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NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting
Thursday 30 January 2020

Agenda and papers

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St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: Thursday, 30 January 2020, 10:00-13:30
Venue: Hyde Park Room, 1st Floor Lanesborough Wing, St George's, Tooting

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	Awarded to Shamini Nair, Registered Nurse, General Surgery	Chairman	-	Oral
1.0 OPENING ADMINISTRATION					
10:30	1.1	Welcome and apologies	Chairman	Note	Oral
	1.2	Declarations of interest	All	Assure	Oral
	1.3	Minutes of meeting - 19 December 2019	Chairman	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
10:35	1.5	CEO's Report	Acting Chief Executive Officer	Inform	Report
2.0 QUALITY & PERFORMANCE					
10:45	2.1	Quality and Safety Committee Report	Committee Chairman	Assure	Report
10:55	2.2	Care Quality Commission Inspection Report	Chief Nurse	Note	Report
11:05	2.3	Integrated Quality & Performance Report and Emergency Care Update	Chief Transformation Officer/Chief Operating Officer	Assure	Report
11:25	2.4	Cardiac Surgery Update	Chief Medical Officer	Assure	Report
11:35	2.5	Emergency Preparedness, Resilience and Response (EPRR)	Chief Operating Officer	Assure	Report
11:40	2.6	Seven Day Services Implementation Update	Chief Medical Officer	Assure	Report
11:55	2.7	Quality Improvement Academy (Q3) Report	Chief Transformation Officer	Note	Report
3.0 FINANCE					
12:00	3.1	Finance and Investment Committee Report	Committee Chairman	Assure	Report
12:10	3.2	FIC (Estates) Report	NED Estates Lead	Assure	Report
12:20	3.3	Finance Report (Month 09)	Acting Chief Financial Officer	Update	Report

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Time	Item	Subject	Lead	Action	Format
4.0 GOVERNANCE, STRATEGY & RISK					
12:30	**4.1**	**Audit Committee Report**	**Committee Chairman**	Assure	Report
12:40	**4.2**	**Quality and Safety Strategy**	**Chief Nurse**	Approve	Report
12:50	**4.3**	**Corporate Objectives (Q3) Report**	**Chief Strategy Officer**	Assure	Report
13:00	**4.4**	**Board Assurance Framework (Q3) Report**	**Chief Nurse**	Assure/ Approve	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: Improving the experience of patients with Sickle Cell in the Emergency Department**	**Sarina Vitalis, Patient** **Carol Rose, Lead Clinical Nurse Specialist-Sickle Cell**	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, 27 February 2020, 10:00-12:30
Hyde Park Meeting Room

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St George's University Hospitals NHS Foundation Trust

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
Andrew Grimshaw	Acting Chief Executive Officer/Chief Finance Officer	ACEO
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Stephen Collier	Non-Executive Director	NED
Prof. Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li	Associate Non-Executive Director	ANED
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		
Harbhajan Brar	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Ellis Pullinger	Chief Operating Officer	COO
Suzanne Marsello	Chief Strategy Officer	CSO
Tom Shearer	Acting Chief Financial Officer	ACFO
Sally Herne	Quality Improvement Director – NHS Improvement	NHSI-QID
Secretariat		
Tamara Croud	Head of Corporate Governance/Board Secretary	HOCG-BS
Apologies		
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.*	

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Board Walkabout - Thursday 30th January 2020, 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 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.

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Groupings- 30th January 2020

NED	Exec / Divisional Chair	Divisional Representation	Area Visiting, 08:30 – 09:45
Gillian Norton, Chair	James Friend	Alex Grimster David Robinson (Matron)	Cardiac Investigations (Ground floor AMW) Charles Pumphrey Unit (2nd Floor AMW)
Ann Beasley Pui-Ling Li	Andrew Grimshaw	John Dela Luna (Matron)	Brodie Ward (2nd Floor AMW) McKissock (2nd Floor AMW)
Parveen Kumar	Richard Jennings	Natasha Dillon (Matron) Marlene Johnson (Head of Nursing) Julie Paska (Matron)	Thomas Young (3rd Floor LNS) Oncology Ambulatory Care (Gordon Smith 3rd Floor LSW)
Sarah Wilton	Avey Bhatia Stephen Jones	David McCall (Matron)	Marnham Ward (3rd Floor STJ) Cavell Ward (5th Floor STJ)
Prof Jenny Higham	Harbhajan Brar	Sarah Hemmings (Recruitment Team Leader) Justin Sharp (Staff Bank Manager)	Recruitment Team (Blackshaw Annex) Staff Bank (Blackshaw Annex)
Stephen Collier	Suzanne Marsello	Salomi Ojakovo (Matron) Yvonne Bascombe (Matron)	Rheumatology Outpatients (Ground Floor LNS) Acute Gynecology Unit (Ground Floor LNS)
Tim Wright	Ellis Pullinger Tom Shearer	Terry Wynn (Security Manager) Aaron Maderia (Retail Manager) Catherine Leak (General Manager)	Security (Ground Floor GVR) Ingredients restaurant (1st Floor LNS)

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Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 19 December 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
Jenny Higham	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
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
Andy Stephens	Director of Financial Planning	DFP
SECRETARIAT		
Tamara Croud	Interim Assistant Trust Secretary (Minutes)	IATS
APOLOGIES		
Jacqueline Totterdell	Chief Executive Officer	CEO
Andrew Grimshaw	Chief Finance Officer/Deputy Chief Executive Officer	CFO/DCEO
Stephen Collier	Non-Executive Director	NED
Sally Herne	NHSI Quality Improvement Director	NHSI-QID

Feedback from Board Visits

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

- Pinckney Ward and Central Playroom – Chairman and CPO
- Emergency Department and Therapies Outpatients – Ann Beasley and COO
- Mortuary and Energy Centre – Sarah Wilton and CCAO
- Heberden Ward and McEntee –Jenny Higham, CSO and CTO
- Holdsworth and Gray Ward – CMO
- Benjamin Weir and Belgrave – Tim Wright, Parveen Kumar and CN

The dedication and hard work of teams across the Trust was evident from the areas visited. Despite the challenges facing the Trust staff remained patient-focused and continued to deliver high quality

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Feedback from Board Visits
care. It was noted that the 'outstanding' rating from the Care Quality Commission (CQC) for the services to children and young people was well deserved and had been welcomed by the team. The emergency department environment was much improved and the emergency staff demonstrated a willingness to do anything to further improve patient flow and give patients the best possible care, despite significant pressures. The Trust and the Board recognised the dedication of all staff and expressed special thanks to those who continued to deliver busy workloads in services where there were estates works or service transitions. The Board noted the updates and agreed that the CFO/DCEO would address estates issues related to the Mortuary service, namely privacy around the ventilation areas and appropriate disabled access for family and carers. It was also agreed that the CN would write and thank staff on behalf of the Board in services where there were transitioning works. The Chairman expressed her thanks to Professor Dame Parveen Kumar, who would shortly be joining the Board as a new Non-Executive Director and Chair of the Quality and Safety Committee, for attending the Board visits.

Values Award
The Board welcomed and thanked Joanna Hardman, Deputy Head of Children's Therapies who had been nominated to receive a staff values award. Joanna was nominated for continuing to demonstrate care and compassion for patients and her team.

		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. John Hallmark, Public Governor (Wandsworth), was in attendance as an observer.	
1.2	**Declarations of Interest** The Board noted the register of Board members' interests. Jenny Higham advised that she had joined the Boards of Universities and Colleges Employers Association and Universities UK. Neither of these roles gave rise to a conflict of interest with her role on the Trust Board. It was also noted that the description of Ann Beasley's Trust role would be updated. The CCAO advised that following the implementation of the declarations of interest portal and the publication of Board members declarations on the Trust website, the Board would no longer receive the existing monthly report.	
1.3	**Minutes of the meetings held on 28 November 2019** The minutes of the meeting held on 28 November 2019 were agreed as an accurate record subject to clarifying, under item 2.1 (page 4, paragraph 2), that the issue lay with completion of assessments of compliance with NICE guidance as opposed to non-compliance with such guidance.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log and the following updates:	

		Action
	• **TB31.10.19/01:** The Board noted that the communication from NICOR had been circulated to Board members. The Board agreed that the action in relation to the comprehensiveness of the paper would be considered as part of the discussion of item 2.4 on the Board's agenda. • **TB31.10.19/02**: The CPO advised that steps had been taken to ensure that the Trust completed internal staff surveys each quarter. However, it had not been possible to retrospectively complete the internal staff survey for quarter two 2019/2020. With the assurance that this issue would not reoccur, the Board agreed that this action could be closed. • **TB31.10.19/03:** The CCAO advised that as the CEO reported at the last meeting work was underway to improve reporting to the Board and its Committees. As part of this work, steps would be taken to strengthen reporting and assurance in relation to progress in delivering and embedding corporate objectives. However, the CEO considered that monthly reporting to each Board Committee on corporate objectives would not deliver this in a proportionate way. **The Board agreed that plans for reporting on and providing effective assurance through Committees to the Board on corporate objectives would be picked up as part of the process for agreeing the objectives for 2020/21.** The Board agreed to close those actions proposed for closure, and noted those actions not yet due.	**CSO / CCAO**
1.5	**Chief Executive Officer's Update** The CN presented the Chief Executive Officer's Update in the absence of the CEO. The following key points were noted: • The Critical Care Outreach Team had been launched to provide mobile support for deteriorating and acutely unwell adult patients on wards. The Trust's Emergency Department (ED) remained challenged. Factors impacting on the service included increased activity in the winter months, higher acuity of patients and the challenges in repatriating patients to the appropriate care settings outside the hospital. The Chairman commented that performance in the ED remained variable regardless of whether or not admissions are high and noted that this would be discussed further under item 2.3. • The Trust's haematology department had received the Myeloma UK Clinical Service Excellence Programme accreditation. The Trust was one of two London trusts to receive the accreditation and this was an example of the excellent services being provided. • A project on organisational culture had been launched and staff had been asked to put themselves forward to be part of the group that would support the diagnostics phase of the project. • The Trust had achieved 59.5% response rates to the national staff survey which was much improved from the previous year and effectively met the internally-set target response rate of 60%. In addition, 86% of staff had received the flu vaccination, which was a significant achievement. The CPO reported that the Trust was no longer required to provide daily situation reports to the NHS England with regards to a no-deal UK exit from the	

		Action
	European Union, but it would continue to work closely with system partners as appropriate. • The Care Quality Commission (CQC) inspection report had been published on 18 December 2019. The Trust welcomed the news that the CQC had recommended to NHSE&I that the Trust be taken out of quality special measures. The CQC had found improvements in many services across the Trust, in particular, services to children and young people which had been rated outstanding. It was also encouraging to note the positive observations regarding the Trust-wide well led results. The Trust would develop responses to the two requirement notices and submit this to the CQC, as required, by 16 January 2020. A wider plan to respond to the must and should do actions would also be developed. It was noted that the report had enthused and motivated staff across the Trust. The CCAO advised that the CQC report had also commented specifically on a range of improvements in the cardiac surgery service particularly in relation to leadership and governance and this was a significant step forward since its report of December 2018.	
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 12 December 2019 which set out the key issues raised at the meeting. The Committee had welcomed the new style reporting on serious incidents and had agreed that alongside this it would receive a bi-annual thematic review focusing on how the learning had been identified, disseminated and embedded. It was also noted that, given the pressures on the ED, a review of incidents would be undertaken including consideration of patient experience. The Committee had also scrutinised a number of items that were on the agenda for the Board meeting. The Board noted the report.	
2.1.1	**Complaints Annual Report (2018-2019)** The Board received the Complaints Annual Report for 2018-2019. The CN advised that complaints performance had significantly improved, with the Trust having 100% of the 25-day response target and noted that the team was to be commended for this good progress. Given the improvements made, the CN suggested that it may be timely for the Trust to consider whether the 60- and 40-day targets for response rates were appropriate. The CN advised that the cases with the 60/40 days response rates were normally very complex and, in some cases, related to a serious incident which often required more time in order to complete a comprehensive response to the complainant. These cases were very low in number. Divisions were represented at the Patient Safety and Quality Group where the learning from complaints was shared and discussed. However, it was recognised that more work was needed to ensure that divisions were sharing and embedding learning, and this work was ongoing. There were a number of complaints related to communications or simple process issues which, if addressed, would improve services to patients and reduce the number of complaints. There are plans in place to improve procedural mechanisms to address these issues.	

		Action
	The Board received the annual complaints report, were pleased to see the improvement achieved and noted that next iteration would be presented in July 2020.	
2.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 8 (November 2019), which had been scrutinised at both the Finance and Investment Committee and the Quality and Safety Committee the previous week, albeit that due to the timing of Committees the full IQPR had not been available. Of note was the reduction in the percentage of emergency caesarean sections (including no labour) which was a result of a national reclassification of the data. The Trust had worked closely with the London Ambulance Service which was impacting positively on the number of inappropriate attendances at the Trust's Emergency Department. The Trust's DMO1s (diagnostics waiting times) for echocardiograms performance had deteriorated to 4.8%. The Trust had completed a forward trajectory and now planned to meet the 1% threshold for patients waiting 6 weeks by 31 March 2020. There had been nine 12-hour trolley breaches in the reporting month. These were not just a factor of the pressure on Trust beds but also related to patients waiting to be transferred to mental health services. The Quality and Safety Committee would conduct a deep dive on trolley breaches at its January 2020 meeting. In relation to workforce issues, in November 2019 the Trust's agency spend was lower than in previous months and this was a positive shift. The CN also provided an update on the immediate actions taken following the never event which related to two newly qualified nurses using the wrong syringe to administer insulin to a patient. The Trust had reassessed the nurses' competency for using insulin syringes, sent out an all staff communication to raise awareness of the issues, and reiterated the correct protocols. Additional training would also be given to support nurses in administering insulin to patients. Importantly, the patient was well and had no adverse reaction to the excess insulin. The Trust was also supporting these two new nurses who had been deeply distressed by the incident. The Board received and noted the report.	
2.3	**Emergency Care Performance Report** The COO presented the report on emergency care performance for November 2019 and provided a verbal update on current performance. The Trust continued to work hard on improving its performance against the four-hour operating standard but the Emergency Department (ED) remained severely challenged. A rapid assessment zone had been introduced and was now in operation. The Trust's recent non-admitted performance was 80% and fluctuated between 63-72% at the weekends. The new model was working well but there continued to be variation. Good progress was being made on reducing patients' length of stay. Long stay patients impacted on the Trust's ability to triage patients from the ED to appropriate admitted beds. There were around 329 patients with an average length of stay of over seven days compared with 359 in the previous month. The multi-agency discharge events were reaping benefits but this was not sufficient to turn around the position. The Trust was now working with partners to find other options. The Emergency Care Delivery Board (ECDB) continued to give focus to recovering the non-admitted patient's performance and the CTO and COO were attending the ED huddles.	

		Action
	The Board noted that a lot of work was required to turn around the position but it was nevertheless very disappointing that the CTO and COO had needed to get involved personally in the day to day management of the ED. The Trust had refreshed the ED clinical team and the increased involvement of the executive leadership would support with the transition and ensure that the leadership team was focusing on the right issues. Other organisations were facing the same challenges with ED activity and there was a national challenge to meet the four-hour standard. However, it was important that the Trust ensured that patient safety and experience were not compromised. The Board noted the report.	
2.4	**Cardiac Surgery Update** The Board received and noted the cardiac surgery update. The CMO reported that the service was improving with significant changes having been made to strengthen clinical leadership, introduce and embed improved clinical governance frameworks and enhanced learning from incidents. These had been recognised by the Care Quality Commission (CQC). Board members welcomed the comprehensive report and agreed that this met the action requested at the October 2019 meeting. The Board noted that the Trust did not conduct elective cardiac surgery procedures on patients with a Euroscore (predicted mortality rate) of 5 % or more. 85% of the procedures that the Trust undertook had a Euroscore of less than 5%. The Care Group Lead and Associate Medical Director for cardiac surgery, Steve Livesey, was the only surgeon permitted to conduct surgery on patients with a higher Euroscore. The Trust would explore, with system partners, in 2020 the options and model for cardiac surgery in south London. The current position pointed to significant service improvements and developments. The CMO was keen to ensure that his report to the Board and the improvements it documented were recognised by those running the service. Even with stronger leadership and better quality governance there remained some cultural issues which need addressing and this work was ongoing. The Board noted and welcomed the recent CQC inspection report which had highlighted a number of improvements in the service. While there was undoubtedly more to do, the progress set out in the CQC report was significant and the observations regarding the effective leadership of the service that had been put in place were particularly encouraging. The National Institute for Cardiovascular Outcomes Research (NICOR) had confirmed that the risk-adjusted mortality rates following cardiac surgery at the Trust in the period April 2015 to March 2018 were within the normal range and that the Trust was no longer an outlier for mortality. This was significant but it was also important that the Trust benchmark its current performance with more recent comparative data. **The Board agreed that the CMO would share the Cardiac Surgery Report with the cardiac surgery team and invite comments to ensure that the teams are aligned to the current position.** **It was also agreed that the CMO would seek other sources of comparative data to include in future reports.** The Board received and noted the report.	**CMO** **CMO**

		Action
2.5	**Clinical Governance Review** The Board considered the report on the external clinical governance reviews (phase 1 and phase 2) and the progress against the recommendations. It was clarified that the Medical Examiner (ME) was an independent function with a reporting line to the CMO. The Medical Examiner Officer and Mortality Review Service, however, reported to the Nursing Directorate and acted as the clinical governance link between the ME's office and the Trust's clinical governance processes. It was agreed that action lists arising from the reviews should be developed to include timescales and other information to enable the Board to track progress. The significant investment required to deliver the improvements set out in the reviews had been considered and a level agreed by the executive team. The Board noted that a key area of learning from the review was ensuring that external reviewers were provided with a comprehensive list of stakeholders that needed to be part of the review's engagement and factual accuracy checking process. For example, in section 8.7 on page 120, the reviewers had not engaged with the Quality Improvement team which resulted in a number of factual inaccuracies in the section on quality improvement and learning. This lack of engagement was similarly reflected with the senior leadership team in legal services where the executive lead for the Trust's legal services function had not been consulted by the reviewers. It was noted that the lack of engagement and factual inaccuracies did not impact on the final recommendations. **The Board agreed that the action plan would be further developed in the form of a Gantt chart which would be presented to the Quality & Safety Committee regularly, for review and that this would include clear timescales to enable the Board to track progress.** The Board noted the findings from the phase two review, the update on progress against recommendations from the reviews and the plans to strengthen the clinical governance structure in the Trust.	**CMO/CN**
2.6	**Referral to Treatment (RTT) Clinical Harm Impact Review Closure Report** The Board received and discussed the RTT clinical harm impact review closure report. The Trust had commissioned an independent assessment in 2016 when it had come light there was a data quality issue in relation to recording accurate RTT data. The CMO reported that of the thousands of patient cases reviewed and assessed by the Trust or local General Practitioners, four patients had died and the review had concluded that the delay in the RTT pathway may have contributed to three of those patients' death. However, it was very difficult to establish direct causation. Senior Coroner, Dr Fiona Wilcox, had asked the Trust to refer the four cases for her independent judgement. The Trust had worked hard on improving its RTT data quality and, as a result, had returned to formal reporting in 2019 at both its sites. The Trust had also invested in Cerner to improve patient pathway flow. The Trust's RTT position was monitored monthly in the IQPR at the Board, Finance and Investment (FIC), Quality and Safety (QSC) and Trust Executive (TEC) committees. The QSC also received a quarterly report on RTT to ensure there were no quality or safety issues. The closure report was shared with relevant stakeholders and local commissioners. All duty of candour arrangements had been discharged.	

		Action
	The Board noted the report.	
3.0	**WORKFORCE**	
3.1	**Workforce and Education Committee Report** In the absence of the Committee Chair, Sarah Wilton presented the report from the Workforce and Education Committee meeting held on 5 December 2019 which set out the key issues raised at the meeting. The reports considered by the Committee on Freedom to Speak Up and from the Guardian of Safe Working were on the Board's agenda. **The Board noted the report and it was agreed that the CPO would work with the CCAO to arrange for an update on staff sickness to be provided at a future Council of Governors meeting.**	**CPO/CCAO**
3.1.1	**Freedom to Speak Up Guardian Report** The Board discussed Freedom to Speak Up (FTSU) Guardian Report and welcomed Freedom to Speak Up Guardian (FTSUG), Karyn Richards-Wright. The FTSUG reported that there were now a number of FTSU champions across the Trust and each division had its own champion. This was helping to improve the level of staff engagement in the FTSU process. There were still some challenges and a lot of work was required to ensure that the message about FTSU was cascaded across the Trust. However, things were moving in the right direction. The FTSU process was still relatively new and focus was being given to embedding the systems and practice and it was recognised that this would take time but was critical. In discussion, the Board noted that the Trust had procured a new system to support the management, tracking and monitoring of FTSU concerns raised. This new system would also provide greater visibility and enable the identification of trends and hotspots. The Trust supported all FTSU champions and provided them with additional training. The champions also had a group meeting each month with the FTSUG. The FTSU policy was applicable to all staff including those from third party organisations and the Trust worked closely with its contractors to ensure that all staff felt able to raise concerns. A key challenge was the time it took to meet with relevant clinical and divisional leads with conflicting clinical priorities which then impacted on achievement of the key performance indicator targets in the standard operating procedure. Some of the key themes from the issues raised to date related to underlying pressures in the organisation and staff not feeling as if they were being treated fairly which, in turn, could impact on performance. At least 80% of the concerns raised had not been upheld which could lead to staff feeling let down by the process but the process was based on fairness to all staff members. The Trust also needed to do more work on ensuring that staff felt more comfortable in raising concerns about patient safety. The Chairman expressed reservations about the Freedom to Speak Up function being located within the HR department. The CPO explained that robust arrangements were in place to ensure that there was appropriate independence of the function. Nevertheless, the Chairman requested that arrangements for executive sponsorship of the function be reviewed. **The Board thanked the FTSUG for her report and noted the Board would receive this report quarterly and that the Guardian should attend to**	**CPO/**

		Action
	present the report at Board and relevant Board Committees. **The Board agreed that the executive team would ensure that the organisation understands the need to engage with the FTSU process in a timely way and provide a method for the FTSUG to escalate non-engagement**. **The Board also agreed that arrangements for executive sponsorship of the Freedom to Speak Up function should be reviewed.**	**CCAO** **TEC** **CEO**
3.1.2	**Guardian of Safe Working Hours** The Board noted and discussed Guardian of Safe Working Hours (GOSWH) Report and welcomed Guardian of Safe Working Hours (GOSWH), Dr Serena Haywood. The GOSWH reported that the while reporting had improved, some doctors still felt reluctant to submit working hours exception reports and were more likely to raise these issues through the Local Negotiating Committee. There were occasions where there were clusters of reports from trainees. More exception reports had been received from foundation doctors. Some of the comments referenced a culture of bullying and banter and these have been explored. Some of the key drivers related to a 10% rota gap which impacted on the hours doctors work. The Trust needed to do as much as possible to support safe working for its medical work force and also to ensure that these doctors wanted to remain at the Trust after their training had been completed. These issues were picked up through the divisions and with clinical divisional chairs. The GOSWH was supported by the CMO and issues were escalated when there was insufficient traction of responding to issues or where there were challenges with consultants. The Board received and noted the report.	
4.0	**FINANCE**	
4.1	**Finance and Investment Committee Report** Sarah Wilton, who, in the absence of Ann Beasley, chaired the Committee, provided an update on the Committee's meeting, held on 12 December 2019. The two material matters of note for the Board were the increase of the financial risk rating to the maximum score of 25 and the Committee's concern about the level of challenge to recover the financial position and deliver against the Trust's agreed control total for 2019/20. The Board noted the report.	
4.2	**Finance and Investment Committee (Estates) Report (FIC(E))** Tim Wright, NED Estates Lead, provided an update on the meeting held on 12 December 2019. There was a real sense that the Trust had got to grips with the estates issues it faced. Fire and water remained the areas of highest risk. A key challenge for the Trust as it progresses estates plans was the management of the relationship with its Private Finance Initiative (PFI) partners. The performance under the new soft facilities management contract with Mitie had improved but the Trust remained vigilant as activity increased during the winter months. The Trust Chairman noted concerns about the Trust's position on health and safety.	

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		Action
	The Board noted the report and asked that the Health and Safety inspection report be presented to the Committee as a matter of urgency.	**CFO/DCEO**
4.3	**Month 08 Finance Report** The Board noted the Month 8 finance report. The DoFP reported that the Trust remained on plan at month 8 but there was building pressure on delivering the divisional plans. The weekly financial focus meetings continued. The Trust was on target for capital with a majority of capital spend scheduled for quarter four 2019/20. Ann Beasley clarified that the Trust remained on plan as a result of a number of non-recurrent actions but that the underlying position was challenged. The Board noted the report.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from the public** There were no questions from the public.	
5.2	**Any other risks or issues identified** There were no other risks or issues identified.	
5.3	**Any Other Business** There were no matters of any other business raised.	
5.4	**Reflections on the meeting** The Chairman invited Jenny Higham to offer reflections on the meeting. Prof. Higham expressed gratitude to the executive team for stepping up in the absence of the CEO and DCEO. The level of challenge and discussions had been balanced. Whilst recognising the many intractable issues faced by the Trust, such as estates and financial performance, it was important to note the areas of good performance such as the Care Quality Commission's recommendation to NHSE&I to take the Trust out of quality special measures, the closure of the review of clinical harm impact from the referral to treatment problems, and having a plan in place to improve clinical governance. The Trust and the Board was very hard working and this should be celebrated. It was noted that the recruitment campaign to find the new director of estates and facilities was underway and the Trust Chairman reported that the Board recognised how well the estates team were doing with the leadership and support of the CFO/DCEO. Ann Beasley noted that it felt like the Board had managed to close down some longstanding important issues, for example moving out of quality special measures and completing the clinical harm impact assessment in relation to the 2016 data quality issues.	
6.0	**PATIENT & STAFF STORIES**	
6.1	**Patient Story: Patient Experience: Cancer Pathway** The Board welcomed Mr Alan Cruchley who relayed his experience of being	

		Action
	diagnosed with cancer of the bladder and undergoing radical cystectomy at the Trust. Once it was agreed that he would need the operation the Trust moved quickly and he was offered a date for the operation within two weeks. This was the first time he had ever been an inpatient in hospital and despite being a biomedical scientist in a former life he was daunted by the prospect of the operation and being in hospital. He was medically fit and discharged home four days after the operation. Every single member of staff he encountered, surgical teams, nurses, caters, had treated him respectfully and had provided the highest level of care and support. He was admitted to Vernon Ward which was very busy and crowded with little space for visitors and limited space in the toilets. This, however, did not impact on the level of care he received especially given staff on the ward and also in the intensive care unit were caring for very unwell patients with complex needs. He suffered no post-operative complications and the team encouraged him to get up and move around quickly which helped get him back quickly with no post-operative complications. The Board also welcomed, Mr Rami Issa, Urology Consultant, and Deepa Leelamany, Urology Clinical Nurse Specialist and Service Lead, who outlined the key statistics around this type of procedure using the surgical robot. Despite the procedure being high-risk for a majority of the patients the Trust had a zero-percent mortality rate for this type of operation. The service was nurse led and the minimum patient stay was four days. The service also kept a database of patients willing to provide peer support to new patients and this had been offered to Mr Cruchley. The use of the robot allowed the service to deliver more operations and reduce the pain felt by patients. The service was also multi-disciplinary and included, for example, stoma nurses and dieticians. The Board thanked Mr Alan Cruchley for sharing his story.	
Date of next meeting: Thursday, 30 January 2020 in the Hyde Park Room, St George's Hospital, Tooting		

Trust Board Action Log Part 1 - January 2020

Action Ref	Section	Action	Due	Lead	Commentary	Status
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	**See Agenda Item 4.4**	**PROPOSED FOR CLOSURE**
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	**See Agenda Item 2.6 -** Report considered by the Quality & Safety Committee on 23/01/2020	**PROPOSED FOR CLOSURE**
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	**See Agenda Item 2.3**	**PROPOSED FOR CLOSURE**
TB19.12.19/05	**Workforce & Education Committee Report**	The Board noted the report and it was agreed that the CPO would work with the CCAO to arrange for an update on staff sickness to be provided at a future Council of Governors meeting.	30/01/2020	CPO/CCAO	This will form part of the workplan for the Council of Governors which will be considered by the CoG on 19 February 2020	**PROPOSED FOR CLOSURE**
TB19.12.19/06	**Freedom to Speak Up Guardian Report**	The Board thanked the FTSUG for her report and noted the Board would receive this report quarterly and that the Guardian should attend to present the report at Board and relevant Board Committees.	27/02/2020	CPO/CCAO	The FTSUG invited to to present at the Board and the Workforce & Education Committee. Added to the draft 2020/21 forward plans for Board and WEC.	**PROPOSED FOR CLOSURE**
TB19.12.19/04	**Clinical Governance Review**	The Board agreed that the action plan would be further developed in the form of a Gantt chart which would be presented to the Quality & Safety Committee regularly, for review and that this would include clear timescales to enable the Board to track progress.	30/01/2020	CMO/CN	This action as been added to the Quality and Safety Committee action log and the next version of the report will incorporate this. The timing of bringing the item back to the QSC will be considered as part of discussions about forward plans for the Committee.	**PROPOSED FOR CLOSURE**
TB19.12.19/02	**Cardiac Surgery Report**	The Board agreed that the CMO would share the Cardiac Surgery Report with the cardiac surgery team and invite comments to ensure that the teams are aligned to the current position.	30/01/2020	CMO	The report was shared with clinicians by the service lead.	**PROPOSED FOR CLOSURE**
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**
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**
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.	28/05/2020	CMO	Not yet due.	**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 yet due.	**NOT DUE**
TB19.12.19/01	**Action Log & Matters Arising**	**Plans for Providing Effective Assurance at Committees (Corporate Objectives):** The Board agreed that plans for reporting on and providing effective assurance through Committees to the Board on corporate objectives would be picked up as part of the process for agreeing the objectives for 2020/21.	26/03/2020	CSO/CCAO	Not yet due.	**NOT DUE**
TB19.12.19/03	**Cardiac Surgery Report**	It was also agreed that the CMO would seek other sources of comparative data to include in future reports.	27/02/2020	CMO	The CMO is exploring what, if any other appropriate performance management benchmarking can be included in the Cardiac Report and an update would be provided in February.	**NOT DUE**
TB19.12.19/07	**Freedom to Speak Up Guardian Report**	The Board agreed that the executive team would ensure that the organisation understands the need to engage with the FTSU process in a timely way and provide a method for the FTSUG to escalate non-engagement.	26/03/2020	TEC	Update to be provided following Workforce & Education Committee 18 February 2020	**NOT DUE**
TB19.12.19/08	**Freedom to Speak Up Guardian Report**	The Board also agreed that arrangements for executive sponsorship of the Freedom to Speak Up function should be reviewed.	26/03/2020	CEO	Update to be provided following Workforce & Education Committee 18 February 2020	**NOT DUE**
TB19.12.19/09	**Finance and Investment Committee (Estates) Report (FIC(E))**	The Board noted the report and asked that the Health and Safety inspection report be presented to the Committee as a matter of urgency.	27/02/2020	CFO/CEO		**NOT DUE**

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Meeting Title:	Trust Board		
Date:	30 January 2020	**Agenda No.**	**1.5**
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Andrew Grimshaw, Acting Chief Executive		
Report Author:	Andrew Grimshaw, Acting 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 – January 2020

Shortly after our last Trust Board meeting in December, Gillian Norton, our Chairman, announced that Jacqueline Totterdell, Chief Executive, was unwell and likely to be absent from work until mid-February. I am pleased to say that Jacqueline is on the mend and recovering well, but rightly taking time away from work to rest and recuperate.

Until Jacqueline returns, I will continue in the role of Acting Chief Executive, with Tom Shearer, Deputy Chief Finance Officer, covering my substantive position of Chief Financial Officer during this period. Executive responsibility for estates remains with me while I cover for Jacqueline. Suzanne has kindly agreed to act as the executive lead for IT.

I am grateful to the Trust Board for their support in recent weeks, and Jacqueline has asked me to thank colleagues – including Board members – for their kind words and thoughtful messages.

Developments in our external environment:

We continue our work to become a more outward facing and collaborative partner.

I am confident the CQC's inspection report – published just before Christmas – will be viewed positively outside the organisation. The progress we have made in recent years is due in no small part to the support we've had from regulators and partner organisations, including locally; which is another reason why we must continue to engage, and share both opportunities and challenges.

On this theme, I am pleased that Suzanne Marsello, our Chief Strategy Officer, has recently been made Senior Responsible Officer for the South London Renal Operational Delivery Network, which will inform how this key specialised service is delivered across south London and into Surrey going forward. Suzanne also organised – in partnership with the Health Innovation Network - a workshop held at St George's last week to explore new integrated approaches to improving care for people in Wandsworth and Merton with diabetes and serious mental illness. People with a dual diagnosis like this have a life expectancy 20 years less than other people of the same age, so this is a significant health inequality that needs to be tackled. The event was attended by over 60 people, with guest speakers and attendees from across the local health economy.

Elsewhere in south west London, the six CCGs serving Wandsworth, Croydon, Merton, Kingston, Richmond and Sutton will become one single CCG from 1 April this year. This won't impact on key relationships between ourselves and the CCG, but it is a significant step forward, and worthy of noting.

Finally, it is also important to note that the consultation led by NHS Surrey Downs, NHS Sutton and NHS Merton Clinical Commissioning Groups into planned investment in Epsom, St Helier and Sutton Hospitals has now begun, and runs until 1 April. We will be responding formally to the consultation in due course.

Delivering on our vision and strategy:

One of our five year strategic objectives is to create strong foundations for the organisation, so the CQC's inspection report published in late December 2019 is an important milestone on this journey.

The CQC recognised the 'significant improvements' we'd put in place since their last inspection in July 2018; and a number of services – including surgery and children and young people – were singled out for particular praise.

Crucially, the CQC also recommended to NHS England and NHS Improvement that the Trust be taken out of Quality Special Measures – which would be a big step forward for the organisation. However, we mustn't be complacent - despite making real and measurable progress, we are still rated 'requires improvement' overall, and I know our staff and stakeholders are keen to push for bigger and better things.

We are continuing to innovate for the benefit of patients. For example, Miss Shamim Umarji, one of our Consultant Orthopaedic Surgeons, is leading a pilot study that involves patients using virtual reality headsets to reduce anxiety during wide awake surgery. Our new research strategy – agreed by the Trust Board in November and published earlier this month – will help drive innovations such as this and others, and also push up participation in clinical trials, an area in which we are already very strong.

We are continuing to invest in our hospital estate and clinical IT systems, and we will shortly begin the process of informing staff and patients about the range of improvement works planned, and (crucially) how we plan to keep noise and disruption to an absolute minimum. The works are essential to maintaining the safety of core infrastructure – including water, fire and electrical safety – and the upgrades to be announced soon are a key part of improving the reliability and effectiveness of our St George's Hospital estate.

Our financial position:

At the start of this financial year, we planned to deliver a deficit of £3 million by year end. In recent weeks, this position has looked increasingly challenged, and today, we have brought a revised financial forecast to the Trust Board that will see us deliver a deficit of £12 million by March 2020.

This revised forecast still represents a significant improvement on our financial position compared to 2018/19. But while there are reasons for the revised forecast, I am naturally disappointed that we haven't been able to deliver the original figure we said we would.

Given the revised forecast, it is particularly important that – between now and the end of March - we continue to press ahead with our cost improvement plans, and reduce spending through a range of internal control mechanisms. We have begun the process of planning for next year, with a stronger focus than ever before on reducing the deficit and delivering efficiencies, whilst also providing a safe, high quality service for our patients. Finance, performance and quality go hand in hand and only by delivering all three will be succeed in delivering outstanding care, every time for our patients, staff and the communities we serve.

Our staff:

Our staff continue to go above and beyond in their roles, which I am seeing in new and different ways as Acting Chief Executive.

Just before Christmas, our paediatric surgery and neonatal teams worked together to help a young family whose baby was born with a large cyst under his tongue. Little Oliver's story was the subject of positive media coverage, which helped showcase the skills of the different staff involved in his care. Indeed, we have just embarked on a new documentary series with Channel 4 which we are confident will showcase the work of teams involved in caring for our very youngest patients – so watch this space for further updates.

We have talked at length about the importance of delivering on our diversity and inclusion agenda. As a result, I am pleased that – from the beginning of this month – all interviews for Agenda for Change band 8A posts and above require a BAME representative to sit on the panel. This is just one of the initiatives we are putting in place to make St George's a fairer, more equitable employer – and one that I think our staff will welcome.

The same is true of our work to improve organisational culture. We have successfully recruited over 20 members of staff from different teams and levels across the Trust to lead on this important piece of work, in partnership with Jacqueline Totterdell, our Chief Executive, when she returns to work in mid-February. Our champions met for the first time last week, and work now begins in earnest to truly understand our organisational culture here at the Trust and drive the change we all feel is needed.

Finally, I want to formally acknowledge some recent changes to the leadership of our three clinical divisions. Dr Rafik Bedair, Critical Care Consultant and Clinical Director for Adult Critical Care since 2018, is now Divisional Chair for our Children's, Women's, Diagnostics, Therapeutics and Community Division whilst Mr Nick Hyde, Consultant Maxillofacial Surgeon, has taken up the role of Divisional Chair for our Surgery, Theatres, Neurosciences and Cancer Division. Rafik and Nick succeed Justin Richards and Tunde Odutoye, who both held their respective positions for a number of years – and to whom huge thanks is due.

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Trust Executive Committee

Since the Board last met on 19 December 2019, the Trust Executive Committee (TEC) has met three times. 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.

The Committee has continued to focus on our plans for delivering financial improvement in the current year, as well as starting the planning for the next financial year. As noted above, the Board will consider a revised financial forecast for 2019/20 at its January 2020 meeting and the Committee closely scrutinised this and agreed to recommend it to the Board. Business planning for next year is now underway and the Committee considered plans for developing these and bringing the outputs to the Board over the next two meetings.

The Committee formally received and welcomed the CQC inspection report. It noted that the Trust has responded with action plans to the two requirement notices ahead of the 16 January 2020 deadline, and also asked that detailed plans be developed both to respond to the 'must do' and 'should do' actions identified in the report as well as, importantly, to be clear what actions are needed for the Trust to achieve its ambitions of providing outstanding care, every time and, in doing so, improve its CQC rating.

The TEC continues to give close scrutiny and oversight to the Trust's operational performance and has maintained a sustained focus on improving our emergency care performance. The latest ED performance data and commentary is included in the IQPR for the Board meeting.

Andrew Grimshaw
Acting Chief Executive
30 January 2020

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2

Meeting Title:	**Trust Board**		
Date:	**Thursday, 30 January 2020**	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	**Dame Parveen Kumar, Chairman of the Quality and Safety Committee**		
Report Author:	**Dame Parveen Kumar, 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 January 2020.		
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		

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Quality and Safety Committee Report

Matters for the Board's attention
The Quality and Safety Committee met on 23 January 2020 and agreed to bring the following matters to the Board's attention:

1. Deep Dive: 12 Hour Trolley Breaches

This month's deep dive focused on the number of patients waiting in the Trust's Emergency Department (ED) for inpatient admission in excess of 12 hours during the period April – November 2019. The Trust recorded 21 trolley breaches in this period related to patients on an acute care pathway but most of these adverse incidents related to patients waiting for admission on a mental health pathway.

The Trust commissioned the Emergency Care Intensive Support Team (ECIST) to review the Trust's mental health provision and analysis concluded that the trolley breaches related to limited suitable space or sufficient flexibility at high demand times in the ED, not having sufficient psychiatric liaison capacity to meet demand and similarly the limited number of approved mental health professionals and approved doctors to conduct mental health act assessments. Significantly, the core of the issue is the number of beds available in mental health providers in the catchment area. This means that patients with mental health needs who are medically fit may be admitted to an acute bed. A times of pressure this then impacts on the ability to admit patients on an acute care pathway.

The Trust is cognisant of the current upward trend in the number of 12 hour trolley breaches and wants to introduce a zero-tolerance to 12 hour trolley breaches for patients on an acute care pathway. The following actions have been identified as part of its Emergency Care Delivery Board (ESDB) programme:

- Conduct a pilot of rapid deployment of mental health assessment in the ED Department and redirect patients to more appropriate community or mental health care settings if they are medically fit;
- As an identified Health-Based Place of Safety the Trust is required to admit any mental health patient if there are no mental health beds in the system. However it is recognised that the Trust needs to consider how it works with its mental health partner organisations to ensure that the system is operating within the framework of the Mental Health Compact; and
- Review all adverse incidents for 12 hour trolley breaches at the ECDB.

The Committee noted the systemic issues and the challenges that are inherent when supporting patients with mental health needs. Having mental health patients who are medically fit in an acute bed is not the right place for these patients and the Trust needs to work with mental health organisations to ensure that these patients are repatriated to the right care setting. The Trust needs to work on its processes to ensure that where mental health patients present to the ED with no physical medical issues they are redirected to local and community settings such as their GPs, crisis cafes etc. The Committee remains concerned about the current trend in 12 hour trolley breaches and as such agreed to receive a further report once the actions have been embedded before it is assured that the Trust is moving toward zero-tolerance.

2. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality performance at month 9. The Committee noted there was a never event which was related to a retained product following eye surgery. The retained product was discovered and removed before the patient was discharged home well. This incident should never have occurred as the retained product should have been part of the surgical count at the beginning and end of the procedure. This message has been strongly reinforced with teams. During the reporting period the Trust also

had one patient test positive for legionella. Given the patient was in the Trust for a very short period of time and due to the mitigations the Trust put in place Public Health England has decided not to assign the incident to the Trust. The patient was well and discharged home with antibiotics. Whilst the Trust has a long standing issue with legionella in the past year it has embedded a robust estates and infection control programme to ensure that all taps are fitted with filters and regular audits are undertaken. The Trust's infection control scorecard was red in month 9 and this relates to one methicillin-resistant staphylococcus aureus (MRSA) incidents in October 2019 (with a further MRSA in January 2020), against a threshold of zero. The position was also being impacted by 26 Methicillin-sensitive Staphylococcus aureus (MSSA) cases against a threshold of 25 cases for the year. The Committee noted that root cause analyses were being undertaken for MSSA and MRSA incidents however wanted further assurance that learning from these incidents was truly embedded.

