings with a long lead-time, bank fill achieved was 92% - although for short-term bookings it was more difficult to secure a bank fill, and therefore bank fill fell to 41% and agency use increased to 25%. The clear message was that early notice of demand supports a cost-effective solution. There is a move for the bank to work collaboratively across the whole of south-west London.

Theme 4 – Compliance

Freedom to Speak Up – we received a progress report from Liz Woods on the Trust's Guardian programme, and noted that the processes appeared to be working, with concerns being raised and escalated. This Report covered the period July to September with 19 concerns raised, 15 related to bullying and four to patient safety. (The previous quarter had seen 9 concerns in total, although it is not clear whether the increase reflects increased awareness of the Guardian's role, or a step change in the level of concern within the Trust) However, the speed with which concerns are being addressed and resolved by the Trust is an increasing issue, and so Harbhajan Brar will review with the Guardian what steps can be taken to address this, and report back to the Committee at its next meeting.

Safe Working – Junior Doctors - We reviewed a detailed report from the Trust's Guardian Of Safe Working Hours, Dr Serena Haywood. The general picture is of a modest reduction (against prior quarter) in exception reports, but still an increase on prior year as reporting becomes more established. The position across different care groups is stark and it is clear that there are some areas where there is a persistently high level of exceptions being reported. One cause of this is rota gaps in those areas, generally driven by the challenges of recruiting to junior doctor posts. Across the Trust, as at the end of November, there were 18 rota gaps (out of 172 posts) and it was noteworthy that 11 of these gaps were in adult critical care. Serena acknowledged that the Trust was getting better at covering these, but one consequence was that this was shifting the pressure from our junior doctors to our Consultants and our Hospital Trust Doctors and Fellows although a reporting system like that for the trainees would help provide the scale of this. Serena's full report will be in the Board papers.

Serena's assessment continues to be that our junior doctors are generally more willing to flag and report concerns, and that consultants are becoming more receptive to this and taking actions to address it. Engagement from Divisional representatives appeared to be better, with an improved focus on addressing issues as they arose, rather than after the event. Improved anticipation of rota gaps would help address them in advance, and the roll-out of the e-rostering would flag gaps earlier. The Trust has still not reached a decision on how the £60K junior doctor wellbeing grant from DHSC is to be used, although a working group has now been set up to progress this.

The overall conclusion though was that despite good intentions all round, the core driver remained rota gaps (currently running at circa 10%, and largely a function of a tightening junior doctor employment market) and the intensity of out-of-hours service demand at busy times.

The Committee noted the changes that were being made to rotas following the 1 December implementation of the new contract for junior doctors. This will create additional pressures, notably as a result of its prohibition of 1 in 2 working. Much work has been done internally to prepare for this, but there will be some areas that cannot deliver compliance and which will therefore, for a permitted transitional period, continue to use a 1-in-2 rota.

Fit and Proper Persons Test - Policy – we reviewed and endorsed an updated FPPT Policy, and this has already been to Board for approval.

MHPS – we received an update on the work being done to update the Trust's policy on Managing High Performance Standards for Consultants and Hospital Doctors.

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

10 December 2019

Appendix 1 – Temporary Staffing Fill charts

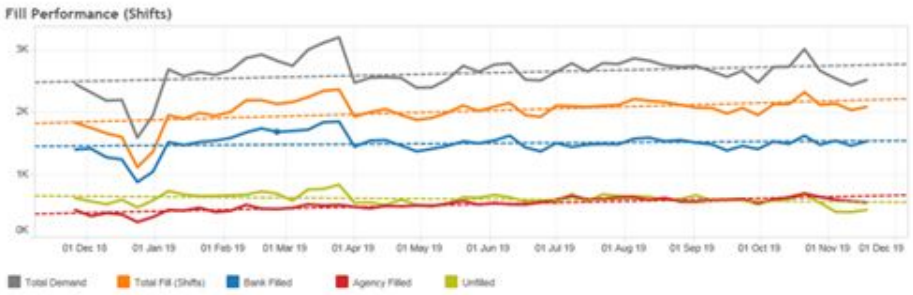
Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

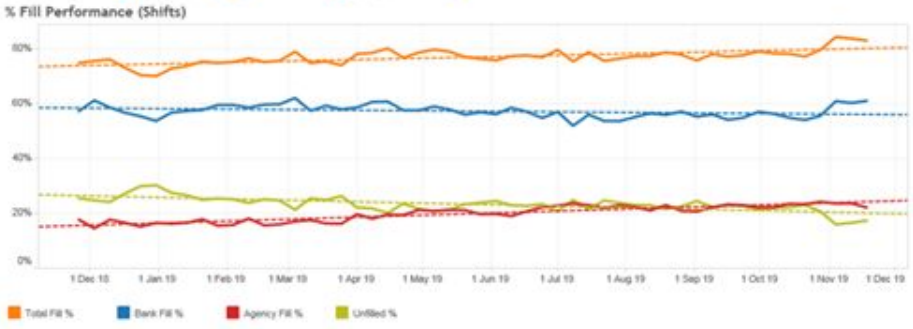
3.1

Temporary Staffing Demand and Fill performance

Trust total



Over the last year the trend for Temporary Staffing Demand has increased, Bank fill has a small increase, Agency fill has significantly increased, and unfilled shifts have slightly decreased.



The graph above shows that Bank is filling more actual hours, as a percentage of the total Demand, Bank fill is slowly decreasing. Agency fill % is increasing dramatically, and unfilled shift % is decreasing.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

3.1

Meeting Title:	Trust Board		
Date:	19 December 2019	**Agenda No**	**3.1.1**
Report Title:	Freedom to Speak Up Guardian Report - Raising Concerns Update		
Lead Director/ Manager:	Harbhajan Brar, Chief People Officer		
Report Author:	Karyn Richards-Wright, LIAiSE Adviser and Freedom to Speak Up Guardian Liz Woods, Head of Staff Engagement and Recognition		
Presented for:	Assurance		
Executive Summary:	This report provides an update about current activity in the Trust around raising concerns and freedom to speak up.		
Recommendation:	The Board is asked to note the current Freedom to Speak Up activity and the actions taken to date against both the 'learning from case reviews' plus actions taken against the new guidance issued in July 2019 by the National Guardian's office.		
Supports			
Trust Strategic Objective:	Build a better St George's; Champion Team St George's		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	Failure to comply with the requirements around Freedom to Speak Up, a regulatory requirement, risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.		
Legal/Regulatory:	NHSI, Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy for the NHS, April 2016. Sir Robert Francis QC, Freedom to Speak Up: An independent report into creating an open and honest reporting culture in the NHS, 2015.		
Resources:	n/a		
Equality and Diversity:	n/a		
Previously Considered by:	Workforce & Education Committee Trust Executive Committee	**Date**	05/12/2019 11/12/2019
Appendices:	n/a		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Freedom to Speak Up Guardian Report
Raising Concerns Update

1.0 PURPOSE

1.1 This report seeks to update the Trust Board about on-going work to manage and enhance the Trust's raising concerns function.

2.0 BACKGROUND

2.1 The Trust's corporate objective of Champion Team St George's is set to deliver a significant shift in the St George's culture through, amongst other things, taking a zero tolerance approach to bullying and harassment where staff know how to raise concerns (through Freedom to Speak Up) and feel confident the Trust will take action to address these.

3.0 CURRENT ACTIVITY

3.1 During Quarter 1 (April to June 2019), 9 concerns were raised pertaining to bullying and harassment and patient care.

3.2 During Quarter 2 (July to September 2019), 19 concerns were raised. Of these 19, 15 had elements of bullying and harassment, culture and leadership and four had elements of safety and quality.

3.2 Work to identify a suitable software provider for a new Raising Concerns recording system is progressing. We have identified the preferred supplier; we have procured the software and are working with IT to ensure our systems can provide the infrastructure to support the installation of supplier software. We anticipate implementation and roll out during January 2020.

3.3 Our network of Freedom to Speak up Champions is now fully trained. Further comprehensive training for Directors is planned for January 2020. This will provide the opportunity for the policy and the function to be understood and embedded further.

3.4 The Guardian remains concerned at how long it can take for some concerns to be responded to. It is anticipated that the implementation of the new software (see 3.2 above) will trigger alerts and the upcoming training for Directors (see 3.3 above) will see an improvement in this. There is still however an issue to be addressed with regard to the length of time HR processes take and the knock on effect this is having on staff morale and sickness rates. For example, the Guardian is still receiving reports of staff waiting up to 18 months for cases to be resolved; some staff have reported to the Guardian that they have been off sick for nearly all of that time due to stress and anxiety.