3. Care Quality Commission (CQC): Response to 2019 Inspection

The Committee received and discussed the CQC inspection report and Trust response to the two requirement notices which is discussed later on the Board agenda.

4. Exception Report: Care Quality Commission Outstanding Actions

The Committee continues to receive monthly reports on the outstanding CQC action related to achieving the mandatory training target of 85% which is being largely impacted by the Trust's inability to attain the target for resuscitation training. The Committee noted that June 2020 is the revised trajectory for delivery against the 85% performance standard (subject to approval at the Trust Executive Committee) and that this action would be incorporated in the full action plan for 2019 inspection. The Committee also heard that attendance at mandatory training was being monitored through staff appraisal.

5. Nurse Staffing Report (Planned vs. Actual)

The Committee considered the nurse staffing reports for November and December 2019. The overall fill rate for was 96% and 95% respectively. These fill rates were within the normal limits with any exceptions effectively managed to ensure there were no outstanding safety issues. Whilst safe staffing red flags were raised these were effectively managed and mitigated.

6. Cardiac Surgery Update

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

7. Serious Incident Reporting

The Committee considered the serious incidents declared and previous closed investigations. The Committee noted that there were no key trends arising from the serious incidents in the month and that although it must always be of concern if any never events occur, the patient did not suffer serious harm from the never event that occurred in this reporting period.

8. Update on 2019 Quality Priorities

The Committee heard that a comprehensive review of the nine quality priorities within the Quality Account 2019/20 had been completed and although progress had been made in all areas and completed in one area, the Trust had not been able to achieve all the targets set for these priorities. As such the management team are exploring rolling these over into the Quality Account 2020/21 or where appropriate have incorporated these improvement priorities into the Quality and Safety Strategy 2019-24 which is discussed later on the Board agenda.

9. Quality Improvement Academy (Quarter 3) Update

The Committee received the quarter three update from the Quality Improvement Academy which is discussed later on the Board agenda. The Committee noted that audits are conducted to assess progress and the degree to which quality improvement initiatives are embedded in the Trust. The Committee also asked that future reports include measurement of impact for each initiative.

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

The Committee received a summary report from the PSQG meeting held in December 2019. The Committee heard that work continues to complete NICE compliance assessments with 21 assessments undertaken since the last meeting and it is expected that all assessments would be completed by end-January 2020.

11. Elective Care Update: Referral to Treatment (RTT) Quarter three

The Committee considered the quarter three report on RTT. The Trust's performance for incomplete RTT was 84.2% against a trajectory of 86.5% in November 2019 and it was also noted that the 52 week breach position had deteriorated. The Improvement Support Team (IST) conducted a data quality assessment in November 2019 and the Trust was progressing the nine recommendations.

12. Seven Day Service Standards Implementation

The Board at its November 2019 meeting asked the Committee to consider the progress made in preparing the Trust to meet the seven day service standards by April 2020. The Committee considered the report and noted the action plan for the Trust to improve its performance against the seven day service clinical standards. The Committee heard that it was very unlikely that the Trust would achieve full compliance by April 2020 as there was a particular challenge to attain Standard 2 in all clinical areas (*all emergency admissions seen and having a thorough assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital)*. It was recognised that only a minority of Trusts have achieved full compliance with the core clinical standards nationally, but that they remain very important quality and safety goals, and that this Trust's performance against them can and should improve. The report will be discussed later on the Board agenda.

13. Update on Policy trust-wide

The Committee noted the update on patient care related trust-wide policies. There is now a robust process of tracking and monitoring Trust policies however the responsibility for updating policies lay with the relevant clinic teams and divisions. Good progress had been made with updating patient care policies with 61% being in-date. This will improve to 80% of patient care policies in-date by the end of March 2020. The remaining 20% out-of-date require a confirmed plan as to the timeline for reviewing these policies and will be addressed at PSQG.

14. Quality & Safety Strategy

The Committee noted and endorsed the Quality & Safety Strategy which will be discussed at later on the Board agenda. The Committee recommends that the Board approve the strategy.

15. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register focusing on the four strategic risks (SR) which fall within its remit. Three new risks were added to the corporate risk register related to delivery of paediatric and adult echocardiogram services and meeting the seven day service standards. The Committee agreed that in relation to strategic risks SR1, SR2, SR3 and SR16 to accept the partial assurance rating and risk scores. The BAF would be discussed later on the Board agenda.

16. Committee Member

The January 2020 meeting was Sarah Wilton's last before she steps down as a non-executive director after nine years at the Trust. The Committee thanked Sarah Wilton for her invaluable support and contribution to the Trust and the Committee.

Dame Parveen Kumar
Committee Chair
January 2020

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2

Meeting Title:	**Trust Board**		
Date:	**30 January 2020**	**Agenda No**	**2.2**
Report Title:	**CQC Inspection Report (Published December 2019)**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control** **Richard Jennings, Chief Medical Officer**		
Report Author:	**Alison Benincasa, Director of Quality Governance and Compliance**		
Presented for:	**Noting**		
Executive Summary:	The purpose of this report is for the Committee to formally receive the CQC Inspection Report 2019. The CQC inspection was conducted between July and September 2019, five of our eight core services were assessed (Urgent and Emergency Care, Medical Care, Surgery, Children and Young People and Outpatients) including an assessment of Trust leadership (well led). Surgery was rated as good overall and services for Children and Young people were rated as outstanding (see page 17 of the report for detail about other core services). The CQC confirmed the overall rating for the Trust as ***Requires Improvement*** and has recommended to NHSI/E that the Trust is removed from Quality Special Measures. The Trust received two requirement notices (MUST dos), see appendix 2 for the detailed improvement action plan. **MUST do's – Trust wide** • Make sure all patient records are stored securely, completed accurately and kept confidential • Make sure consent is correctly recorded in patients notes in line with best practice The Trust was informed of forty-four further issues across six service areas where the Trust should make improvement: **SHOULD do's – Urgent and Emergency care** • Complete all documentation correctly, including fluid balance charts, pain scales and Glasgow Coma Scales • Check that all equipment is clean, safe for use, and appropriate checklists completed • Improve the BAME knowledge and support within the department • Display information about how to raise a concern in all patient areas • Ensure all medicines correctly prescribed and administered • Ensure all patients have necessary risk assessments completed and documented, and that these are updated **SHOULD do's – Medical Care** • Continue work to improve vacancy, sickness and turnover rates amongst nursing staff • Continue work to improve completion rates of mandatory training amongst		

	medical staff • Improve the consistency of completion of patient records including risk assessments and reach out to me forms • Improve the recording of actions taken when fridge temperatures are out of range • Continue with plans to improve the catheter laboratory to provide a safe service for patients and staff • Reduce the number of patient-moves at night • Improve the referral to treat time (RTT) in the five specialities where they fell below the England average **SHOULD do's – Surgery** • Continue work to improve vacancy, sickness and turnover rates amongst nursing staff • Continue work to improve the environment across the surgical division • Continue work to improve completion rates of mandatory training amongst medical staff • Continue work to improve appraisal rates for staff across the surgical division • Consider further ways to improve staff wellbeing in light of staffing shortages • Update and ensure staff have access to the deteriorating patient policy • Ensure all locum medical complete a full local induction • Continue work to improve waiting times from referral to treatment and arrangements to admit, treat and discharge patients to bring them in line with national standards **SHOULD do's – Surgery at QMH (day case unit)** • Have a policy in place for seeing paediatric patients Improve staff awareness on learning from incidents Ensure records are stored securely Update and ensure staff have access to the deteriorating patient policy Continue to work to improve nurse staffing levels Ensure relevant learning from audits is shared across both sites and ensure data is consistently collected for audits and action plans completed where necessary Work to improve staff appraisal rates Ensure consent form documentation is fully completed Ensure senior staff are clear of who has overall responsibility and oversight of surgery (day case) at Queen Mary's Hospital Ensure risk registers are completed with up to date information **SHOULD do's – Children and Young People** • Continue work to improve completion of nursing staff annual appraisals • Continue work to improve the amount of staff qualified in speciality working within the neonatal unit and paediatric intensive care • Continue work to improve completion rates of mandatory training amongst medical staff • Consider further ways to improve staff engagement, well-being and address concerns highlighted in staff survey • Continue with recruitment and retention strategies to reduce vacancy, turnover and sickness rates • Consider how to avoid mixed sex breaches • Continue with the planned refurbishment to make the premises suitable for modern day healthcare

	SHOULD do's – Outpatients • Consider an effective process for quality improvement and risk management • Improve its local audit programme and review national audit outcomes to improve patient outcomes • Complete infection prevention and control audits regularly and take action to address concerns including risks associated with the environment for decontamination of naso-endoscopes were embedded in practice • Improve staff compliance with mandatory training, including information governance safeguarding level three and resuscitation • Provide adequate seating facilities in clinics, to ensure patients and relatives have enough seating areas • Develop systems and processes which enable the trust to determine the quality and performance of its outpatients department
Recommendation:	The Board is asked to: 1. Formally receive the CQC Inspection Report 2019; 2. Note the Trust action plan to address the two requirement notices (MUST dos) which was submitted to the CQC on 16 January 2019; and 3. Note the Trust-wide action plan to address all improvement actions is currently under development and requires divisional input and sign off.
Supports	
Trust Strategic Objective:	Treat the patient, treat the person
CQC Theme:	Safe, Effective, Responsive, Caring and Well-led
Single Oversight Framework Theme:	1. Quality of Care (safe, effective, caring, responsive) 2. Leadership and Improvement Capability (Well-led)
Implications	
Risk:	Failure to deliver quality improvements in line with the expectations of the CQC will result in reputational damage, loss of confidence in the organisation, and perceived failure of leadership
Legal/Regulatory:	Level of compliance with CQC key lines of enquiry
Resources:	N/A
Equality and Diversity:	No issues to consider
Previously Considered by:	Patient Safety and Quality Group Trust Executive Committee Quality and Safety Committee **Date** 15.01.2020 22.01.2020 23.01.2020
Appendices:	Appendix 1 - CQC Inspection Report 2019 Appendix 2 - CQC Requirement Action Plan (MUST dos)

St George's University Hospitals NHS Foundation Trust

Inspection report

St Georges Hospital
Blackshaw Road, Tooting
London
SW17 0QT
Tel: 02086721255
www.stgeorges.nhs.uk

Date of inspection visit: 17 July to 5 Sept 2019
Date of publication: This is auto-populated when the report is published

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**
Use of resources rating for this trust	**Requires improvement**

Summary of findings

Combined quality and resource rating for this trust

Requires improvement

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Background to the trust

St George's University Hospitals NHS Foundation Trust is a teaching trust with two hospital locations; St George's Hospital, Tooting, and Queen Mary's Hospital, Roehampton.

The main acute site is St George's Hospital, which provides general and specialist services including PPCI, HASU and Major Trauma Centre and has an emergency department. Queen Mary's Hospital does not have an emergency department, but it does have a Minor Injuries Unit.

St George's University Hospitals NHS Foundation Trust has 1,083 beds; 995 at St George's and 88 at Queen Mary's. The beds at St George's Hospital comprise of 871 general and acute, 67 maternity, 57 critical care. The beds at Queen Mary's Hospital comprise of 46 for people with limb amputations who require neurorehabilitation and 42 for sub-acute care, treatment and rehabilitation of older people. The hospitals are both in the London Borough of Wandsworth. The lead clinical commissioning group is Wandsworth, who co-ordinates the commissioning activities on behalf of the other local clinical commissioning groups such as Merton and Lambeth.

The trust serves a population of 1.3 million across south west London. Several services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

The number of staff employed by the trust as of May 2019 was 8,932 staff.

The trust was had been in Quality Special Measures since November 2016 and Financial Special Measures since April 2017.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

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What this trust does

St George's University Hospitals NHS Foundation Trust provides acute district general and specialist services to the whole population of south west London and more specialist services for the population of Surrey and Sussex. St George's Hospital in Tooting is the only trust location which provides accident and emergency department services.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Summary of findings

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected St George's Hospital and Queen Mary's Hospital. At St George's Hospital, we inspected the core services of urgent and emergency services, medical care, surgery, services for children and young people and outpatients, as part of our continual checks on the safety and quality of healthcare services.

At Queen Mary's Hospital, we inspected surgery.

We selected the services for inclusion in this inspection based on those that were rated 'requires improvement' as a result of our findings at the previous inspection carried out in March 2018. Intelligence information we held on these areas indicated the need for re-inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed; Is this organisation well-led?

What we found

Our overall findings indicated that many areas made improvements. Of the services inspected, one was rated as outstanding, one was rated good and four were rated as requires improvement.

Overall, we rated safe, effective, responsive and well-led as requires improvement. We rated caring as good. We rated both St George's Hospital and Queen Mary's Hospital as requires improvement.

The trust was in special measures for both quality and finance. The trust was meeting the 62-day cancer standard and the two-week standard, but not meeting the accident and emergency four hour wait target. The trust returned to reporting Referral to Treatment (RTT) data for the St George's Hospital site to NHS England/Improvement in January 2019, after a two-year suspension. The trust was not meeting this standard, though it was meeting the trajectory it had agreed with NHS England/Improvement for this standard.

We found the urgent and emergency services at St George's Hospital remained as requires improvement. Effective and well-led improved from requires improvement to good. Caring remained as good. Safe and responsive remained as requires improvement.

Medical care at St George's Hospital remained as requires improvement. Caring remained as good. Safe and effective remained requires improvement. Responsive and well-led decreased from good to requires improvement.

Surgery at St George's Hospital improved to good. Safe and effective improved from requires improvement to good. Caring and well-led remained as good. Responsive remained as requires improvement.

Services for children and young people improved to outstanding. Caring and responsive improved from good to outstanding. Safe and well-led improved from requires improvement to good. Effective remained as good.

Outpatients at St George's Hospital remained as requires improvement. Safe improved from requires improvement to good. Caring remained as good. Responsive remained as requires improvement. Well-led improved from inadequate to requires improvement. We did not rate effective.

Summary of findings

Surgery at Queen Mary's Hospital remained as requires improvement. Safe improved from requires improvement to good. Effective and well-led remained as requires improvement. Caring remained as good. Responsive reduced from good to requires improvement.

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good. We rated one of the trust's 12 core services across two locations as outstanding, three as good, six as requires improvement and two were not rated. In rating the trust, we took into account the current ratings of the five services not inspected this time.
- We rated well-led for the trust overall as requires improvement.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Medical care and children and young people services did not always have enough staff with the right qualifications, skills, training and experience. However, there were mitigations in place to keep patients safe from avoidable harm.
- **Records were not always stored securely.** In the emergency department, casualty cards were unsecured in the cubicles in majors. In surgery at St George's Hospital, some patient identifiable information and do not resuscitate forms were in folders that were not marked as confidential. In the day care unit at Queen Mary's Hospital, some records were left in persons unlocked cabinets during the day. This meant records were accessible to unauthorised persons.
- Services provided mandatory training in key skills to all staff, however, not all staff had completed them.
- **Services did not always control infection risk well.** We saw examples of staff not washing their hands between patient contact.
- **Services were dealing with an ageing estate which at times was a risk to patient safety.** The trust had taken some actions to control the risk, such as filters on taps to prevent legionnaires disease and the pipework was flushed regularly to prevent leaks, but this was an ongoing challenge.

However:

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse, and they knew how to apply it.
- **Staff completed risk assessments for each patient swiftly.** They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.
- **Services managed patient safety incidents well**. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people who used services and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- **Some policies were out of date.** This meant that staff did not have access to the most up to date evidence-based practice.
- The number of staff who received an annual appraisal was below the trust target in many wards and departments.

Summary of findings

- **Staff did not always monitor the effectiveness of care and treatment and did not always use audit findings to make improvements and achieve good outcomes for patients.** For example, on the medical care wards, not all patients had a pain score recorded in their records, which meant staff were not able to see whether a patient's pain score had changed after administering analgesia. However, wards used the results of their accreditation scheme to drive improvement.
- **Staff did not always record consent in patients' records.** We saw some examples in surgery at Queen Mary's Hospital, of forms not completed in full and inconsistent recording which meant staff were not sure correct consent for treatment had been obtained.
- **Not all patients had a pain score recorded in their records.** Some staff told us they did not use a pain score tool for patients and no score was recorded in their records. This meant staff were not able to see whether a patient's pain score had changed.

However:

- **Services provided care and treatment based on national guidance and evidence-based practice.** For example, they followed guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons
- **Staff gave patients enough food and drink to meet their needs and improve their health.** They used special feeding and hydration techniques when necessary. Services made adjustments for patients' religious, cultural and other needs.
- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- **Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.** They used agreed personalised measures that limited patients' liberty.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- **People were not able to access services in a timely way**. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- **Referral to treatment (RTT) data for non-admitted pathways was worse than the England overall performance.** However, the trust only returned to reporting on referral to treatment data for St George's Hospital in January 2019.
- The trust was not meeting the emergency department national standard to admit, treat or discharge patients within four-hours.

Summary of findings

- **The trust did not always meet their threshold for 'did not attend' rates.** However, leaders discussed 'did not attend' rates at meetings and measures to improve them were considered, including texting and making phone calls to patients, prior to their appointment. .
- The average length of stay for medical elective patients was higher than the England average.
- Facilities and premises were designed for the services delivered. However, there were limitations on space within clinics and waiting areas, in the outpatients' department at St George's Hospital.

However:

- **Services planned and provided care in a way that met the needs of local people and the communities served.** They also worked with others in the wider system and local organisations to plan care.
- **Services were inclusive and took account of patients' individual needs and preferences.** Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- **Services treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.** However, there was a lack of patient information displayed in some areas, on how to raise a concern.

Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

- **Most leaders had the skills and abilities to run their services.** However, we had concerns that there was insufficient oversight and management of issues in surgery at Queen Mary's Hospital, and the outpatient department at St George's Hospital.
- Some frontline clinical and non-clinical OPD staff were unaware of their services strategy document and were not involved in the development of the services strategy.
- Some black, Asian and minority ethnic (BAME) were not aware of the equality network they could join.
- **Some leaders did not operate effective governance processes and not all staff at all levels were clear about their roles and accountabilities.** For example, there was no clarity of who had overall responsibility and oversight of surgery at Queen Mary's Hospital, and some senior staff in the outpatient department at St George's Hospital, could not tell us their responsibility for the development of the service.
- Some staff and middle grade managers were not aware of what was on their department's risk register and arrangements for managing risks were not always clear.

However:

- Leaders collaborated with partner organisations to help improve services for patients.
- **Staff were committed to continually learning and improving services.** They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
- Leaders were visible and approachable in services for patients and staff.

We rated use of resources as requires improvement because:

The trust does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care.

Please see the separate use of resources report for details of the assessment. The report is published on our website at www.cqc.org.uk/provider/rj7/reports.

Summary of findings

Combined quality and resource

Our combined rating of quality and resource is requires improvement because:

- We rated safe, effective, responsive, and well-led as requires improvement; and caring as good;
- We took into account the current ratings of the five services across the two locations not inspected this time.
- We rated six services across the trust as requires improvement.
- We rated one service as outstanding.
- We rated three services as good.
- We did not rate two services.
- The overall ratings for each of the trust's acute locations remained the same.
- The trust was rated requires improvement for use of resources.

See guidance note 7 then replace this text with your report content. (if required)…

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice at St George's Hospital.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found 42 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued two requirement notices to the trust. Our action related to breaches of two legal requirements in the emergency department and medical care services at St George's Hospital.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve it services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found examples of outstanding practice in the emergency department:

Summary of findings

- The emergency department had an extensive research programme in progress. Staff were encouraged to participate in the research programme. We saw that trained nurses were able to rotate through the programme for 6-month periods.
- The 'hot lab' in the emergency department was able to produce a full blood count within minutes. This could have a significant benefit when treating patients with certain conditions and reduce the use of unnecessary broad-spectrum antibiotics. This also benefitted patients as they were able to go home rather than being admitted or having to wait in the emergency department.
- The emergency department were also able to test for influenza within the department. This had a significant benefit as patients were able to be tested for 'flu' quickly. This reduced the use of unnecessary anti-viral medicines, as well as reduced the amount of patients being isolated unnecessarily. This also benefitted patients as they were able to go home rather than being admitted or having to wait in the emergency department.
- We saw the use of the sepsis REDS score being used in the adults' emergency department. This was an innovative sepsis specific scoring tool that had been developed by one of the emergency department consultants as part of the newly developed emergency department pathway for patients suspected as having sepsis. The REDS score helped give guidance to clinicians in managing the septic patient and allowed for early escalation to intensive care if necessary.

We found examples of outstanding practice in surgery at St George's Hospital:

- In February 2019, the trauma and orthopaedic team became the first in the UK and second in the world to use a new type of tibial nail in surgery.
- The service had developed an innovative programme called 'Get Set 4 Surgery' to help patients prepare for having an operation and understand what would happen at each stage of their journey, from surgical assessment to discharge and recovery at home. The service had been recognised for this innovative practice through an award from Healthy London Partnership.

We found examples of outstanding practice in the children and young people service:

- The service had implemented situation awareness for everyone (SAFE) safety huddles in paediatrics. Aimed to improve outcomes for acutely unwell children on paediatric wards and reduce variation in service delivery quality. Used in the safety huddle to improve situational awareness and facilitate improved communication.
- The trust had implemented the reducing harm by keeping mothers and babies together programme. This was part of the national Avoiding Term Admissions into Neonatal units' programme. This promotes all maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so.
- On the paediatric intensive care unit had introduced weekly "Druggle" rounds which reviewed medicine prescribing errors with support from pharmacy.
- Introduction of coffee mornings on Wednesdays for parents with babies on the paediatric intensive care unit.
- There was quarterly joint paediatric medicine, paediatric emergency department and paediatric intensive care clinical governance meetings, where joint audits and quality improvement projects were presented.
- Weekly safeguarding teaching sessions were undertaken. These were led by the safeguarding responsible doctor. These were open to all but were mainly attended by doctors and medical students. The sessions included a variety of safeguarding subjects and any past of current safeguarding cases.

Summary of findings

- The trust was in the process rolling out a new scheme to provide every primary and secondary school with an emergency asthma kit, which was believed to be the first initiative of its kind in London. The scheme, which was in conjunction with the Wandsworth and Merton Children's Asthma Board, was devised to ensure that all state schools in Wandsworth and Merton had an emergency asthma kit available in line with the Department of Health guidelines and as part of a drive to improve asthma awareness and education.
- Parents were given a pager by theatre staff when they had left their child in theatre for an operation. When the patient was in recovery and awake theatre staff called the pager to notify the parent to come back to the theatre as their child was in recovery.
- On the neonatal unit, there was a weekly parent meeting on a Wednesday led by either Consultant, Matron/Senior nurse/Family-care Coordinator.

Areas for improvement

Action the trust MUST take to improve

- Make sure all patient records are stored securely, completed accurately and kept confidential.
- Make sure consent is correctly recorded in patients notes in line with best practice.

Action the trust SHOULD take to improve

In the emergency department:

- Complete all documentation correctly, including fluid balance charts, pain scales and Glasgow Coma Scales.
- Check that all equipment is clean, safe for use, and appropriate checklists completed.
- Improve the BAME knowledge and support within the department.
- Display information about how to raise a concern in all patient areas.

In medical care:

- Continue work to improve vacancy, sickness and turnover rates amongst nursing staff.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Improve the recording of actions taken when fridge temperatures are out of range.
- Continue with plans to improve the catheter laboratory to provide a safe service for patients and staff.
- Reduce the number of patient-moves at night.
- Improve the referral to treat time (RTT) in the five specialities where they fell below the England average.

In surgery at St George's Hospital:

- Continue work to improve vacancy, sickness and turnover rates amongst nursing staff.
- Continue work to improve the environment across the surgical division.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Continue work to improve appraisal rates for staff across the surgical division.
- Consider further ways to improve staff wellbeing in light of staffing shortages.

Summary of findings

- Update and ensure staff have access to the deteriorating patient policy.
- Ensure all locum medical staff complete a full local induction.

In surgery at Queen Mary's Hospital:

- Have a policy in place for seeing paediatric patients in the day case unit.
- Improve staff awareness on learning from incidents.
- Ensure records are stored securely.
- Update and ensure staff have access to the deteriorating patient policy.
- Continue to work to improve nurse staffing levels.
- Ensure relevant learning from audits is shared across both sites and ensure data is consistently collected for audits and action plans completed where necessary.
- Work to improve staff appraisal rates.
- Ensure consent form documentation is fully completed.
- Ensure senior staff are clear of who has overall responsibility and oversight of surgery at Queen Mary's Hospital.
- Ensure risk registers are completed with up to date information.

In services for children and young people:

- Continue work to improve completion of nursing staff annual appraisals.
- Continue work to improve the amount of staff qualified in speciality working within the neonatal unit and paediatric intensive care.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Consider further ways to improve staff engagement, well-being and address concerns highlighted in staff survey.
- Continue with recruitment and retention strategies to reduce vacancy, turnover and sickness rates.
- Consider how to avoid mixed sex breaches.
- Continue with the planned refurbishment to make the premises suitable for modern day healthcare.

In the outpatients' department:

- Consider an effective process for quality improvement and risk management.
- Improve its local audit programme and review national audit outcomes to improve patient outcomes.
- Complete infection prevention and control audits regularly and take action to address concerns including risks associated with the environment for decontamination of naso-endoscopes were embedded in practice.
- Improve staff compliance with mandatory training, including information governance safeguarding level three (3) and resuscitation.
- Provide adequate seating facilities in clinics, to ensure patients and relatives have enough seating areas.
- Develop systems and processes which enable the trust to determine the quality and performance of its outpatients' department.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust stayed the same. We rated well-led as requires improvement because:

The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. There was a stable executive team in post who were all focused on improving care for patients and the financial position within the trust and the commitment and abilities to tackle the challenges within the trust.

Each of the executive directors had a team to provide them support and oversight of their portfolio, and on the whole, these provided the support required to move forward the strategy and objectives within the trust.

There were good working relationships between the executive and non-executive directors, at board and through subcommittees. The chair and chief executive had a strong working relationship.

There were positive working relationships with partners in the system. A number of executives had lead roles within the system. This would be strengthened through the appointment of the trust chair as the chair of a nearby trust, which occurred shortly after our inspection.

The trust had a clear vision and set of values with quality and sustainability as the top priorities. How the trust set out to achieve the vision was entitled the St George's Way. The board had a clear commitment to the vision. Although not all staff were able to clearly articulate it, board members were optimistic that all staff would get to the point where they "live and breathe" the vision of Outstanding Care Every Time and that this would be embedded.

The trust's clinical strategy was entitled 'Delivering outstanding care, every time: Our strategy for 2019-2024. The strategy was published in April 2019 and aimed to achieve its goals through four priorities: strong foundations; excellent local services; closer collaboration; and leading specialist healthcare. The strategy had been developed with the involvement of staff and clinical teams. The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. Supporting strategies were being developed and planned for publication later in the 2019/20 business year, with timescales agreed by the trust Board. Without these supporting strategies in place, the trust's ability to effectively and systematically achieve the organisational priorities and deliver good quality care could be hampered.

Culturally, there had been much progress within the trust. However, there were still areas for improvement, which the trust had identified. These included:

- Continuing work on addressing bullying and harassment within the trust.
- Embedding and ensuring that there were clear objectives for, and awareness of, equality and diversity networks.
- Promoting equality and diversity in staff's day to day work and when looking at opportunities for career progression for BAME staff.
- Building improved relationships with trades unions.
- Supporting leaders and managers throughout the organisation through a development programme.
- Developing a clear organisation development strategy.

Summary of findings

The board were sighted on most of these areas and were developing programmes to support this. There was a real focus on providing good quality patient care articulated by the board and across the trust, with improvements seen in core services.

There were systems in place to support staff to speak up, with a Freedom to Speak Up Guardian and Guardian of Safe Working Hours in place and there was board oversight of this. The board was sighted on the fact that there were areas of the trust that people did not feel confident to speak up and had asked that the Speak Up service to pull together a strategy to overcome this. The Freedom to Speak up Guardian was line managed by the Listening into Action Lead, who sat within the human resources directorate. Whilst the Freedom to Speak up Guardian had direct access to the Chief People Officer, there was an agreement that individual cases were not be discussed with him.

It was also notable that the trust had learnt from challenges in team dynamics within areas of the trust. We saw evidence that they had taken action to resolve difficulties in team dynamics relating to leadership and relationships amongst senior staff in an area. Mediation and organisational development support had been arranged swiftly to help to resolve these issues.

The trust had governance structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Although further embedding of these structures were needed.

There was a board assurance framework in place which had been reviewed. It identified the strategic risks and provided assurance to the board, of the trust awareness of those strategic risks and had a plan to address them. However, it was long and not as user friendly as it could have been, with a presentational disconnect between the risk and mitigations or assurance statements.

Neither the board nor the trust executive committee (TEC), reviewed the whole board assurance framework all at once, but leaders were sighted and recognised that this needed to happen. The trust's executive governance structures were at differing stages of development and ensuring these were fully implemented and embedded was essential for the board to be able to gain assurance and oversight.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed.

Non-executive and executive directors were clear about their areas of responsibility. There was good working in board subcommittees. Non-executives and executives undertook walkabouts and were visible within the organisation.

Governors were actively engaged in the operation of the trust. The trust reported good working relationships with governors. Governors were able to attend both parts of the board meeting and all sub-committees. Governors were clear that their role was to hold non-executives to account. However, there was potential for governors to be too close to the operational decision-making process, which could lead to them seeking to hold executive directors, rather than non-executive directors to account.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'. The corporate risk register included divisional risks, which had a risk level of 10 and above. The corporate risk register was reviewed by all executive directors who attended the risk management executive, which was a sub-group of the trust executive committee (TEC). However, two-thirds of the risks on the corporate risk register, had not moved or had got worse over the two years prior to our inspection. This implied the controls or mitigation were not having the maximum effect.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems.

Summary of findings

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. At the time of the inspection, several important performance targets were not being achieved by the trust. These included the 4-hour emergency access target and referral to treatment. However, the trust had performed well against diagnostics and had achieved this target over the past 12 months. In May 2019, the trust's performance was 99.30% against a national median of 97.23%. This placed the trust in the first (best) quartile nationally. It was worth noting that the trust was utilising Statistical Process Control charts in its board reporting and this was to be commended as good practice and would allow the board to focus on areas of variation.

The trust had faced challenges for several years and had an agreed control total of £3m deficit for the 2019/20 financial year. To meet this target, the trust needed to achieve £45.8m in savings. They had achieved significant savings in the previous year. At the time of the inspection, the trust was forecasting achieving its financial position, but the savings programme was weighted towards the second half of the year and the whole value was not yet identified.

At month three for the financial year 2019/20, the trust was forecasting achieving the year end plan and it was the view of the chief financial officer, chair of the finance and investment committee and chief executive that it would be achieved, despite the risks.

Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Where cost improvements were taking place, we saw they did not compromise patient care.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability.

The trust had a structured and systematic approach to engaging with people who used services, those close to them and their representatives. The patient engagement strategy was launched in 2018. This strategy set out the steps the trust planned to take to engage patients, listen to their views, and act upon them. The strategy was developed with input from patients and staff. The trust had a long history of engaging with patients and had active groups for maternity, kidney and renal patients. There was a patient, partnership and engagement group.

The trust sought to actively engage with people and staff in a range of equality groups. Staff engagement by the trust had been improving, but board members recognised that they had a long way to go, before changing the culture in the organisation. The trust published its staff engagement plan in November 2017, in response to feedback from staff. Following the inspection, the trust informed us that the 2017 engagement plan was a two-year plan and a refreshed staff engagement plan was approved by the trust board in September 2019.

The staff engagement plan identified three target areas to be improved:

- Improve overall staff engagement
- Address bullying and harassment
- Improve equality and diversity

There were organisational systems to support improvement and innovation work. The trust had made improvements since our last inspection which had been systematic. The ward accreditation system had been embedded with most staff groups. Staff knew what the standards and expectations were through the ward accreditation programme. The programme had been both supportive and a good mechanism for holding people to account. There was also a quality improvement academy and staff had received training in improvement methodologies and used standard tools and methods. The director of quality improvement told us of plans to embed quality improvement principles into the organisation. There was a quality improvement team which engaged with staff to inform them about the quality improvement methodology 'The St George's Way'.

Summary of findings

The trust, being a teaching hospital, also had a significant research and innovation base which was evident throughout.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
St George's Hospital	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019
Queen Mary's Hospital	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019
Overall trust	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for St George's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Requires improvement → ← Dec 2019
Medical care (including older people's care)	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Good → ← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement → ← Dec 2019
Surgery	Good ↑ Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Good → ← Dec 2019	Good ↑ Dec 2019
Critical care	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Maternity	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Services for children and young people	Good ↑ Dec 2019	Good → ← Dec 2019	Outstanding ↑ Dec 2019	Outstanding ↑ Dec 2019	Good ↑ Dec 2019	Outstanding ↑↑ Dec 2019
End of life care	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Outpatients	Good ↑ Dec 2019	Not rated	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement → ← Dec 2019
Overall*	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Queen Mary's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good ↑ Dec 2019	Requires improvement →← Dec 2019	Good →← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Outpatients	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall*	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

St George's Hospital (Tooting)

Blackshaw Road
Tooting
London
SW17 0QT
Tel: 02086721255
www.stgeorges.nhs.uk

Key facts and figures

St George's Hospital is located in Tooting, London and managed by St George's University Hospitals NHS Foundation NHS Trust. The hospital serves a population of around 1.3 million people in South West London, with services commissioned by Wandsworth, Merton and Lambeth Clinical Commissioning Groups.

The hospital has 995 beds, including 51 children's beds.

St George's Hospital operates 24 hours per day and has an accident and emergency department and a major trauma centre. The hospital provides acute hospital services and specialist care for the most complex of injuries and illnesses, including trauma, surgery, neurology, cardiothoracic medicine, renal transplantation, cancer care and stroke.

In 2018/19, St Georges Hospital had 159,912 emergency attendances, 160,199 admissions (includes maternity) and 683,210 outpatient attendances.

During the inspection, we spoke with over 81 patients, over 24 relatives and over 180 members of staff from various disciplines. We reviewed over 62 sets of patient records. We observed care being delivered and attended safety briefings and handovers.

Summary of services at St George's Hospital (Tooting)

Requires improvement 

Our rating of services stayed the same. We rated them as requires improvement because:

- Staff did not always complete and update risk assessments for each patient. Documentation in patient files was inconsistent and not always completed; and in medical care, consent forms were not always completed in full.
- Some services did not keep detailed records of patients' care and treatment. Some records were not clear, up-to-date, stored securely or easily available to staff providing care.
- Some services did not control infection risks well. Some staff did not use equipment and control measures to protect patients, themselves and others from infection. Some areas of the emergency department were not visibly clean.
- Some facilities and premises were not always ideal and in need of modernising or refurbishment. For example, some of the departments and wards were excessively hot in the summer months due to lack of air conditioning.

Summary of findings

- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. The number of nursing staff who had received an annual appraisal was below the trust target in many wards and departments.
- People could not always access the service when they needed it and did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- Not all risks on some risk registers were completed thoroughly.
- Services provided mandatory training in key skills to all staff, however, not all staff had completed the training required.

However;

- Staff had training in key skills and understood how to protect patients from abuse. Services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve services.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Services planned care to meet the needs of local people and took account of patients' individual needs.
- In children and young people services, staff found innovative ways to enable children and young people to manage their own health and care when they could and to maintain independence as much as possible.
- Most services had enough staff to care for patients and keep them safe, despite there being vacancies in many areas.
- The trust scored highly in the Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade A in latest audit.

Urgent and emergency services

Requires improvement 

Key facts and figures

St George's Hospital provides urgent and emergency care services which are open 24 hours a day, 365 days per year. The hospital provides services to the local populations within south west London including the London boroughs of Wandsworth, Merton, Lambeth. St George's emergency department (ED) is a major trauma receiving unit for emergency adult, paediatric and maternity patients.

From February 2018 to January 2019 there were 167,547 attendances. Of these 33,112 were children and young people under the age of 17 years.

Patients present to the department by walking into the reception area, arriving by ambulance via a dedicated ambulance-only entrance or by the Helicopter Emergency Medical Service (HEMS). Patients transporting themselves to the department were seen by a streaming nurse who would triage them.

The ED had different areas where patients were treated depending on their acuity including majors, resuscitation area, clinical decision unit (CDU), and the urgent care centre (UCC). There was a separated paediatric ED with its own waiting area.

During this inspection we spoke with over 35 members of staff from a range of clinical and non-clinical roles and of varying grades. We spoke with 30 patients and 10 relatives. We reviewed 45 patient records, including 10 related to children and young people. We made observations and looked at documentary information accessible within the department and provided by the trust.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. Some areas of the emergency department were not visibly clean.
- Staff did not always complete risk assessments for each patient swiftly. They did not remove or minimised risks and did not update the assessments.
- Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date, stored securely and easily available to all staff providing care.
- The service did not use systems and processes to safely prescribe, administer, record and store medicines.
- People could not always access the service when they needed it and did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Patients did not receive treatment within agreed timeframes and national targets.
- It was not easy for people to give feedback and raise concerns about care received. There was a lack of patient information displayed in public areas on how to raise a concern. This was something we found on the previous inspection.
- Not all staff understood the service's vision and values, and how to apply them in their work.

However:

Urgent and emergency services

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. Cleaning records were not always up-to-date and did not demonstrate that all areas were cleaned regularly. Not all equipment was labelled to show when it was last cleaned. Some areas of the emergency department were not visibly clean. The department participated in monthly hand hygiene audits. The department scored 80.4%, which is below the trust target of 95%.
- Staff did not complete risk assessments for each patient swiftly. They did not remove or minimised risks and did not update the assessments. Patients who had presented to hospital having had a fall did not always have a falls risk assessment completed. The risk of the patients having another fall while in the department had not been assessed. Staff did not always complete Waterlow assessments for frail patients who had been in the department for more than 6 hours. Patients had not been assessed for risk of developing pressure ulcers.
- Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date, stored securely and easily available to all staff providing care. Pain assessments, falls risk assessments, pressure ulcer risk assessments and fluid balance charts were not always completed. During our last inspection we found that medical notes were not being stored securely. On this inspection we found that this was still the case. Medical notes which included patient identifiable information and confidential medical information were stored in unsecure folder holders in cubicle areas.
- The service did not use systems and processes to safely prescribe, administer, record and store medicines and there were inconsistences using the electronic drug charts. Staff in the emergency department were unable to prescribe or administer medicines using electronic drug charts as they had not yet been trained in its use. Patients who had been prescribed medication electronically by specialist teams did not have these administered as emergency department staff could not use the electronic prescriptions.

However:

- The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Urgent and emergency services

- The service mostly had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They mostly used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Is the service caring?

Good →←

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Urgent and emergency services

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when they needed it and did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From June 2018 to May 2019 the trust failed to meet the standard. From June 2018 to May 2019 performance worsened from 94% to 86%.
- Patients did not receive treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard in any month from April 2018 to March 2019.
- It was not easy for people to give feedback and raise concerns about care received. There was a lack of patient information displayed in public areas on how to raise a concern. This was something we found on the previous inspection.

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Urgent and emergency services

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However:

- Not all staff were aware of the department's vision and strategy. Staff were aware of the trust's vision and strategy, but most were not aware of the emergency department's vision and strategy.
- Staff had little knowledge of the BAME network. Neither BAME and non BAME staff were able to tell us if the department had a BAME network. Staff were not aware of the BAME support available in either the department or the trust.

Outstanding practice

- The ED had an extensive research programme in progress. Staff were encouraged to participate in the research programme. We saw that trained nurses were able to rotate through the programme for 6-month periods.
- The 'hot lab' in the ED was able to produce a full blood count within minutes. This could have a significant benefit when treating patients with certain conditions and reduce the use of unnecessary broad-spectrum antibiotics. This also benefitted patients as they were able to go home rather than being admitted or having to wait in the ED.
- The ED were also able to test for influenza within the department. This had a significant benefit as patients were able to be tested for 'flu' quickly. This reduced the use of unnecessary antiviral medicines, as well as reduced the number of patients being isolated unnecessarily. This also benefitted patients as they were able to go home rather than being admitted or having to wait in the ED.
- We saw the use of the sepsis REDS score being used in the adults ED. This was an innovative sepsis specific scoring tool that had been developed by one of the ED consultants as part of the newly developed ED pathway for patients suspected as having sepsis. The REDS score helped give guidance to clinicians in managing the septic patient and allowed for early escalation to intensive care if necessary.

Areas for improvement

The service MUST:

- Ensure all patients records are stored securely.

The service SHOULD:

- Ensure all documentation is correctly completed including fluid balance charts, pain scales and Glasgow Coma Scales.
- Ensure all equipment is clean, safe for use, and appropriate checklists completed.
- Improve the BAME knowledge and support within the department.
- Ensure information about how to raise a concern is displayed in all patient areas.

Urgent and emergency services

- Ensure all medicines are correctly prescribed and administered.
- Ensure all patients have necessary risk assessments completed and documented, and that these are updated.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

The Acute and General Medicine service provides a range of general and specialist inpatient, ambulatory and outpatient care. Adult patients are admitted via the Acute Medical Unit except for some specialist pathways.

The inpatient aspect of specialist medical services including gastroenterology, respiratory, diabetes and endocrinology are delivered by dual-accredited specialist teams with oversight from the Inpatient Medicine care group.

The hospital provided tertiary service provision for intestinal failure, nutrition, hepatology, weaning/acute-domiciliary ventilation and lymphoedema.

Inpatient beds:

- AMU 51 inpatient beds
- General Medicine 112 inpatient beds

The trust had 43,385 medical admissions from February 2018 to January 2019. Emergency admissions accounted for 18,602 (38.4%), 3,005 (6.2%) were elective, and the remaining 26,778 (55.3%) were day case.

During our inspection we visited the following wards: Allingham, Amyand, Belgrave, Caesar Hawkins, Champneys, Charles Pumphrey Unit, Dalby, Gordon Smith, Kent, Marnham, Richmond, Rodney Smith, Trevor Howell And William Drummond. We spoke with approximately 50 members of staff including nursing and medical staff of all grades, allied health professionals such as occupational therapists, healthcare assistants, housekeeping and catering staff, and managers. We spoke with 25 patients and their relatives. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff however not all staff had completed it. Medical staff in the division did not meet the trust target for most mandatory training and safeguarding training modules.
- Staff did not always complete and update risk assessments for each patient. Documentation in patient files was inconsistent and not always completed, and consent forms were not always completed in full.
- The service did not always have enough staff, including nurses and doctors, with the right qualifications, skills, training and staff told us this was a potential risk to patient safety.
- Records of patients' care and treatment were not always stored securely or easily available to all staff providing care. Electronic records were not always accessible in a timely manner and paper records were not always securely stored. We saw paper records that included patient identifiable information and do not resuscitate forms accessible in folders and were not secure or marked as confidential.
- The service did not always coordinate between pharmacy and ward staff use systems and processes to safely store medicines. We found examples of fridge temperature recordings consistently higher than the recommended temperature and ward staff were not clear what action had been taken. Staff could not be sure the medicines was safe to use.

Medical care (including older people's care)

- The catheter laboratory had aging equipment that needed replacing and two beds had been decommissioned as a result. There was a risk of further equipment failure and a temporary mobile catheter laboratory had been commissioned by the trust. The trust is a designated heart attack centre. Following the inspection, the trust advised us that a business case for the provision of equipment was approved by the board in September 2019.
- Patients were at a higher risk of readmission following discharge when compared to the national average. The risk of readmission for both elective and non-elective treatment was higher than the national average in two of the top three specialities by number of admissions.
- The service did not encourage black, Asian and minority ethnic (BAME) to join the staff BAME network where they could seek support. Staff we talked to were not aware of the network and senior staff were not able to direct us to information on the intranet for staff to access.

However:

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The division had worked hard to reduce the number or patient falls. We saw examples of initiatives such as "bay watch", where a designated member of staff always remained in a bay to assist patients and patients were provided with socks with grip to prevent slips. All staff we talked to had a good awareness of initiatives and why they were important.
- The trust scored highly in the Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade A in latest audit.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff did not always complete and update risk assessments for each patient. Documentation in patient files was inconsistent and not always completed in full. During our inspection we saw examples of risk assessments being completed, partially completed or not at all.
- Records of patients' care and treatment were not always stored securely or easily available to all staff providing care. Electronic records were not always accessible in a timely manner and paper records were not always securely stored. We saw paper records that included patient identifiable information and do not resuscitate forms accessible in folders and were not secure or marked as confidential.
- The service provided mandatory training in key skills to all staff however not all staff had completed it. Medical staff in the division did not meet the trust target for most mandatory training and safeguarding training modules. No staff group met the trust target for lifesaving training and staff told us this training had been difficult to access.

Medical care (including older people's care)

- The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. For nurses, the vacancy, turnover and sickness rate continued to be higher than the trust target and 19% of hours set to be filled by bank or agency staff were unfilled. On the days we visited, we saw wards where the planned number of staff was not filled.
- The service did not always coordinate between pharmacy and ward staff or use systems and processes to safely store medicines. We found examples of fridge temperature recordings consistently higher than the recommended temperature and ward staff were not clear what action had been taken. Staff could not be sure the medicines was safe to use.
- The service did not always control infection risk well. We saw example of staff not washing their hands between patient contact and this was reflected in one ward's hand hygiene score for June 2019 of 88.1%.
- The trust and division were dealing with an ageing estate which at times was a risk to patient safety. The trust had taken some actions to control the risk, such as filters on taps to prevent legionnaires disease and the pipework was flushed regularly to prevent leaks, but this was an ongoing problem.

However:

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff told us there was an open and honest culture and they were encouraged by their managers to report incidents and staff were able to give us examples of when duty of candour had been applied.
- Dalby ward was refurbished and opened in December 2018 to provide a safe, dementia friendly environment for patients. Comfort cooling, an air-cooling system, was installed so the bays did not reach high temperatures and the exit and entry system was designed to allow patients to walk freely around the ward without the risk of them leaving unattended.
- The division had worked hard to reduce the number or patient falls. We saw examples of initiatives such as "bay watch", where a designated member of staff always remained in a bay to assist patients and patients were provided with socks with grip to prevent slips. All staff we talked to had a good awareness of initiatives and why they were important.

Is the service effective?

Requires improvement  

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not always record consent appropriately. We saw examples of forms not completed in full and inconsistent recording which meant staff were not sure correct consent for treatment had been gained.
- Not all patients had a pain score recorded in their records. Staff we talked to told us they did not use a pain score tool for patients that could articulate their pain and no score was recorded in their notes. This meant staff were not able to see whether a patient's pain score had changed.
- Patients were at a higher risk of readmission following discharge when compared to the national average. The risk of readmission for both elective and non-elective treatment was higher than the national average in two of the top three specialities by number of admissions. This had not improved since our last inspection.

Medical care (including older people's care)

- Not all staff received an appraisal of their work. The trust set a target of 90% of staff to receive an annual appraisal and the division did not meet this target for any staff group. This had not improved since our last inspection.
- The division did not meet the seven-day clinical standards target in all specialities. Access to Magnetic resonance imaging (MRI) was limited and four medical specialities were not compliant at the weekend.
- We saw a deprivation of liberty safeguards (DoLS) application that had no expiry or review date recorded.

However:

- Staff gave patients enough food and drink to meet their needs and improve their health and we saw staff encouraging patients to drink in hot weather.
- Following the National Diabetes Inpatient Audit 2017, the division had secured funding for a specialist inpatients diabetes teams to work with ward staff, supporting them to provide safe care for diabetic patients.
- The trust scored highly in the Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade A in latest audit.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Patients told us that staff were caring and this was consistent across all wards we visited.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Patients, relatives and staff could access multi faith, multi denomination, chaplaincy services.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. We saw staff having conversations with patients and relatives about their care, treatment and prognosis. This was delivered with compassion and patients and relatives were able to ask questions.
- We saw examples of compliments from patients displayed in the wards we visited, thanking staff for the care they received.

However:

- The response rate for the Friends and Family test on some wards was less than five per month and meant a score was not recorded as the sample was too low.

Is the service responsive?

Requires improvement ↓

Our rating of responsive went down. We rated it as requires improvement because:

Medical care (including older people's care)

- Five medical specialities were below the England average for admitted referral to treatment time (RTT). The worst performing speciality was cardiology which was 34% below the England average of 81.1% patients seen within 18 weeks.
- The average length of stay for medical elective patients was 8.6 days which was higher than the England average of 5.9 days.
- Elective work was placed early in the day which did not account for emergency patients and reduced patient flow through the hospital.
- We saw blank "reach out to me" forms use to record patient's personal preference and we were not assured these were consistently completed.
- There were 572 patient moves at night within the division. The three wards with the highest number of moves were Belgrave (102), Kent (57) and Trevor Howell (45). Night moves after 10.30pm are not in line with best practice.

However:

- The service planned took account of patients' individual needs. Dalby ward was refurbished to meet the needs of patients living with dementia and Heberden ward was undergoing refurbishment to a similar standard.
- Ambulatory care had been introduced in two areas of the hospital to improve the number of patients that were treated and reduce the number or patients admitted to a ward.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Staff gave us examples of complaints they dealt with and knew how to escalate concerns when needed.
- The service used the butterfly scheme to identify patients living with dementia and those with suspected delirium. This was a discrete way for staff to easily identify patients that needed additional support.

Is the service well-led?

Requires improvement ● ↓

Our rating of well-led went down. We rated it as requires improvement because:

- Staff could not provide examples of a change in practice following an incident, complaint or action taken after open conversations with senior management.
- Not all staff we talked to were aware of the vision and strategy was for the trust or the ward they worked on. Four nurses we talked to did not know what the vision and strategy was and were not aware a new strategy had been launched in April 2019.
- Not all low risks on the divisional risk register had met the action due date or been updated for over 12 months.
- The trust had recently established a group for black, Asian and minority ethnic (BAME) staff to network and seek support. However, staff we spoke with were not aware of the network and senior staff were not able to direct us to information on the intranet for staff to access.
- Four staff networks had recently been established, BAME, Disability and Wellbeing, LGBTQ+ and women's. They had not yet set their objectives and staff were not able to locate information on the intranet.
- Not all wards used GREATix to celebrate compliments about their staff. GREATix was a trust wide system where staff could nominate other staff members, recognising excellence. The trust recorded 152 GREATix submissions in medical care between March 2017 and November 2019.

Medical care (including older people's care)

However:

- The leaders of the service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders told us about their aim to improve the elderly care service which considered the increasing numbers of this patient group.
- Staff felt respected, supported and valued and were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. All staff we talked to told us there was an open reporting culture and they were encouraged to report incidents.
- Leaders operated effective governance processes, and staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service.
- All staff were committed to continually learning and improving services and leaders encouraged innovation.

Areas for improvement

The service MUST:

- Make sure all patient records are stored securely, completed accurately and kept confidential.
- Make sure consent is correctly recorded in patients notes in line with best practice.

The service SHOULD:

- Continue work to improve vacancy, sickness and turnover rates amongst nursing staff.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Improve the consistency of completed patient records including risk assessments and reach out to me forms.
- Improve the recording of actions taken when fridge temperatures are out of range.
- Continue with plans to improve the catheter laboratory to provide a safe service for patients and staff.
- Reduce the number of patient moves at night.
- Improve the referral to treat time (RTT) in the five specialities where they fell below the England average.

Surgery

Good ↑

Key facts and figures

The surgery service at St George's Hospital Tooting includes a wide variety of surgical disciplines and is a tertiary hub for South West London and Surrey, covering major trauma, complex cardiology and the hyper-acute stroke unit. The trust had 29,700 surgical admissions from February 2018 to January 2019. Emergency admissions accounted for 10,838 (36.5%), 11,078 (37.3%) were day case, and the remaining 7,784 (26.2%) were elective.

During our inspection we visited the following wards: Benjamin Weir, Brodie, Caroline, Champneys, Chelsden, Florence Nightingale, Gray, Gunning, Holdsworth, Keate, McKissock and Vernon. We also visited a selection of theatres, the Surgical Admissions Lounge and the Nye Bevan Unit. We spoke with approximately 40 members of staff including nursing and medical staff of all grades, allied health professionals such as occupational therapists, healthcare assistants, housekeeping and catering staff, and managers. We spoke with 10 patients and their relatives. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and took account of patients' individual needs.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The design of the environment did not always follow national guidance. Many ward areas were cluttered with equipment at various points throughout the day (for example, when receiving orders). However, leaders and housekeeping staff we spoke to confirmed there was a transformation programme underway to improve this.
- Vacancy, turnover and sickness rates amongst nursing staff did not meet the trust's target, although the service was taking action to address this.

Surgery

- From April 2018 to March 2019, 75.3% of required staff in surgery at St George's Hospital received an appraisal compared to the trust target of 90%. This meant the trust could not be assured that all staff received an appraisal of their work performance.
- People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not line with national standards.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure most staff completed it. Where there were areas of lower compliance, leaders oversaw action plans to encourage improvement.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

However:

- The design of the environment did not always follow national guidance. Many ward areas were cluttered with equipment at various points throughout the day (for example, when receiving orders). However, leaders and housekeeping staff we spoke to confirmed there was a transformation programme underway to improve this.
- Vacancy, turnover and sickness rates amongst nursing staff did not meet the trust target. Despite this the service was taking action to address this, and we did not observe any impact upon patient safety as a result.

Is the service effective?

Good ↑

Surgery

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However:

- Managers did not always appraise staff's work performance regularly. From April 2018 to March 2019, 75.3% of required staff in surgery at St George's Hospital received an appraisal compared to the trust's target of 90%. This meant the trust could not be assured that all staff received an appraisal of their work performance.

Is the service caring?

Good ➔➔

Our rating of caring CHOOSE A PHRASE. We rated it as CHOOSE A RATING because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

Surgery

- People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not line with national standards. From January 2019 to April 2019, the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. Therefore, this had a negative impact on our rating for responsive. Despite this, leaders described ongoing work to improve this.
- From February 2018 to January 2019 the average length of stay for patients having elective surgery at St George's Hospital (Tooting) was 4.2 days, which was worse than the England average of 3.9 days.
- The service treated concerns and complaints seriously but did not always investigate them in a timely way. The trust took an average of 27 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 25 working days.

However:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. For example, the service had also developed an innovative programme called 'Get Set 4 Surgery' to help patients prepare for having an operation and understand what would happen at each stage of their journey.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were approachable in the service for patients and staff.
- Leaders had taken action to improve all aspects of the leadership and culture of the cardiac surgery service.
- The service was developing a vision for what it wanted to achieve and a strategy to turn aspirations into action, developed with all relevant stakeholders.
- Most staff we spoke with felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service collected reliable data and analysed it.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Surgery

Outstanding practice

- In February 2019, the trauma and orthopaedic team became the first in the UK and second in the world to use a new type of tibial nail in surgery.
- The service had developed an innovative programme called 'Get Set 4 Surgery' to help patients prepare for having an operation and understand what would happen at each stage of their journey, from surgical assessment to discharge and recovery at home. The service had been recognised for this innovative practice through an award from Healthy London Partnership.

Areas for improvement

The service SHOULD:

- Continue work to improve vacancy, sickness and turnover rates amongst nursing staff.
- Continue work to improve the environment across the surgical division.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Continue work to improve appraisal rates for staff across the surgical division.
- Update and ensure staff have access to the deteriorating patient policy.
- Ensure all locum medical staff complete a full local induction.
- Continue work to improve waiting times from referral to treatment and arrangements to admit, treat and discharge patients to bring them in to line with national standards.

Services for children and young people

Outstanding ☆ ↑↑

Key facts and figures

The trust provides specialist children's services and an integrated mix of tertiary care and specialist services as a regional centre for Wandsworth, South West London and further afield.

There is a comprehensive range of specialist services in both medical and surgical specialties cared for over three wards. These are supported by paediatric intensive care, the neonatal unit and neonatal intensive care.

There is a children's community nursing team and clinical nurse specialists who are supported by play specialists and child psychology services. Psychology is the scientific study of the human mind and its functions.

The trust has a consultant-led rapid referral service for GPs to contact their paediatricians (doctors specially trained to care and treat children) to help reduce pressures on the emergency department by diverting appropriate patients to the paediatric ambulatory unit (Blue- Sky).

Surgical services cover all aspects of paediatric surgery (excluding cardiac) including minimally invasive techniques. The department is the designated lead paediatric surgery centre for South West London and Surrey.

The hospital has 101 inpatient paediatric beds:

- Frederick Hewitt Ward: 17 beds
- Pinckney Ward: 15 beds
- Nicholls Ward: 19 beds
- Paediatric intensive care unit (PICU): 12 beds
- Neonatal unit: 38 beds

In addition, there are 15 beds on Jungle Ward, the paediatric day case unit.

During our inspection, we spoke with more than 20 members of staff including consultants, doctors, nurses, play specialists and domestic staff. We spoke to 14 parents, and three children and young people who were using the service at the time of our inspection. We observed care and treatment and looked at seven patient records and seven medication charts.

Summary of this service

Our rating of this service improved. We rated it as outstanding because:

- The Children's service had made significant improvements in safeguarding training and supervision, meeting the individual needs of children and young people, reduction of surgical site infections, improved outcomes in the National Diabetes audit, management of risks, maintaining dignity and respect, meeting guidelines for consultants to review patients within 14 hours of admission and the leadership of the service. Many of the issues identified in our previous inspection had been addressed or there were effective plans to address.
- The service had enough staff to care for children and young people to keep them safe. However, some departments were still heavily reliant on bank and agency staff, but a successful recruitment campaign meant this would be addressed. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well. Although the staff qualified in speciality on the neonatal unit and paediatric intensive care unit

Services for children and young people

did not meet the national guidelines, it had improved since our last inspection. The service controlled infection risks well. Staff assessed risks to children and young people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff recognised and respected the totality of the needs of children, young people and their families. They always took their personal, cultural, social and religious needs into account, and found innovative ways to meet them.
- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from people who used the service, those close to them and stakeholders was always very positive about the way staff treated people.
- Staff found innovative ways to enable children and young people to manage their own health and care when they could and to maintain independence as much as possible.
- There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs.
- The service planned care to meet the needs of local children and young people and took account of their individual needs and made it easy for them to give feedback. Children and young people could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. A Children's Strategy Priorities was awaiting final ratification, some staff had knowledge of this. Staff understood the service's values, and how to apply them in their work. Staff felt more respected, supported and valued since our last inspection. Morale was still low in some areas but improving. Staff were focused on the needs of children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children and young people and the community, to plan and manage services. All staff were committed to improving services continually.

However:

- The neonatal unit was not still meeting British Association of Paediatric Medicine staffing standards for units providing neonatal intensive care. The standards require 70% of nurses to be qualified in the specialty. However, this had improved since our last inspection; 58% were now qualified, compared to 40% at the time of the last inspection. The paediatric intensive care unit was still not meeting national standards requiring 70% of nurses to be qualified in the speciality. However, this had improved since our last inspection and 63% were now qualified, compared to 61% at the time of our last inspection. The service had a tangible plan to ensure this standard was met within the next 12 months.
- The number of nursing staff who had received an annual appraisal was below the trust target in many wards and departments. Across the whole service 72% of nursing staff had received and appraisal which (trust target 95%).

Services for children and young people

- There were still high level of staffing vacancies on the neonatal unit and paediatric wards, which meant the service had high use of agency and bank staff. Agency staff were not able to carry out all the procedures undertaken by permanent staff. Staffing levels on the inpatient wards had been increased following an establishment review, although the trust still did not have enough staff of the right qualifications, skills, and training. Due to a recent successful recruitment programme the service would be over established with nurses in September 2019.
- Some facilities and premises were not always ideal and in need of modernising or refurbishment, but we didn't observe this having an adverse effect on the care patients received. For example, some of the departments and wards were excessively hot in the summer months due to lack of air conditioning.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.
- The service was mostly meeting guidelines for consultants to review patients within 14 hours of admission. This was an improvement since our last inspection.
- We found a thorough risk assessment had been undertaken on Jungle ward in relation to the amount of space in between the beds and the risks mitigated. There had been no incidents reported in relation to the bed space. This was identified as an area of concern during the last inspection.
- The service provided mandatory training in key skills to all staff. The majority of staff had received up-to-date mandatory, statutory and clinical training.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had the correct level of training on how to recognise and report abuse, and they knew how to apply it. Staff received safeguarding supervision regularly this was an improvement since our last inspection.
- The service controlled infection risk well. Staff adhered to infection prevention and control practice and kept equipment, and the premises clean. They used control measures to prevent the spread of infection.
- Staff completed and updated risk assessments for each child or young person. They kept clear records and asked for support when necessary. Staff used the Paediatric Observation Priority Score tool to observe children and young people. Staff had training on when to escalate and to refer appropriately for medical help. Staff used the World Health Organisation checklist for surgical practice and operations. This ensured safety for children and young people.
- Staff kept detailed records of care and treatment of children and young people. Records were clear, up-to-date, and easily available to all staff providing care.
- The service followed best practice when prescribing, administering, and recording medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However:

Services for children and young people

- There were still high level of staffing vacancies on the neonatal unit and paediatric wards, which meant the service had high use of agency and bank staff. Agency staff were not able to carry out all the procedures undertaken by permanent staff. Staffing levels on the inpatient wards had been increased following an establishment review, although the trust still did not have enough staff of the right qualifications, skills, and training. Due to a recent successful recruitment programme the service would be over established with nurses in September 2019.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.
- The service targeted and took a proactive approach to health promotion and prevention of ill-health, and they use every contact with people to do so. The trust was in the process rolling out a new scheme to provide every primary and secondary school with an emergency asthma kit, which was believed to be the first initiative of its kind in London. The scheme, which was in conjunction with the Wandsworth and Merton Children's Asthma Board, was devised to ensure that all state schools in Wandsworth and Merton had an emergency asthma kit available in line with the Department of Health and Social Care guidelines and as part of a drive to improve asthma awareness and education.
- The service participated in relevant national clinical audits. Outcomes for children and young people were positive, consistent and generally met or exceeded expectations, such as national standards.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service had developed a comprehensive action plan to address performance in the 2016 National Paediatric Diabetic audit. The 2017 National Paediatric Diabetic audit showed improved performance.
- Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored children and young people regularly to see if they were in pain. They supported those unable to communicate using assessment tools and gave additional pain relief to ease pain.
- Staff of different kinds worked together as a team to benefit children and young people. Doctors, nurses, play specialists and other healthcare professionals supported each other to provide good care. There was a strong focus on multidisciplinary team work with specialists to improve outcomes for children and young people.
- Key services were available seven days a week to support timely care for children, young people and their families. The only exception to this was availability of MRI scans out of hours.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff understood how and when to assess whether a child or young person had the capacity to make decisions.

However:

- The number of nursing staff who had received an annual appraisal was below the trust target in many wards and departments. Across the whole service, 72% of nursing staff had received and appraisal which (trust target 95%).

Services for children and young people

- The neonatal unit was not still meeting British Association of Paediatric Medicine staffing standards for units providing neonatal intensive care. The standards require 70% of nurses to be qualified in the specialty. However, this had improved since our last inspection; 58% were now qualified, compared to 40% at the time of the last inspection. The paediatric intensive care unit was still not meeting national standards requiring 70% of nurses to be qualified in the speciality. However, this had improved since our last inspection and 63% were now qualified, compared to 61% at the time of our last inspection. The service had a tangible plan to ensure this standard was met within the next 12 months.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from people who used the service, those close to them and stakeholders was always very positive about the way staff treated people.
- The anti-ligature bay on Frederick Hewitt Ward, maintained the privacy and dignity of children and young people. During the last inspection, this was not that case, as curtains were transparent.
- Staff recognised and respected the totality of the needs of children, young people and their families. They always took their personal, cultural, social and religious needs into account, and found innovative ways to meet them. We observed staff taking into account a child's religious needs into account, only female staff cared for the child.
- Staff involved children, young people and those close to them in decisions about their care and treatment. Parents were made to feel welcome and involved in their child or young persons care and were able to stay with them.
- Staff provided emotional support to children, young people and their families to minimise their distress. The emotional and social needs of children, young people and those close to them were seen as being as important as their physical needs. A parent told us how the service had provided counselling for a year after their baby was born due to provide support at a very difficult time.
- Staff were fully committed to working in partnership with children, young people and their families and making this a reality for each person. Staff showed determination and creativity to overcome obstacles to delivering care. Play specialists supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach. Play specialists worked with children and young people who attended regularly for intravenous (into a vein) injections to develop coping techniques to enable them to have the cannula inserted without the support of a play specialist.
- Staff recognised that children, young people and their families needed access to, and links with, their advocacy and support networks in the community and they supported them to do this. For example, the service could access Redthread to provide support to young victims of crime. Redthread is a youth work charity aiming to support and enable young people in south London to lead healthy, safe and happy lives.
- Staff found innovative ways to enable children, young people and their families to manage their own health and care when they could and to maintain independence as much as possible. Staff gave basic life support training to parents of children at risk of becoming very unwell at home. Parents were also given training in more advanced skills such as tracheostomy care to enable children to be cared for at home. A tracheostomy is an opening created at the front of the neck, so a tube can be inserted into the windpipe to help breathing.

Services for children and young people

- Staff were exceptional in enabling people to remain independent. Staff encouraged and supported children and young people to attend the school within the hospital when they felt well enough. Play specialists took time to find out what the interests and hobbies were of children and young people and found ways of pursuing these whilst in hospital.
- Staff were discreet and responsive when caring for children young people and families. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were skilled in communicating with children and young people.
- Staff always empowered children, young people and their families to have a voice and to realise their potential. For example, on the neonatal unit, there was a weekly parent meeting on a Wednesday led by either a consultant, matron, sister/ or family-care co-ordinator. Presentations included common neonatal medical conditions such as jaundice, prematurity and nutrition. These were followed by discussions and questions.

Is the service responsive?

Outstanding ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The hospital delivered a broad range of services for children and young people, including a number of highly specialist paediatric services. The service took into consideration the holistic needs of children, young people and their families. Services were planned in a manner to limit the disruption to children and young people's education.
- The service had developed pathways with referring hospitals to ensure patients received the correct care and treatment quickly. For example, Jungle ward had set up a plastic surgery pathway.
- The services provided were flexible, provide informed choice and ensured continuity of care. Children and young people with cancer had their care planned and coordinated by the hospital. The service worked in partnership with local hospitals, children's community nursing teams and GP's to provide 'care closer to home' for children and young people with cancer and their families during and following their treatment
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Children and young people had access to same day and next day clinics. GPs could obtain advice from paediatricians via a hotline. The service had specific pathways which could be assessed to prevent unnecessary attendance to the emergency department. For example, there was a pathway for new born babies with jaundice or that were failing to gain weight.
- The service ensured that play services were an integral part of the service to ensure psychological need were met. The hospital play team provided a very comprehensive programme of play support to children across all paediatric clinical areas. The variety of play support ensured that children and young people understood the strange environment and unpleasant procedures so that the risk of harm from hospitalisation was mitigated.
- It was easy for children, young people and their families to give feedback and raise concerns about care received and the service encouraged it. The service treated concerns and complaints seriously, investigated them promptly and thoroughly, and included children, young people and their families in the process. The service shared lessons learned with all staff in the service and more widely
- Children, young people and their families had access to interpreting services so that they were kept fully informed.

Services for children and young people

- The service organised an interpreter during the inspection so that a parent could give feedback to us about the care their child had received. The feedback was positive, and they felt they had been involved in their child's care and treatment and were kept informed with the use of an interpreter.
- The hospital school was rated as 'outstanding' by Ofsted and teachers at the school provided educational and learning support to children and young people across the hospital.
- Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities.
- The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which was accessible and promoted equality. For example, the development of transitional services had been identified as a key strategic objective by the service to ensure the needs of these young people were met.
- Children, young people and their family's individual needs and preferences were central to the delivery of tailored services. The service held a Safari Club every Saturday morning on Jungle Ward. The sessions were designed to introduce children and their families to the hospital and ward environment and meet some of the staff who will be looking after them when they attend hospital for surgery. The sessions involved the opportunity to try on hospital gowns, theatre masks and see cannulas. The play specialist facilitated this in a fun, engaging way that helped to alleviate anxiety for both the children and their families. Parents were also invited to share any concerns or fears they or their child had a head of surgery so that this can be addressed on the day.
- Jungle Ward had a variety of entertainers, magicians, singers, balloonists, musicians and therapy dogs who visited to entertain and amuse children.
- Play specialists produced photo albums of the different stages a child would go through when they had an operation. They used these to show the child and explain what was happening at each stage.

However:

- Some facilities and premises were not always ideal and in need of modernising or refurbishment, but we didn't observe this having an adverse effect on the care patients received. For example, some of the departments and wards were excessively hot in the summer months due to lack of air conditioning.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The governance structure had been strengthened since our last inspection. Regular multi-disciplinary, directorate departmental governance meetings were undertaken.
- There were improved governance processes, responses to staff feedback, development a strategy and improvements made since our last inspection.
- There was a new directorate leadership team since our inspection. The Head of Nursing for Children's services had been in post since March 2019. Staff were positive about the new leadership team and especially the positive impact of the Head of Nursing.

Services for children and young people

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, this was awaiting final ratification from the trust board. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- Most staff felt respected, supported and valued. Bullying and harassment was identified as a problem in the 2019 staff survey. No staff reported feeling bullied or harassed to us during the inspection. Staff reported that morale had been low due to staffing issues and a very hard winter period. All staff we spoke to were optimistic about the future of the service and that “they were moving in the right direction”. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. The trust had a Quality Improvement Academy as part of this the service had a quality improvement programme which included more than 50 different innovations.

Outstanding practice

- The service had implemented situation awareness for everyone (SAFE) safety huddles in paediatrics. Aimed to improve outcomes for acutely unwell children on paediatric wards and reduce variation in service delivery quality. Used in the safety huddle to improve situational awareness and facilitate improved communication.
- The trust had implemented the reducing harm by keeping mothers and babies together programme. This was part of the national Avoiding Term Admissions into Neonatal units’ programme. Which promotes all maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so.
- On the paediatric intensive care unit had introduced weekly “Druggle” rounds which reviewed medicine prescribing errors with support from pharmacy.
- Introduction of coffee mornings on Wednesdays for parents with babies on the paediatric intensive care unit.
- There was quarterly joint paediatric medicine, paediatric emergency department and paediatric intensive care clinical governance meetings, where joint audits and quality improvement projects were presented.
- Weekly safeguarding teaching sessions were undertaken. These were led by the safeguarding responsible doctor. These were open to all but were mainly attended by doctors and medical students. The sessions included a variety of safeguarding subjects and any past of current safeguarding cases.

Services for children and young people

- The trust was in the process rolling out a new scheme to provide every primary and secondary school with an emergency asthma kit, which was believed to be the first initiative of its kind in London. The scheme, which was in conjunction with the Wandsworth and Merton Children's Asthma Board, was devised to ensure that all state schools in Wandsworth and Merton had an emergency asthma kit available in line with the Department of Health guidelines and as part of a drive to improve asthma awareness and education.
- Parents were given a pager by theatre staff when they had left their child in theatre for an operation. When the patient was in recovery and awake theatre staff called the pager to notify the parent to come back to the theatre as their child was in recovery.
- On the neonatal unit, there was a weekly parent meeting on a Wednesday led by either Consultant, Matron/Senior nurse/Family-care Coordinator.

Areas for improvement

The service SHOULD:

- Continue work to improve completion of nursing staff annual appraisals.
- Continue work to improve the amount of staff qualified in speciality working within the neonatal unit and paediatric intensive care.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Consider further ways to improve staff engagement, well-being and address concerns highlighted in staff survey.
- Continue with recruitment and retention strategies to reduce vacancy, turnover and sickness rates.
- Consider how to avoid mixed sex breaches.
- Continue with the planned refurbishment to make the premises suitable for modern day healthcare.

Outpatients

Requires improvement 

Key facts and figures

Outpatient services at St Georges Hospital Tooting is provided in several locations within the main hospital and in different locations within the London borough of Wandsworth.

The trust provides outpatient services for a range of specialties including general outpatients; medical, surgery, cardio-thoracic surgery, transplant, diagnosis and pre and post-operative assessment, women and children's services, ophthalmology, ear, nose and throat (ENT), dental and oral surgery, trauma and orthopaedics, pain, rheumatology, stroke, elderly care, haematology/oncology, breast care, therapy services, audiology, podiatry and paediatrics. The trust has a range of specialist neurology clinics, including memory, motor neurone disease (MND) and infusion services.

More than 1000 clinics are held every week and around 1,049,437 patients attend each year for outpatient consultations and treatment. The trust had 857,157 first and follow up outpatient appointments from February 2018 to January 2019.

Outpatient clinics are supported by multidisciplinary teams including doctors, nurses, healthcare assistants and allied health professionals. Allied health professionals such as audiologists, orthoptists, therapists and specialist nurses run outpatient clinics alongside medical teams.

We visited a range of clinics in all the outpatient areas. We spoke with 25 staff including nursing, medical, physiologists, senior staff and administrative staff. We met with 15 patients and relatives who shared their views and experiences of the outpatient service. We observed how people were being cared for and reviewed 12 care/treatment records.

We also reviewed national data and performance information about the trust, and a range of policies, procedures and other documents relating to the operational of the outpatients' department.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The trust returned to reporting on their referral to treatment time (RTT) data for the St George's Hospital site. However, this reporting was still in its early days. This meant the outpatient department could not yet be fully assured that all patients had received their appointments.
- The trust's target for completion of mandatory training was not achieved in some areas.
- Staff did not always audit practice regularly to check whether they had made improvements for patients care and treatments.
- Systems to monitor the effectiveness of care and treatment were not embedded in the service.
- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. Appraisal rates for some staff groups working in the outpatient services were below the trust target.
- Most staff and middle grade managers were not aware of what was on their department's risk register.
- Not all risks on the risk register had associated actions, a date for review or a date by which actions to be completed and the risk owner.

Outpatients

- There was not always a registered nurse available to manage the outpatients' clinic, some clinics were managed by healthcare assistants as compared to qualified nurses, however all clinics had a registered nurse oversight.
- We uncovered issues with heavy workloads for some key staff and a lack of senior staff support in some areas of the outpatients' department.

However:

- The service provided mandatory training in key skills and most staff completed the training in line with the trust's target.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up to date, and generally available to all staff providing care.
- Medicines in outpatients were managed safely. Medicines and prescription pads were kept locked when not in use.
- Care and treatment were provided based on national guidance. Speciality clinics followed relevant national guidance and participated in national and local audits.
- People were treated with compassion, kindness, dignity and respect, when receiving care. Staff communicated with people in a way that supported them to understand their care and treatment.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Staff kept appropriate records of patients' care and treatment. Records were clear, up to date, and generally available to all staff providing care.
- Medicines in outpatients were managed safely. Medicines and prescription pads were kept locked when not in use. The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

However:

Outpatients

- The trust's target for completion of mandatory training was not achieved in some areas.

Is the service effective?

Not sufficient evidence to rate

We do not rate effective

- The service provided care and treatment based on national guidance. Speciality clinics operating within the outpatient department followed relevant national guidance.
- The service made sure staff were competent for their roles. Staff that were new to the department had an appropriate induction and appraisal rates within outpatients were high.
- Staff gave patients enough food and drink, where appropriate, to meet their needs whilst in the outpatient department.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Nurses undertook a wide range of monthly audits recorded on the Trust RATE system. Remedial action plans were in place for improvements.

However;

- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. Appraisal rates for some staff groups working in the outpatient services were below the trust target.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Patients were treated with kindness, dignity and respect, when receiving care. Feedback from people who used the service, those who were close to them and other stakeholders, were positive about the way staff treated people.
- Doctors, nurses, healthcare assistants and allied health care staff provided compassionate and considerate care to patients. Staff introduced themselves and attempted to build a good rapport with patients.
- Staff throughout the department understood the need for emotional support. Patients and relatives felt that their emotional wellbeing was cared for.
- Staff included patients in their care and consultants explained things to them clearly in a way they could understand.

Is the service responsive?

Requires improvement ➔➔

Outpatients

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Some people could not access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- The trust returned to reporting on their referral to treatment time (RTT) data for the St George's Hospital site. However, this reporting was still in its early days. This meant the outpatient department could not yet be fully assured that all patients had received their appointments.
- The RTT for non-admitted pathways was worse than the England overall performance. The latest figures showed 83.1% for the trust, as compared to the England average of 87% of patients had been treated within 18 weeks.
- The did not attend (DNA) rate for the hospital was slightly higher than the national average.

However:

- Trust performance for cancer waiting times was better than the operational standard and the national average in the most recent two quarters.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- Delays and cancellations were explained to people and the trust closely monitored clinics that were cancelled in less than six weeks with a view to reducing late cancellations and the impact these had on patients. Data showed that the proportion of cancelled clinics had reduced.
- There was evidence of learning and improvement from complaints. Complaints were responded to in line with the trust's complaints policy.
- The trust had a range of support teams available including dementia, learning disability and mental health liaison to meet patient's individual needs.
- There was access to face to face and telephone translation services and patient information leaflets could be accessed in languages other than English upon request.

Is the service well-led?

Requires improvement  

Our rating of well-led improved. We rated it as requires improvement because:

- The frontline clinical and non-clinical outpatients' department staff were unaware of the strategy document and were not involved in the development of the service strategy.
- Most staff and middle grade managers were not aware of what was on their departments risk register and arrangements for managing risks were not always clear.
- Not all risks on the risk register had associated actions, a date for review or a date by which actions to be completed and the risk owner.
- We were not fully assured that local governance arrangements were effective. For example; the knowledge about the risk register by staff and lack of local audits such as clinic waiting times and late starts.

However:

Outpatients

- There was a monthly OPD directorate governance meeting with representation from matrons, admin manager and service management. This meeting reported to divisional governance and management groups.
- The outpatient services had local leadership capacity and capability to deliver high-quality, sustainable care. We were told that matrons were supportive and visible within the department.
- The culture within the outpatient department was centred on the needs and experience of people who use the service and staff felt supported, respected and valued.
- The service had systems and processes in place to engage with patients, staff, the public and local organisations to plan and manage services. Patients had been involved in service improvement activities within the department.

Areas for improvement

The service SHOULD:

- Encourage an effective process for quality improvement and risk management.
- Improve its local audit programme and review national audit outcomes to improve patient outcomes.
- Encourage all eligible staff to be compliant with mandatory training, including information governance safeguarding level three (3) and resuscitation.
- Review whether there are adequate seating facilities in clinics, to ensure patients and relatives have enough seating areas.
- Developed systems and processes which enable the trust to determine the quality and performance of its outpatients' department.

Queen Mary's Hospital

Roehampton Lane
Roehampton
London
SW15 5PN
Tel: 02087253206
www.stgeorges.nhs.uk

Key facts and figures

Queen Mary's Hospital (QMH) provides services for adults and children and young people. The hospital offers more than 60 services, which are provided by St George's University Hospitals NHS Foundation Trust and other NHS trusts.

Services provided by Queen Mary's Hospital include outpatients (adults and children and young people), community inpatients, neurorehabilitation, limb fitting, burns dressing and dermatology, a day case unit which offers diagnostic service for endoscopy and urology. There are 88 inpatient beds and 10 day case beds.

There are two inpatient wards which provide sub-acute care, treatment and rehabilitation for older people and rehabilitation and support for adults who have had limb amputations.

The majority of services are provided on weekdays only with the inpatient wards open 24 hours a day, seven days a week.

In 2018/19, Queen Mary's Hospital had 17,063 attendances, 585 admissions and 89,337 outpatient attendances.

Summary of services at Queen Mary's Hospital

Requires improvement ➔➔

Our rating of the service stayed the same. We rated it as requires improvement because:

- Leaders did not run services well using reliable information systems and did not always support staff to develop their skills. The leadership team were not clear of who had overall responsibility and oversight of surgery at Queen Mary's Hospital. Senior staff in the surgery department at Queen Mary's Hospital relied on the general manager for outpatients to send them performance data as they did not have access to the new electronic system.
- The service did not always manage learning from incidents well. Staff did not always collect safety information and use it to improve the service.
- Managers did not always monitor the effectiveness of the service. Key services were not available seven days a week.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- At the time of inspection, surgery at Queen Mary's Hospital was not reporting its RTT position.

However:

Summary of findings

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- During the previous inspection, staff were not fully complaint with the World Health Organisation (WHO) surgical safety checklist. However, on this inspection we did observe staff following the checklist.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care.

Surgery

Requires improvement 

Key facts and figures

The Day Case Unit (DCU) provides care for patients undergoing Endoscopic and Surgical procedures which are carried out under sedation, local anaesthesia and regional block. The unit consists of a first and second stage recovery, two endoscopy rooms, decontamination room and an operating theatre. The DCU provides diagnostic and surgical services in upper and lower gastroenterology, urology, plastic surgery, ophthalmology and podiatry. Procedures requiring general anaesthetic are not carried out on the unit and patients are normally discharged on the same day as the procedure.

The trust had 29,700 surgical admissions from February 2018 to January 2019. Emergency admissions accounted for 10,838 (36.5%), 11,078 (37.3%) were day case, and the remaining 7,784 (26.2%) were elective.

During our inspection we visited the surgery day case unit over three days. We then came back for another day and observed podiatry surgery in the day case unit. We spoke with approximately 35 members of staff including nursing and medical staff of all grades, allied health professionals, healthcare assistants, housekeeping staff and managers. We spoke with 13 patients and their relatives and checked 10 patient records. This was a routine inspection on a comprehensive basis. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Leaders did not run services well using reliable information systems and did not always support staff to develop their skills. The leadership team were not clear of who had overall responsibility and oversight of surgery at Queen Mary's Hospital. Senior staff in the surgery department at Queen Mary's Hospital relied on the general manager for outpatients to send them performance data as they did not have access to the new electronic system.
- The service did not always manage learning from incidents well. Staff did not always collect safety information and use it to improve the service.
- Managers did not always monitor the effectiveness of the service. Key services were not available seven days a week.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- At the time of inspection, surgery at Queen Mary's Hospital was not reporting its RTT position.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- During the previous inspection, staff were not fully complaint with the World Health Organisation (WHO) surgical safety checklist. However, on this inspection we did observe staff following the checklist.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care.

Surgery

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff used equipment and control measures to protect patients, themselves and others from infection.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Nursing staff were meeting trust compliance rates for mandatory training in nine out of 10 modules.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

However:

- The day case unit treated a small number of paediatric patients and the trust was unable to provide written guidance or policies stating how to manage paediatric patients in this setting.
- Records were not always stored securely. Although records were kept in lockable cabinets behind reception, this was unlocked and open in the day, there were times when the reception staff would need to leave the desk. This left notes accessible to the unauthorised persons.
- The service did not always manage patient safety incidents well. Most of the staff we spoke with were unable to provide examples of learning from incidents when questioned.
- The nursing staff vacancy rate was 22% which was above the trust target of 9.6%. Staff sickness rate was 5.4% which was above the trust target of 3.4%.

Is the service effective?

Requires improvement →←

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- Although audits for Local Safety Standards for Invasive Procedures were carried out, data was not always submitted, and we did not observe action plans from the audit.
- British Association of Dermatology had recommendations put in place, however, it was unclear from the audit provided by the trust what the action plans were to implement the recommendations.
- Results and action plans from the national bowel screening audit were not presented to the staff at QMH. Staff told us they did not have the opportunity to attend clinical governance days as they were run at St George's Hospital and not QMH.