3.5 The reporting line for the Freedom to Speak Up function and the Guardian needs to be formally reviewed. This issue has been picked up in both the CQC report and accords with advice from the National Guardian's Office.

4.0 LEARNING

4.1 Earlier this year, the Trust Board received a report detailing the learning from case reviews undertaken by the National Guardian's Office and how we would apply this learning at St George's. What follows updates on progress the Trust has made on implementing the learning's and it also includes an update against the new guidance issued in July 2019 by the National Guardian's office.

4.2 This guidance is also helpful in providing a template for future FSUG (assurance) reports to Trust Boards

Recommendation	Status
The Trust should ensure that all concerns raised by staff are addressed in accordance with good practice including where staff have raised serious safety issues.	• The good practice checklist has been introduced and is being used by the Freedom to Speak up Guardian and Champions.
Evidence of bullying in the Trust, including existence of a bullying culture within specific teams that made staff fear the consequence of speaking up. The Trust should provide all staff with mandatory, regular and updated training on speaking up.	• This item is outstanding. • The Guardian is in the process of scoping up a training programme and plan for delivery.
The Trust should ensure that in accordance with its own policies and procedures and in accordance with good practice, all managers and leaders responsible for handling speaking up concerns provide feedback to every individual who raises an issue, including any actions they intend to take in response.	• The good practice checklist has been introduced.
The Trust should take steps to identify which staffing groups feel particularly vulnerable when speaking up, where this is the case and how those groups can be supported to speak up freely and are protected from any detriment having done so.	• All areas of the Trust now have access to a champion/guardian. • New software will enable us to identify particular staff groups.
The Trust must ensure that all existing and new staff are aware of the contents of its revised raising concerns policy.	• Freedom to Speak Up has a regular slot at Corporate Induction; we have also produced a FSU Quick Guide for staff. • We continue to communicate out the role through various communications channels. • Training for Executive planned, advocacy of Champions.
The Trust must ensure that all investigations into the alleged conduct of staff who have previously spoken up also seek to identify whether such allegations are motivated by a desire to cause detriment because that staff member spoke up and, where such evidence is found, take appropriate action. This should include amending the Trust disciplinary procedure to require such action.	• The good practice checklist has been introduced.

Recommendation	Status
A communications and engagement strategy should be developed to promote Freedom to Speak Up. This should include strategies to provide feedback on actions taken in response to speaking up and actions to tackle barriers to speaking up.	• Items in eG at least every other week, incorporating feedback/learning/actions.
Staff leaving the Trust should be given the option of an exit interview with the Guardian should they so wish to raise any concern which may have prompted the individual's decision to resign.	• The Guardian's details will be included in leaving questionnaire/email sent to staff, so they can request a FSUG exit interview.
The Trust should ensure that workers who wish to raise matters with the non-executive director responsible for speaking up are able to do so via routes of communication that appropriately support their confidentiality.	• The NED contact details are included in policy and available from Guardian and Champions.
The Trust should ensure that, in line with good practice, it values the views of its workers, including consulting staff about changes to their services.	• Include in relevant policies and training.
The Trust should ensure that all speaking up cases are investigated by suitably independent persons.	• Active list of independent persons is now available.
The NHSI speaking up policy requires that investigators into speaking up matters should be "suitably independent". It is advised that the trust draws up a list of independent persons who can investigate speaking up cases.	• Active list of independent persons is now available.
The Trust should take appropriate steps to ensure that where the grievance process is used to respond to a worker speaking up the Trust's grievance policies and procedures are correctly followed, including in respect of providing an initial scoping meeting to discuss the matter the worker is speaking up about and the range of alternative processes for handling it.	• We are working to ensure that this is included in grievance policy and good practice checklist.
The Trust should take appropriate steps to ensure that all workers who speak up are meaningfully thanked for doing so, in accordance with Trust culture, training and good practice.	• Good practice checklist introduced.

Recommendation	Status
The Trust should develop an action plan to develop a working culture that is free from bullying, including providing anti-bullying training for all staff.	• This is part of the 2019/2020 Corporate Objective Champion Team St George's and is a core work stream in the Staff Engagement Plan.
The Trust should take appropriate steps to ensure that minority and vulnerable workers, including BME workers, are free to speak up.	• All areas now have access to a champion/ guardian. • New software will enable us to identify staff groups.
The Trust should take steps to actively promote the use of mediation, where appropriate, to resolve issues arising from speaking up/grievances/conflict.	• Pool of mediators are now available; mediation actively offered by Guardian and Champions as a principle of good practice.
The Trust should take appropriate steps to follow their policies, ensuring that workers who take periods of sickness leave, including in relation to their speaking up, are provided with support upon returning from that leave that is in strict accordance with the values, policies and guidance of the Trust.	• Staff returning from sick leave routinely have 'Return To Work' interviews. We do however need to ensure this is applied consistently.
The Trust should ensure that it has a conflicts of interest policy, in line with national guidance from NHS England and ensure all staff are aware of its purpose and all relevant staff make appropriate declarations, including those relating to conflicting loyalty interests.	• The conflicts of interest policy has been reviewed and takes account of these.
****NEW**** All executive directors are expected to be able to articulate both the importance of workers feeling able to speak up and the trust's own vision to achieve this.	• Guardian to roll out executive training sessions from early 2020 with updates throughout the year when new guidance is released.
****NEW**** All executive directors are expected to behave in a way that encourages workers to speak up.	• Open, honest communication with senior leaders and visible senior leaders.
****NEW**** The board must demonstrate its commitment to creating an open and honest culture where workers feel safe to speak up.	• We have named exec and non-exec leads responsible for speaking up. • Regularly send out clear messages that it will not tolerate the victimisation of workers who have spoken up. • Have a well-resourced Freedom to Speak up Guardian and Champion model.

Recommendation	Status
	• Invite workers who speak up to present their experiences in person to the Board.
****NEW**** Have a strategy to improve FTSU culture	• Ensure this is integrated into the forthcoming culture work in 2020 and will specifically include a strategy to improve the freedom to speak up culture across the Trust. • Needs to describe ambitions and aims based on a diagnosis of the issues the trust currently faces in relation to raising concerns and includes clear and smart objectives, measures and targets to demonstrate improvement. • Good practice guidance from the National Guardian's Office places the responsibility for this with Trust Boards.
****NEW**** Support your FTSU Guardian • Capability • Wellbeing • Capacity	• Guardian has completed the Guardian Education and Training Guide and is working at between L3 and L4 (L4 being the highest). • Guardian has direct access to exec lead and non-exec leads and Guardian to attend external peer supervision group (Jan 2020). • Guardian is currently able to allocate protected time dependent on the needs of the service.

****NEW**** Triangulating Data
 	
****NEW**** Board Assurance
	• The Guardian should have access to data such as Patient complaints, patient claims, serious incidents, near misses, never events, grievance numbers and themes, employment tribunal claims, sickness and retention figures, WRES and WDES data, levels of suspension and use of settlement agreements to ensure that wider issues can be identified and be addressed.
	• The Guardian must be able to ensure that:-
	  • Workers know how to speak up
	  • Risks are quickly escalated
	  • Confidentiality is maintained
	  • Workers are not victimised after they have spoken up

Recommendation	Status
	Work still needs to be done to provide the Guardian with access to this data, so that this data can be triangulated (as above).
****NEW**** Guardian report content	The Guardian ensures that the board has assurances as to: • Number and types of cases being dealt with by the Guardian. • Action being taken to improve the raising concerns culture. • Potential patient safety or worker issues (that the Guardian has been made aware of). • Learning from case reviews.

5.0 RECOMMENDATION

5.1 The Board is asked to note the current Freedom to Speak Up activity and the actions taken to date against both the 'learning from case reviews' plus actions taken against the new guidance issued in July 2019 by the National Guardian's office.