Surgery

- Staff did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements and achieved good outcomes for patients.
- We observed some policies that were out of date and the previous report had recommended that all policies should be reviewed and updated in line with agreed timescales. This meant that staff did not have access to the most up to date evidence-based practice.
- Staff did not always follow national guidance to gain patients' consent. We observed gaps in documentation for consent forms and the consent policy was due for review in June 2019.
- Managers did not always appraise staff's work performance regularly. From April 2018 to March 2019 nursing and medical staff did not reach the trust target appraisal completion rate of 90%. Results showed a completion rate of 11.8% for nursing staff. However, on inspection, most the staff we spoke with had completed their appraisals.

However:

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- During the previous inspection, staff were not fully complaint with the World Health Organisation surgical safety checklist. However, on this inspection we did observe staff following the checklist.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. People told us that they felt that staff understood the emotional impact of their conditions.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.
- Staff had mechanisms in place to support patients who became distressed in an open environment, and to help maintain their privacy and dignity.

However:

- None of the patients we spoke with reported being asked for feedback on their care or being given a friends and family test questionnaire. We raised this with staff who knew there was an issue with the text system that was used to ask for feedback.
- Discussions about patient appointments could be heard in waiting areas.

Is the service responsive?

Requires improvement ↓

Surgery

Our rating of responsive went down. We rated it as requires improvement because:

- At the time of inspection, surgery at QMH was not reporting its RTT position. However, shadow reporting was being undertaken in readiness for return to reporting at QMH.
- QMH had a validation team that monitored the patient tracking list and checked if any patients had not met the 18-week referral to treatment time period. If QMH had breached the 18-week referral to treatment time, this was escalated to the general manager. However, data specific to surgery would be available once the new electronic system came into place.
- At the time of the inspection, the trust had not returned to reporting referral to treatment data at Queen Mary's Hospital but were shadow reporting.
- The trust did not always meet their threshold for did not attend rates from April 2018 to April 2019. They did have a did not attend rate team that phoned patients 72 hours in advance to check if they were attending surgery, however the text messaging reminder service was due to be implemented in September 2019.
- Staff were unable to provide details of any actions that had been implemented as a result of a complaint.
- We requested to see responses sent from complaints and action plans, but the trust did not provide us with information.

However:

- The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- Clinic letters contained information about transport, access, patient support and facilities. This included information such as support for patients with hearing impairments, assistance dogs, catering facilities and breast feeding and baby changing facilities.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Leaders did not have all the skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were approachable in the service for patients and staff.
- Leaders did not operate effective governance processes, throughout the service and with partner organisations. Not all staff at all levels were clear about their roles and accountabilities. There was no clarity of who had overall responsibility and oversight of surgery at Queen Mary's Hospital.
- The governance arrangements were not clearly explained due to the complexity of the leadership at Queen Mary's hospital. However, there was some oversight of governance via the monthly management and staff team meetings.
- The head of nursing from St. George's Hospital visited Queen Mary's Hospital weekly, however, some staff we spoke with commented that staff from St. George's Hospital were not visible.
- Leaders and teams did not always manage performance effectively. They did not always identify and escalate relevant risks and issues. The risks identified during the inspection did not reflect all the risks on the risk register. Career progression opportunities were limited for nursing staff in day case surgery.

Surgery

- Senior staff in the surgery department at Queen Mary's Hospital relied on the general manager for outpatients to send them performance data as they did not have access to the new electronic system.

However:

- Most staff we spoke with felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Most of the staff we spoke with were aware of the trust's vision and strategy and if not, they were able to point to a board which displayed this information.

Areas for improvement

The service SHOULD:

- Have a policy in place for seeing paediatric patients in the day case unit.
- Improve staff awareness on learning from incidents.
- Ensure records are stored securely.
- Update and ensure staff have access to the deteriorating patient policy.
- Continue to work to improve nurse staffing levels.
- Ensure relevant learning from audits is shared across both sites and ensure data is consistently collected for audits and action plans completed where necessary.
- Work to improve staff appraisal rates.
- Ensure consent form documentation is fully completed.
- Ensure senior staff are clear of who has overall responsibility and oversight of surgery at Queen Mary's Hospital.
- Ensure risk registers are completed with up to date information.

This section is primarily information for the provider

2

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Cath Campbell, Head of Hospital Inspection at CQC led this inspection. An executive reviewer, Anna Morgan, supported our inspection of well-led for the trust overall.

The team included one inspection manager, 11 inspectors, two assistant inspectors, and 12 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RJ7
Our reference	INS2-6341882901
Organisation Name	St George's University Hospitals NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Treatment of disease, disorder or injury Diagnostic procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent
	How the regulation was not being met:
	1. Consent forms were not always completed in full on some medical wards. Regulation 11

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

In line with the Obtaining Valid Consent for Treatment Policy the Trust uses standardised paper consent forms recommended by the Department of Health. The Trust will continue to use the recommended standardised consent forms downloaded from the DoH website:

- Consent form 1: Patient agreement to investigation or treatment
- Consent form 2: Parental agreement to investigation or treatment for a child or young person
- Consent form 3: Patient/ parental agreement to investigation or treatment (procedures where consciousness not impaired)
- Consent form 4: Form for adults who are unable to consent to investigation or treatment

To meet the regulation the Trust will complete the following actions:

Action	**By when**
Confirm a medical lead for consent supported by an identified nurse lead.	31.01.2020
Following the appointment of the medical lead and nurse lead for consent, a Task and Finish Group for consent will be established with representation	28.02.2020

from Clinical Directors and/or Care Group Leads to ensure divisional representation and ownership of actions and with support from the Chief Clinical Information Officer and Chief Nursing Information Officer. The Task and Finish Group will have responsibility to design, implement and analyse the Trust wide consent audit and specifically will: ➢ Review and revise existing consent audit template ➢ Agree audit methodology ➢ Agree audit schedule ➢ Develop and implement improvement action plan based on findings of baseline audit with support from Divisional Quality Improvement leads ➢ Develop KPI framework to monitor performance against a target of 100% ➢ Agree reporting framework to monitor performance to Patient Safety Quality Group, Quality and Safety Committee and Clinical Quality Review Group (external quality monitoring group chaired by the CCG) and Trust Executive Committee to Trust Board	
The medical lead for consent supported by the nurse lead will review and, where appropriate, update the Obtaining Valid Consent for Treatment Policy. The Policy will then be reviewed at the Patient Records Group ahead of going to the Patient Safety and Quality Group for ratification and will be supported by an agreed implementation plan and communication strategy.	31.03.2020
The Patient Records Group will review and, where appropriate, recommend updates to the information provided to new staff about consent requirements during the induction process.	31.03.2020
The monitoring of valid consent will be reinforced through the agreed audit schedule at ward rounds, safety huddles, matrons and ward manager checks and WHO checklist. Feedback from the audits will be provided to the multi-disciplinary team.	31.07.2020
We will investigate the opportunity to develop an electronic process for consent audit to facilitate improved reporting on the completeness of consent documentation through a single electronic enquiry rather than a manual review of individual patient records.	31.07.2020
Who is responsible for the action?	Richard Jennings, CMO
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
To ensure that improvements are sustainable members of the Patient Records Group and the Task and Finish Group will be fully representative of the three divisions and of the multidisciplinary team to secure local ownership of the consent improvement agenda and the actions required.	

The KPIs which capture the level of performance will be included in the monthly ward and departmental posters for display and will be included in the Trust Integrated Quality and Performance Report. To further support sustainability the measures we will put in place to check this are that a repeat audit will be undertaken in Quarter 2 to establish the impact of the improvement action plan. The documentation of consent audit will form part of the Trust's annual audit calendar and will be completed on a quarterly basis. The findings of the on-going quarterly audit will be reported at Divisional Governance Boards to provide visibility of performance at service level and at the Patient Safety and Quality Group, reporting onwards to Trust Executive Committee, Quality and Safety Committee and the Trust Board. In addition, the quarterly thematic analysis of the learning from claims will be used to check for any issues about whether our patients are fully informed.	
Who is responsible?	Richard Jennings, Chief Medical Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
No additional resource required	
Date actions will be completed:	31 July 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There is a risk that patient records do not accurately document the type of consent given for a procedure or treatment. To raise awareness of consent, posters and information for patients and carers/relatives about the need for consent are on display and available in clinical areas. All incidents relating to consent will be recorded on the Trust's risk management system Datix.

Completed by: (please print name(s) in full)	Alison Benincasa
Position(s):	Director of Quality Governance and Compliance
Date:	15 January 2020

Regulated activity(ies)	Regulation
Treatment of disease, disorder or injury Diagnostic procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance
	How the regulation was not being met:
	1. Patient records were not always stored securely, completed accurately and kept confidential in the emergency department and some medical wards. Regulation 17

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has a Quality Improvement Programme (QIP) to drive improvements in a number of areas. Part of the QIP focusses on improving the fundamentals of care though our ward and departmental accreditation scheme. We want to protect all our patients by ensuring patient records are stored safely and kept confidential in clinical areas and corporate areas, ensuring there is no opportunity for unauthorised access to patient records and that we know where patient records are at any one time. We also want to ensure that patient records are completed accurately.

To meet the regulation the Trust will complete the following actions:

Action	By when
Confirm a clinical lead for patient records	**COMPLETE**
The clinical lead for patient records will re-establish the Patient Records Group, which will report regularly through the Patient Safety Quality Group. The revised terms of reference will include issues relating to consent.	28.02.2020
The clinical lead for patient records, with support from the Chief Clinical Information Officer and Chief Nursing Information Officer, will establish a Task and Finish Group for governance of patient records with representation from Clinical Directors and/or care group leads to ensure divisional ownership to: ➢ Review and revise existing patient records audit template ➢ Agree methodology ➢ Agree audit schedule ➢ Develop and implement improvement action plan based on findings of baseline audit with support from Divisional Quality Improvement leads ➢ Develop KPI framework to monitor performance through spot-check audits of ED and medical wards and no moderate or above level incidents recorded on Datix	28.02.2020

➢ Agree reporting framework to monitor performance to Patient Safety Quality Group, Quality and Safety Committee and Clinical Quality Review Group (external quality monitoring group chaired by the CCG) and Trust Executive Committee to Trust Board	
The clinical lead for patient records will communicate with all staff to reinforce the need to ensure that records are securely stored. This will be supported by a ward and departmental poster campaign. Communication with all staff will continue on a quarterly basis.	28.02.2020
The Patient Records Group will review and, where appropriate, recommend updates to the information provided to new staff about patient record management during the induction process.	31.03.2020
The clinical lead for patient records will review and, where appropriate, update the Health Records Policy. The Health Records Policy will then be reviewed at the Patient Records Group ahead of going to the Patient Safety and Quality Group for ratification and agreement with reference to implementation and communication.	31.03.2020
The monitoring of safe storage and accurate completion of patient records will be reinforced through the agreed audit schedule at ward rounds, safety huddles, matron and ward manager checks. In addition, a safe storage of patient records audit will be developed and implemented on a quarterly basis. Feedback from the audits will be reported to the Patient Safety and Quality Group. The Patient Safety and Quality Group will report issues of concern to specific multi-disciplinary teams for attention.	31.12.2020

Who is responsible for the action?	Richard Jennings, Chief Medical Officer

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

As for improvements required to comply with Regulation 11 outlined above, the Trust will ensure that improvements are sustainable; members of the Patient Records Group and the Task and Finish Group will be fully representative of the three divisions and of the multidisciplinary team to secure local ownership of the actions needed to improve the governance of patient records.

The KPIs which capture the level of performance will be included in the monthly ward and departmental posters for display and will be included in the Trust Integrated Quality and Performance Report.

To further support sustainability the measures that we will put in place to check this are that a repeat audit will be undertaken in Quarter 2 to establish the impact of the improvement action plan. The patient records audit will form part of the Trust's annual audit calendar and will be completed on a quarterly basis. The findings of the on-going quarterly audit will be reported

at Divisional Governance Boards to provide visibility of performance at service level and at the Patient Safety and Quality Group, reporting onwards to Trust Executive Committee, Quality and Safety Committee and the Trust Board. The Trust is currently developing its Information Technology Strategy 2019-24 which will include our ambition to be a paperless organisation. As the Trust moves forward its strategic agenda we will also remain sighted on deliverable and sustainable electronic improvements.	
Who is responsible?	Richard Jennings, Chief Medical Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
No additional resource required	
Date actions will be completed:	31 December 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
If we do not meet the regulation, there is a risk that information related to our patients may be inadvertently viewed by others. Incidents relating to patient records will be recorded to enable these incidents to be fully investigated and the learning shared and any actions taken forward by the relevant teams.

Completed by: (please print name(s) in full)	Alison Benincasa
Position(s):	Director of Quality Governance and Compliance
Date:	15 January 2020

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St George's University Hospitals NHS Foundation Trust

2

Meeting Title:	**Trust Board**		
Date:	30 January 2020	**Agenda No**	**2.3**
Report Title:	**Integrated Quality and Performance Report (IQPR)**		
Lead Director/ Manager:	James Friend, Chief Transformation Officer Ellis Pullinger, Chief Operating Officer		
Report Author:	Ellis Pullinger, Chief Operating Officer Emma Hedges, Mable Wu, Kaye Glover		
Presented for:	Assurance		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, quality, patient access and performance. **Our Finance & Productivity Perspective** Outpatient activity remains below plan; all other activity is on plan. Non-elective Length of stay is above the upper process limits as a result of new emergency department initiative, Rapid Assessment Zone (RAZ) and an increase in Surgery and Trauma length of stay. **Our Patient Perspective** The Trust's quality metrics continue to show positive outcomes across a range of areas, seeing sustained improvement within our complaints monitoring achieving all targets for the past five months and steady improvement seen within our quality priority metrics. The percentage of women having 3rd or 4th degree tear increased in the month and exceeded the target; this is actively being reviewed by the service. In the month of December one patient never event was reported, immediate actions are in place as a result. Other areas that remain challenged have been identified. Targeted support and monitoring is on-going. **Our Process Perspective** Referral to Treatment 1) The Trust reported seven 52 week breaches in November 2019 against a planned trajectory of zero. Six of the seven were in General Surgery. The General Surgery Care Group, with input from the Chief Operating Officer, Clinical Care Group Lead and Clinical Director, are now involved in a patient by patient review of the General Surgery patient tracking list (PTL) with a particular focus on patients getting through the 'non-admitted' part of their pathway faster. The Trust Board is asked to note that Trust Executive Committee (TEC) and Finance and Investment Committee (FIC) will have received a more detailed referral to treatment (RTT) update, including the above approach to General Surgery, in the January meetings prior to this Board. This update will also include a detailed analysis on the overall size of the RTT PTL and targeted work to reduce the volume of patients on it – through both additional clinical activity and/or improved RTT coding (which results in RTT clock stops). 2) To support the above discussion both TEC and FIC will also be given an advanced view on the December 2019 RTT position at Trust level against the national standard. The Board is reminded that this position is not		

publicly available, as yet, due to the national reporting timelines falling out of synch with the Trust's Board meeting dates.

3) The Trust Board will also receive an update on progress against the NHSE/I agreed funding for elective transfer of work to the private sector as part of the February IQPR report. The Trust requested funding to utilise private sector capacity to support bariatric surgery which is a sub-specialty of General Surgery with a profile of long waits for surgery.

Diagnostics

Further to the update available in the IQPR, the Trust Board will receive an update in its Part 2 meeting on the recovery plan approved by TEC to bring waits for echo to within the 6 week diagnostic waiting time standard by May 2020.

Cancer

The Board is to be advised that the Chief Operating Officer will have provided TEC and FIC with a provisional closing position for the two week rule and breast symptomatic standard for December that will be non-compliant. The main reason for this under delivery is patients choosing not to have their outpatient appointment over the Christmas period. However, the Trust is still expecting to meet the two week rule standard for Q3 2019/20.

Emergency Care

The Board has received two papers in November and December 2019 which focussed on specific recovery actions that the Trust's internal Emergency Care Delivery Board (ECDB) was doing to get performance back to its monthly trajectory. The Trust's trajectory for December 2019 was 87%. At a reported December position of 79.4%, the proposed key actions in the plan clearly did not deliver but this update will highlight areas of improvement in the month of December and progress to date in January 2020. It will re-visit key areas of focus from the December Board report.

1) **Patient Flow through the Trust (Access/Discharge)**
Objective: Stretch target of 3% improvement in the December 2019 Four Hour Operating Performance standard. This is an update on one of the two priority actions to support the delivery of this objective:

Reduction in patients with a length of stay over 21 days: The Trust had, on average, 140 patients with a length of stay of over 21 days at the start of December which is circa 17% of the total general and adult bed stock of the Trust. Each 1% reduction in the percentage of patients that are 21 days or longer, gives a 0.6% Type 1 performance improvement. An ECDB workstream targeted a reduction of 40 patients in this cohort (i.e. delivering on the existing commitment to return the Trust's ambition of having no more than 100 such patients at any one time.

One of the key step changes in this action (as of w/c 18th November) has been to invite both Wandsworth and Merton Social Service teams into the established Trust long length of stay meetings (starting with the Medicine Division) in order to prioritise and manage appropriate system wide actions for each patient. This additional management support from our local Social Services partners is mirrored by increased Trust clinical and operational management presence in this meeting.

As of the 24th December, the Trust did deliver a reduction in the number of patients with a length of stay of over 21 days to 101 and for the week ending the 1st January 2020 the Trust reported performance of 85.98%

	against the 4 hour standard (for noting: this performance ranked the Trust 16th out of 123 Type 1 Trusts in the UK for that one week reporting period over the Christmas period). The Trust is targeting an ambition level of no more than 100 patients over 21 days which, with all other things being equal, could improve performance by 3% against the 4 hour standard. In the week ending the 1st January, the Trust, in part, did demonstrate delivery against this plan. However, it is clearly not consistent and the reality for the Trust, as of the 16th January 2020, is that there are now over 140 patients at 21 days length of stay and, as a result, we see continued pressure in delivering the admitted performance. One of the pre-planned actions to address this challenge is the Trust held a multi-disciplinary event with system partners (social services and community providers) on Wednesday 15th January to focus on long length of stay patients in the Trust. 88 patients were reviewed as part of this event with an expectation that at least 60% will be discharged this month. **2) Emergency Care Processes (including Urgent Care Waits and Direct Access to Ambulatory Units)** **Objective:** Target of 1% improvement in the December 2019 Four Hour Operating Performance standard (potential for up to 3% improvement in future months). There are two priority actions to support the delivery of this objective: i) Reducing crowding in Emergency Department (ED) The Trust continues to develop its Rapid Assessment Zone (RAZ) with a post-implementation review to be undertaken in late January 2020 to evaluate it formally. So far RAZ teams have seen on average 31 patients per day with the median performance of patients on a RAZ pathway at 85.7% against the 4 hour standard. This is encouraging progress albeit it is completely accepted it has not, as yet, contributed to the full recovery of the performance trajectory. ii) Direct Access to Ambulatory Units (i.e. Nye Bevan and AAA) The Trust now has a Direct Access dashboard on Tableau that tracks GP accepted work that goes directly to an ambulatory unit in the Trust as opposed to being seen and treated in the Emergency Department. The Chief Transformation Officer, through the work of his team, has supported the development of this dashboard and the pathway work to achieve it. In doing so, in the first three days of the week commencing the 13th January 2020, 32 GP referred patients that have gone to AAA or AMU, 22 have gone there directly, reducing ED congestion. Again, marginal but important progress being made. **Our People Perspective** The Trust was within the monthly agency cost in December for the first time this year with agency costs of £1.22m against a target of £1.25m. Appraisal rates for clinical and non-clinical areas remain consistently below target of 90% with rates of 83.6% and 72.3% respectively.
Recommendation:	The Board is asked to note the report
Supports	
Trust Strategic Objective:	Treat the Patient; Treat the Person; Right Care; Right Place; Right Time
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led
Single Oversight	Quality of Care

Framework Theme:	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:	Trust Executive Committee Finance and Investment Committee Quality and Safety Committee	**Date**	22 Jan 2020 23 Jan 2020 23 Jan 2020
Equality Impact Assessment:			
Appendices:			

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St George's University Hospitals NHS Foundation Trust

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 30 January 2020
Reporting Period – December 2019

James Friend
Chief Transformation Officer

16th January 2020

Our Outcomes

How Are We Doing?

December 2019

Daycase and Elective Surgery operations

Actual: 4,181

Target: 4,615

AMU bed occupancy at 12 Noon

Actual: 95% Target: 85%

Four Hour Emergency Standard

Actual: 79.4%

Plan: 95%

Whole Trust Inpatient Friends and Family Test

Actual 96.8%

Target 95%

Outpatient First Attendence

Actual 14,455

Plan 15,442

November 2019

Referral to Treatment Standard - Incomplete pathways

Actual: 84.2%

Target: 92%

Balanced Scorecard Approach

Executive Summary – December 2019

Our Finance and Productivity Perspective

- Outpatient Activity at Trust level was 2.4% higher than the same month last year although is below SLA year to date. Activity levels remained within normal process limits and showed no sign of special cause variation for either first or follow-up activity.
- Daycase and Elective activity is just below SLA plan year to date however the number of procedures per working day has previously remained above the mean and we expect this to continue once coding is complete for December. The Trust's Elective activity is currently 5.9% ahead of the same year to date period last year. Theatre utilisation remains within the upper and lower control limits however average cases per session remains below the mean.
- Non-elective length has increased above the upper control limit showing signs of special cause variation. The increases are primarily within Acute medicine where front door pathway changes have reduced the number of zero stay admissions and an increase in Surgery and Trauma length of stay.

Our Patient Perspective

- There were no MRSA incidents in December 2019 and the year to date number of Cdiff cases is 37 against a target of 48.
- The Complaints department continues to meet all of its response compliance targets.
- There was one Never Event declared in December 2019.
- The number of 3rd or 4th degree tears exceeded the target for the first time since June 2018 and the department is reviewing patient level data to see if there is a pattern.

Our Process Perspective

- The number of emergency patients either discharged, admitted or transferred within four hours of arrival in the month of December was 79.4%. Both admitted and non-admitted performance remains significantly below the lower control limit and lower compared to the same period last year.
- The Trust achieved six out of the seven Cancer standards in November. The Trust remained compliant against the 14 day standard and 62 day standard, however was below the target of 90% for Cancer 62 day referral standard for Screening.
- The Trust was below its RTT incomplete trajectory in November with a performance of 84.2% against a target of 86.5%. The Trust reported seven 52 week breaches against a trajectory of zero.
- In December, the Trust did not achieve the six week diagnostic standard with an adverse performance of 6.7% against a National Threshold of 1% and London performance of 3.4%. Trajectories and improvement projects are in place to recover and sustain performance.
- In Quarter three the Trust has seen an increase in the number of on the day cancellations compared to the same period last year, however with a larger amount of elective activity going through our theatres, the number of cancelled operations as a percentage of activity has dropped.

Our People Perspective

- The Trust was within the monthly agency cost in December for the first time this year with agency costs of £1.22m against a target of £1.25m
- The Trust's total pay for December was £43.73m. This is £0.68m adverse to a plan of £43.05m.
- Appraisal rates for clinical and non-clinical areas remain consistently below target of 90% with rates of 83.6% and 72.3% respectively.

Balanced Scorecard Approach

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

Key

Current Month

A Previous Month

Our Finance & Productivity Perspective

Activity against our Plan

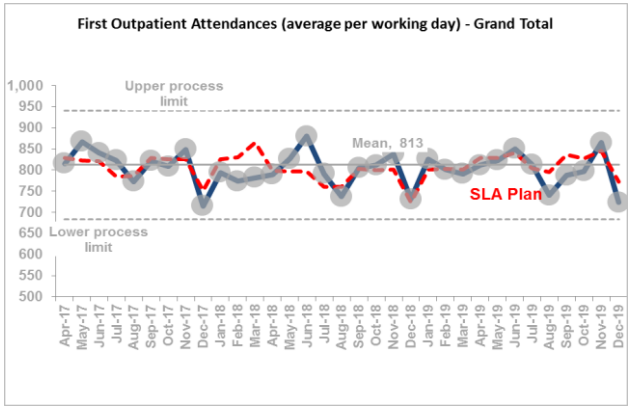
		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Dec-18	Dec-19	Variance	Plan Dec-19	Variance	YTD 18/19	YTD 19/20	Variance	Plan YTD	Variance
ED	ED Attendances	13,862	13,797	-0.47%	14,374	-4.01%	125,916	127,677	1.40%	127,519	0.12%
Inpatient	Non Elective	3,965	4,318	8.90%	4,108	5.11%	35,943	36,334	1.09%	35,844	1.37%
	Elective & Daycase	3,978	4,181	5.10%	4,615	-9.40%	43,286	45,851	5.93%	46,320	-1.01%
Outpatient	OP Attendances	46,747	47,883	2.43%	50,876	-5.88%	500,786	501,995	0.24%	515,498	-2.62%

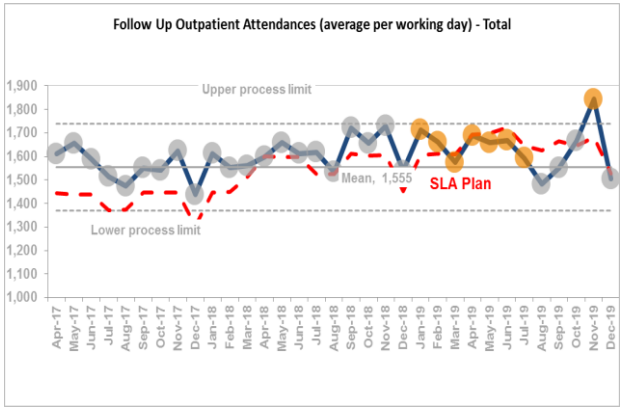
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

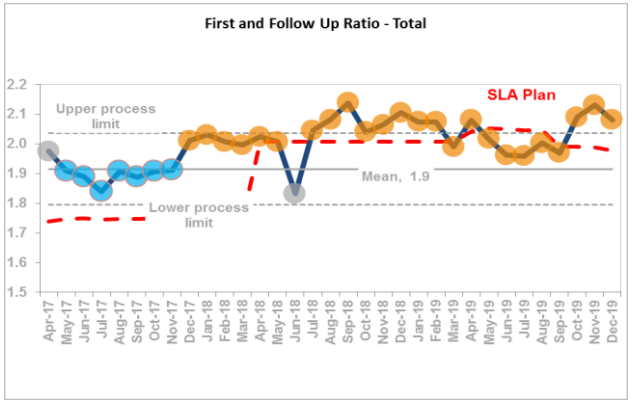
Note: Figures quoted are as at 09/01/2020, and do not include an estimate for activity not yet recorded (eg. un-cashed clinics). The expected performance vs. plan by Point of Delivery (POD) post catch up is:

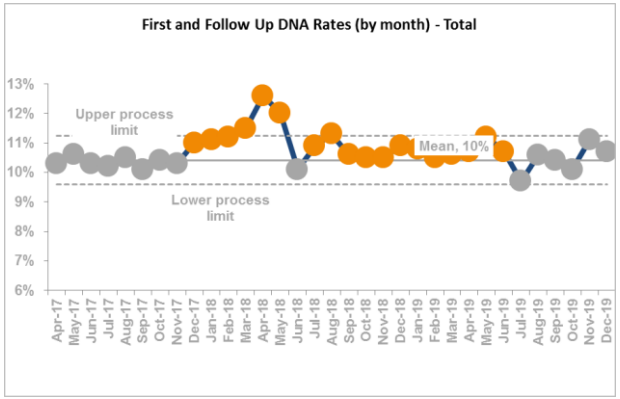
ED – No change
Elective and Daycase – On Plan
Outpatients – Underperformance against plan (c2-3%)

Outpatient Productivity









Actions and Quality Improvement Projects

- No updates

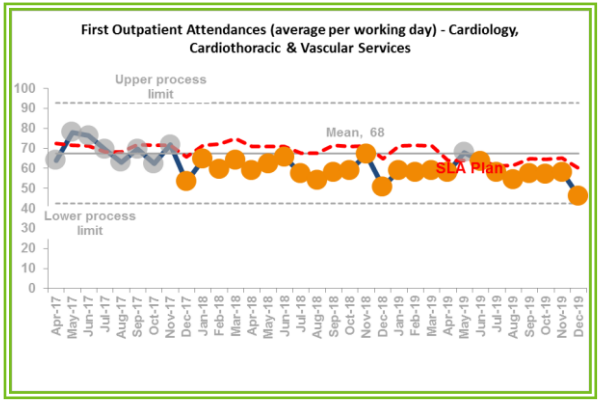
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

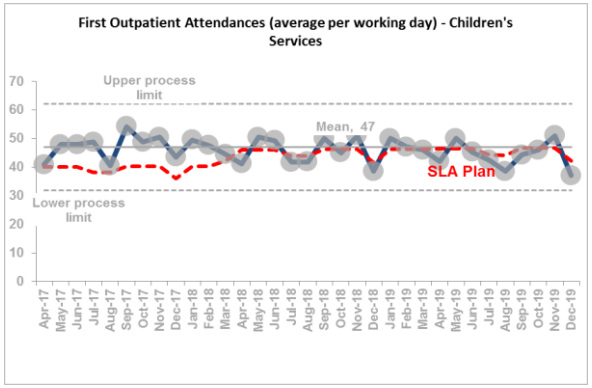
What the information tells us

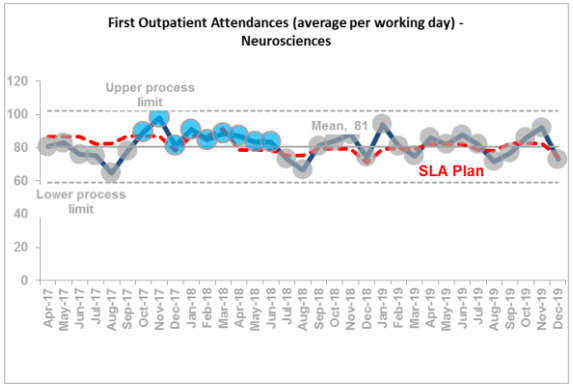
- Outpatient first and follow-up activity remains within the upper and lower control limits at Trust level however overall activity has fallen below plan in December however there will be an element of data catch to follow.
- Cardiology, Cardiothoracic and Vascular first outpatients activity remains below the mean and SLA plan. Surgery and Women's services has fallen below the lower control limit however we expect this to increase once coding has fully completed. All other services are within their control limits.
- At Trust level follow-up activity has returned to within its process limits after a spike was seen in November.
- Cardiothoracic Surgery and General Surgery outpatient follow-up activity has had several months with their follow-up activities below mean.
- Specialty Medicine outpatient follow-up activity remain above their mean impacting on the new to follow up ratio. Surgery has continued to see a reduction in the number of follow-up activity
- The Trusts first to follow-up ratio continues to be above the mean showing special cause variation for the month of October reporting above the upper control limit.
- Neurosciences and Specialty Medicine continue to see the ratio above the mean reflecting the increase in follow-up activity.
- The Trust DNA rate is within its process limits and shows common cause variation.
- Women's services and Renal & Oncology DNA rates have consistently been below its means whereas Neurosciences and Other (Acute Medicine, Therapies and Diagnostics) have all been consistently above their means for over a year showing a significant increase within Other since October but improvement showing within Neurosciences.

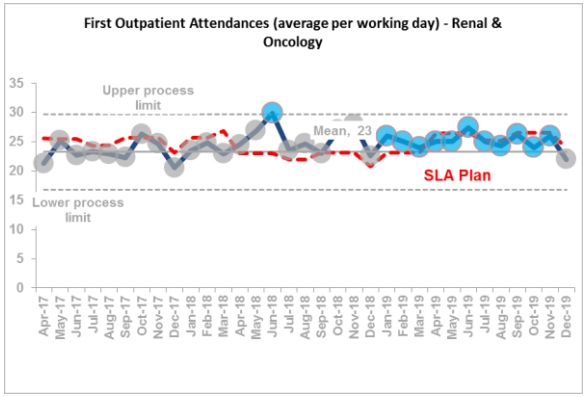
Number of First Outpatient attendances per Working Day

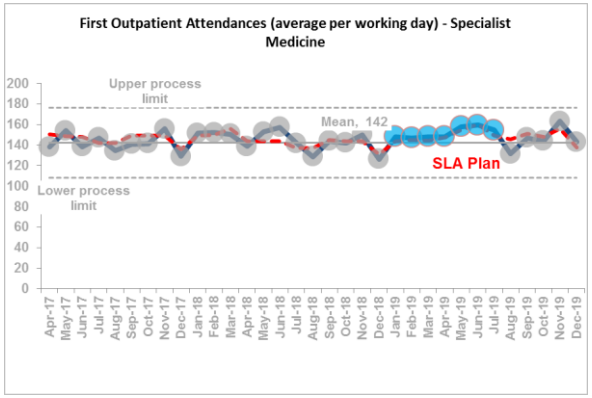
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

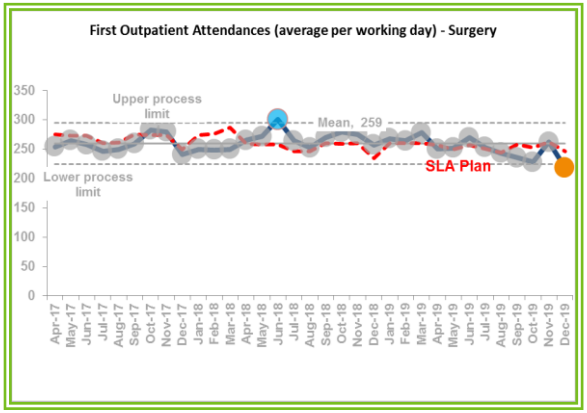


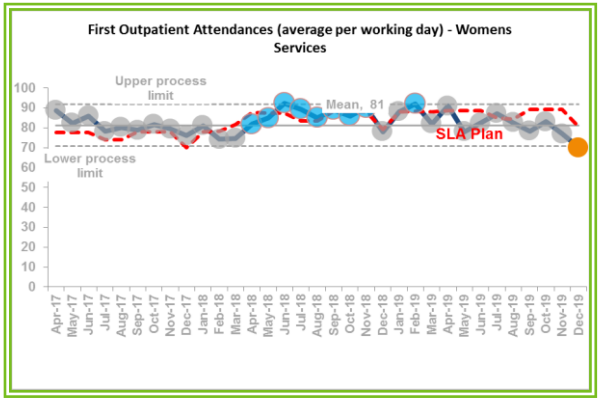


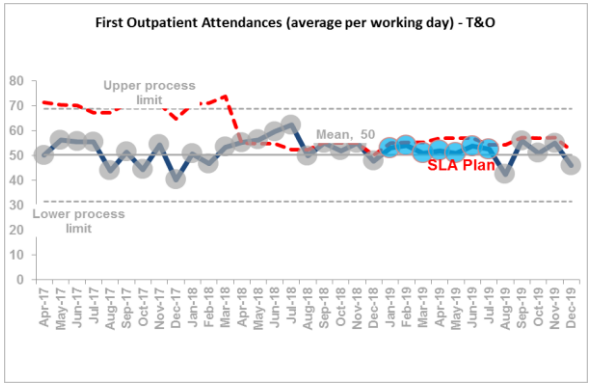






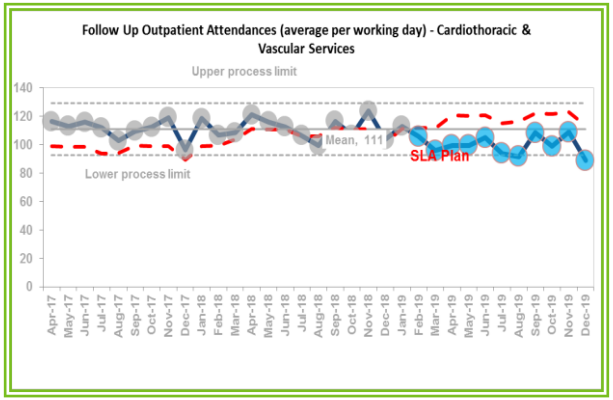


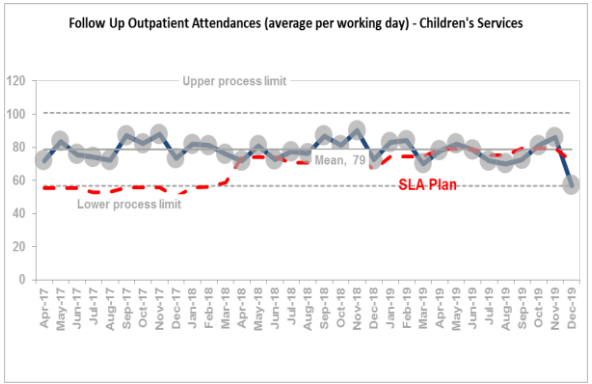


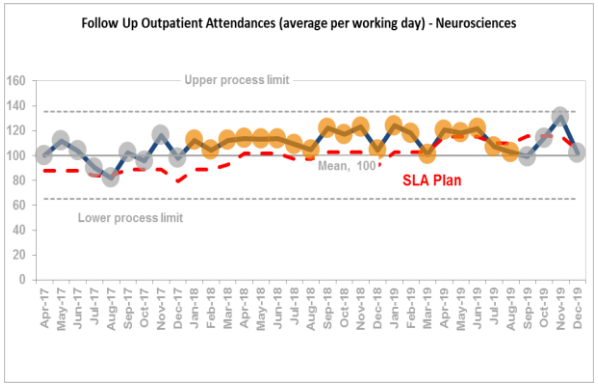


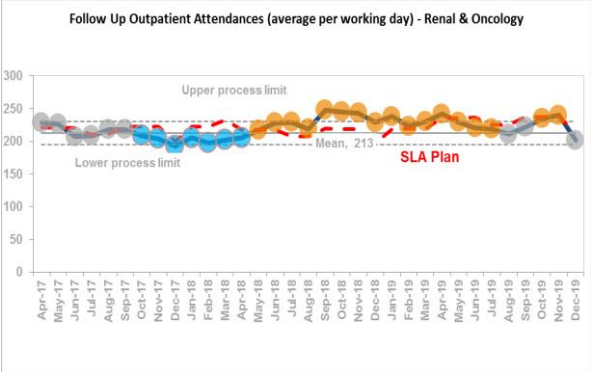
Number of Follow Up Outpatient attendances per Working Day

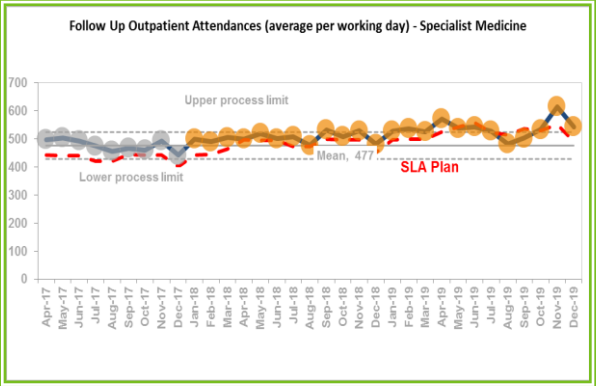
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