Meeting Title:	Trust Board
Date:	19 December 2019
Report Title:	Guardian of Safe Working Hours Report *Covering periods 01/07/2019-28/11/2019 (Quarter 2 and Quarter 3)*
Lead Director/ Manager:	Dr Richard Jennings, Chief Medical Office
Report Author:	Dr Serena Haywood, Guardian of Safe Working Hours (GOSWH)
Presented for:	Assurance
Executive Summary:	• This paper summarises progress in providing assurance that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016. • The data for training posts including general practitioners (GPs) in training and trust or fellow doctors (who are included in the rota but not by the Doctor in Training Contract). • Rota gaps were 57 (approximately 10%). Gaps numbered 78 in the first quarter. Rota gap data was not available for the second quarter. • There is active recruitment in most departments. However, trainee doctors continue to submit reports with 184 (87 – 2nd quarter plus 97 – 3rd quarter) exceptions related to working hours /conditions in this quarter with 19 due to lack of breaks and 1 due to lack of opportunity to attend teaching. From August there was an expected increase compared with the quieter summer months where exceptions were 38 but significant decrease with the last 2 years' second quarters with 202 and 164 reports. A year ago, in the third quarter there were 46 exception reports; reporting has increased compared with a year ago. • The GOSWH is supporting a repeat survey of the BMA Fatigue charter compliance by the new JDF chair and a Wellbeing panel has been set up to look at the spend options for the Department of Health £60,000 wellbeing money. The results are pending. • Fines totalling £1430.44 were made (£1263.74 for surgery and one, to gastroenterology). • Eight immediate safety concerns were raised; three in medicine, on in renal transplant one each in gastroenterology, haematology and paediatrics. • The GOSWH has taken steps to address concerns raised by four F1 trainees who experienced a challenging culture while working in two surgical teams. They described experiencing exclusionary 'banter'. The GOSWH has talked with the Divisional Director of Operations for Surgery and the Training Programme Director for the foundation trainees. • The GOSWH is concerned about the fears trainees raised in a recent JDF about exception reporting as it might reflect badly on them. The GOSWH has been invited to present this at the local negotiating committee. • The Director of Medical Education post vacancy has reduced the

	opportunity for the GOSWH to talk to a senior trust member about issues of training and long term strategies, but it has been re-advertised, applications have been received, and interviews are planned in December. • The cardiology exception reports have reduced as a locum junior doctor is now working in the department. The full report from Health Education England from their review on the 4th November.
Recommendation:	The Trust Board is asked to receive and note the Guardian of Safe Working Hour's report.
Supports	
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.
CQC Theme:	Well led Safe
Single Oversight Framework Theme:	Quality of Care
	Implications
Risk:	Failure to ensure that doctors are safely rostered, and enabled to work hours that are safe, risks patient safety and the safety of the doctor. Failure to ensure that doctors are safely rostered, and enabled to work hours that are safe, risks overtime payments and fines being levied.
Legal/Regulatory:	Compliance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.
Resources:	Funding for overtime payments, fines and service changes arising from work schedule reviews. Additional PA allocation in consultant job plans for time taken to personalise work schedules, resolve exception reports and perform work schedule reviews. Administrative support for the role of GOSWH.
Equality and Diversity:	N/A
Previously Considered by:	Compliance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 — **Date 28/11/2019**
Appendices:	• Exception reports in detail • Current Medical Vacancies • Summary of Contract new Terms and Conditions Changes • Compliance of rotas with new contract terms and conditions • Summary of exception reports over last 2 years

Guardian of Safe Working Hours Report

1.0 PURPOSE

1.1 This paper provides assurance to the Board on the progress being made to ensure that junior (trainee) doctors' working hours are safe, and to highlight all fines and work schedule reviews relating to safe working hours.

1.2 This report also includes information on all rota gaps on all shifts.

2.0 BACKGROUND

2.1 The Guardian of Safe Working Hours (GOSWH) is a senior appointment made jointly by the Trust and junior doctors. The GOSWH ensures that issues of compliance with safe working hours are addressed by the doctor and/or Trust and provides assurance to the Board that doctors' working hours are safe.

2.2 As the Trust is the Lead Employer Organisation for General Practice training across South London, the GOSWH will receive reports for all of the doctors under its employment from the GOSWH's host organisations.

2.3 The GOSWH reports to the Board through the Workforce and Education Committee of the Board, as follows:

i. The Workforce and Education Committee will receive a *Guardian of Safe Working Hours Report* no less than once per quarter on all work schedule reviews relating to safe working hours. This report will also include data on all rota gaps on all shifts. The report will also be provided to the Local Negotiating Committee (LNC).

ii. A consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps, will be included in a statement in the Trust's Quality Account, which must be signed off by the Trust chief executive. This report will also be provided to the LNC.

iii. Where the GOSWH has escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, for decision and action, and where these have not been addressed at departmental level and the issue remains unresolved, the GOSWH will submit an exceptional report to the next meeting of the Board.

iv. The Board is responsible for providing annual reports to external bodies, including Health Education South London, Care Quality Commission, General Medical Council and General Dental Council.

2.4 There may be circumstances where the GOSWH identifies that certain posts have issues that cannot be remedied locally, and require a system-wide solution. Where such issues are identified, the GOSWH will inform the Board. The Board will raise the system-wide issue with partner organisations (e.g. Health Education England, NHS England, NHS Improvement) to find a solution. The GOSWH also reports regularly to the General Medical Council (GMC) via local liaison.

2.5 The GOSWH is accountable to the Board. Where there are concerns regarding the performance of the GOSWH, the BMA or other recognised trade union, or the Junior Doctors

Forum will raise those concerns with the Trust Chief Medical Officer. These concerns can be escalated to the senior independent director on the Board where they are not properly addressed or resolved. The Senior Independent director is a Non-executive director appointed by the Board, to whom concerns regarding the performance of the Guardian of Safe Working Hours can be escalated where they are not properly resolved through the usual channels.

3.0 ANALYSIS

3.1. Fines

I. An F1 in General Surgery (Lower Gastrointestinal Surgery) was asked to work 8 hour shifts. These were on her zero days. She was given two zero days in lieu the following week and thanked for her hard work and support of the unit. But in so doing, she had worked from the Monday in week 4 of her rota until the Monday of her week seven (8 days consecutive days).

Total hourly figure 468.63 Hourly penalty rate (£), paid to the doctor 214.47 Hourly fine (£), paid to the guardian of safe working hours 254.16

II. An F1 in General Surgery (Lower Gastrointestinal Surgery) was in excess of her hours by 4 hours and 45 minutes

Total hourly figure 247.33 Hourly penalty rate (£), paid to the doctor 113.19 Hourly fine (£), paid to the guardian of safe working hours 134.14

III. An F1 in General Surgery was asked to work an 8 hour shift. This was on her zero day. In the subsequent two weeks she worked a total of an extra 30.5 hours.

Total hourly figure 1614.17 Hourly penalty rate (£), paid to the doctor 738.73 Hourly fine (£), paid to the guardian of safe working hours 875.44

IV. One fine was levied to gastroenterology at a total of £307.35 of which the trainee received £140.65 and the GOSHW fund received £166.70. The fine was levied because on the dates 23rd September – 27th September and then again 30th September - 4th October 2019, an F2 trainee worked an extra 16 hours in total at the end of their shifts to complete work and ensure an adequate handover. The outcome of the resultant discussion with the gastroenterology trainee programme director appears later in the report.

This is a total of £1430.44 to the GOSWH fines fund.

3.2. Exception Reports

A total of 184 (87 – 2nd quarter plus 97 – 3rd quarter) exception reports were sunmitted related to working hours /conditions in this quarter with 19 due to lack of breaks and 1 due to

lack of opportunity to attend teaching. From August there was an expected increase compared with the quieter summer months where exceptions were 38 but significant decrease with the last 2 years' second quarters with 202 and 164 reports. A year ago, in the third quarter there were 46 exception reports; reporting has increased compared with a year ago.

All reports were eligible for review (which suggests the doctors remain comfortable with the process). Reporting is done according to the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016. St George's is the lead employer of GP trainees across South London and one exception episode was reported by this cohort of doctors in training during the period covered in this report. The GOSWH will close incomplete exception reports on the Allocate software with a note to the trainee to ensure they claim any outstanding overtime payment if Time Off In Lieu (TOIL) has not been possible to claim within a month. The Update to the Contract asks that TOIL is completed within 48 hours. This is an on-going problem for trainees as there is limited time to take TOIL. They are therefore paid overtime.

3.3 Exception Report Breakdown

Division	Number of exceptions	Breakdown
Medicine and Cardiovascular	141	57 Acute Medicine including AMU 27 gastroenterology 0 Endocrinology 1 neurology 26 Respiratory 14 cardiology 0 ED 14 Haematology 2 care of the elderly 0 Cardiac surgery 0 Cardiothoracic surgery
Children's, Women's, Diagnostics and Therapeutics	9	1 Obstetrics and gynaecology 8 Paediatrics 0 Neonatal medicine 0 Paediatric surgery
Surgery, Theatres, Neurosciences and Cancer	33	27 general surgery 4 vascular surgery

Division	Number of exceptions	Breakdown
		1 Plastic Surgery 0 urology 0 ENT 1 Renal transplantation 0 neurosurgery 0 Trauma and orthopaedics
Community	0	0 QMH rehab 0 psychiatry 0 The Priory

3.4 Reasons for exception reports

There was an increase of reports highlighting missed breaks (19) following a reminder by the GOSWH that this could be reported upon. All other reports were related to working hours /conditions, with the addition of missed teaching opportunities being mentioned in several.

3.5 Immediate Safety Concerns (concerns raised by trainees)

No work schedule reviews were carried out, as these safety concerns were primarily about departmental workload and not about rota issues of the individuals reporting

Quarter 2

a) 10/07/2019: A concern raised by an F2 in general medicine about breaks "*Covering the equivalent of 2 doctors on the rota. I was due to cover St James wing from 5pm until 9pm (multiple medical wards + medical outliers) for 2 evening ward cover shifts. Known F1 rota gap -pre-existing due to F1 on the rota being switched to another rotation. I was not informed of any of this and as a result was expected to cover both roles. A busy shift even when fully staffed, it was extremely difficult to prioritise and multi-task handed over jobs from the day and sick patients which the nurses were calling about - having to answer twice as many bleeps throughout. Ended up having to hand over multiple jobs and reviews to the night SHO - knock on effect*".

Action Taken: see below

b) 11/07/2019: A concern raised by an F2 in general medicine. "*The F1 doctor named on the rota is no longer on this rotation. Despite this being planned months previously, their name had not been removed and no efforts had been made to find appropriate cover. I was not informed there was no F1 until I worked it out myself after unsuccessfully trying to bleep them during the shift. I was therefore expected to cover both roles as a result. The following day I highlighted this to the rota coordinator who thanked me for pointing it*

out but did not make any attempts to ask anyone to work a few extra hours for the next shift with the exact same problem. This was despite me asking for cover. I would suggest that the rota coordinators at least inform doctors on call if they expect them to cover two roles. Again, it is disappointing - lack of effort to look for cover and lack of effort to at least inform me of known extra role/stress and no support on a busy 4 hour ward cover".

Action Taken: see below

c) 10/08/2019: A concern raised by an F1in general medicine. Two hours extra worked. Problems also as below.

Action taken; See below.

d) 11/08/2019 A concern raised by an F1 in general medicine "*No SHO cover for the very first F1 long day ward cover shift, had to deal with medical emergencies. Appreciate the Reg on call being able to help by phone, but more support was required, especially as this is the very first ward cover shift of the year*".

Action Taken: see below

e) 17/08/2019 A concern raised by an ST3 in medicine. In brief (the original has patient references) "…*Not feeling able to escalate to anyone (I doubt I could ask a consultant from another ward to help)...I had to handle the four critical situations on my own. The many numbers I bleeped numerous times seemed unable to answer my bleeps. Bleeps I was able to get through to suggested I need to talk to someone else, but those people were not available and when I tried to call alternatives, including the individuals I called initially, I had no reply. It even got to the point where I tried to contact numbers for people on call, who are senior to me but not specialists or trainees in fields pertinent to these patients' needs. For an hour, maybe more, I was on my own and had to attempt to be as safe as I could, while acting in the patients' best interests. When I did get help, it was from a speciality who the patient was under, but not the most appropriate as another speciality's senior was more able to provide care for this patient. I am not sure that I made all the people I asked help from fully aware of the fact that my shift had finished when I finally did get in contact with them, but I am almost certain I did for at least two of those I did manage to get through to. I was stuck until 11pm, trying to ensure the safety of these patients*."

Action taken for reports a)-e):

Immediate support was offered by the department to the doctor, including support on how to contact senior doctors. The summer intake support is being revised for 2020. A meeting has been held with the Training Programme Director (TPD) for the foundation year to plan for next year's intake.

The Care Group Lead is aware that there had been significant gaps in the rota, which have now improved (09/12/2019). No suitable locums had been identified up until this point. The middle grade doctors have been reminded who to contact on call in case the advice is needed which has also included revising the SPR induction. Additionally, a second induction is being offered to those juniors who missed out on induction. Meanwhile, a confidential

messaging service has been set up for juniors to ensure that rota gaps are highlighted immediately.

f) 18/08/2019: A concern raised by an F1 in Renal Transplant Surgery for an extra 1 hour and 20 minutes worked, "*due to lack of staffing on the surgical team. Quite often, my surgical colleagues are in theatre and I cover the ward as the only surgical member!"*

Action taken: GOSW has contacted the renal team - a response is pending.

Quarter 3

a. 04/11/2019: Gastroenterology. In order to protect the identity of the trainee, no further details will be described here. The GOSWH met with the trainee's educational supervisor on 20/11/2019 and the trainee programme director 27/11/2019 to discuss the issues raised. The issues raised by the concerns are being discussed within the department and the trainee is being supported.

b. 15/11/2019: ST3 Haematology. Three and a half hours extra were worked. *"3 registrars and 1 SHO covering the whole of haematology. Stayed late to do urgent jobs, hand over to evening team and take weekend handover, put out blood test requests for the weekend etc. I do not feel that we can offer a safe 'daytime' service with this level of junior staffing."* The GOSWH met with the haematology training supervisor on 21/11/2019 who acknowledged that this additional cover was necessary for safe patient care. The department holds a Local Faculty Group meeting to discuss any issues raised by trainees and workload had been discussed 12/11/2019. The department is very supportive of the exception reporting system. Unexpected staffing issues had arisen, meaning that there were 4 trainee gaps on that day. Another gap has already been recruited for. Consideration is being given to employing an F3 if possible. A laptop has been provided to support trainees who were having difficulties accessing enough terminals for iClip based note keeping. The trainees have reported to the department that they feel well supported.

c. 19/11/2019 ST1 in paediatrics. *"Night shift handover overran due to volume of patients/workload".* The GOSWH met with the Service Lead, the Clinical Lead for Acute Paediatrics and the College Tutor 28/11/2019. The workload in the paediatric department is acknowledged as very high during the winter months and handover can overrun. The acute consultants will support the trainees in ensuring it is done within half an hour and adjust the rotas to make sure that all rotas reflect the worked handover time with busy times being Friday nights and Monday mornings when teams change over. This will be done for the next rota and the current trainees will be given time off in lieu for any overrunning this rota cycle. The day rotas will be changed from 08.00-17.00 to 08.30-17.30 in the next rota cycle. There was a recognition that moving more trainees onto the night shifts took away their training potential during the days, this had been tried but was not workable for this reason. The trainees will be asked to be very specific about where they see safety concerns arising and asked to contact their consultants early. Paediatric trainees are always encouraged to talk with their consultants and this will be reinforced again. The trainees are involved in the night safety huddles. Further work is planned, involving the nurses as well as the doctors, to look at further ways of working efficiently, as intensity will increase over the winter period, particularly for the holder of the busy on call bleep. Further faculty meetings are going to take place to look at optimising working and support for the trainees.

3.6. Paediatric surgery teaching

Three consecutive paediatric surgical trainees have raised the issue that they are unable to attend the general paediatric training. Despite suggestions being put into place by the College Tutor, the trainees found it not possible to attend. The College Tutor has given the assurance that this will change soon, as a teaching timetable has been prepared, and the mentoring process is about to be launched.

3.7. Concerns raised by surgical trainees

Workload and staffing were repeatedly raised as issues by F1 trainees, particularly those at the F1 level. This is especially an issue when the trainees join in August. The trainees feel that they are responsible for training the Physician Associates and do not get opportunities to experience surgery as they are busy with ward duties. Their attendance at training is good. The Training Programme Director (TPD) for Foundation Year 1 (FY1) doctors will be meeting with divisional leads to look at middle grade support and particularly at the changeover in summer, the seniority in surgical trainees (FY1 vs. FY2 doctor proportions) and whether more can be done to support the new trainees.