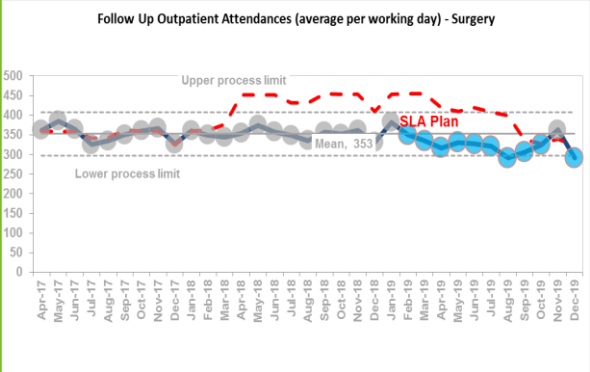


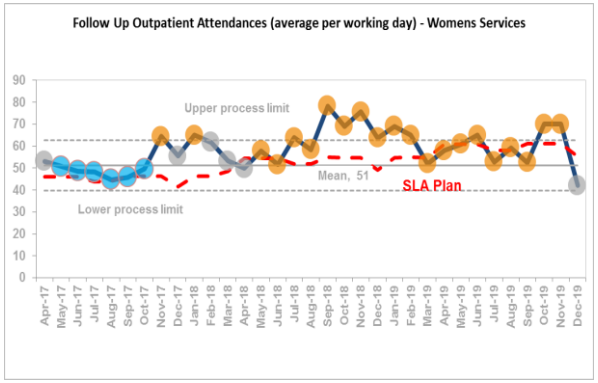


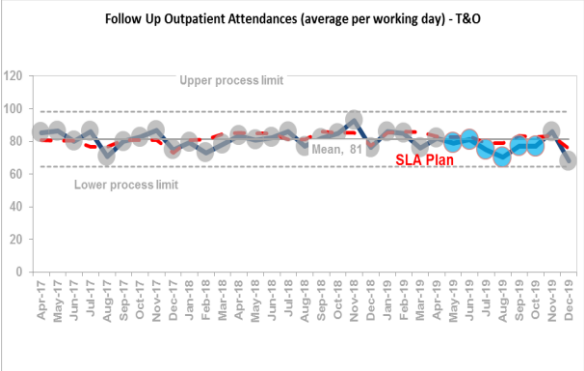






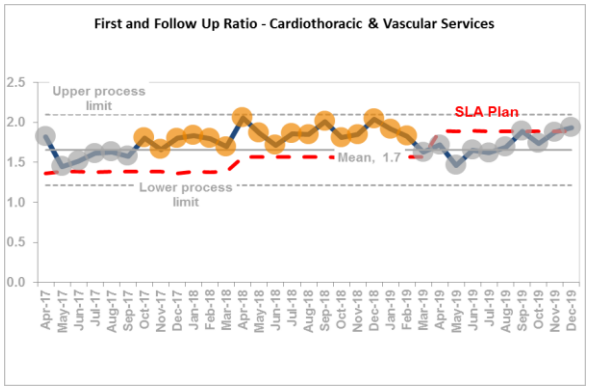


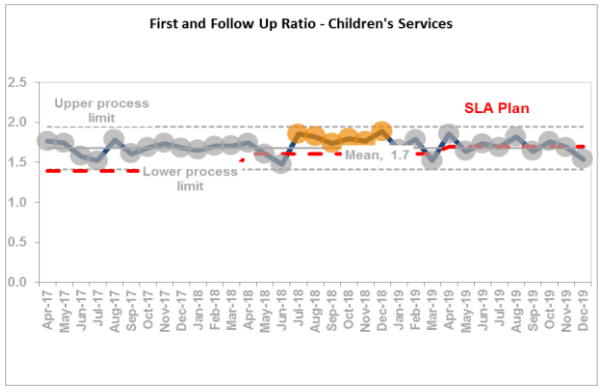


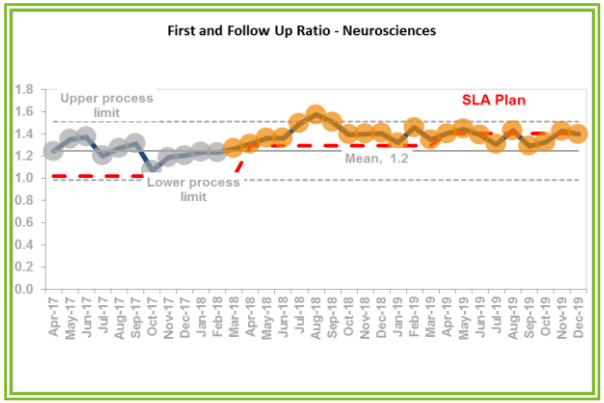


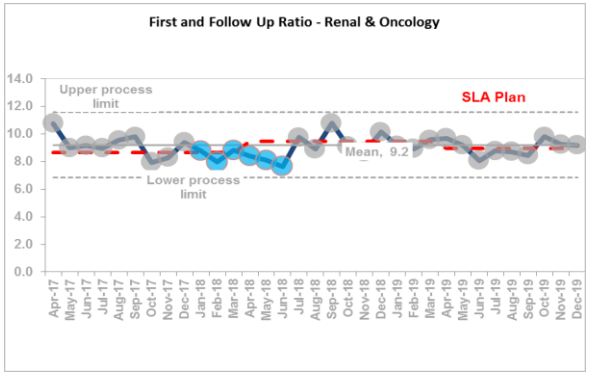
New to Follow Up Ratios

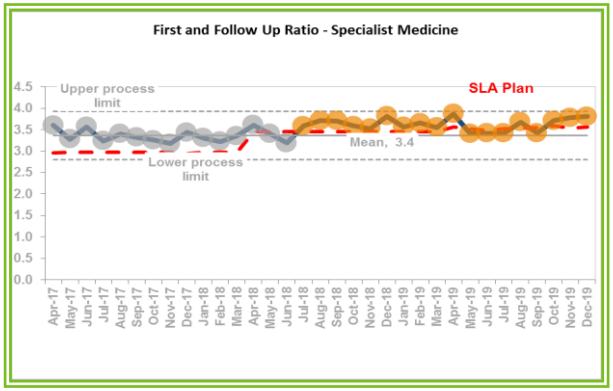
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

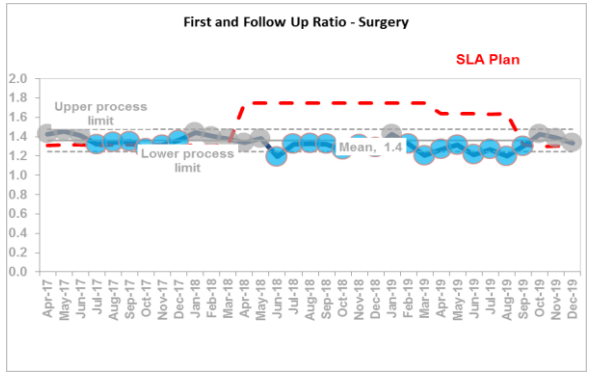


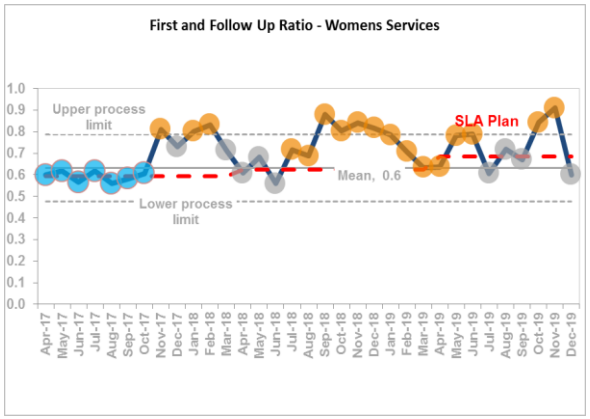


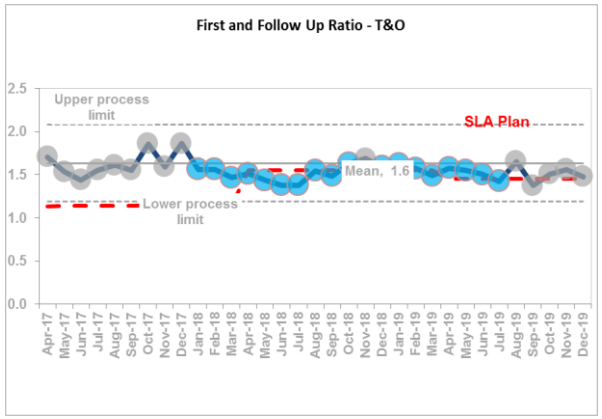






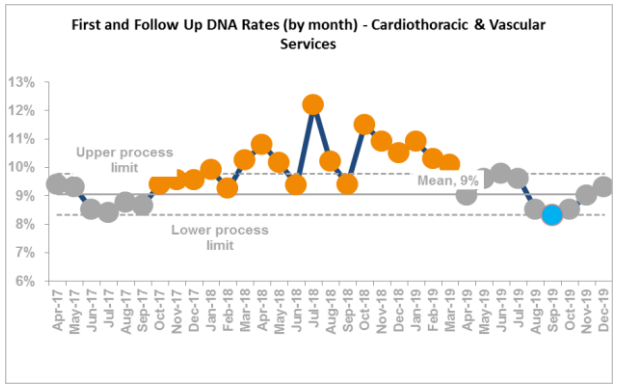


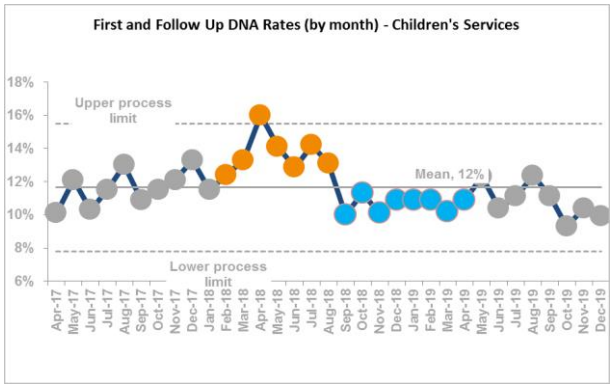


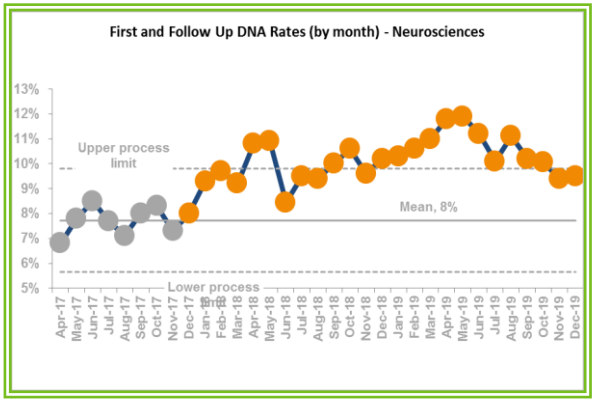


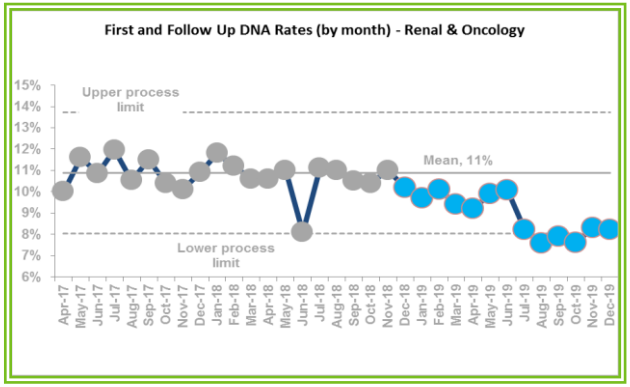
Number of Patients that did not attend

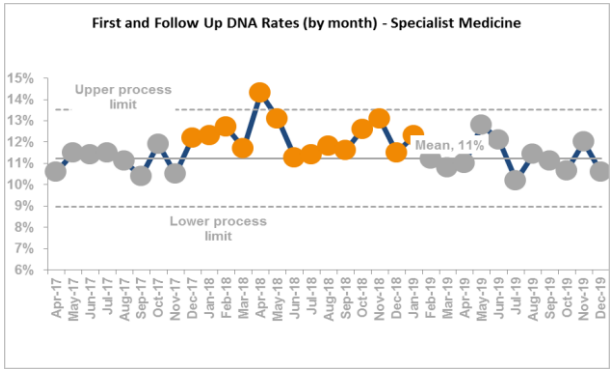
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

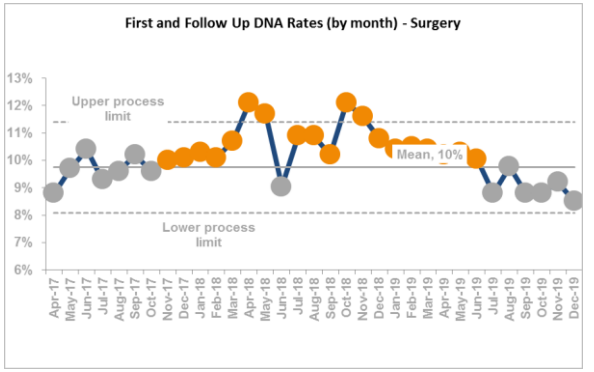


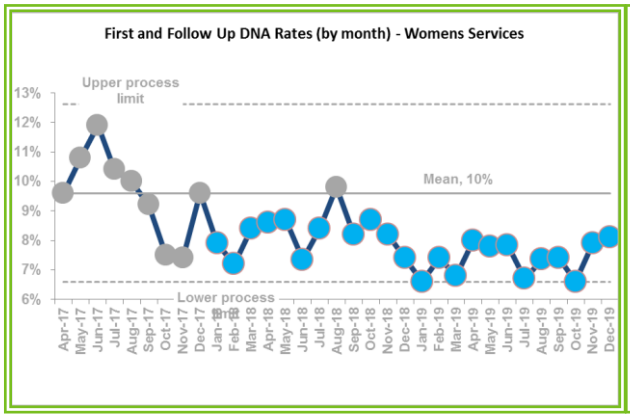


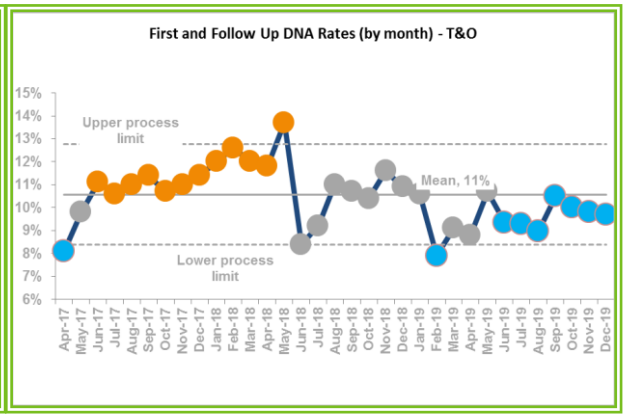


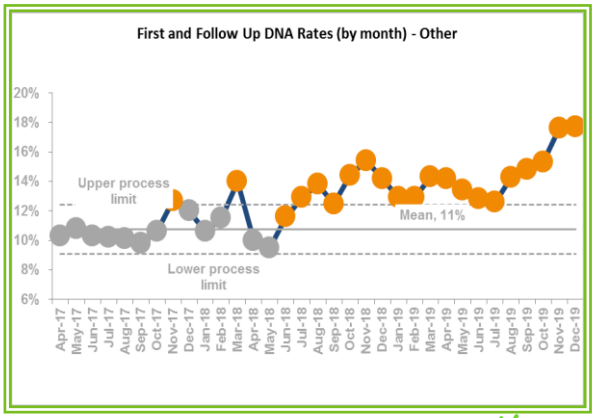






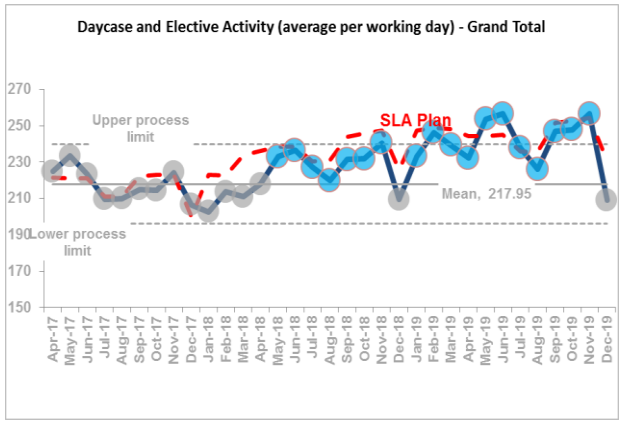


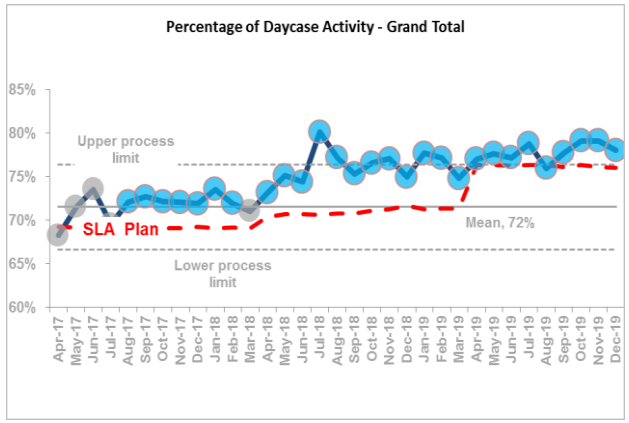


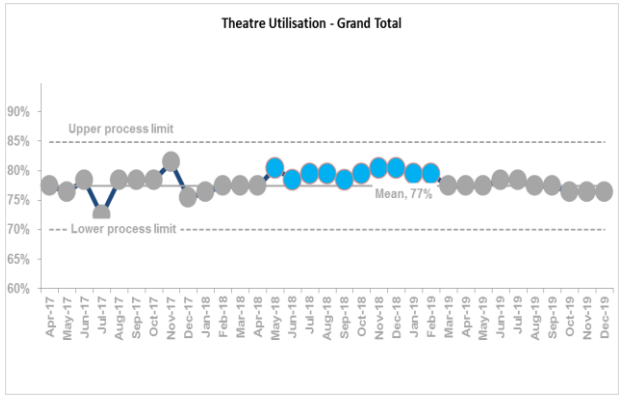


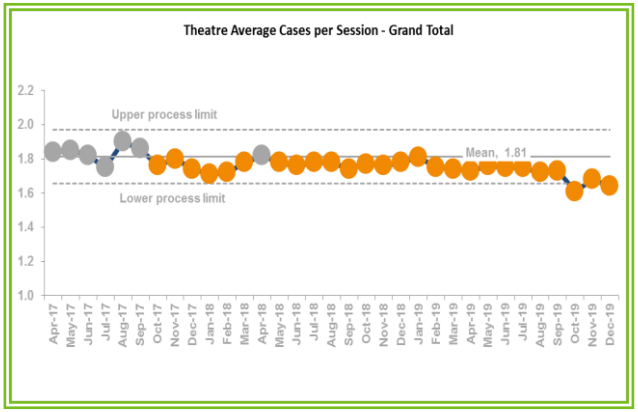
Theatre Productivity

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









Actions and Quality Improvement Projects

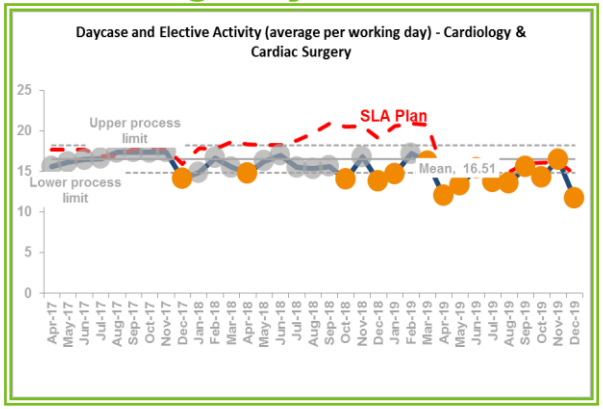
- No updates

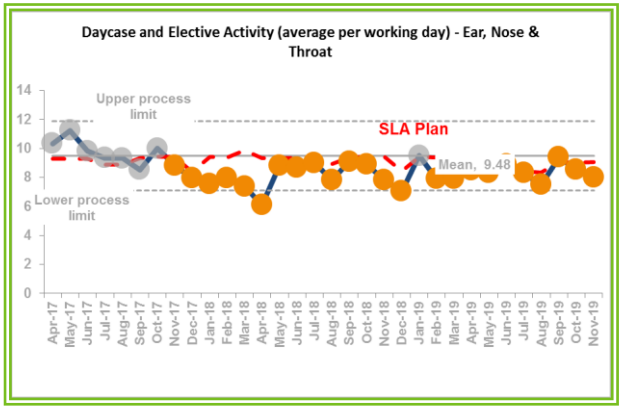
What the information tells us

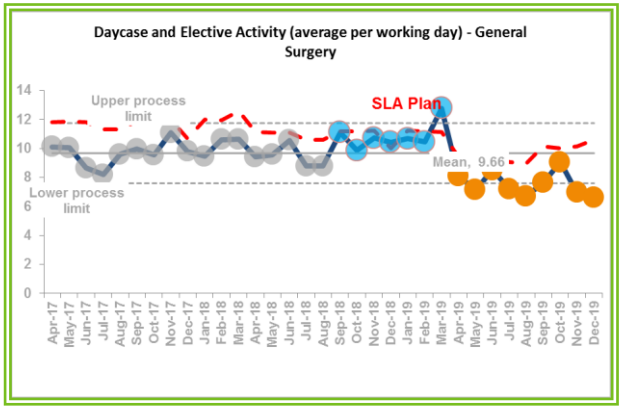
- Activity data for elective treatments has been above the mean all year however the December activity has been reported below mean and SLA plan. There will be an element of data correction and catch up.
- Cardiology & Cardiac Surgery, General Surgery and Ear Nose and Throat specialties are showing special cause variation as these specialties are below their means for over six months.
- All of the other specialties are within their expected process limits.
- The percentage of daycase activity is currently above the mean line at Trust level with a number of specialties above their target line. Oncology and Plastic Surgery are above the upper control limit. Vascular, Haematology and Endoscopy are not meeting SLA target
- The Trust's Cases per Session has fallen below its lower process control limit indicating special cause variation for the third month.
- Ear, Nose & Throat have continued to increase throughput in the month of December staying above the mean.
- Neurosurgery, Plastics and General Surgery have been consistently performing below their means.
- The Trust's Theatre utilisation remains within its control limits.

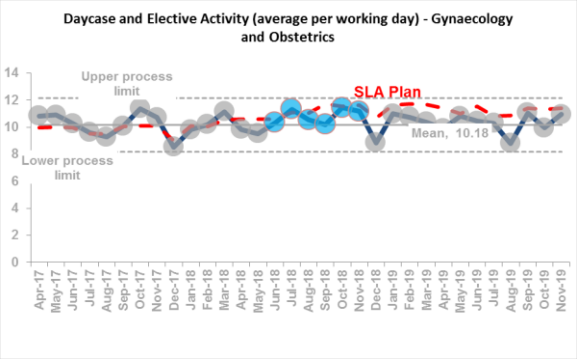
Number of Elective and Daycase Patients treated per Working Day

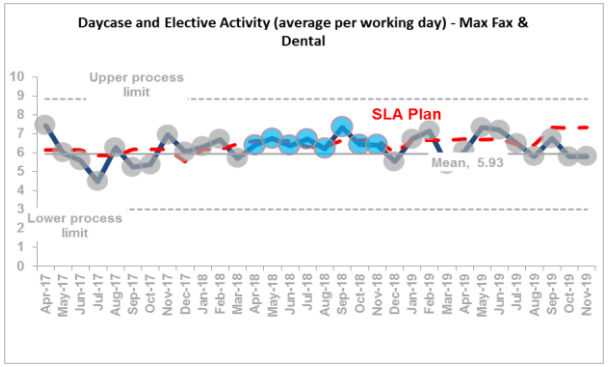
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

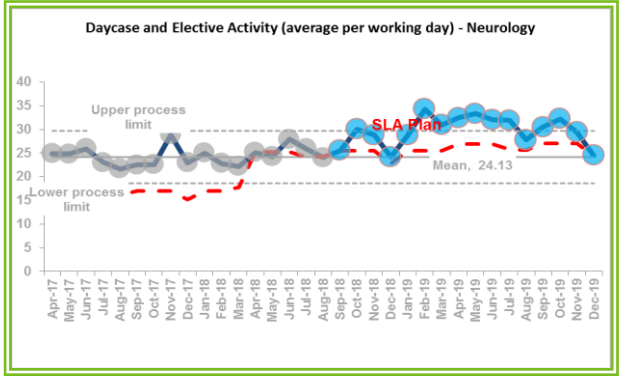


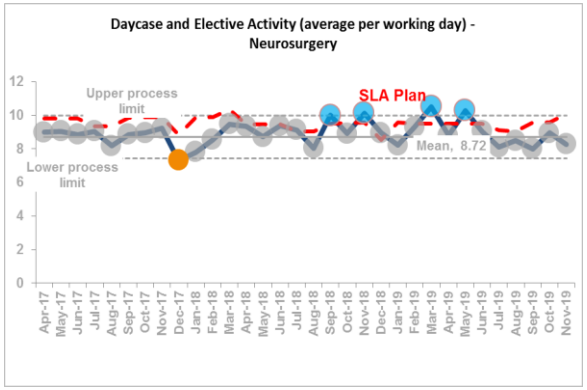


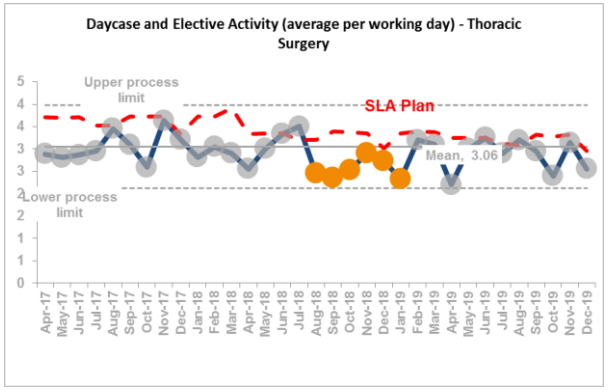


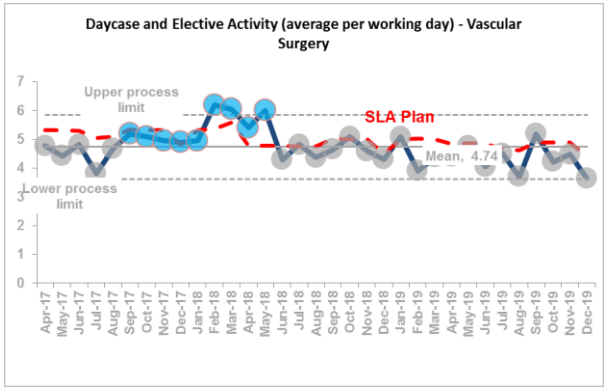






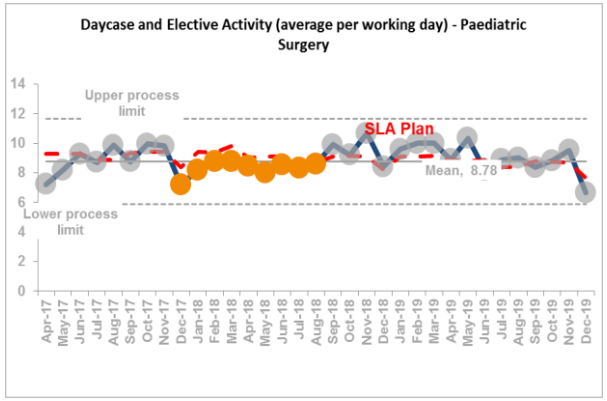


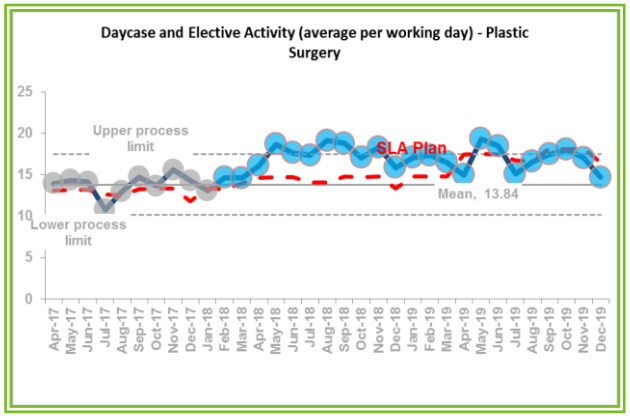


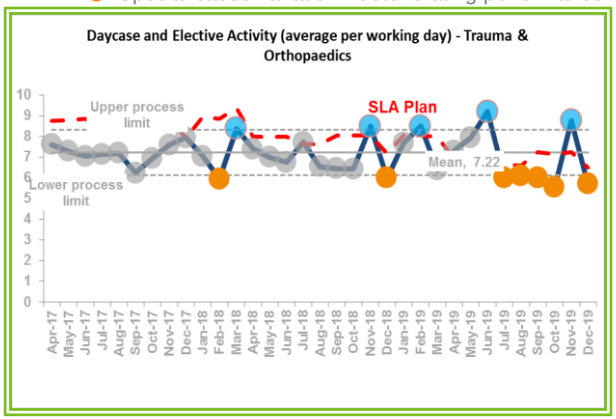


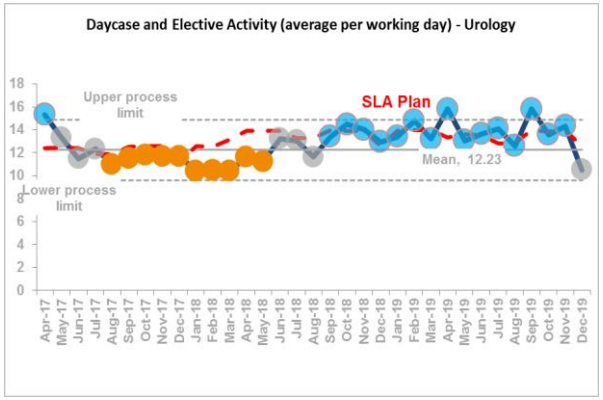
Number of Elective and Daycase Patients treated per Working Day

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





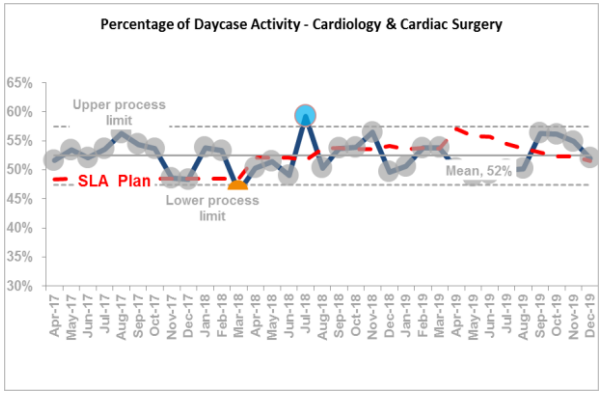


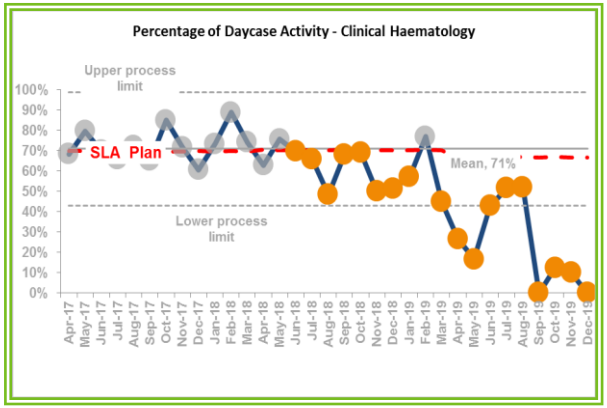


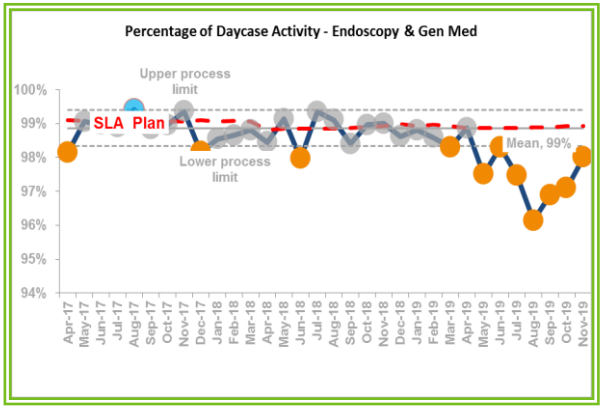
Our Finance & Productivity Perspective

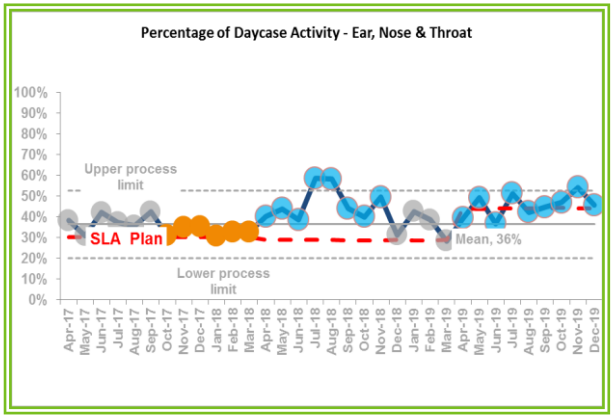
Percentage of daycase activity

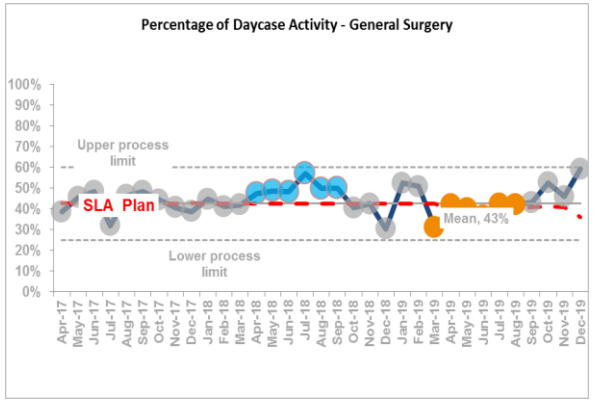
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

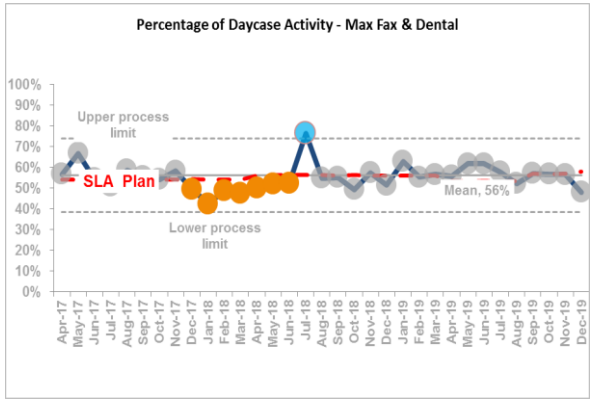


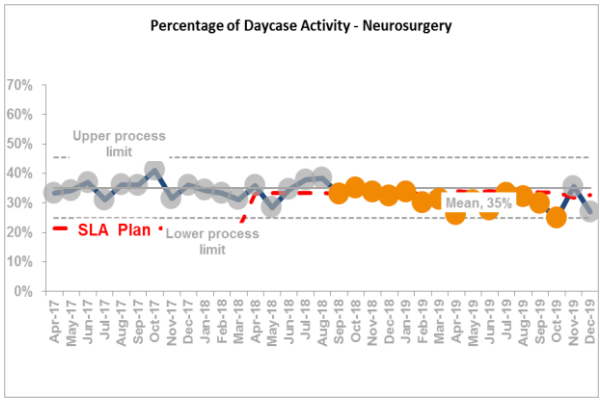


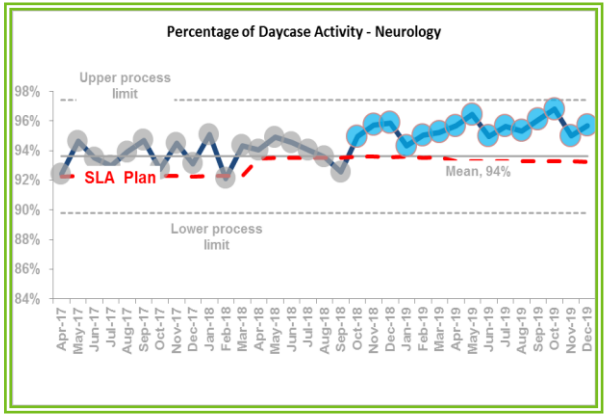


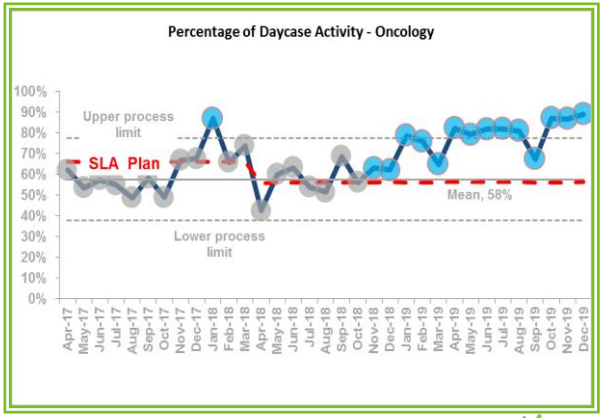






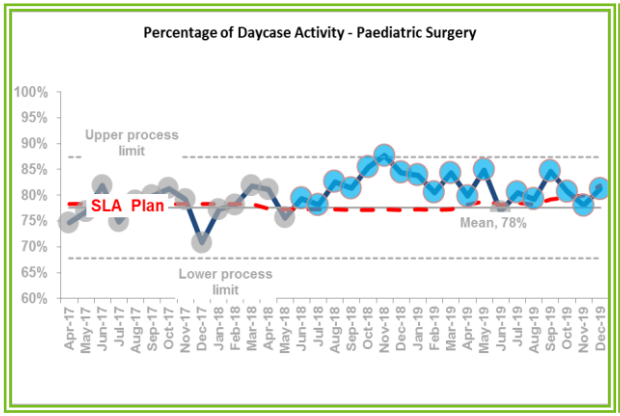


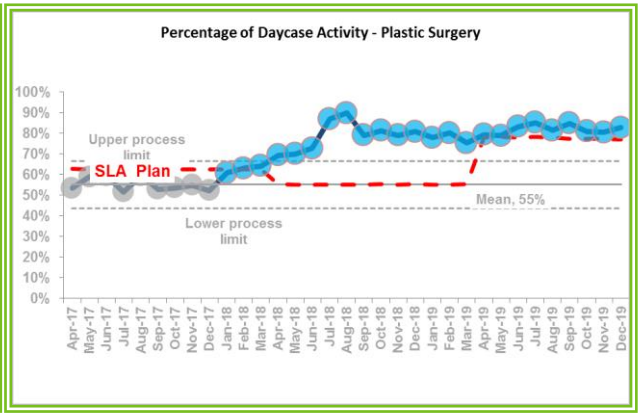


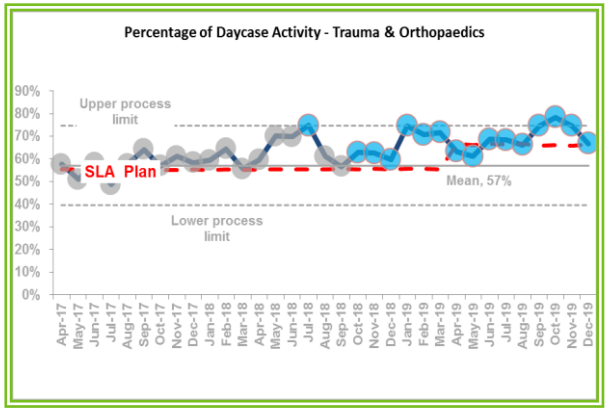


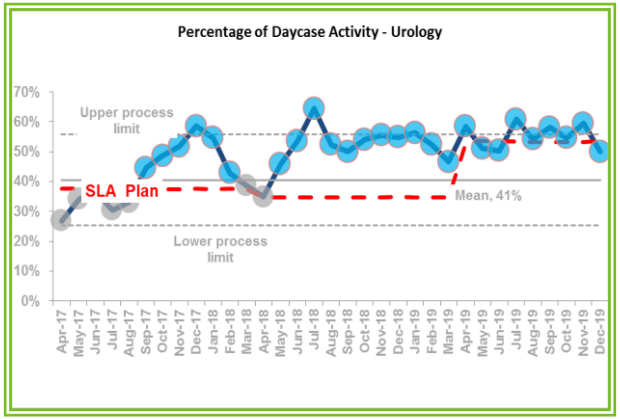
Percentage of daycase activity

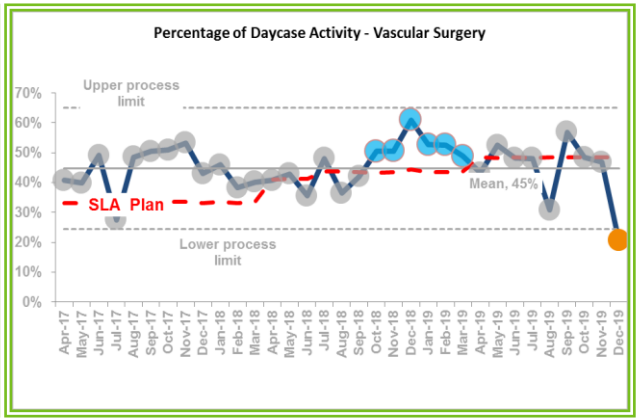
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance





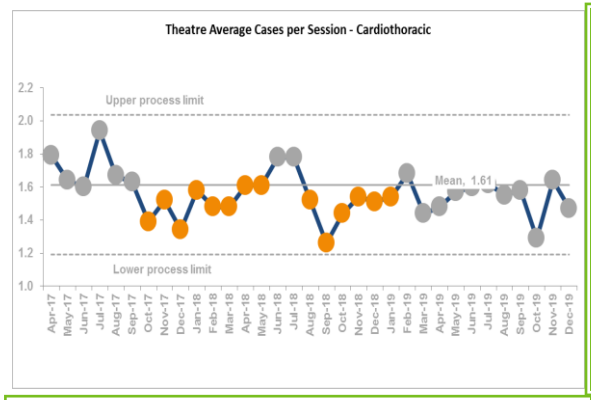


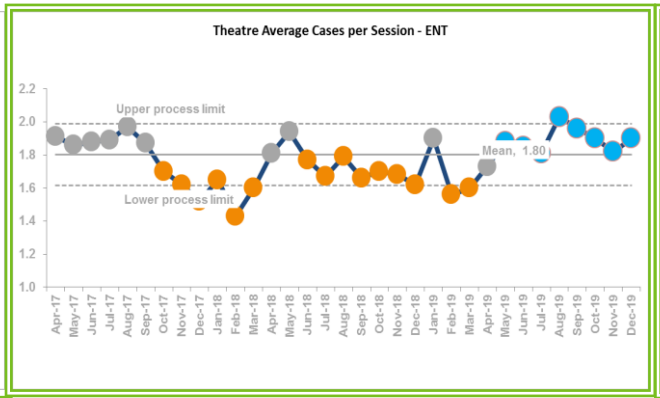


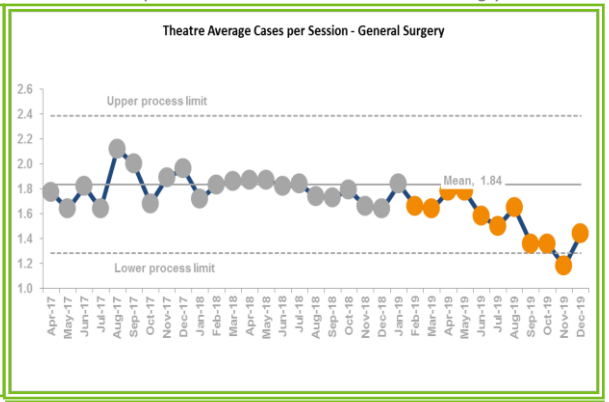


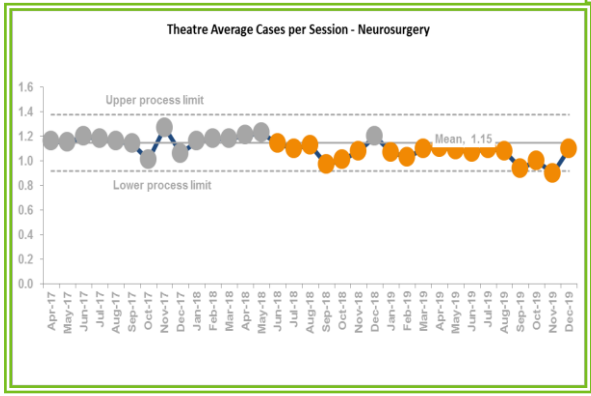
Theatre productivity – Cases per Session