The GOSWH met with the Divisional Director of Operations to discuss the previous reports. A suggested way forward is for the GOSWH to meet with the surgical department educational supervisors to discuss how to share exception reports with the division. This would enable the Division to evaluate any safety concerns raised by the trainees early and to support any trainees needing extra supervision. This will be coordinated by the office of the Director of Medical Education.

3.8 Cardiology

There were 14 exception reports all in relation to workload and one for missed breaks. There were no immediate safety concerns. The 2019 first quarter GOSWH report describes the recommendations made to and by Health Education England (HEE). A report from the HEE inspection of Cardiology on 4th November is awaited. A business case for two physician associates and a prescribing pharmacist is being submitted in order to strengthen the cardiology workforce and relieve pressure on junior doctors.

3.9 Gastroenterology

Gastroenterology accounted for 27 out of 73 exception reports in the MedCard Division, and a number of these reports were made by a single trainee. The GOSWH met with the trainee's educational supervisor on 20/11/2019 and the Training Programme Director (TPD) for gastroenterology to discuss this and the other exception reports. Gastroenterology is acknowledged as a very busy specialty with a number of outlying patients particularly in the winter months. The current trainee staffing is for hepatology; one registrar, one senior fellow, one core trainee, one F2 and one F1. For the gastroenterology/Luminal team the staffing is one registrar, one senior fellow, two core trainees and one F1. In order to support the most junior members of the team, the middle grade doctors need to be available to discuss cases. There is a commitment by consultants to also support the trainees. The workload excess described by the trainees (who also report difficulties in getting times for breaks) is when the 'in reach' or referral calls are exceptionally busy, the ambulatory care unit is also busy, a full

ward (Allingham is acknowledged as a very busy ward particularly in winter) and a large number of patients on outlying wards. The hepatology and luminal trainees are told at induction that they are to ensure that jobs are completed in both hepatology and gastroenterology and one team is not left late to complete work. A number of suggestions have been made by the TPD about managing workload with allocation of trainees on a day to day basis, supporting trainees with different support needs including possibly trialling a mentoring or buddy system for junior trainees, supporting TOIL which has been very difficult for those in the acute medical unit to take before they rotate to the luminal/liver team and is under discussion with the acute medical TPD and will be discussed in a local faculty meeting. The Guardian will update the WEC at the next (fourth quarter) meeting.

3.10 Wellbeing

The GOSWH has met with 4 trainees in the period covering this report because of issues that gave the GOSWH concern for their well-being. The details of the issues remain confidential, but the GOSWH recommended to all four trainees that they make a self-referral to occupational health to access further support.

The Guardian has heard concerns raised by trainees who report experiencing gender related bullying, lack of awareness of support for mental health difficulties in trainees by senior staff and workload related stress. Where appropriate, the GOSWH has recommended the trainees to refer themselves to their General Practitioner and/or to the Practitioner Health Programme.

The GOSWH has taken steps to address concerns raised by four F1 trainees who experienced a challenging culture while working in two surgical teams. They described experiencing exclusionary 'banter'. The GOSWH has talked with the Divisional Director of Operations for Surgery and the Training Programme Director for the foundation trainees.

The action that has been taken over this concern is that the GOSWH has discussed it with the Trust's Responsible Officer (RO). The GOSWH and the RO are together liaising with the relevant Training Programme Directors to identify ways in which this may be negatively impacting on training, and to identify mitigations for this.

The GOSWH and RO are remaining vigilant with regards to this concern. If further instances are identified, the GOSWH and RO will consider taking advantage of a General Medical Council (GMC) initiative to pilot facilitated interventions to support departments in moving towards more positive cultures for trainees.

In addition to these steps the GOSWH has met with the Divisional Director of Operations (DDO) for Surgery Neurosciences Cancer and Theatres (SNCT), and the GOSWH and DDO will meet jointly with each of the educational supervisors in surgery to give them advice and guidance about providing proactive support to any trainees experiencing these issues.

Further discussions are planned with the F1 programme director. Another trainee (ST3) was referred to occupational health directly by the GOSWH on the 21st November but to protect their identity, no further details will be given other than to say this was in relation to workload and not service cultural issues. In the latest GOSWH Update (published 6 times a year), trainees were reminded of Trust procedures if bullying or concerns in relation to workplace culture are encountered.

3.11 Rota gaps

Rota gap information is shown in Appendix A. This shows vacancies for trainees, clinical fellows and trust doctor posts across St George's but not vacant Physicians' Associate or other Advanced Practitioner posts. A total of 57 posts are unfilled across the Trust of a total of 571 posts (10% of posts).

3.12 Junior Doctor Forum

The Junior Doctor Forum (JDF) continues to meet monthly. Attendance remains high. The GOSWH is supporting a renewed survey of the British Medical Association (BMA) Fatigue Charter compliance. Preliminary findings suggest that rest, fresh food and reliable Information Technology (IT) remain the most expressed needs. The position of the Doctors' Mess was also seen as less inaccessible to those in Atkinson Morley and St James' Wings and so rest areas not used overnight are being explored. Monies that have been held back as the Mess location was being considered due to potential paediatric divisional expansion will now be spent on flooring. The Fine money and Wellbeing money will contribute to refitting the shower and developing a rest area in the Mess. The final results of the survey will be discussed in the next report.

3.13 New Terms and Conditions and rota implications

The first deadline is the 1st December 2019 for weekends to be no more frequent than one in three. If the trainees agree, a rota can be kept at that frequency in the service load can be demonstrated as needing this. All rotas are being currently brought into compliance.

3.14 Themes raised in discussions with educational leads, TPDs, college tutors, operational leads and trainees

Common themes about safety were raised, and these themes will continue to be important given the impending winter pressures and numbers of rota gaps;

a. The number and quality of locums and fellows applying has dropped across the trust. Divisions are keen to fill gaps but are challenged by the lack of applicants.
b. The gaps affecting middle grade doctors have the additional effect of reducing the on-ward support junior trainees have available. Trainees have been reminded in many cases that they can ring consultants directly.

Trainees will be encouraged by the GOSWH to be very specific in their safety concerns in exception reports and reminded that these safety concerns should be reported not only to their educational supervisors (who can report to the clinical leads) but also to clinical leads, so that action can be taken quickly. The GOSWH will raise all of these issues at the next induction meeting.

4.0 IMPLICATIONS

4.1 Risks

The reluctance of some trainees to exception report continues to be a concern. The GOSWH is going to be speaking at the next Local Negotiating Committee (LNC) and hopes that by

engaging the consultant body in embracing the positive changes that can happen with exception reporting, this will strengthen the encouragement of trainees to submit reports.

Doctors are regularly working outside of work schedules in Acute Medicine. Time off in lieu (TOIL) and/or overtime payments will be required (and in many cases have already been granted or paid) unless service changes are made to reduce doctors working hours. The deadline of taking TOIL within 48 hours within the new terms and conditions is very unlikely to be met in the busier jobs. There is a risk that if trainees are unable to take TOIL, they may become fatigued and less able to provide safe care.Divisions have been reminded that they should ensure that all trainees take breaks, ensure that trainees are supported to take TOIL wherever possible.

4.2 Legal Regulatory

The GOSWH follows the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

4.3 Resources -cost pressures from fines

Funding for overtime payments represents a cost pressure. Following work schedule reviews, additional staff may be required to bring doctors' working hours into safe limits and to bring their hours into line with their work schedules. If actual working hours cannot be brought into line with work schedules, then basic pay for staff may need to increase. This would represent a further cost pressure. Lastly, fines may be levied if unsafe working practices continue.

5.0 NEXT STEPS

5.1 Supporting trainees to exception report

The GOSWH will be helping the consultants to help the trainees exception report.

6.0 RECOMMENDATIONS

6.1 The Trust Board is asked to receive and note the Guardian of Safe Working Hour's report.

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Appendix A
Current trainee Vacancies at of 28/11/2019

			Expected numbers			
Speciality	**Grade**	**Expected (as per allocate)**	**Number of Trainees**	**Number of Trust doctors**	**Nov-19**	**GAPS**
Adult Critical Care	F1	3	3	0	3	0
Adult Critical Care	F2/ST1/2	**39**	4	35	33	6
Adult Critical Care	ST3+	**24**	20	4	19	5
GUM	F1	**1**	1	0	1	0
O&G	F1	**2**	2	0	2	0
O&G	ST1-2	**3**	3	0	2	1
O&G	ST3+	**16**	16	0	15	1
O&G	CF	**10**	0	10	9	1
Neonates	F1	**1**	1	0	0	0
Neonates	ST1-3	**11**	8	3	10	1
Neonates	ST4+	**9**	9	0	9	0
Paed Surgery	ST3+	**7**	4	3	7	0
Paeds General	F1	**2**	2	0	0	0
Paeds General	ST1-2	15	15	0	15	0
Paeds General	ST4+	**9**	9	0	8	1
Psychiatry	F1	**2**	2	0	2	0
Radiology	ST1	**5**	5	0	5	0
Radiology	ST2-3	**12**	12	0	12	0
Radiology	ST4+	**22**	20	2	20	2
Total		**190**	**133**	**57**	**172**	**18**

				Expected numbers				
Speciality	**Grade**	**Date rota signed off**	**Expected (as per allocate)**	**No. of Trainees**	**Number of Trust doctors**	**Nov-19**	**Gaps**	**Comments**
Renal Medicine	F2/ST1/2	31/07/2017	**6**	6	0	4	2	
Renal Medicine	ST3+	31/07/2017	**6**	6	0	5	1	
Renal Surgery	All	05/03/2018	**5**	2	3	3	2	
Emergency Med	F2	31/07/2017	**14**	14	0	14	0	
Emergency Med	CT3	20/11/2017	**10**	7	3	9	1	
Emergency Med	GP	02/04/2018	**10**	6	4	10	0	
Emergency Med	ST4+	28/02/2018	**10**	9	1	9	1	
Emergency Med	CF		**15**	0	15	12	2	
Cardiology	ST1-2	05/09/2017	**7**	4	3	4	1	

				Expected numbers				
Cardiology	ST3+	02/10/2017	**13**	11	2	13	0	
Oncology	ST3+	04/09/2017	**5**	4	1	5	0	
Haematology	ST3+	03/09/2018	**8**	7	1	7	1	
Acute / Gen Medicine	F1/F2	31/07/2017	**19**	19	0	18	1	
Acute Medicine	ST1-2	25/04/2018	**15**	11	4	14	1	
Acute Medicine	ST3+	02/10/2017	**20**	15	5	19	1	
General Medicine	F2 ST1-2 (CMT's)	31/07/2017	**27**	21	6	21	4	x 3 senior health x 1 haematology
General Medicine	ST3+	02/08/2017	**12**	12	0	11	1	1 x senior health
Cardiac Surgery	F2/ ST1-2	03/04/2017	**6**	6	0	2	4	x 4 posts covered by agency / locum & SPR's
Cardiac Surgery	ST3+		**8**	0	8	5	3	Covered by locums / agency
Thoracic Surgery	ST3+		**4**	3	1	4	0	
Dermatology	ST3+	31/07/2017	**6**	3	3	6	0	
Microbiology/ID	ST3+	11/06/2018	**11**	11	0	10	1	
Palliative Medicine	F1	10/01/2017	**1**	1	0	1	0	
Vascular Surgery	F2	03/04/2017	**1**	1	0	1	0	
Vascular Surgery	ST3+		**6**	2	4	6	0	
Total			**251**	**187**	**64**	**213**	**27**	

			Expected numbers			GAPS	
Speciality	**Grade**	**Expected (as per allocate)**	**Number of Trainees**	**Number of Trust doctors**	**Nov-19**	**GAPS**	Notes
Neurosurgery	F2, ST1/2	**9**	0	9	9	0	
Neurosurgery	ST3+	**16**	7	9	15	1	
Neurology	ST1-2	**9**	5	4	9	0	
Neurology	ST3+	**16**	16	0	15	1	
General	F1	**9**	9	0	9	0	

			Expected numbers			GAPS	
Surgery							
General Surgery	ST1-2	**13**	11	2	13	0	
General Surgery	ST3+	**12**	12	0	12	0	
Plastic Surgery	F2	**1**	1	0	1	0	
Plastic Surgery	ST1-2	**5**	5	0	5	0	
Plastic Surgery	ST3+	**11**	8	3	11	0	
MaxFax	ST1-2	**7**	4	3	7	0	
MaxFax	ST3+	5	5	0	4	1	
Ophthalmology	F1	1	1	0	1	0	
Urology	F2	**1**	1	0	1	1	
Urology	ST3+	**8**	4	4	8	0	
Anaesthetics (Gen)	ST3+	**8**	8	0	7	2	
Anaesthetics (N/C)	ST3+	**8**	6	2	8	0	
Anaesthetics (Obs)	ST3+	**8**	6	2	6	1	Out to advert
Anaesthetics (PICU)	ST3+	**8**	8	0	6	0	2 x interviews on 28/11
Anaesthetics	CT1-2	**2**	2	0	2	0	
ENT	ST1-2 / F2	8	6	2	8	0	1 x post out to advert
ENT	ST3+	7	7	0	7	0	
T&O	ST1-2	**2**	2	0	2	0	
T&O	ST3+	**16**	7	9	15	1	1 x offered post / awaiting start date
T&O	CF	**5**	0	5	5	0	
Total		**195**	**141**	**54**	**186**	**8**	

Training Scheme	PGMD Post Reference	Post Number	Cost Code	Specialty	Location
St George's	LDN/RJ701/035/SHO/003	6538	CEM	Acute Internal Medicine	St George's Hospital
St George's	LDN/RJ701/023/SHO/002	6541	CAY	Otolaryngology	St Georges's Hospital
St George's	LDN/RJ701/002/SHO/001	3452	CHB	Paediatrics	St Georges's Hospital
St George's	LDN/RJ701/002/SHO/003	6985	CHB	Paediatrics	St Georges's Hospital

Appendix B

Comparison of exception report numbers, fines and immediate safety concerns

Quarters	**Exception reports**	**Immediate Safety Concerns**	**Fine levied**	**Rota gaps**
Q1 2017	86	0	0	NK
Q2 2017	164	2	0	32
Q3 2017	263	0	£10,527.48	100
Q4 2017/2018	203	0	£6437.41	69
Q1 2018	35	2	0	28
Q2 2018	202	12	£35,267.96	53
Q3 2018	46	0	0	46
Q4 2018/2019	87	2	0	45
Q1 2019	38	1	0	78
Q2 2019	97	6	£1263.74	Awaited
Q3 2019	87	3	£166	Awaited

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Meeting Title:	**Trust Board**		
Date:	19 December 2019	**Agenda No**	**4.1**
Report Title:	**Finance and Investment Committee (Core) report**		
Lead Director/ Manager:	Sarah Wilton, Acting Chairman of the Finance and Investment Committee		
Report Author:	Sarah Wilton, Acting Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 12th December 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

4.1

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Finance and Investment Committee (Core) – December 2019

The Committee met on 12 December and in addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on the 2020/21 Financial Plan and an Emergency Capital Bids paper.

Committee members discussed the BAF risks on finance and ICT. A paper on financial risk confirmed the change in the functional risk 'Managing Income & Expenditure in line with budget' to a '25', as well as noting other changes to risk against the forecast risk position. The Committee noted targets not met in Diagnostics, RTT and Emergency Flow as well as outlining the process being undertaken to improve each one. The Committee discussed actions being undertaken to improve the current financial performance in view of the forecasted year end position, and the current work being done in South West London as we move towards a new financial year. **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 noted the increasing of the functional risk 'Managing Income & Expenditure in line with budget' to the maximum score of '25', due to the forecasted year end position, as well as some reduction to risk scores forecasted in cash management and procurement. In addition the 'Manage commercial relationship with non-NHS organisations procuring services from the Trust' risk has not reduced as expected owing to the enhanced focus required on delivering the 19/20 financial position. The Committee accepted the proposed changes.

1.2 ICT Risks – the Chief Information Officer (CIO) noted that there were no material changes to the ICT risks and a task finish group was in place to look at the problems associated with the QMH deployment of iClip.

1.3 RTT Update – the CTO updated the committee on RTT performance in October, where 52 week waits have reduced to 1 against an October target of 0, and the RTT incomplete trajectory in October has a performance of 85.1% against a target of 86.1%. The COO noted the challenge of QMH activity and focus on 52 week waits as contributing to the adverse position. He noted that an outpatient manager was being transferred to QMH to support this.

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 79.4% in November, which is under the Trust's trajectory of 87.5% delivery in the month. The Committee were again concerned at the continued deterioration in performance. The COO outlined some of the focus on long stay patients in the trust, and rapid assessment teams, to improve performance.

1.5 Financial Performance – the DCFO noted performance to date at Month 8 was in line with plan showing a £34.0m Pre-PSF/FRF/MRET deficit.