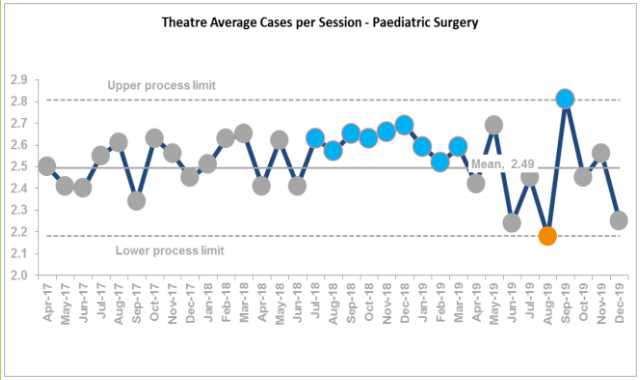
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

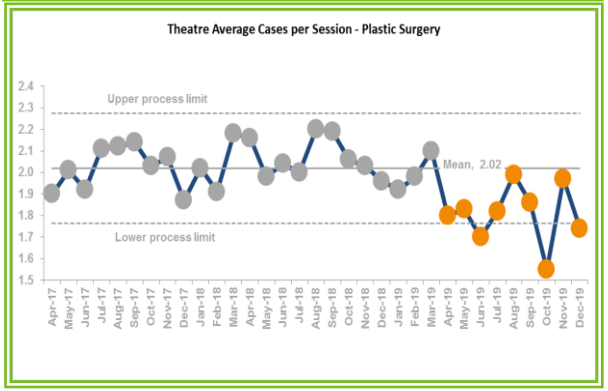


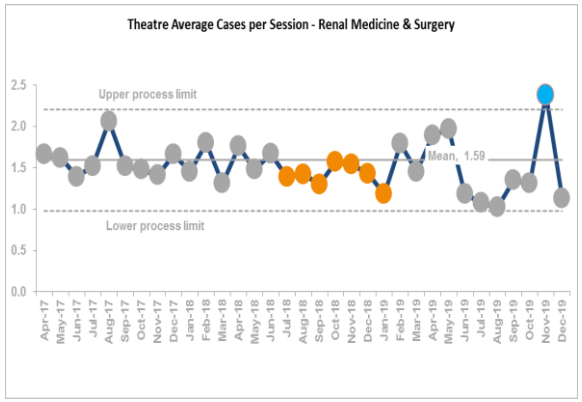


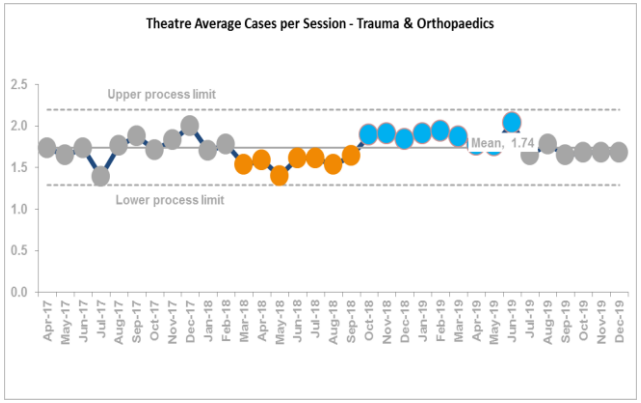


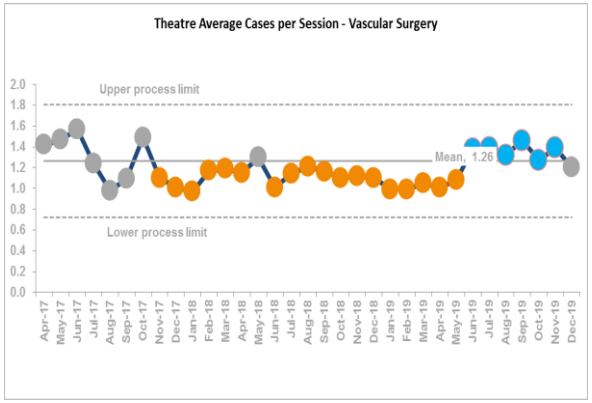






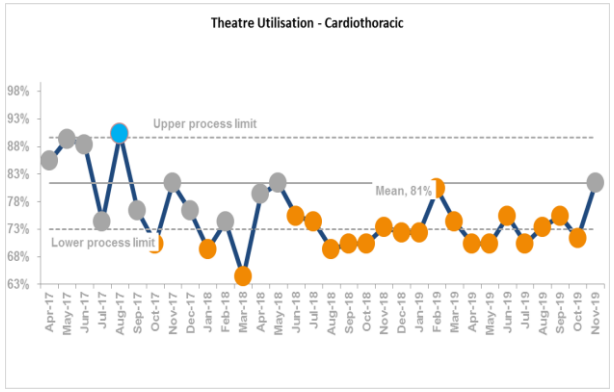


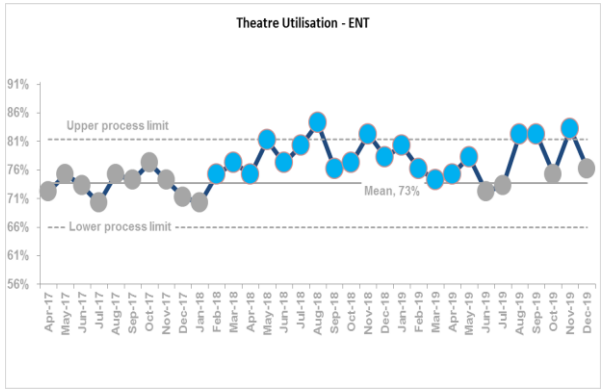


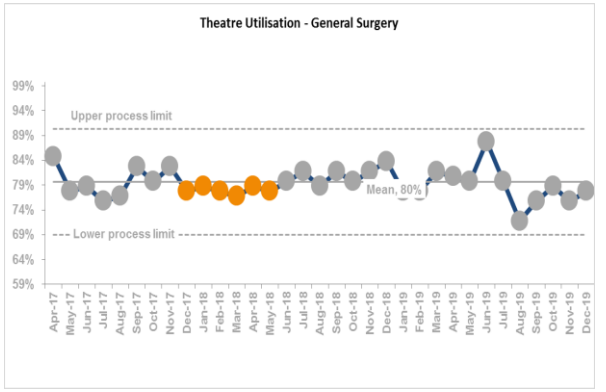


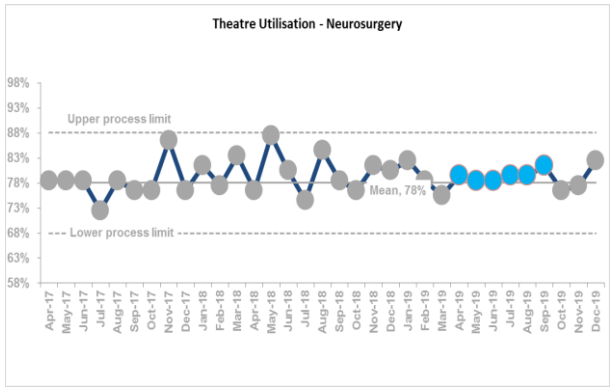
Theatre productivity – Utilisation

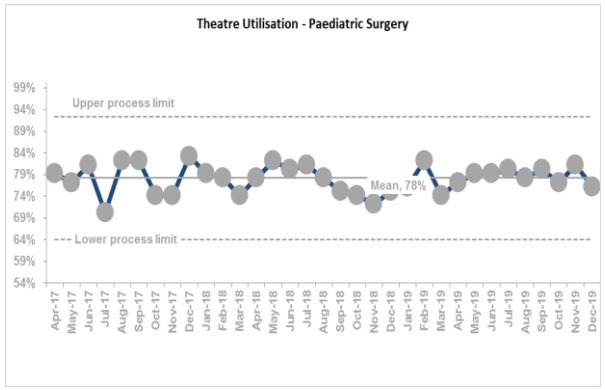
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

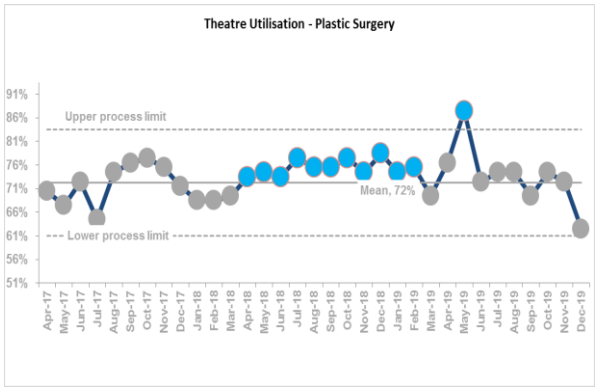


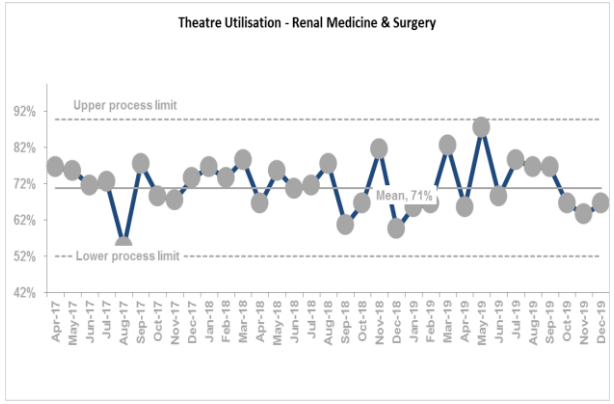


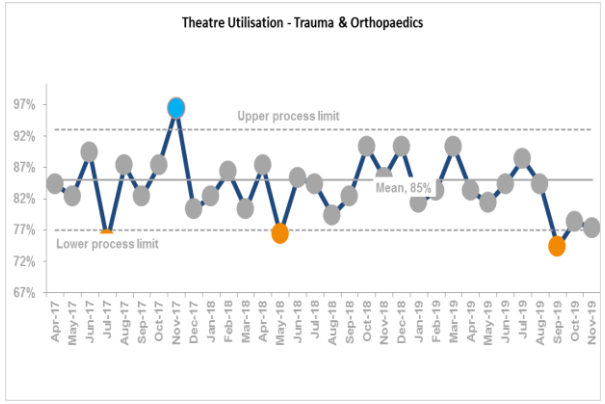


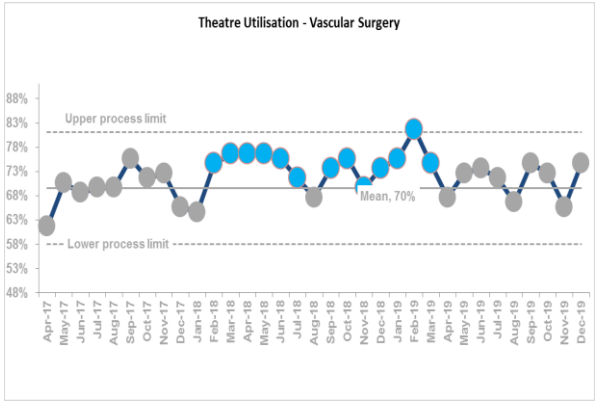




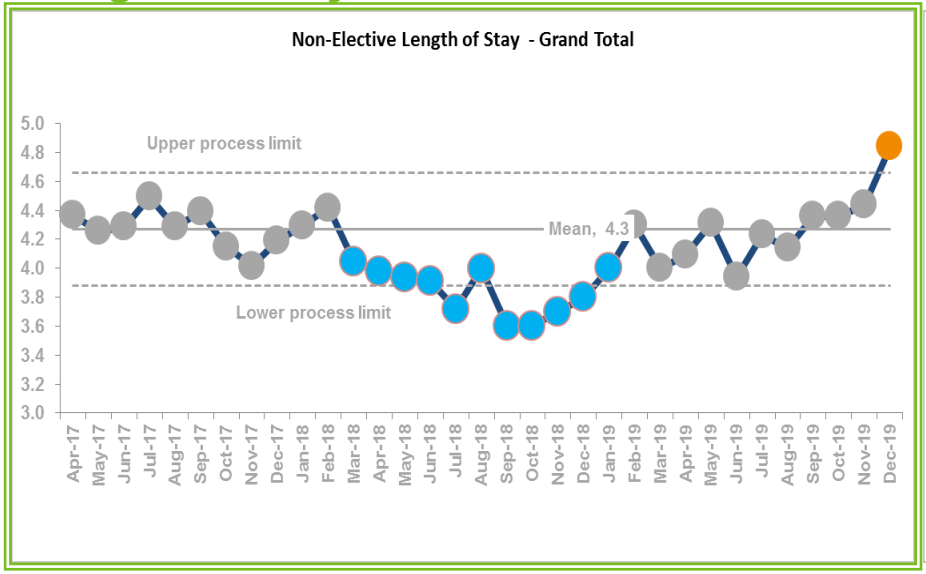


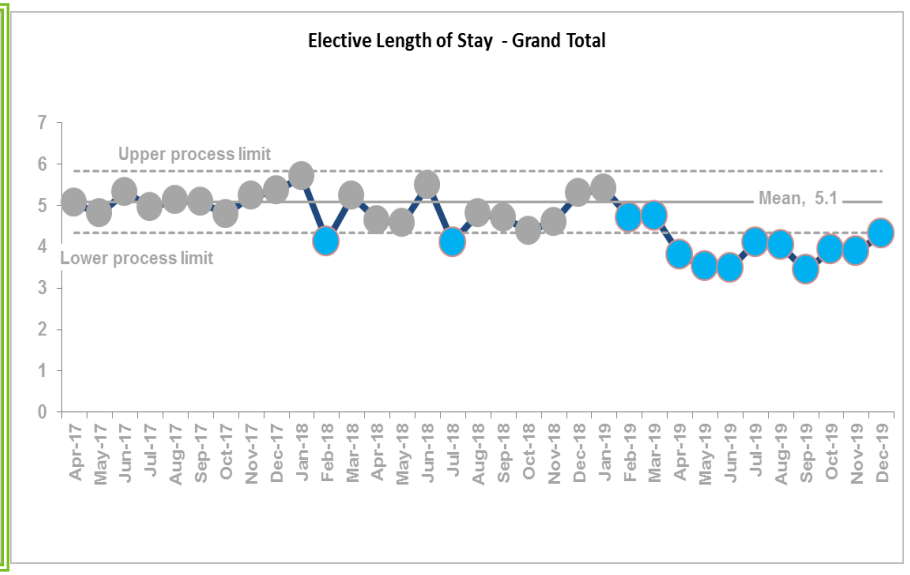






Length of Stay





What the information tells us

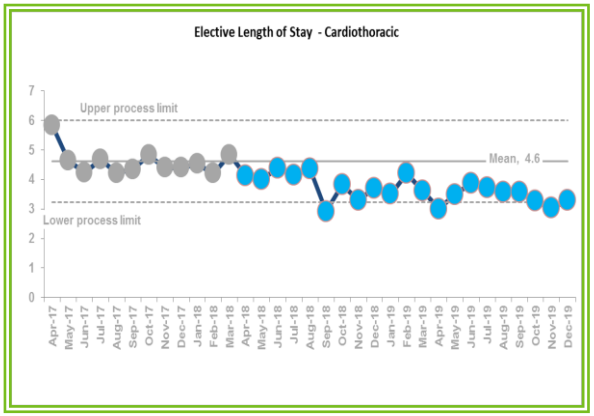
- The Trust's Non-Elective length of stay is showing special cause variation with an increase above the upper control limit in the month of December.
- The increase is primarily seen within Acute Medicine where there has been a reduction in the number of patients with a zero length of stay due to a change in pathway within the emergency department therefore affecting the number of patients admitted for short stay. Special cause variation has also been seen within Surgery and Trauma where there has been an increase in the number of patients admitted in December.
- Senior Health length had seen an increase in length of stay from September driven by the inclusion of Mary Seacole ward at Queen Mary's Hospital since the iClip roll out, however this significantly reduced in December to within normal range, the reduction improvement was assisted following a multi-disciplinary event.
- The average number of patients in a hospital bed with a long length of stay saw a positive reduction in December. As of the 24th December, the Trust delivered a reduction in the number of patients with a length of stay of over 21 days, from 140 patient at the beginning of December to101.
- The Trust's Elective overall elective length of stay continues to perform below its lower control limit showing a sustainable improvement.

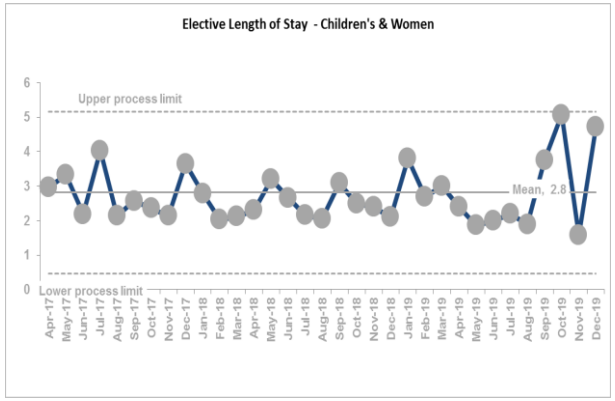
Actions and Quality Improvement Projects

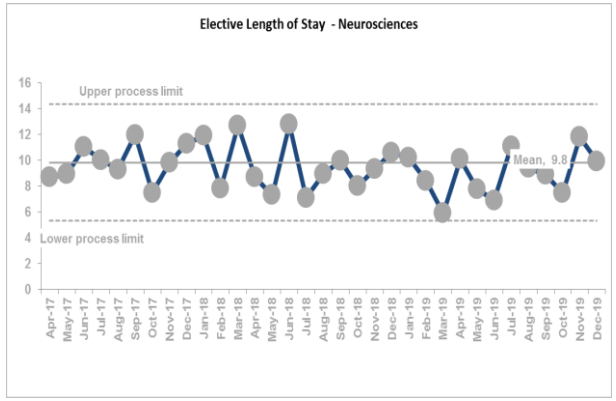
- Both Wandsworth and Merton Social Service teams were invited and have attended the established Trust long length of stay meetings (starting with the Medicine Division) in order to prioritise and manage appropriate system wide actions for each patient.
- Trust will hold a multi-disciplinary event with system partners (social services and community providers) on Wednesday 15th January to focus on long length of stay patients in the Trust.

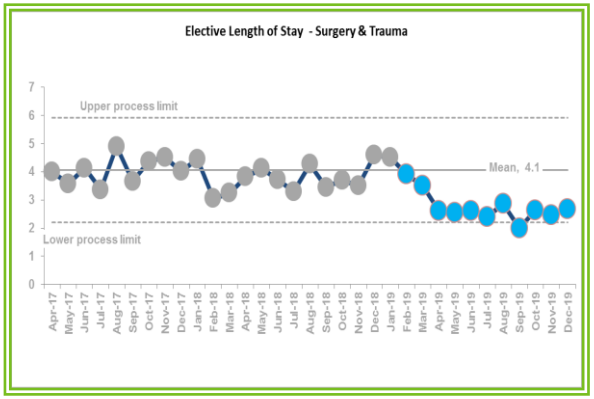
Elective Length of Stay (excluding daycase)

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





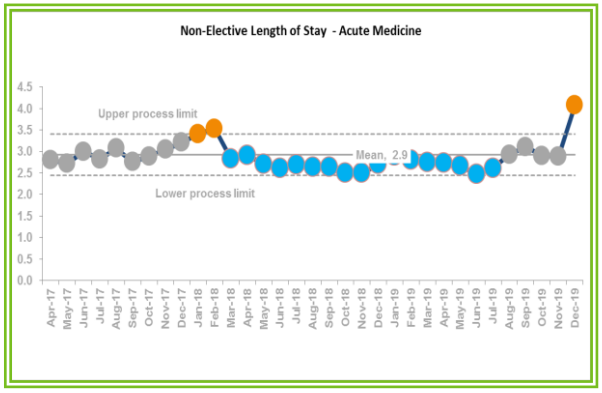


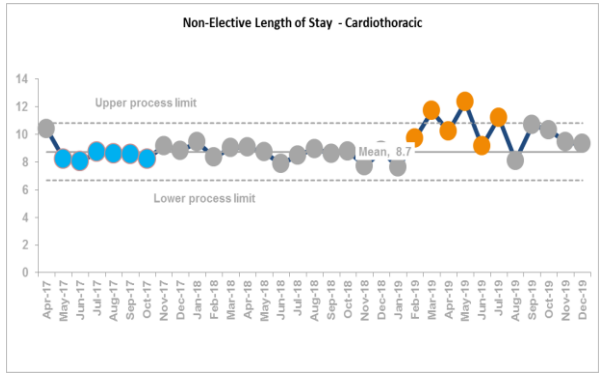


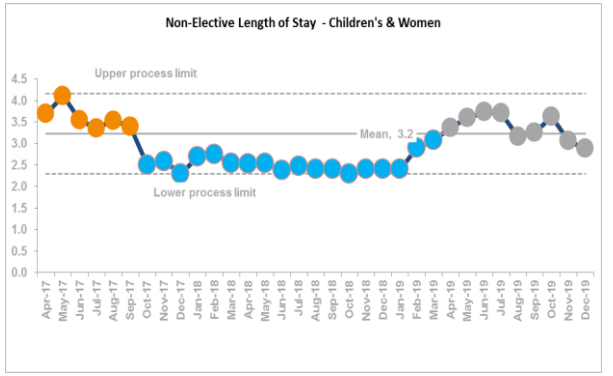
Our Finance & Productivity Perspective

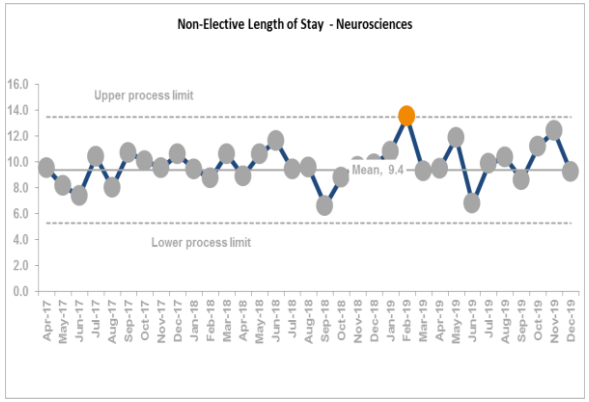
Non Elective Length of Stay

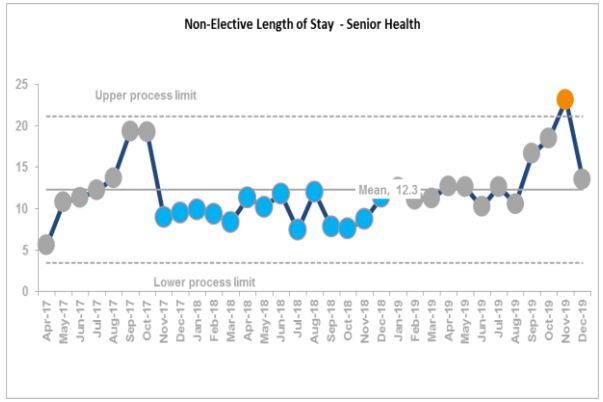
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

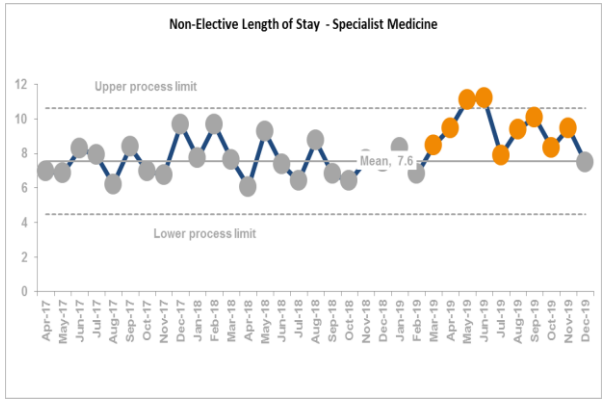


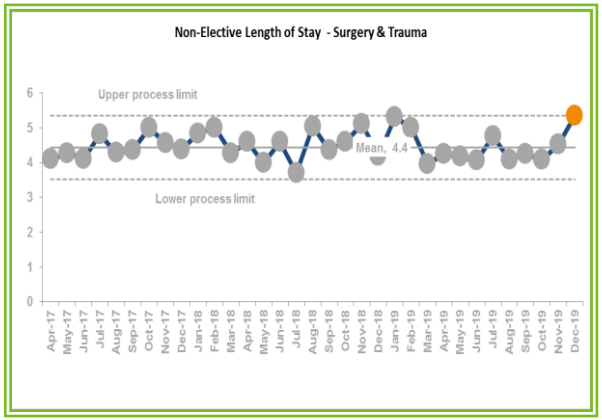


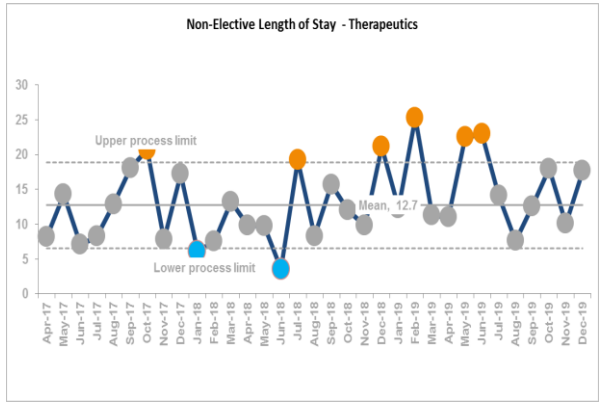












Balanced Scorecard Approach

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

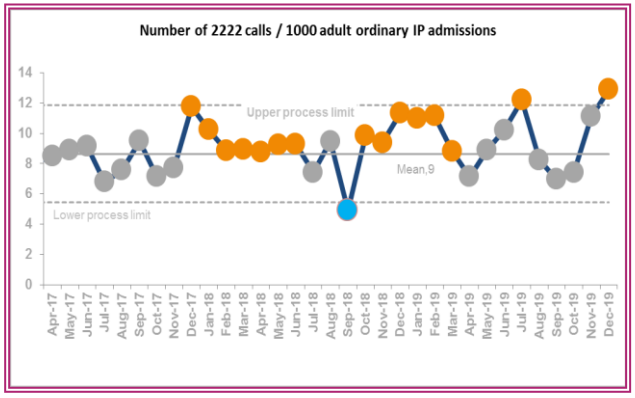
Key

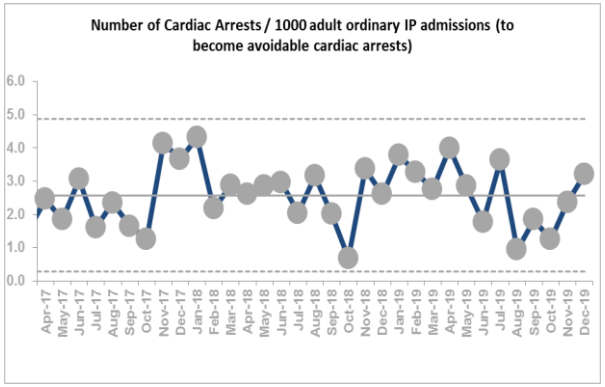
Current Month

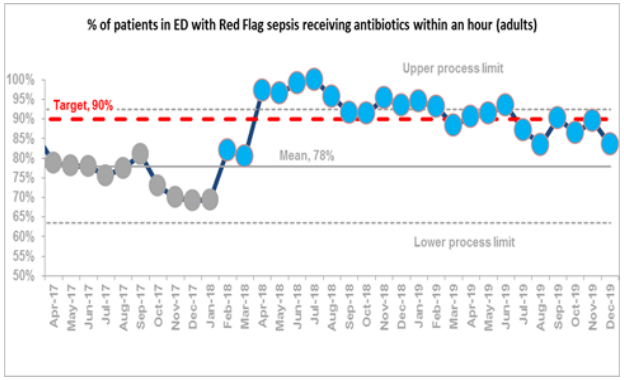
A Previous Month

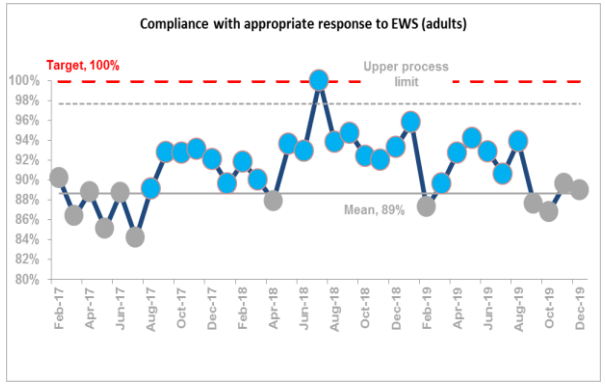
Our Patient Perspective

Quality Priorities – Treatment Escalation Plan









What the information tells us

- The number of 2222 calls has exceeded the upper process limit. The reason for this, we believe, is that the denominator has dropped significantly with the changes to the CDU2 area in ED meaning that the number of inpatient admissions has fallen. These changes were associated with the launch of the Rapid Assessment Zone process that started on 2 December 2019.
- The Trust position of treating at least 90% of adult patients in ED with Red Flag Sepsis receiving antibiotics within an hour is on target and remains within the control limits.
- Compliance with appropriate response to EWS saw an increase in performance

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

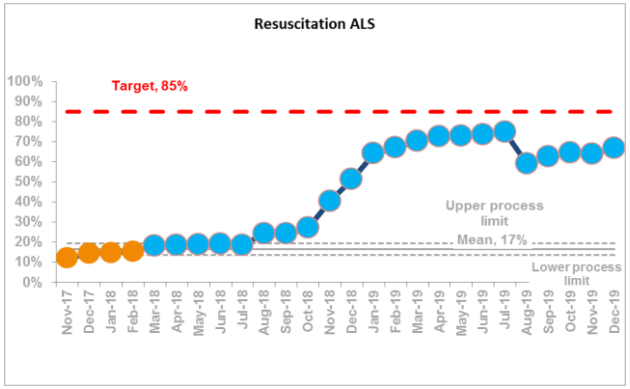
Actions and Quality Improvement Projects

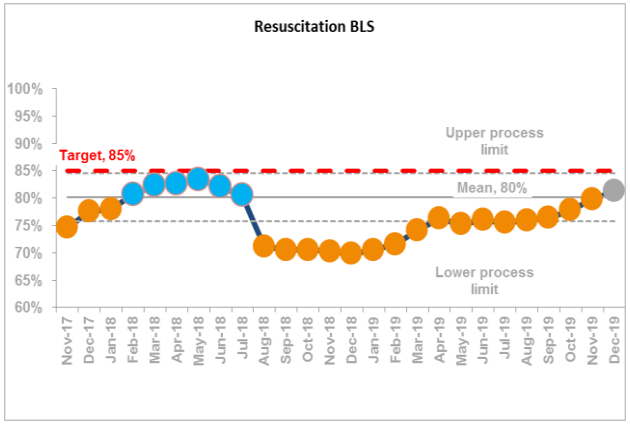
Due to changes in ED, the measure of 2222 and Cardiac arrests per 1000 ordinary IP admissions will be recalibrated to reflect the pathway change.

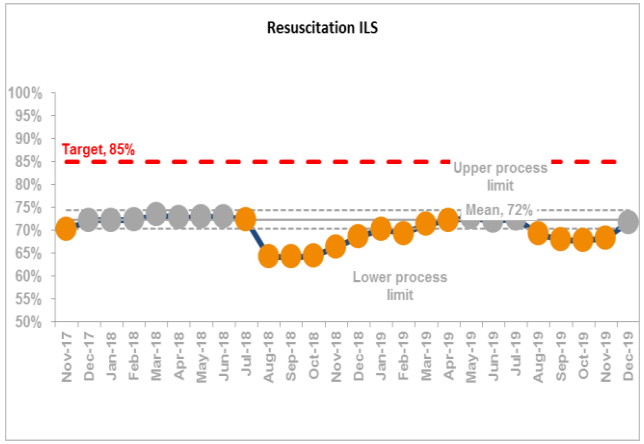
The emergency department (ED) team are continuing to work with the FLOW programme to decongest ED in order to improve sepsis performance

- Information Technology (IT) is working towards Treatment Escalation Plans being on iClip; this is currently in the test domain. Audit measures have been agreed with IT in readiness for electronic audit facility anticipated by end of Q4 due to the upgrade of the IT test environment.
- The governance around the delivery of the clinical priorities has been reviewed and the delivery group is monitoring of progress and supporting delivery. The metric for compliance with appropriate response in EWS is under review with a view to increasing the performance target as the critical care outreach team commenced December 2019.
- Staff reference cards have been developed regarding NEWS calculation, escalation and documentation on iClip and these have been issued to all new nursing staff starting within the Trust.

Quality Priorities – Deteriorating Patients







- ALS (Advanced Life Support) training performance shows improved performance but has not met the 85% performance target.
- BLS (Basic Life Support) and ILS (Intermediate Life Support) training performance is within the process control limits but continue to underperform against the 85% performance target

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

Actions and Quality Improvement Projects

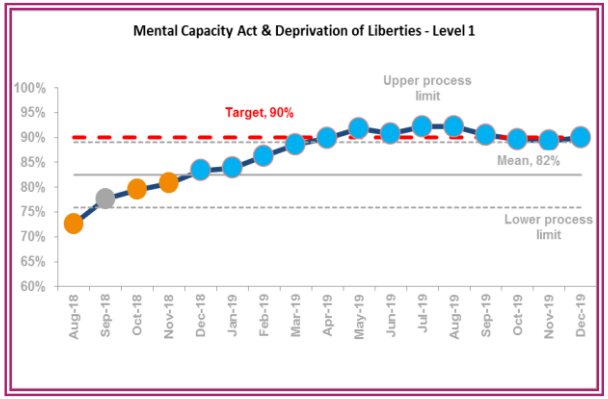
Deteriorating Patients

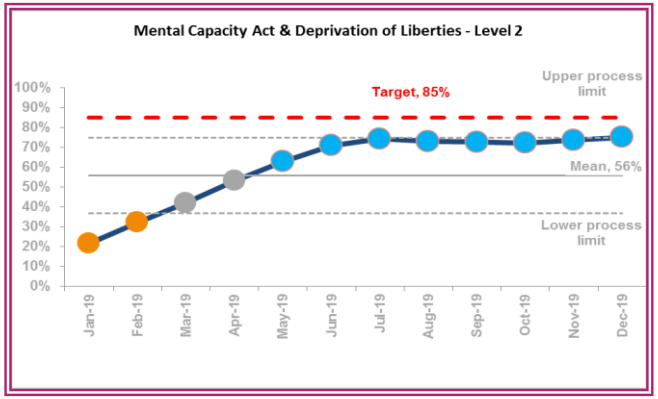
- Improved divisional engagement with Deteriorating Adults Group from nursing with responsibility for driving improvements across the Trust
- Developing management level and monthly audit data with IT for NEWS2 in iCLIP in readiness for electronic audit facility anticipated by end of Q4
- Critical Care Outreach team now launched with full implementation. in Q1 2020/21.

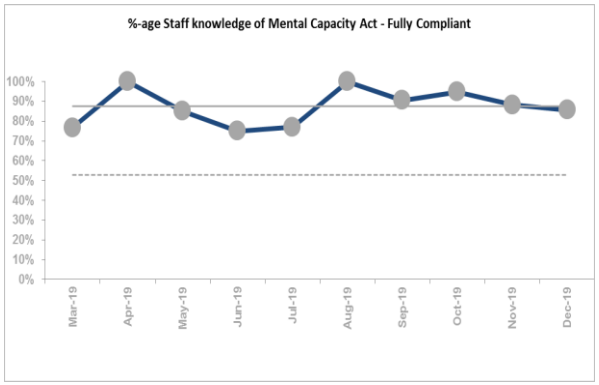
Resuscitation

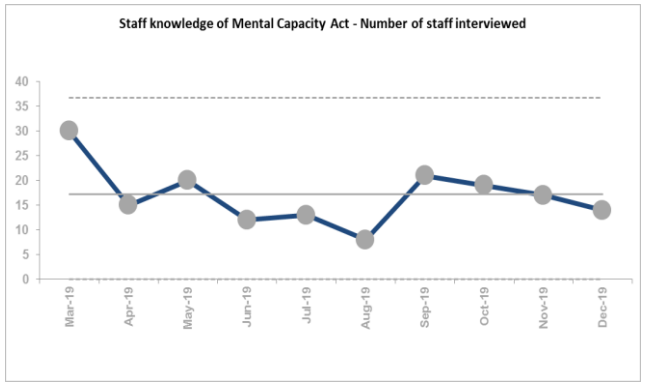
- Additional champions recruited to deliver training
- A revised 85% compliance date of June 2020 has been set for ALS and BLS after training performance missed the end of December delivery date. The compliance target date for ILS is under review
- Weekly Resus CommCell established to monitor performance against the metrics to track attendance and reduce DNA rates.
- Revised trajectories under development to be monitored at Resus CommCell and Patient Safety and Quality Group
- New approach to medical staff induction in place from February to ensure resuscitation certification is captured of completed training within the first 2 weeks of employment

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









What the information tells us

- Mental Capacity Act and Deprivation of Liberties Training – Level 1 remains within target
- Level 2 training performance has plateaued.
- New metrics taken from the ward accreditation system shows the number of staff interviewed and their level of knowledge. Of the 14 staff interviewed in December 86% could fully answer the question on MCA/DoLs.

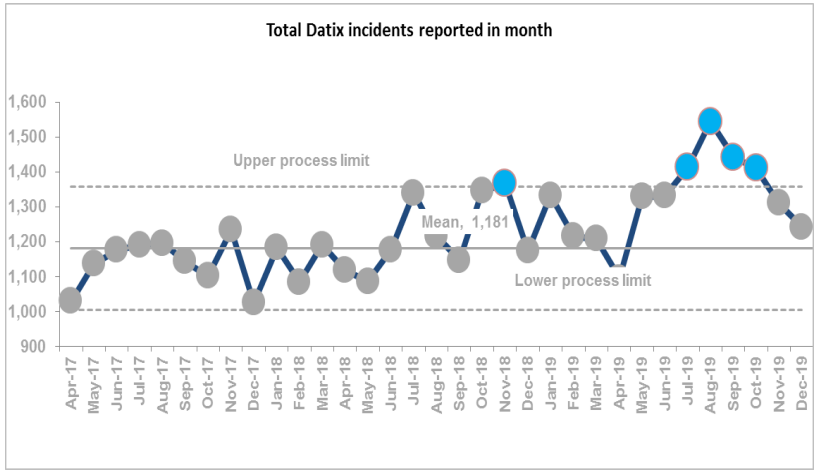
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

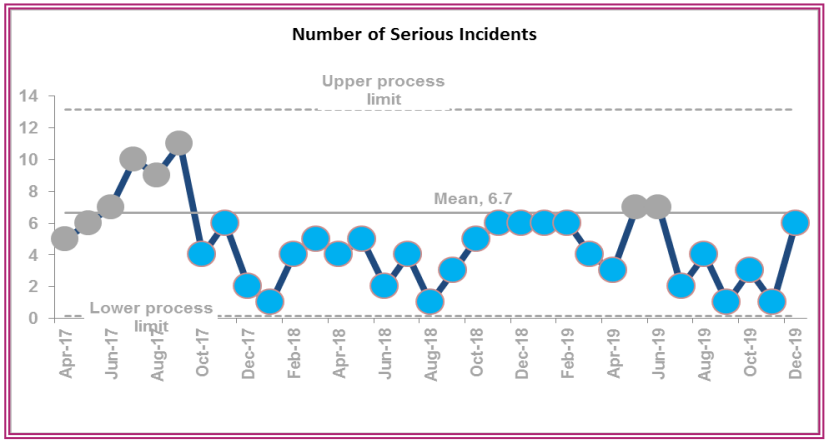
Actions and Quality Improvement Projects

- The Trust, along with SW London sector, has developed a standardised audit tool for staff knowledge. Taking a sector approach will enable the Trust to benchmark practice with similar Trusts and create a community of practice. This will be launched in Q4.
- Electronic templates in iClip for documentation of MCA and Best Interests decisions are built within iClip for implementation Q4
- Divisions receive monthly lists of staff who are non compliant for MCA training for action within teams.
- The Trust has appointed to a Lead Practitioner for MCA and DoLs.
- Staff reference cards developed and issued to all new nursing staff starting within the Trust.

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/ Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Monthly % of incidents low and no harm						97%	97%	99%	97%	98%	97%	97%	96%	data one month in arrears
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%					100.0%	92.0%	100.0%	97.0%	93.0%	97.0%	97.0%	data two months in arrears	
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	78%	67%	62%	Compliance timeframe changed from 10 working days to 20 working days									





What the information tells us

- Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- The number of reported adverse incidents remains constant, with 96% of those reported in November 2019 resulting in no / low harm.
- There was one Never Event in December 2019.

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

Actions and Quality Improvement Projects

- Incidents – The monthly percentage of incidents of low and no harm is now being reported. This will allow for benchmarking against other Trusts and tracking of the harm profile.