1.6 Financial Forecast – the DCFO provided an update for the Committee on the Trust's financial forecast. The CFO updated the Committee on the weekly financial recovery meetings, and the Executive Leads updated on each of their areas of responsibility, including individual schemes to improve financial performance. The areas of responsibility are: 'Income, Non Pay and Provisions', 'Medical pay', 'Nursing and AHP pay', 'Other pay' and

'Divisions'. The Committee expressed concern at the continued challenge in financial performance, and the CFO advised that a further update would be provided at the next committee meeting on progress.

1.7 2020/21 Planning Update – the Director of Financial Planning (DFP) introduced the Committee to the paper providing an update on the financial plan for 2020/21. The Committee welcomed the update and further information expected in January.

1.8 FAC Update – the CFO introduced an update to the committee on the Finance and Activity Committee (FAC) which involves the NHS organisations in South West London. He observed the financial gap of the group of organisations in 2020/21, and discussions ongoing to try to close it.

2.0 Recommendation

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

Sarah Wilton
Acting Finance & Investment Committee Chair
December 2019

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St George's University Hospitals NHS Foundation Trust

4.2

Meeting Title:	**Trust Board**		
Date:	19 December 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 the 12 December 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

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Finance and Investment Committee (Estates) – December 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. It should be noted that the December meeting was shortened as the Part 1 (Core) FIC meeting had been extended to allow more time to discuss the Trust's financial position.

The December FIC E 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 verbal updates on overall Estates risk, the Procure 22 (P22) Project and the Premises Assurance Model (PAM). Committee members thanked the Estates team for their continued efforts in challenging circumstances, noting that good progress continues to be made. The Committee also reflected on the potential to produce a KPI report to summarise all the key information streams and that from April 2020 it may be appropriate for future FIC E meetings to convene less often.

The Committee welcomed updates from the ADs that included information on the Mitie contract, progress on Water, Violence and Aggression, and Fire Safety.

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

1.1 Risk Review - the Chief Financial Officer (CFO) gave a verbal update on Estates risks. He noted no major changes to individual or strategic risks and advised that a full risk review would be provided in January. Water and Fire remain the highest risks and where continued attention is focussed.

1.2 AD Report – Divisional Overview - the Deputy Director of Estates & Facilities (DDE&F) advised that a skilled external resource is now in place to assist with developing the Estates Strategy. A consolidated report has also now been produced on fire safety which draws together previous findings across the site going back to 2018. An external review has identified some particular concerns around fire management in Atkinson Morley Wing which are being discussed with the PFI service provider.

The Committee discussed the latest position on the Cardiac Catheter Labs project where the responsiveness of the PFI provider has improved but progress remains slow. Performance of Mitie has now recovered to contract standard and some helpful lessons learned for future implementations of this kind namely; taking a phased approach to the implementation of change and ensuring adequate provision in plans is made for staff communications and union consultation. The DDE&F also noted the challenge in producing the Community Premises Assurance Model (PAM), where the model is not ideal for community services and will require more work than initially expected.

1.3 AD Report - Estates - the Assistant Director of Estates (ADE) introduced a paper on current performance, highlighting a number of key incidents that occurred during November, a condensate steam failure and an automatic electrical transfer switching issue were amongst them. The Committee discussed the reasons for these issues, the risk based prioritisation approach being applied to maintenance and praised the continued work of the Estates team outside of standard work hours to resolve them.

1.4 AD Report - Facilities - the Assistant Director of Facilities (ADE) confirmed an overall positive assessment for PLACE audits and the Committee noted that appropriate action plans are being developed in response. The team are working closely with Mitie to

understand what is working well across their contracted scope and where further improvement can be made. It was noted that there will be increased pressures during the winter months which will require careful attention. The Committee discussed issues of Harassment and Bullying and shared concern that Divisional Governance Boards need to play their full role in gripping the required actions as it is important that we provide full support to our staff The Committee enquired about the governance process to revise arrangements covered by the Mitie contract and it was advised that EMG and TEC would provide this.

1.5 AD Report – Capital Projects - the Assistant Director of Capital Projects (ADCP) introduced an update on Capital Projects. He noted the completion of the Heberden Ward recant earlier in the month, the imminent intention to decant McEntee to Caeser Hawkins and noted that the MRI planning application is now in process. The Committee noted that an advert for a substantive Capital Projects Project Manager is now out with a view to interviewing early in the New Year. Support from the St George's Hospital Charity for capital projects including the newly proposed Renal development was welcomed and it was noted that the working arrangements and cooperation between the Trust and the charity are much improved.

1.6 AD Report- Medical Physics & Clinical Engineering – The paper reporting on this domain was noted as having no significant update for the committee from the last meeting.

1.7 AD Report- Health & Safety –The AD Health & Safety (ADHS) introduced the paper updating the committee on Health & Safety. He noted the good progress being made on Fire Safety where the team are pushing hard on capital works to address everything from compartmentalisation to fire detection systems and fire evacuation routes. The Committee also reviewed Health & Safety incidents that have been documented, and how these can be more clearly outlined to the Board in future through the Integrated Quality & Performance Report.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Estates) on 12 December 2019 for information and assurance.

Tim Wright
Lead Non-Executive Director, Estates
December 2019

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4.3

Meeting Title:	**TRUST BOARD**		
Date:	**19 December 2019**	**Agenda No.**	**4.3**
Report Title:	**Finance Report (Month 08) 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 M8 of £34.0m which is equal to the Pre-Public Sustainability Funding/Financial Recovery Funding/Marginal Rate Emergency Tariff (PSF/FRF/MRET) plan. Within the position, income is favourable to plan by £5.5m, and expenditure is overspent by £5.5m. CIP performance to date is £22.6m which is in line with plan. The Trust has recognised £19.9m of PSF/FRF/MRET funding YTD to Month 8 in line with plan. The Trust also recognised £0.5m of prior year PSF as discussed at the Finance & Investment Committee in June.		
Recommendation:	The Board is asked to note the Trust's financial performance to M8.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Finance and Investment Committee	Date	12/12/2019
Appendices:	N/A		

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Financial Report Month 08 (November 2019)

4.3

Chief Finance Officer

19th December 2019

Trust Board

Executive Summary – Month 08 (November)

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The Trust is reporting a Pre-PSF/MRET/FRF deficit of £34.0m** at the end of November, which is **on plan**. Within the position, income is favourable to plan by £5.5m, and expenditure is overspent by £5.5m. **M08 YTD PSF/MRET/FRF income of £19.9m** in the plan has **been achieved** in the Year-to-date position. **£4.4m of this is MRET which is expected to be received in all scenarios, and the remaining £15.5m 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 £5.5m favourable to plan year to date. SLA income is £4.6m over plan, mainly due to decreased Challenges and excluded Drugs and Devices which are offset in non-pay. Non-SLA income is £0.9m favourable to plan, which is mainly owing to Private Patients and R&D income.	£5.5m Fav to plan	£1.5m Fav to plan
Expenditure	Expenditure is £5.5m adverse to plan year to date in November. This is caused by Non-Pay adverse variance of £2.7m, related to pass-through income, and Pay adverse variance of £2.8m across all clinical staff groups.	£5.5m Adv to plan	£1.5m Adv to plan
CIP	The Trust planned to deliver £22.6m of CIPs by the end of November. To date, £22.6m of CIPs have been delivered; which is on plan. Income actions of £4.3m and Expenditure reductions of £18.2m have impacted on the position. A £2.6m gap remains in Green schemes identified against the £45.8m target.	On plan	On plan
Capital	Capital expenditure of £29.0m has been incurred year to date. This is to plan. The current month YTD position is £29.0m and the previous month YTD position is £25.6m.	£29.0m To plan	£25.6m To plan
Cash	At the end of Month 8, the Trust's cash balance was £3.1m. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.	£0.1m Fav to plan	£0.8m Fav to plan
Use of Resources (UOR)	At the end of November, the Trust's UOR score was 4 as per plan.	UOR score 4	UOR score 4

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1. Month 08 Financial Performance