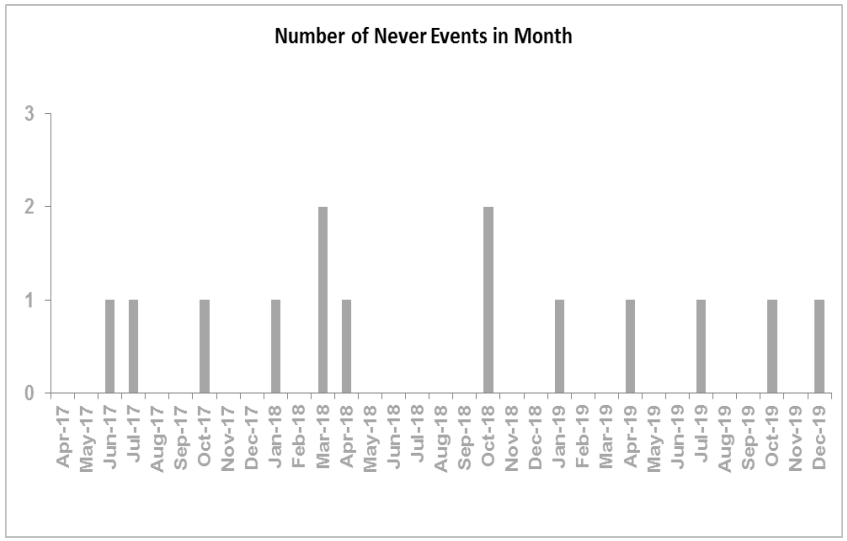
- Never Event

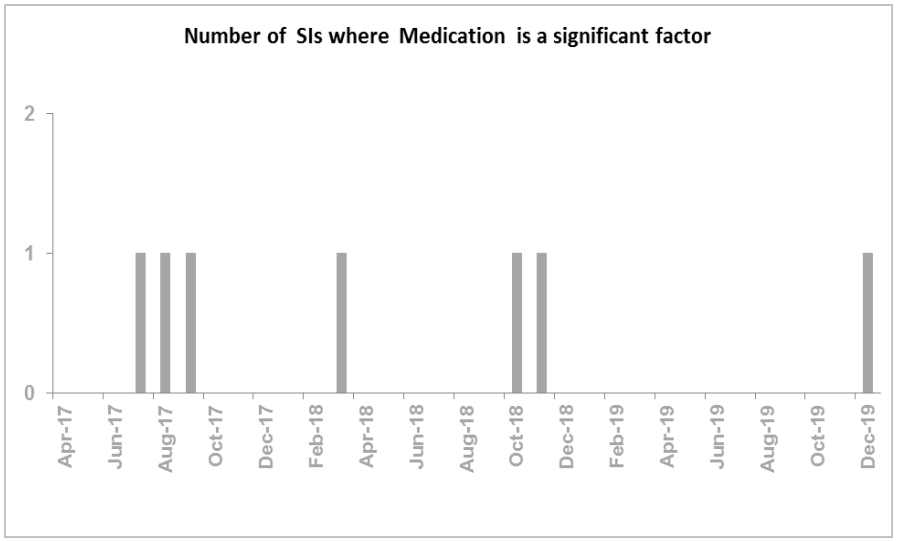
The following immediate actions were taken following the incident:

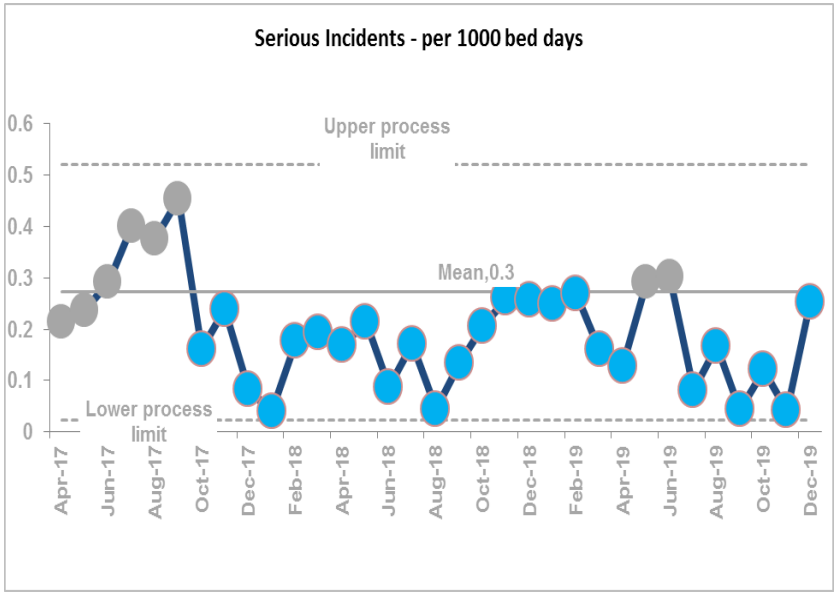
- Trust wide communication to staff and an article in the next edition of the Medicines Matter newsletter issued by Pharmacy.
- Review of medicines management training and competencies.
- Provide support to staff and emphasise the importance of learning from this event.

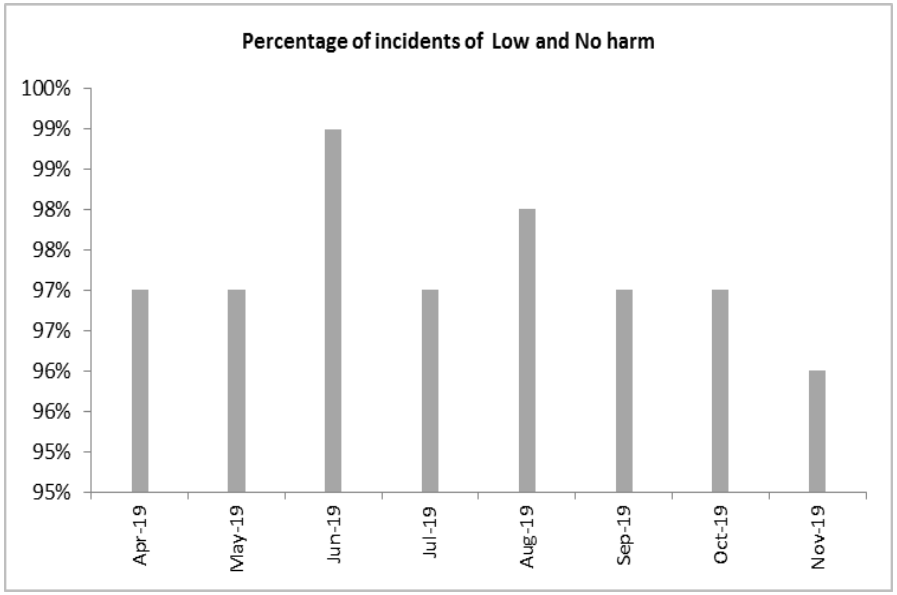
Quality Priorities – Learning from Incidents

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



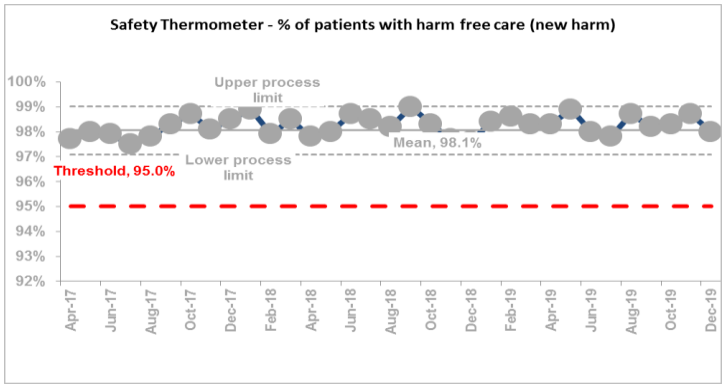


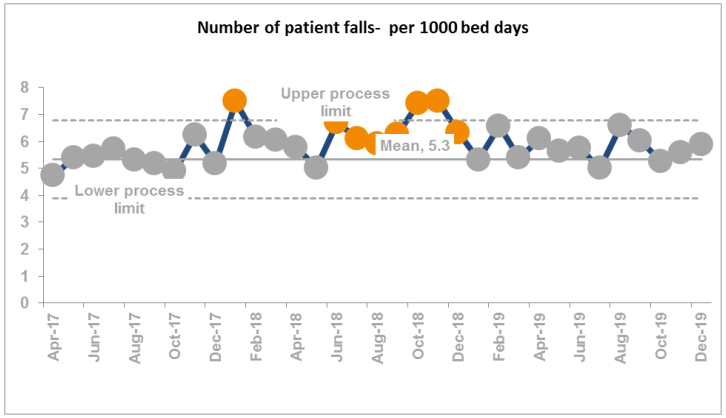


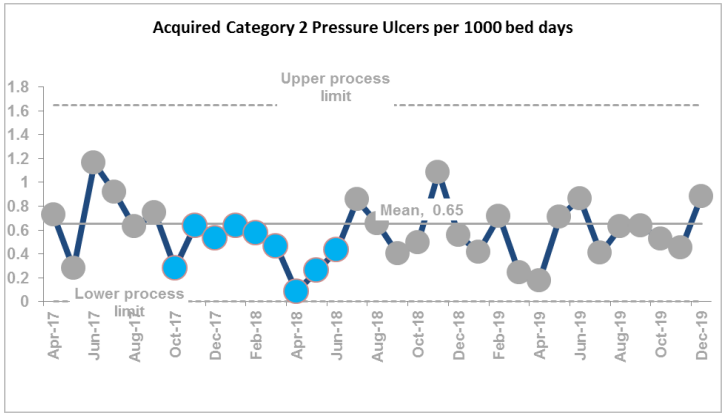


Data is 1 month in retrospect

Patient Safety







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

What the information tells us

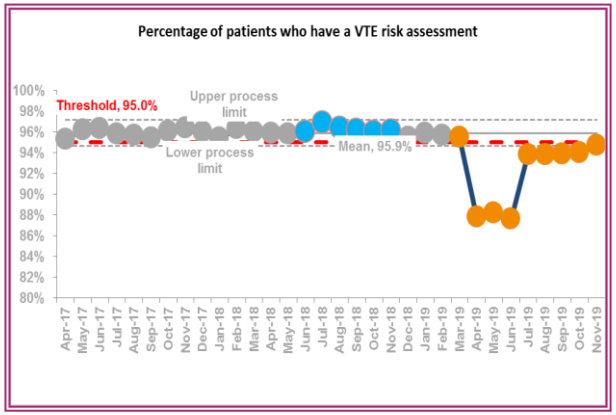
- VTE data– we are unable to report the correct position. The Hospital Thrombosis Group (HTG) has identified there are problems in correctly identifying the inpatient versus outpatient areas on iClip hence affecting the data and reporting on VTE compliance.
- All other metrics show variation due to common cause

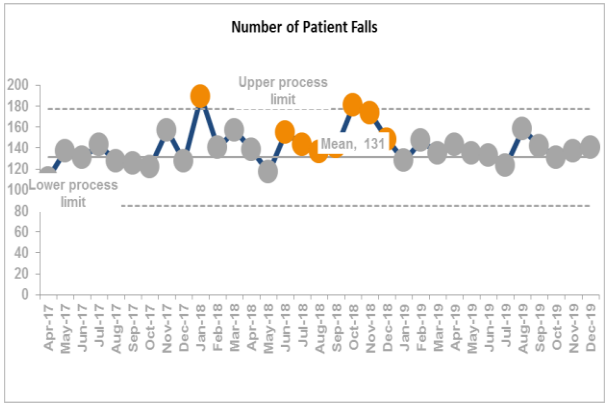
Actions and Quality Improvement Projects

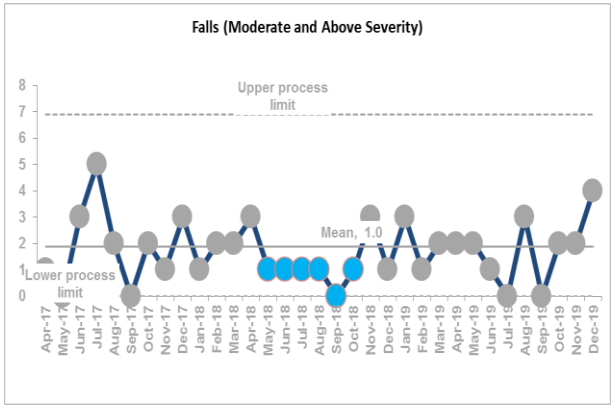
- A meeting with the HTG chair and information analyst is set up to agree on how best to resolve the issue on VTE screening data. The over 16 risk assessment alert has now been launched by the HTG
- Divisional representatives identified to join the HTG. Areas with low VTE compliance have been identified. These areas are receiving targeted support and monitoring.
- The Trust is working to deliver the Falls CQUIN, specifically focussing on lying and standing for patients over 65 in line with NICE guidance. Target work has been completed in Senior Health with respect of this.
- The category 3 and above pressure ulcers have undergone RCA to identify any key learning and are discussed at a cross divisional meeting.
- Target work underway for staff in critical care areas to raise awareness of medical device associated pressure area damage

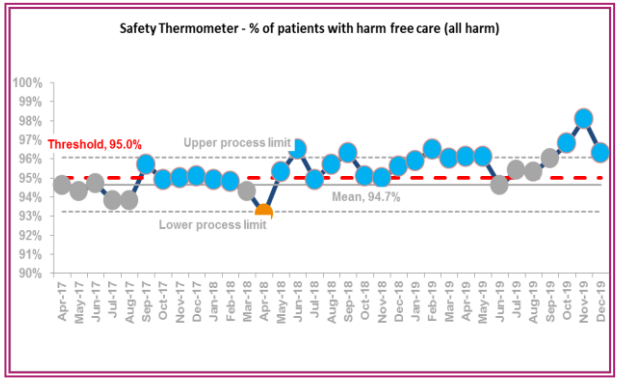
Patient Safety

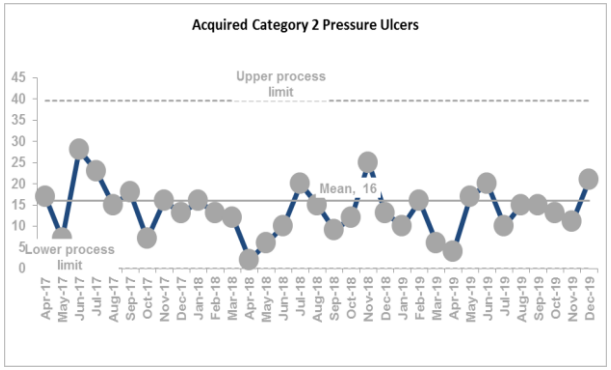
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

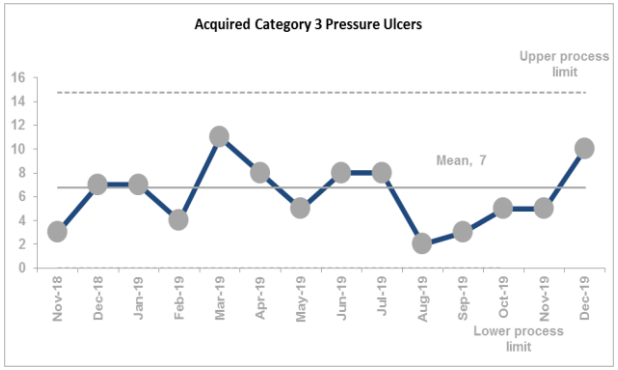


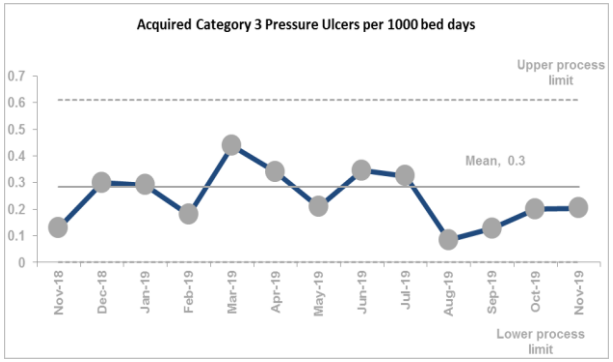












Our Patient Perspective

Infection Control

Indicator Description	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Cdiff Hospital acquired infections	48	3	2	1	3	4	4	3	4	4	6	3	2	2	37
Cdiff Community Associated infections						0	0	2	0	1	0	0	2	0	
MSSA	25	5	3	2	2	4	6	1	0	3	2	2	3	5	26
E-Coli	60	3	1	4	6	4	7	5	7	7	8	6	4	8	56

What the information tells us

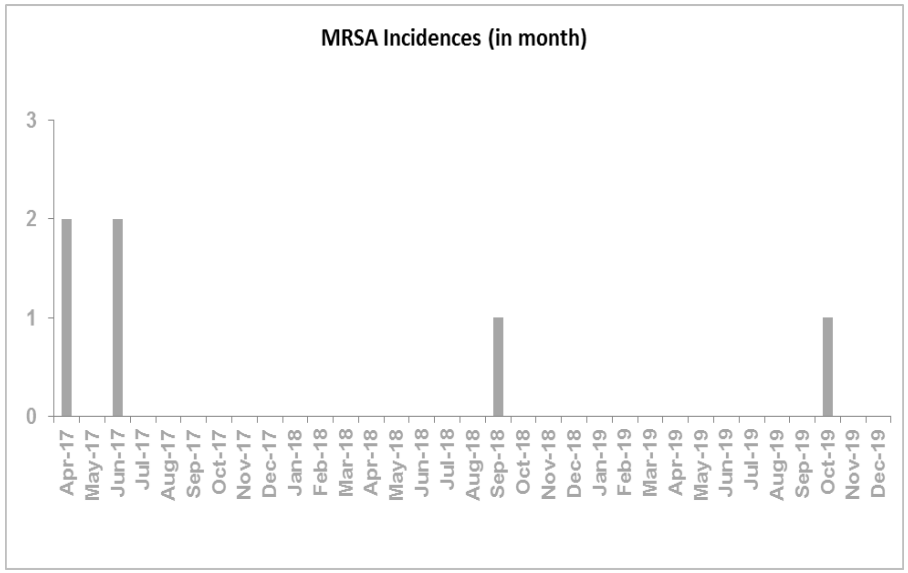
- The Trust has had no MRSA incidents this month.
- This month there were 2 Cdiff incidents both were Hospital Acquired. The Cdiff YTD position is 37 with 32 Hospital Acquired infections and 5 Community Associated infections. This is close to our yearly target of 48 and will be monitored closely.
- The number of Ecoli cases reported remains within the control limits. There was 8 cases this month and E-Coli rates show common cause variation, MSSA infection rates also show common cause variation.

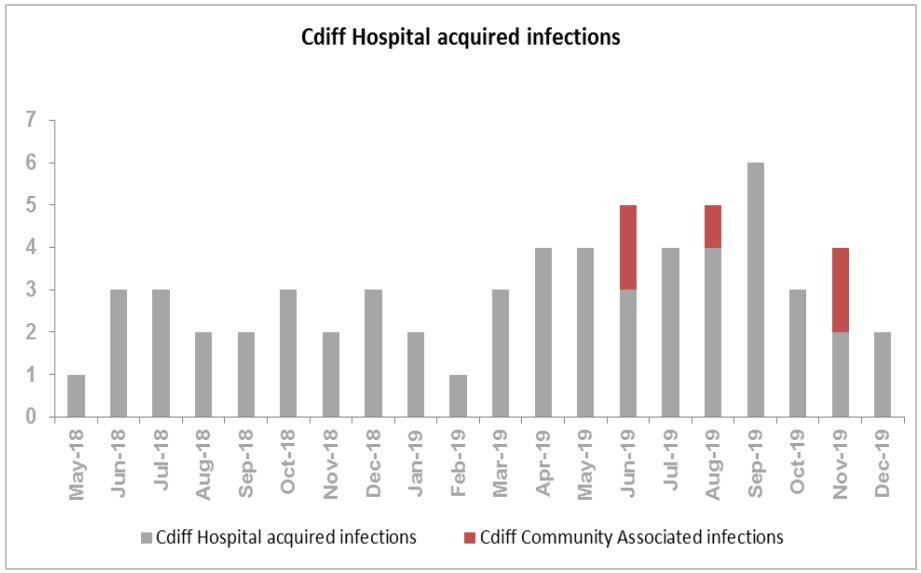
Actions and Quality Improvement Projects

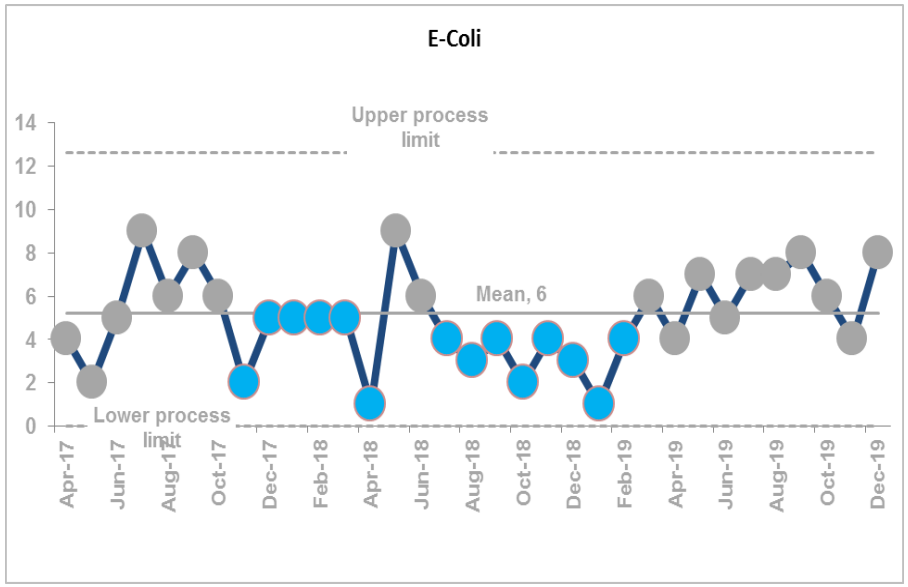
- All Cdiff cases have undergone a Root Cause Analysis (RCA) and are being reviewed for lapses in care. The reviews will be validated by the Clinical Commissioning Group (CCG) for reporting purposes which will inform the Trust position against the threshold
- All MSSA cases are now to undertake a RCA to establish any causes and opportunities for learning and change in practice, and is reported through the infection control committee
- A project group has been established across SWL STP to reduce the number of E-Coli infections. The first area of priority is catheter associated infections, however St Georges numbers are lower than peers in SWL.
- An RCA and panel review is being completed to identify any learning or lapses in care in the MRSA case.

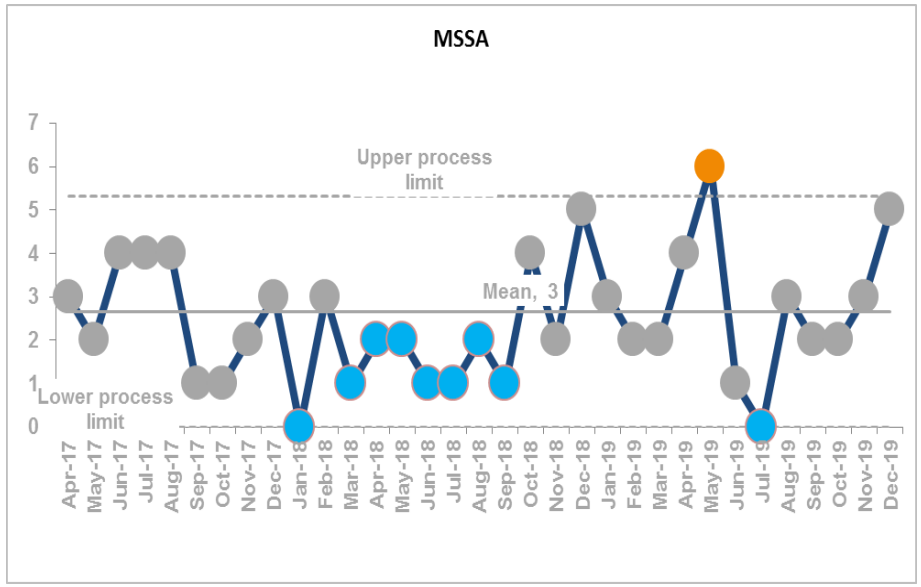
Infection Control

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







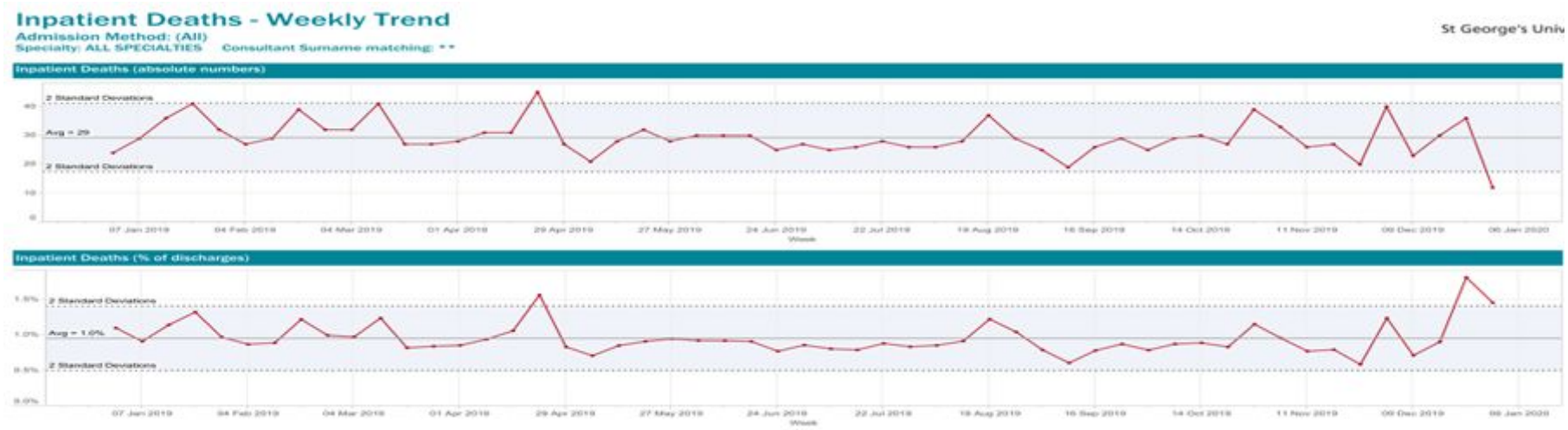


Mortality and Readmissions

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

Indicator Description	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Jun-19 Dr Foster did not update date for May	Jul-19	Aug-19	Oct 2018 to Sep 2019
Hospital Standardised Mortality Ratio (HSMR)	73.0	64.2	76.9	74.5	77.6	78.1	79.4	79.4	91.9	105.5	87.9	92.1	89.3
Hospital Standardised Mortality Ratio Weekend Emergency	62.7	82.4	113.3	79.1	74.6	85.2	82.9	82.9	91.3	113	77.2	93.8	94.4
Hospital Standardised Mortality Ratio Weekday Emergency	68.4	60.1	64.9	78.2	79.4	74.1	76.3	76.3	91.5	100.4	90.8	96.2	87.5

Indicator Description	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
Summary Hospital Mortality Indicator (SHMI)	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.81	0.81	0.81	0.83	0.83
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	8.3%	7.6%	8.2%	7.2%	8.2%	7.9%	8.0%	7.0%	8.3%	9.3%	9.7%	8.4%



Please note SHMI data is based on a rolling 12 month period (published November 2019). HSMR data reflective of period Oct 2018 – Sep 2019 based on a monthly published position (published Oct 2019). Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways

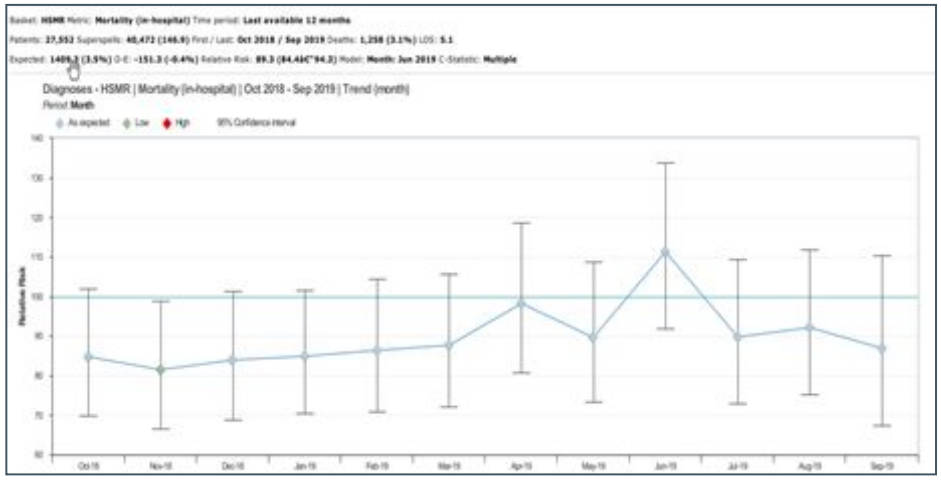
What the information tells us

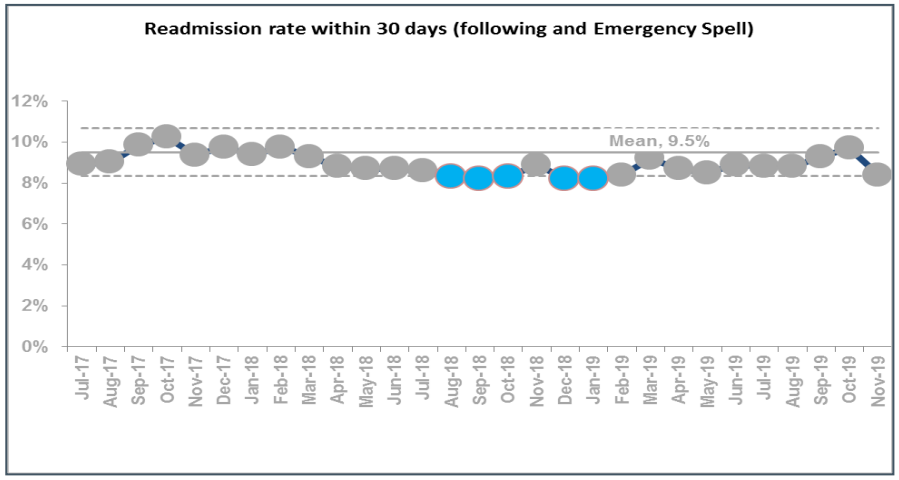
Both the Trust-level mortality indicators (SHMI and HSMR) remain within expected. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over performance and also under performance. The trust monitors and investigates mortality signals in discrete diagnostic and procedure codes from Dr Foster on a monthly basis through the Mortality Monitoring Committee. The latest information reviewed by the committee did not identify areas of concern for further investigation. Additional mortality indicators at specialty level are also considered and we are currently looking in detail at outcome data from the critical care units.

Mortality and Readmissions (Hospital Standardized Mortality Rate)

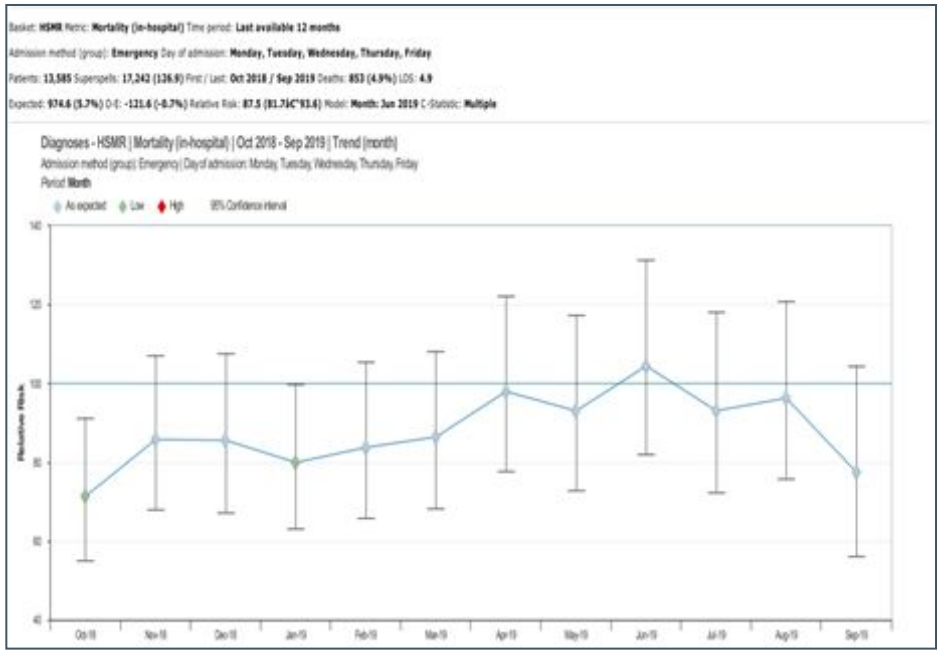
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

Monthly HSMR

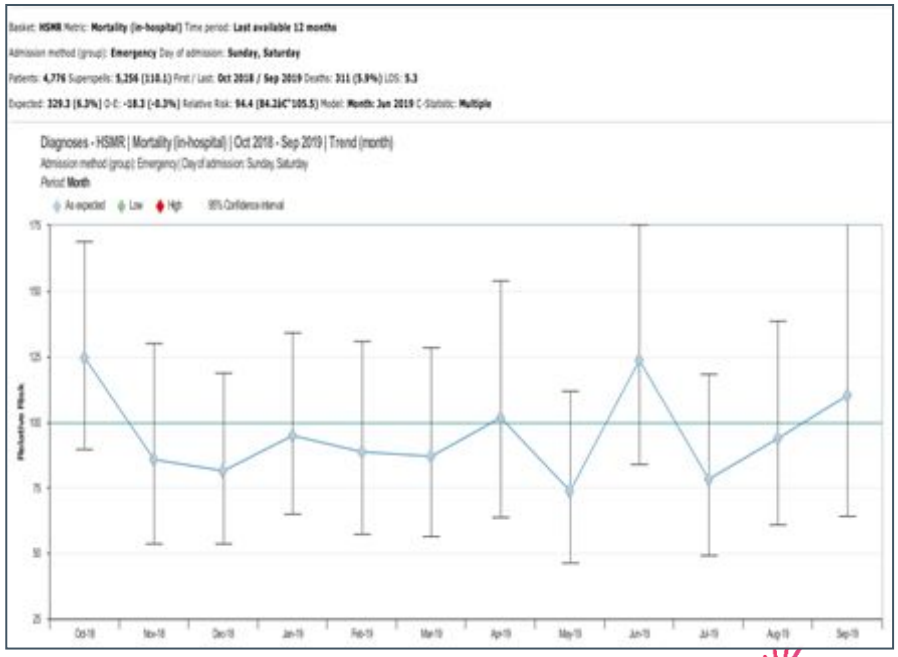




HSMR Weekday

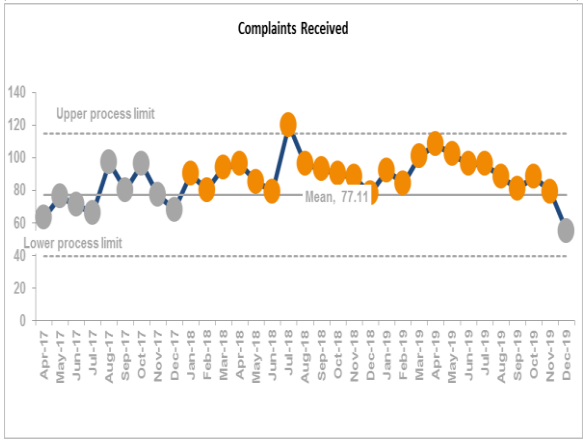


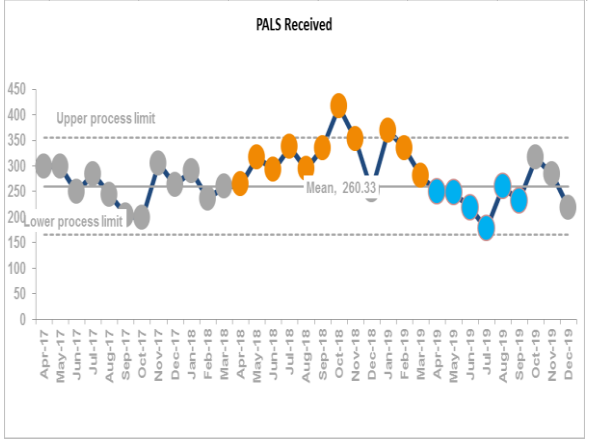
HSMR Weekend

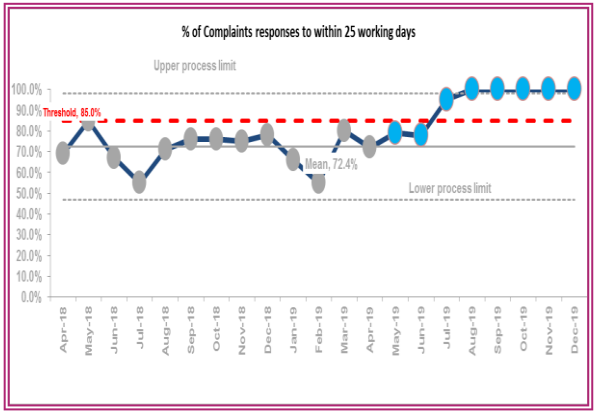


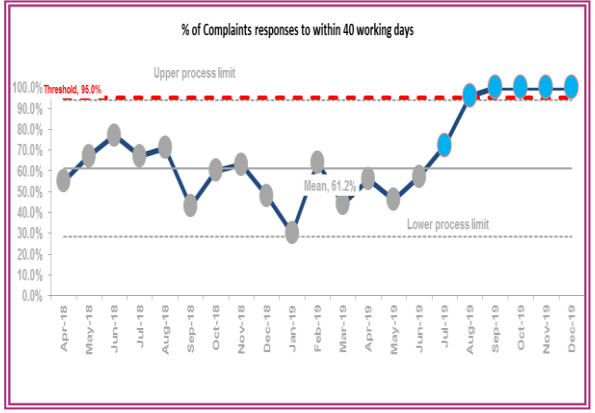
Complaints

Indicator Description	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Complaints Received		78	92	84	101	108	102	96	96	88	81	88	79	55
% of Complaints responses to within 25 working days	85%	78%	66%	55%	80%	72%	79%	78%	95%	100%	100%	100%	100%	100%
% of Complaints responses to within 40 working days	95%	48%	30%	64%	44%	56%	46%	57%	72%	96%	100%	100%	100%	
% of Complaints responses to within 60 working days	95%	None Due	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0









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

What the information tells us

- The number of complaints received in December totalled 55
- Response compliance for all response categories is 100% (25 day) or on track for 100% (40 and 60 day)

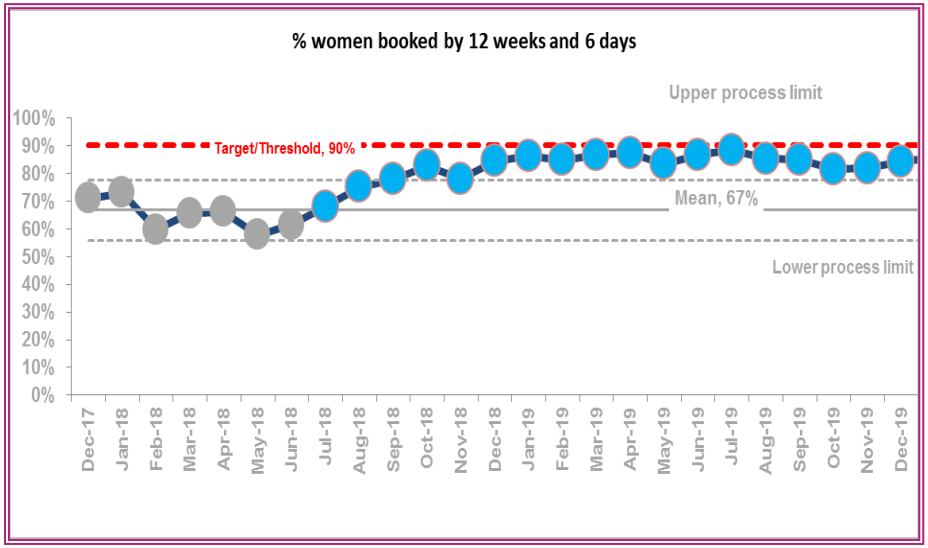
Actions and Quality Improvement Projects

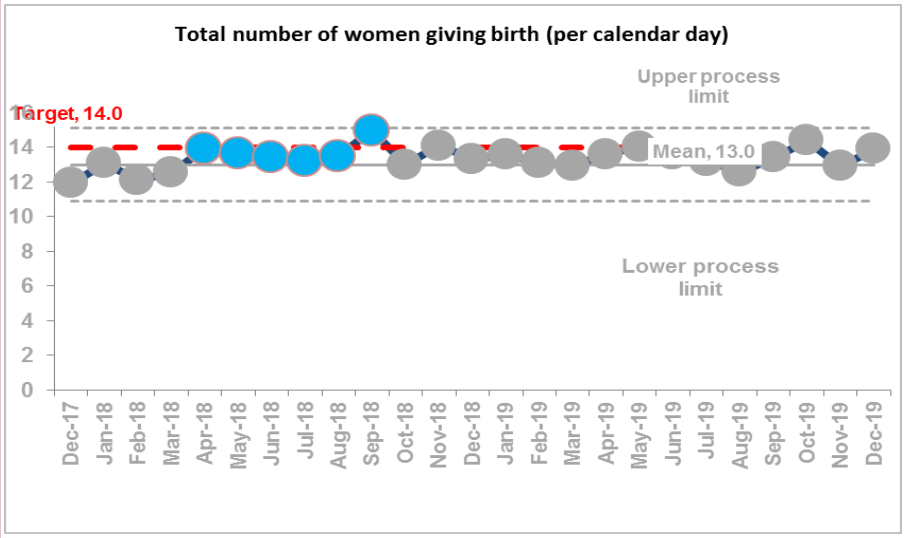
The daily complaints CommCell continues.