			Full Year Budget (£m)	M8 Budget (£m)	M8 Actual (£m)	M8 Variance (£m)	M8 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF/FRF/MRET	**Income**	SLA Income	677.7	56.3	57.1	0.7	1.3%	450.1	454.7	4.6	1.0%
		Other Income	159.6	13.7	17.0	3.3	23.9%	107.2	108.1	0.9	0.9%
	Income Total		**837.3**	**70.1**	**74.1**	**4.0**	**5.7%**	**557.3**	**562.8**	**5.5**	**1.0%**
	Expenditure	Pay	(532.6)	(43.0)	(45.5)	(2.4)	(5.7%)	(360.4)	(363.2)	(2.8)	(0.8%)
		Non Pay	(306.6)	(24.8)	(26.4)	(1.6)	(6.4%)	(207.0)	(209.9)	(2.9)	(1.4%)
	Expenditure Total		**(839.2)**	**(67.9)**	**(71.9)**	**(4.0)**	**(5.9%)**	**(567.4)**	**(573.2)**	**(5.7)**	**(1.0%)**
	Post Ebitda		(35.8)	(3.0)	(3.0)	0.0	0.2%	(23.9)	(23.7)	0.2	1.0%
Pre-PSF/FRF/MRET Total			**(37.7)**	**(0.8)**	**(0.8)**	**(0.0)**	**(1.0%)**	**(34.1)**	**(34.0)**	**0.0**	**0.1%**
PSF/FRF/MRET			34.7	3.4	3.4	0.0	0.0 %	19.9	19.9	0.0	0.0 %
Total			**(3.0)**	**2.6**	**2.6**	**(0.0)**	**0.3%**	**(14.2)**	**(14.1)**	**0.0**	**0.2%**
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)**	**2.6**	**2.6**	**(0.0)**	**0.3%**	**(14.2)**	**(13.6)**	**0.5**	**3.8%**

Trust Overview

- Overall the Trust is reporting a Pre-PSF/MRET/FRF deficit of £34.0m at the end of Month 08, which is on plan.
- **SLA Income** is £4.6m ahead of plan, after adjustment for block contract values. There remains a large level of estimation within the M08 income position due to delays in coding in some specialties.
- **Other income** is £0.9m over plan, which is owing to Private Patient and R&D income.
- **Pay** is £2.8m overspent across all clinical staff groups.
- **Non-pay** is £2.7m overspent, mainly related to pass-through income.
- **PSF/FRF/MRET Income** is on plan at M08 YTD, at £19.9m. The Trust has met the pre-PSF control total target of a £34.1m 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 £22.6m is on plan. Delivery to plan is:
  - Non-pay £1.0m favourable
  - Income £0.2m adverse
  - Pay £0.8m adverse

Financial Report Month 08 (November 2019)
St George's University Hospitals NHS Foundation Trust

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2. Month 08 YTD Analysis of Cash Movement

	M08 YTD Plan £m	M08 YTD Actual £m	YTD Variance £m
Opening Cash balance	**3.2**	**3.2**	**(0.0)**
Income and expenditure deficit	(14.6)	(14.0)	0.6
Depreciation	16.4	16.4	0.0
Interest payable	7.8	8.1	0.3
PDC dividend	0.0	0.0	0.0
Other non-cash items	(0.1)	(0.1)	0.0
Operating deficit	**9.4**	**10.4**	**1.0**
Change in stock	1.3	0.0	(1.3)
Change in debtors	12.0	7.5	(4.5)
Change in creditors	(31.9)	(8.4)	23.5
Net change in working capital	**(18.6)**	**(0.9)**	**17.7**
Capital spend (excl leases)	(16.4)	(16.9)	(0.5)
Interest paid	(7.3)	(7.3)	0.0
PDC dividend paid/refund	0.0	0.0	0.0
Other	(0.4)	(0.4)	0.0
Investing activities	**(24.1)**	**(24.6)**	**(0.5)**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	19.8	2.0	(17.8)
Capital loans	19.4	19.4	0.0
Loan/finance lease repayments	(6.2)	(6.4)	(0.2)
Cash balance 30.11.19	**3.0**	**3.1**	**0.1**

M01-M08 YTD cash movement

- The cumulative M8 I&E deficit is £14.0m, £0.6m 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 £14.0m, depreciation (£16.4m) does not impact cash. The charges for interest payable (£8.1m) and are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating surplus" of £10.4m.
- The operating deficit variance from plan is £1.0m.
- Working capital is better than plan by £17.7m. This favourable variance comprises of £4.5m lower on debtors and £23.5m better on creditors. The change of stock level is £1.3m better than the plan.
- The Trust has borrowed £11.6m to fund the YTD deficit and repaid £9.6m, a net borrowing of £2.0m. The working capital borrowing is £17.8m lower than the YTD plan. Although the Trust can borrow up to £27.3m, however due to the phasing of the I&E at month 8, the Trust has not requested any loans since June. The Trust would have had to repay any excess as the maximum loan cannot exceed £12.8m at the yearend. This £12.8m is £3m for deficit funding and £9.8m for quarter 4 PSF/FRF funding due to timing of the receipt in 20/21.
- The Trust has received £19.4m for capital loan. The Trust has requested a drawdown of capital loan in December of £1.9m with an interest rate of 1.55%.

November cash position

- The Trust achieved a cash balance of £3.1m on 30 November 2019, £0.1m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 15 week cash flow submitted last month.

Loan repayment

NHSI has confirmed that the £48.7m IRS facility due for repayment in March 2019 and the £15.0m due for repayment in March 2020 will be re-scheduled and extended to September 2020 at similar interest rates.

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3. Balance Sheet as at Month 08

Balance Sheet	Mar-19 Audited Account (£m)	M08 YTD Revised Plan (£m)	M08 YTD Actual (£m)	M08 YTD Variance to Plan (£m)
Fixed assets	**390.5**	**402.9**	**403.3**	**0.4**
Stock	7.8	6.5	7.8	1.3
Debtors	101.9	90.2	94.7	4.5
Cash	3.2	3.0	3.1	0.1
Creditors	(126.7)	(106.4)	(129.9)	(23.5)
PDC div creditor	0.0	0.0	0.0	0.0
Int payable creditor	(1.2)	(1.7)	(1.9)	(0.2)
Provisions< 1 year	(0.5)	(0.4)	(0.4)	0.0
Borrowings< 1 year	(57.6)	(176.6)	(171.9)	4.7
Net current assets/-liabilities	**(73.1)**	**(185.4)**	**(198.5)**	**(13.1)**
Provisions> 1 year	(1.0)	(0.8)	(0.8)	0.0
Borrowings> 1 year	(284.3)	(199.3)	(186.0)	13.3
Long-term liabilities	**(285.3)**	**(200.1)**	**(186.8)**	**13.3**
Net assets	**32.1**	**17.4**	**18.0**	**0.6**
Taxpayer's equity				
Public Dividend Capital	133.4	133.4	133.4	0.0
Retained Earnings	(213.4)	(228.1)	(227.5)	0.6
Revaluation Reserve	110.9	110.9	110.9	0.0
Other reserves	1.2	1.2	1.2	0.0
Total taxpayer's equity	**32.1**	**17.4**	**18.0**	**0.6**

M08 YTD Balance Sheet

- **The previous slide explains the variance between the previous and the revised plan, in this slide the Trust is using the revised YTD plan as a comparison to YTD actual.**
- Fixed assets are £0.4 higher than the plan. This includes depreciation charges and capital spend to month 8.
- Stock is £1.3m higher than plan, mainly due to an increase in pharmacy area.
- Debtors is £4.5m higher than plan in month and has reduced by £7.2m from March 2019. Target reduction of £18m by year end is being actively pursued.
- The cash position is £0.1m higher than planned. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.
- Creditors are £23.5 higher than plan in month 8; this includes capital creditors. However have been reduced by £8.4m since March 2019 and are under review to reduce further by year end.
- £19.4m of capital loan was received as at November subject to an interest rate of 1.55%. The Trust has requested drawdown of capital loan in December of £1.9m with the same interest rate as in November.
- 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. Capital programme 2019/20 - M08 update

COMMENTARY

- The bid that the Trust submitted for £27.2m capital funding to NHSI has been approved for investment to address a number of critical risks in the IT and estate infrastructure.
- In addition to this capital bid the Trust has Internal capital of £15.1m and a total capital spend of £47.4m for 2019/20.
- The Trust has spent £28.97m YTD as at M08, which is to plan and includes a £9.2m accrual for commitments to date.
- Trust continues to exert tight control over capital expenditure, approving requisitions for all projects included in the bid.
- The Trust received additional funds of £158k for HSLI in month 6.
- Budgets have been allocated to cost centres with reviews each month of the actual spend against the forecast.