The change in process has had a positive impact on complaints performance with measures showing sustained improvement for the last five months

The focus for improvement has moved to learning from complaints

Maternity





What the information tells us

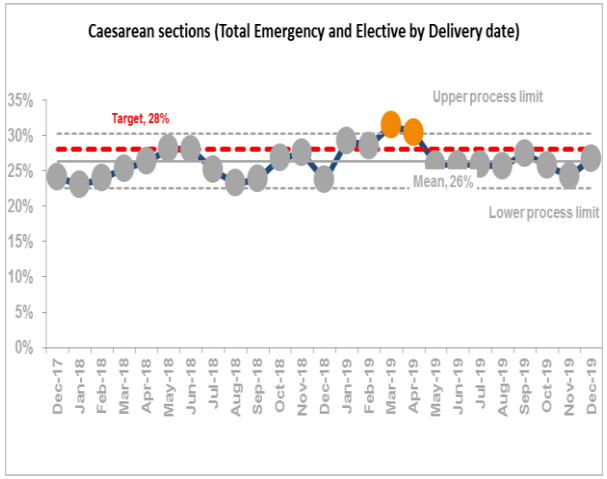
- The overall birth rate was within normal variation in December with the number of births per calendar day at a mean of 14.
- The percentage of women booked by 12 week and 6 days increased to 85.7% in December and remains above the upper control limits, however the performance against the 9 weeks and 6 days target fell slightly.
- The number of 3rd or 4th degree tears exceeded the threshold for the first time since June 2018.
- The percentage of shifts where Carmen Suite was closed decreased compared to the previous two months, but remains high. However, 75 babies were born in the Birth Centre during December which is the highest number since August 2018.

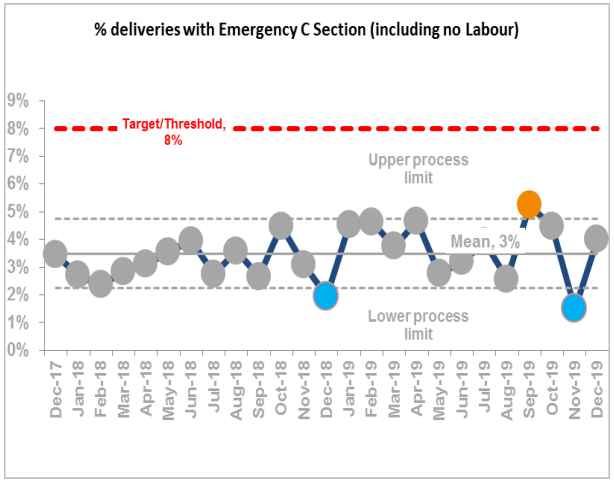
Actions and Quality Improvement Projects

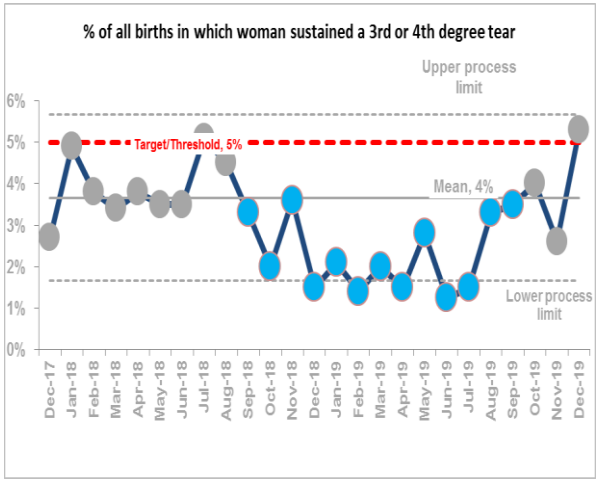
- The percentage of women having a 3rd or 4th degree tear rose in month, and the department is reviewing patient level data to see if there is a pattern
- The percentage of women being booked by 9 weeks and 6 days gestation is being reviewed by team, with support given to teams to try and increase this percentage.

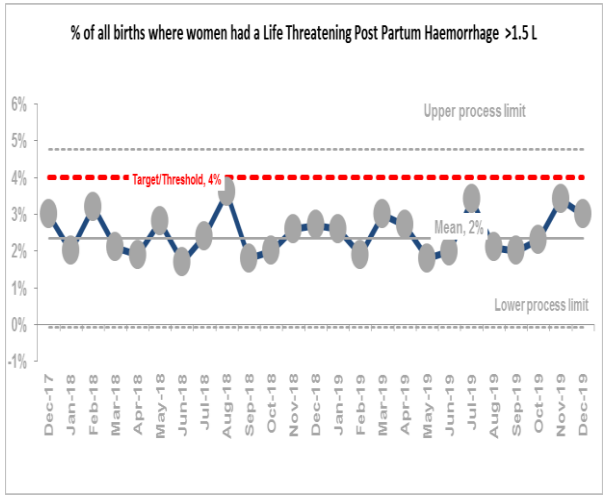
Maternity

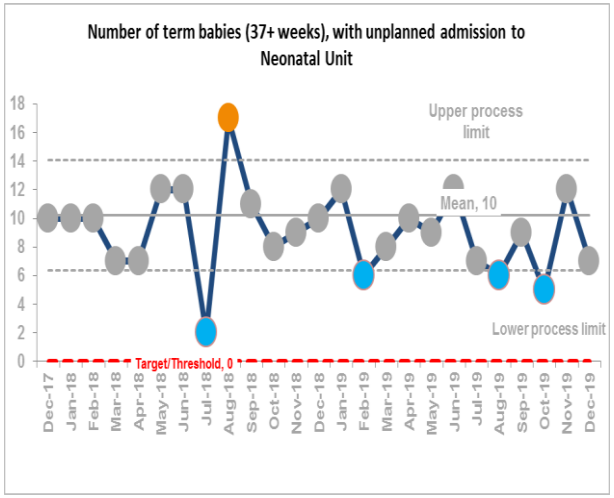
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance





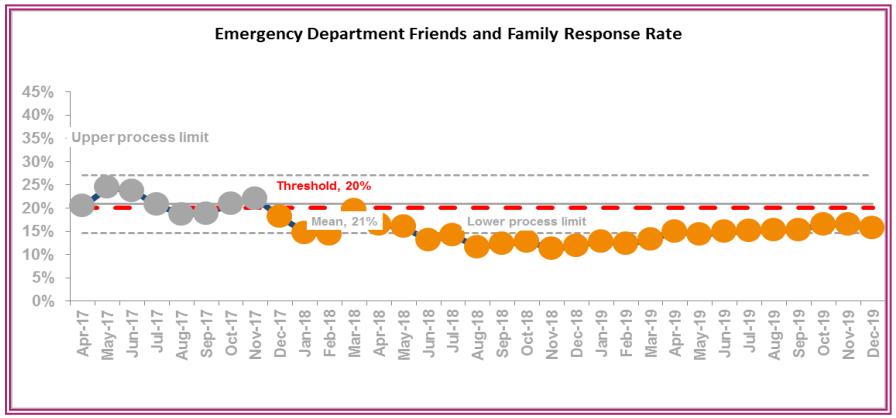


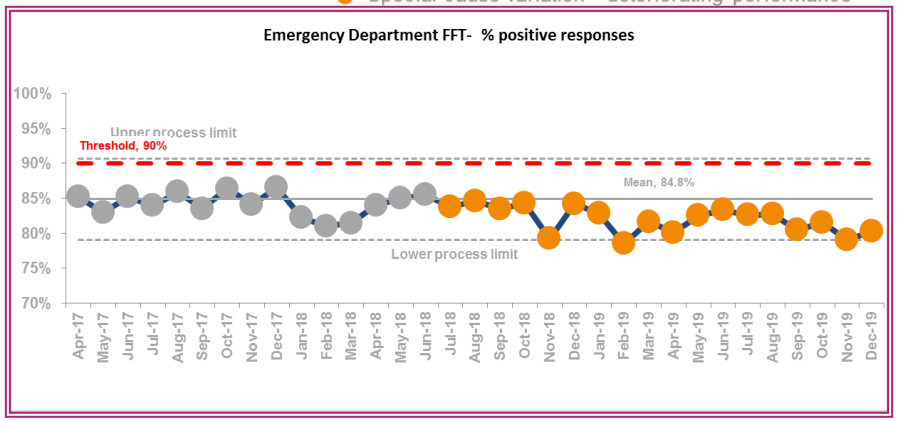


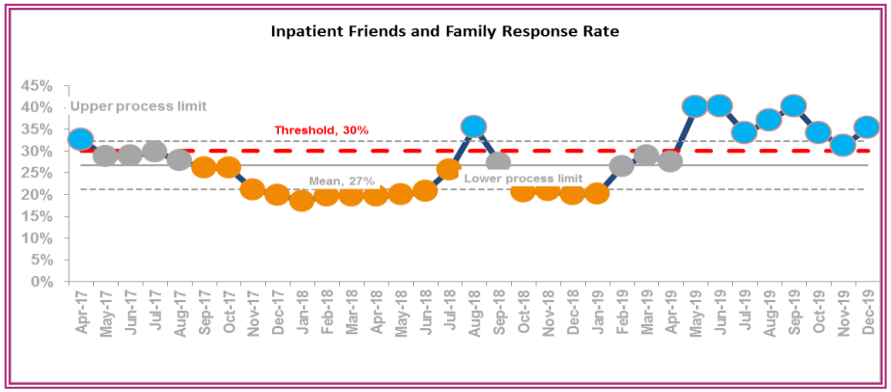


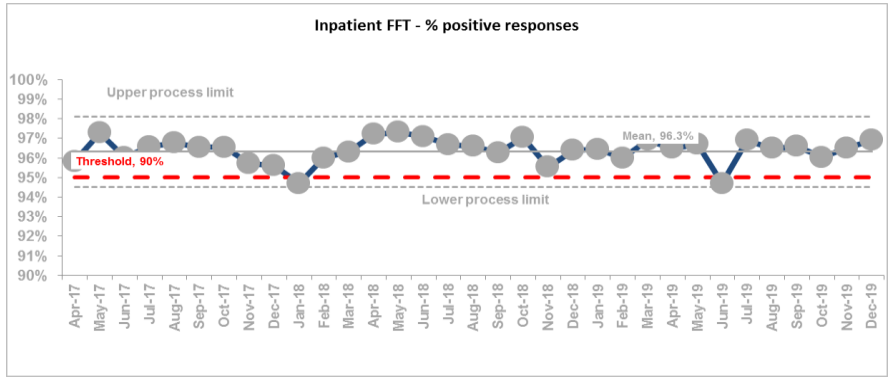
Friends and Family Test

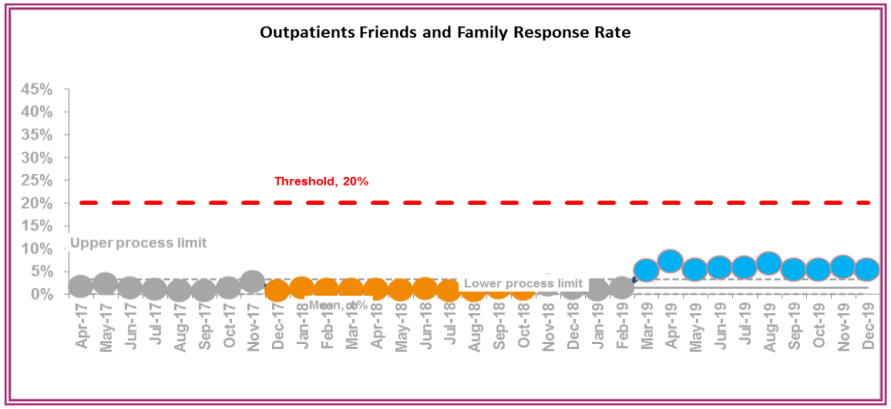
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

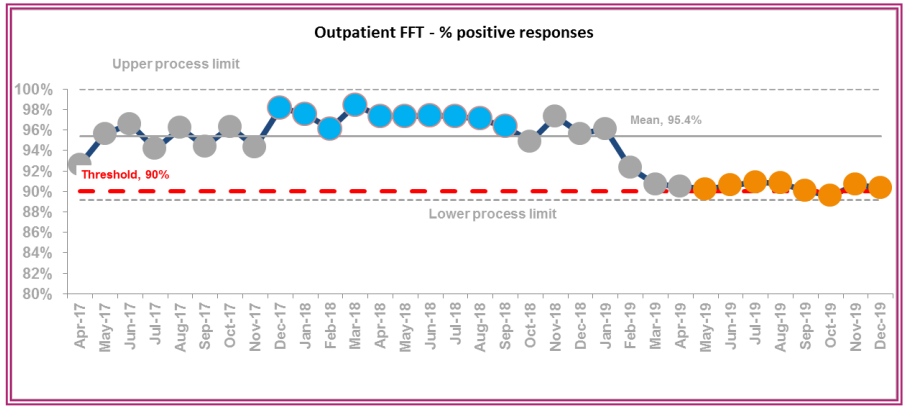






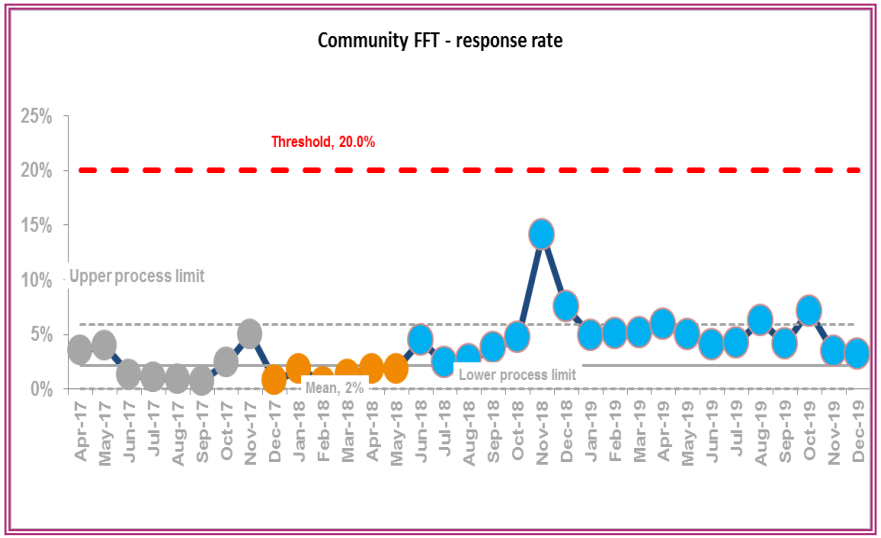


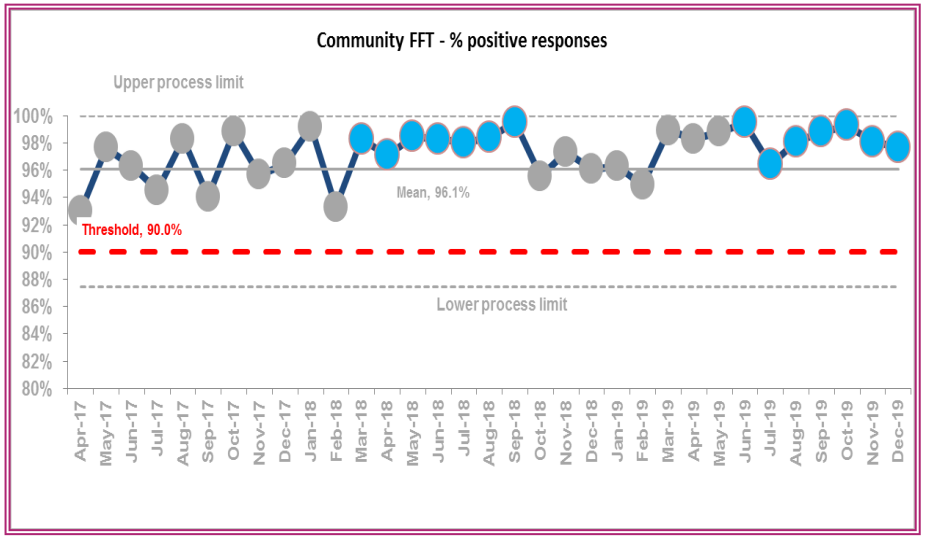


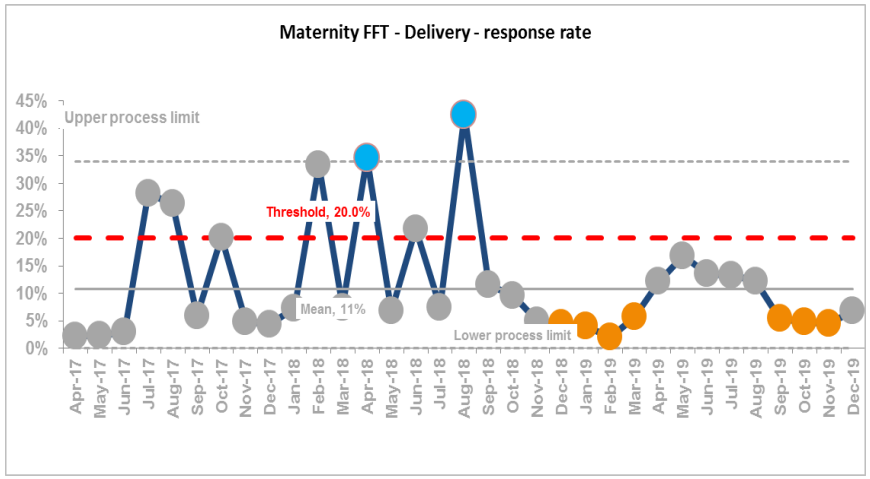


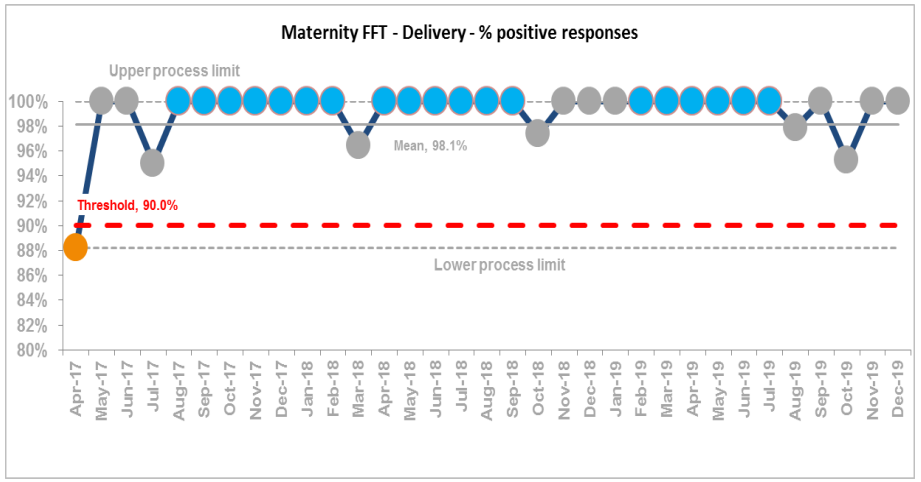
Friends and Family Test

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









Friends & Family Survey

Indicator Description	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Emergency Department FFT - % positive responses	90%	84.2%	82.8%	78.5%	81.6%	80.1%	82.5%	83.3%	82.6%	82.7%	80.5%	81.5%	79.0%	80.3%
Inpatient FFT - % positive responses	95%	96.4%	96.5%	96.0%	96.9%	96.5%	96.7%	94.7%	96.9%	96.5%	96.6%	96.0%	96.5%	96.9%
Maternity FFT - Antenatal - % positive responses	90%					100.0%	90.0%	85.7%	100.0%		100.0%			100.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	95.2%	100.0%	100.0%
Maternity FFT - Postnatal Ward - % positive responses	90%	90.9%	95.6%	95.7%	91.7%	96.4%	94.6%	98.0%	100.0%	98.3%	95.2%	100.0%	97.3%	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%		100.0%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.0%
Community FFT - % positive responses	90%	96.1%	96.3%	94.9%	98.9%	98.3%	98.8%	99.5%	96.4%	98.1%	98.8%	99.3%	98.1%	97.7%
Outpatient FFT - % positive responses	90%	95.6%	96.1%	92.3%	90.7%	90.5%	90.2%	90.6%	90.9%	90.8%	90.1%	89.6%	90.7%	90.3%

What the information tells us

- The Emergency Department Friends and Family Test (FFT) – In the month of December 80.5% of patients attending the emergency department would recommend the service to family and friends. This is above the lower process limit but continues to show deterioration in performance. Analysis of responses received in December identified staff attitude as the top theme for negative responses (and for positive responses) followed by waiting times, environment, clinical treatment and communication. The response was 15.7% in December, against our target of 20%.
- Maternity and Community FFT are above local thresholds in December and work continues to ensure patient responses improves. The London average response rate for community is 4.4% and England is 3.9.
- Our outpatient recommend rate in December was 90.3% against a target of 90%. The response rate remains below target but has been consistently above 5% since May 2019.
- Maternity and Community FFT are above local thresholds in December and work continues to ensure patient responses improves. The London average response rate for community is 4.4% and England is 3.9%.

Actions and Quality Improvement Projects

- Patients can now access the FFT on our website. In addition to the monthly reports of performance to ward areas, a weekly report to matrons/ ward managers is now in place. The weekly report provides the number of discharges against the number of FFT responses completed and clearly identifies areas that need to improve. Text messaging / telephone of the FFT survey after appointment has started in a number of outpatient clinics and this will continue and be adapted as of April 2020 with the new FFT question.
- In Quarter 4 an Outcomes with Learning (OWL) meeting will be implemented to share actions taken and learning from themes from patient feedback surveys and patient experience information trust-wide including learning from complaints.
- Review of London trusts that consistently achieve high response rates for ED and Maternity will be shared with services informing service review.
- The FFT question will be changing substantially in April 2020. A review of National Guidance for changes in FFT reporting has been completed and changes will be implemented to allow more opportunities to capture patient experience. In readiness for this change the Patient Experience Team will agree a set of core questions alongside the new FFT question for all services.

Balanced Scorecard Approach

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

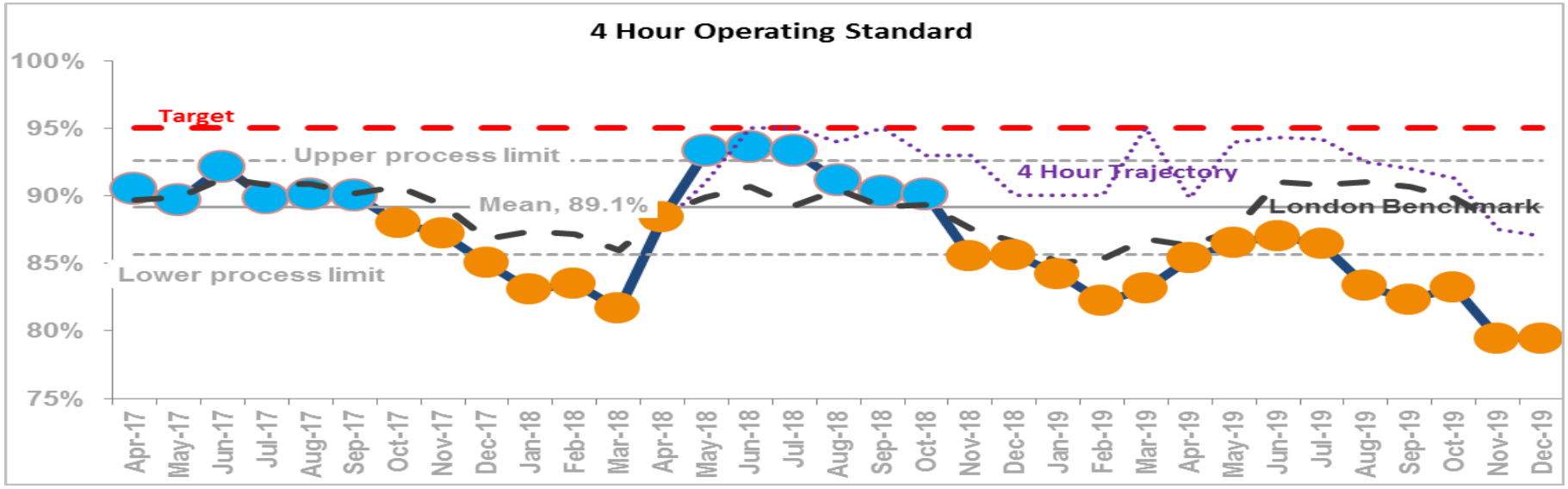
Our Process Perspective

Key

Current Month

A Previous Month

Emergency Flow



What the information tells us:

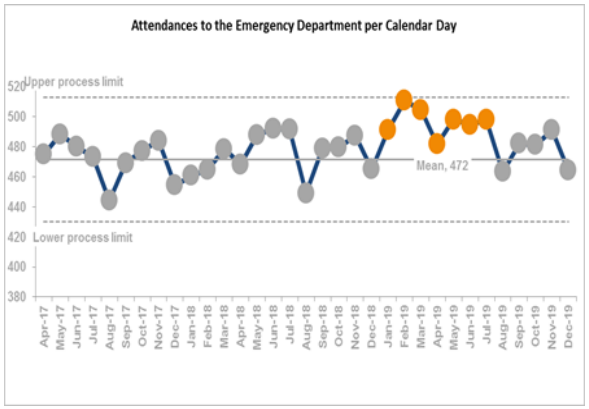
- The number of patients either discharged, admitted or transferred within four hours of arrival in the month of December was 79.4%. Both admitted and non-admitted performance remains below the lower control limit and lower compared to the same period last year.
- The number of overall attendances have remained within the upper and lower control limits and are comparable to the attendance figures seen in Dec 2018, however the emergency department has seen a reduction in ambulance arrivals with the numbers attending below the mean for the past six months.
- Although General and Acute bed occupancy has remained higher, a reduction was seen in the month of December with the average number of long length of stay patients reducing. A reduction in patients waiting over fourteen days was seen following a Multi Agency Discharge Event (MADE) held on the 15 December 2019. The dip in the number of long length of stay patients in December this year is greater than the same period last year.
- The number of patients waiting in the emergency department for over twelve hours following a decision to admit in quarter three has increased, reporting seven patients breaching in the month of December.
- London Ambulance Service (LAS) handover times performance has fallen across the London region with St George's performance remaining below the lower control limit and has seen steady deterioration over the past six months.

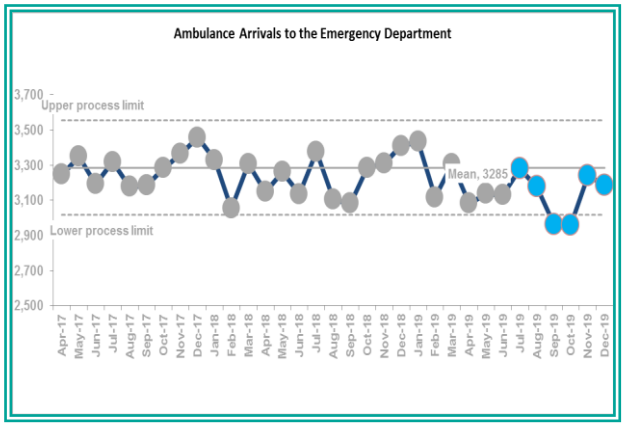
Actions and Quality Improvement Projects

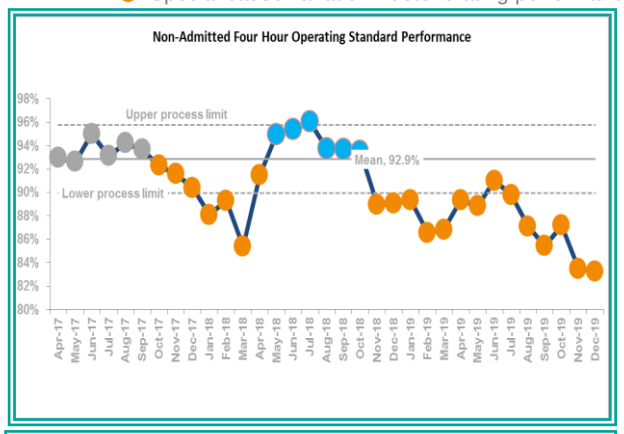
- Focus on specific recovery actions that the Trust's internal Emergency Care Delivery Board (ECDB) is doing to get performance back to its month by month trajectory
- Additional management support from our local Social Services partners as well as increased Trust clinical and operational management presence supporting the long length of stay meetings.
- The Trust continues to develop its Rapid Assessment Zone (RAZ) with a post-implementation review to be undertaken in late January 2020.
- The Trust now has a Direct Access dashboard on Tableau that tracks GP accepted work that goes directly to an ambulatory unit in the Trust.

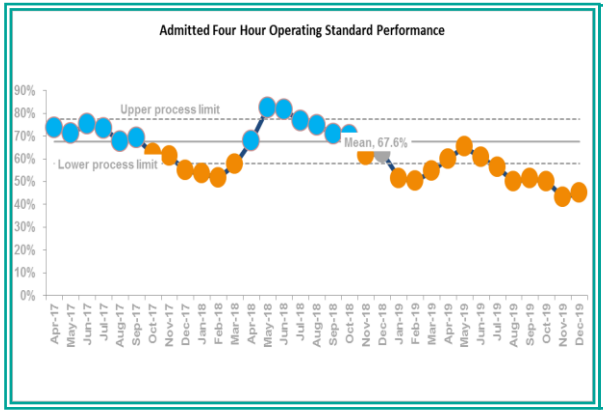
Emergency Flow

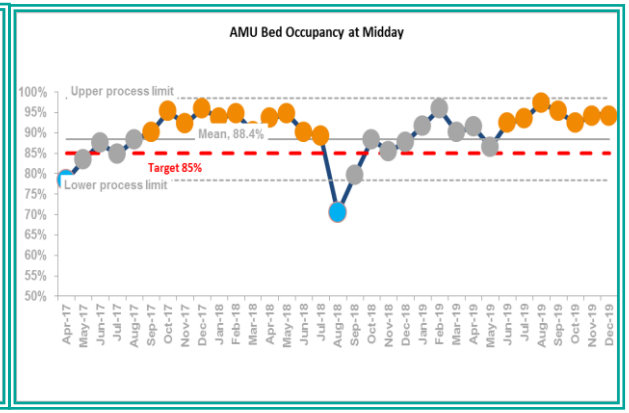
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

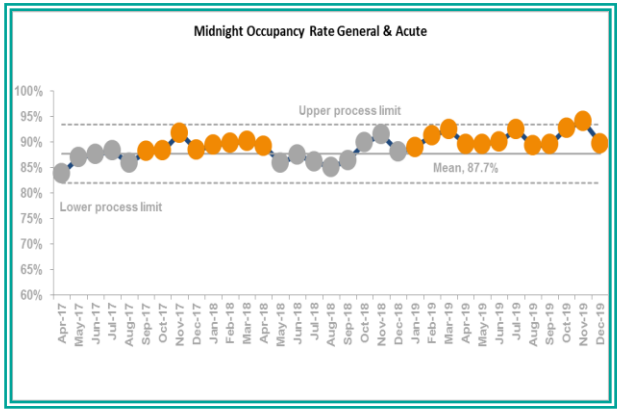


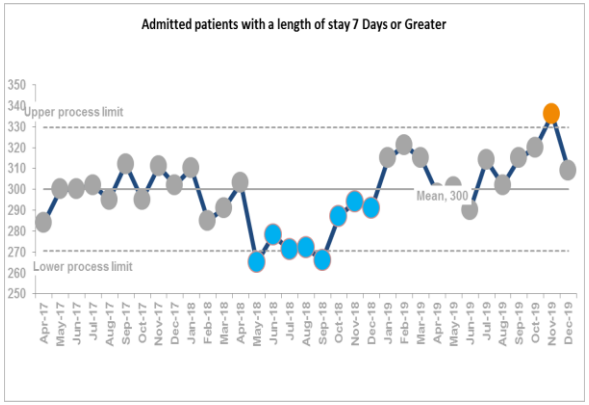


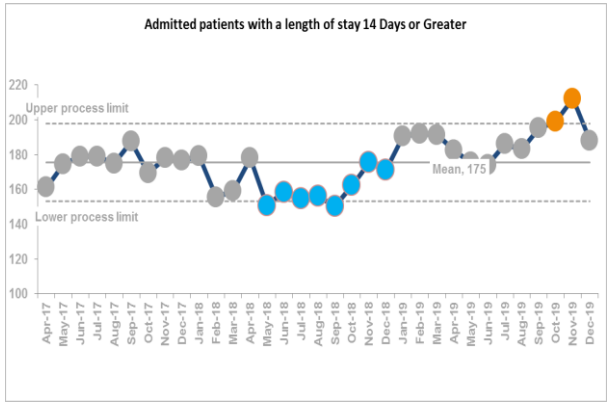


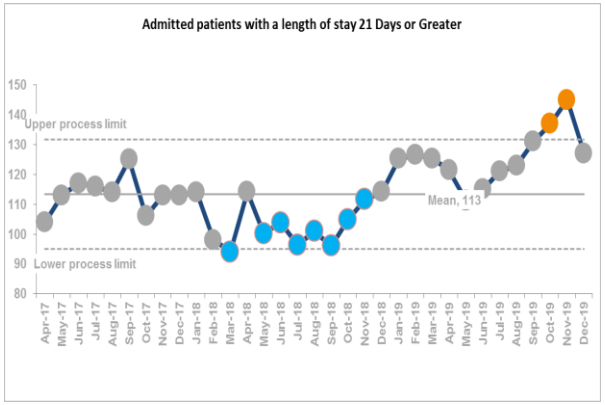






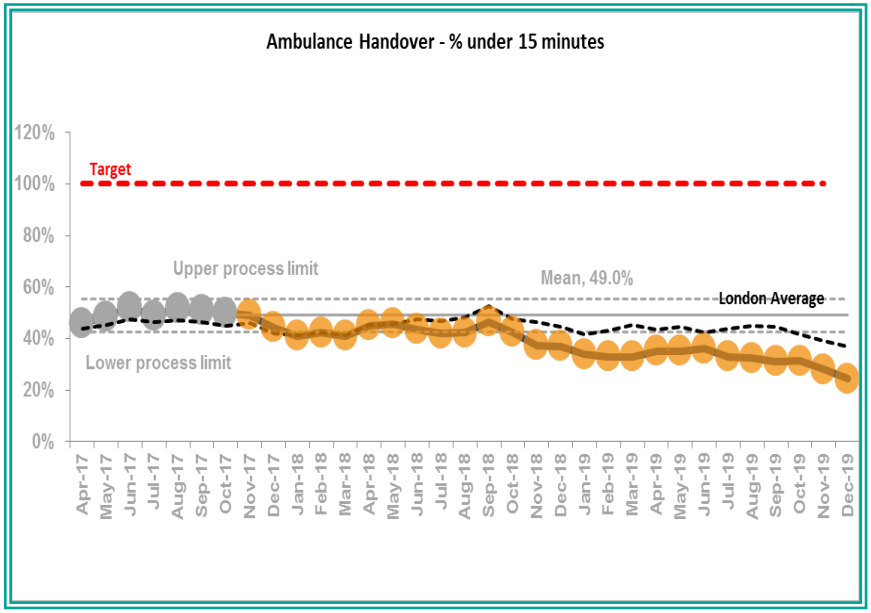


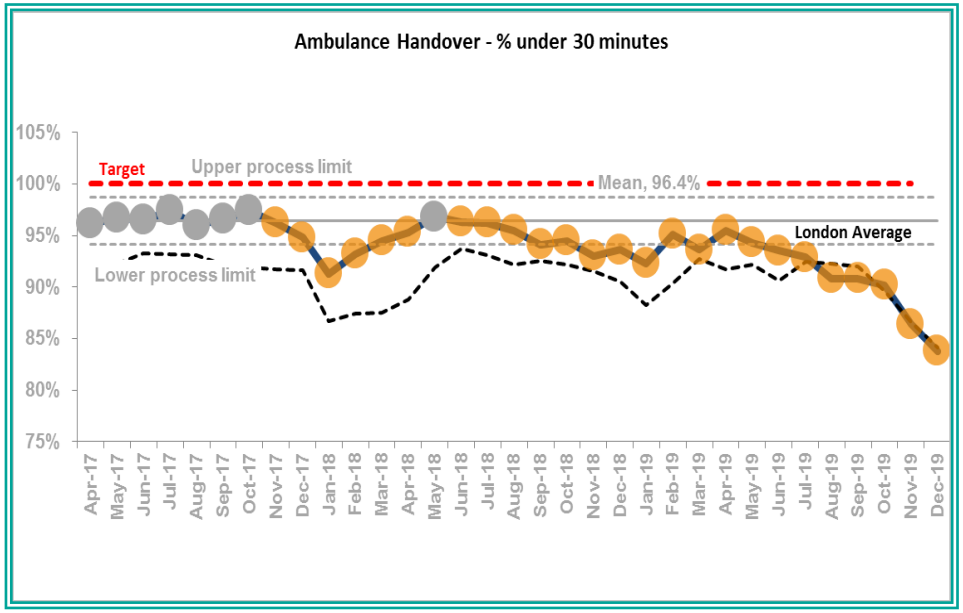


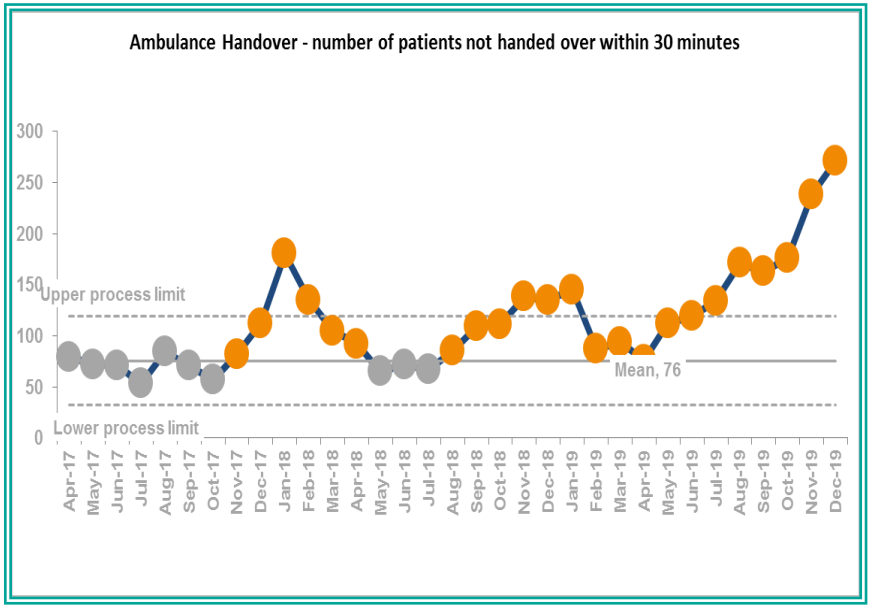


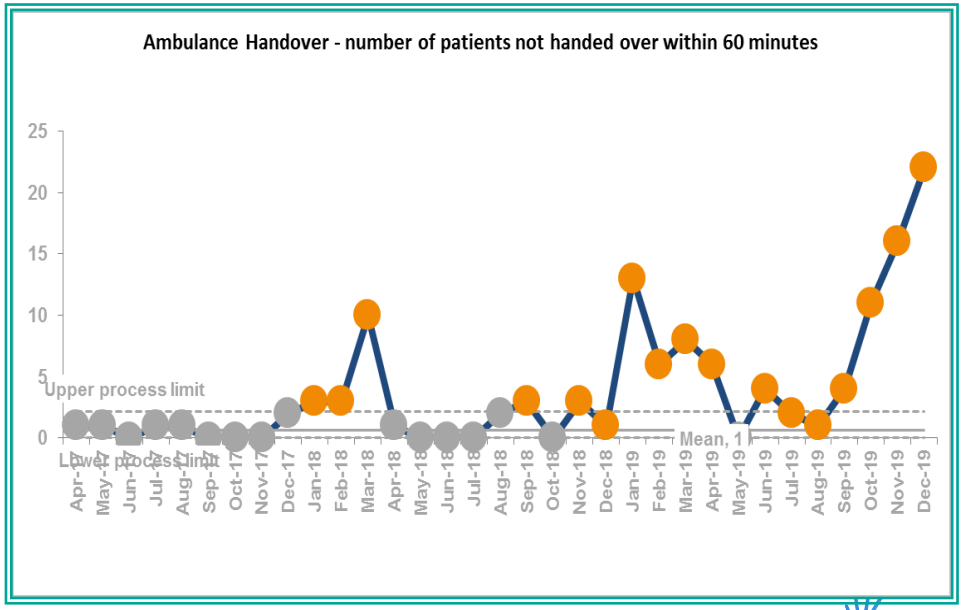
Emergency Flow

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





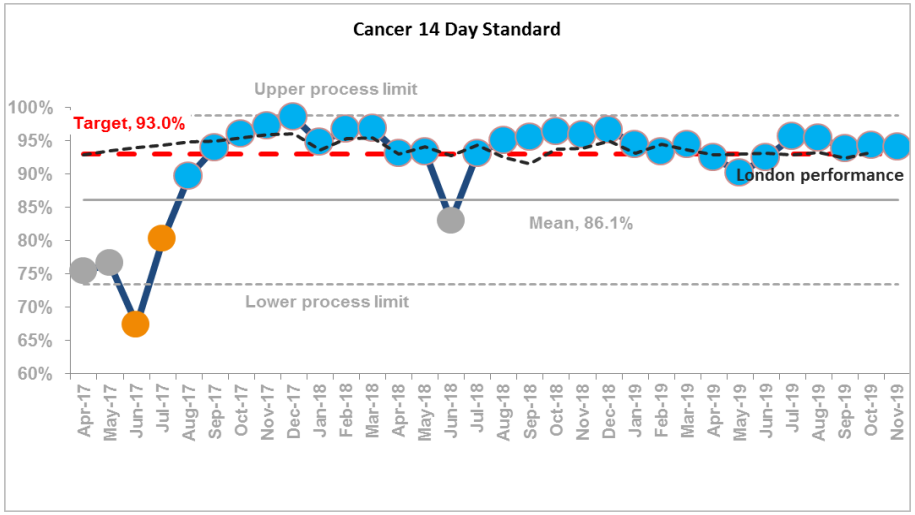


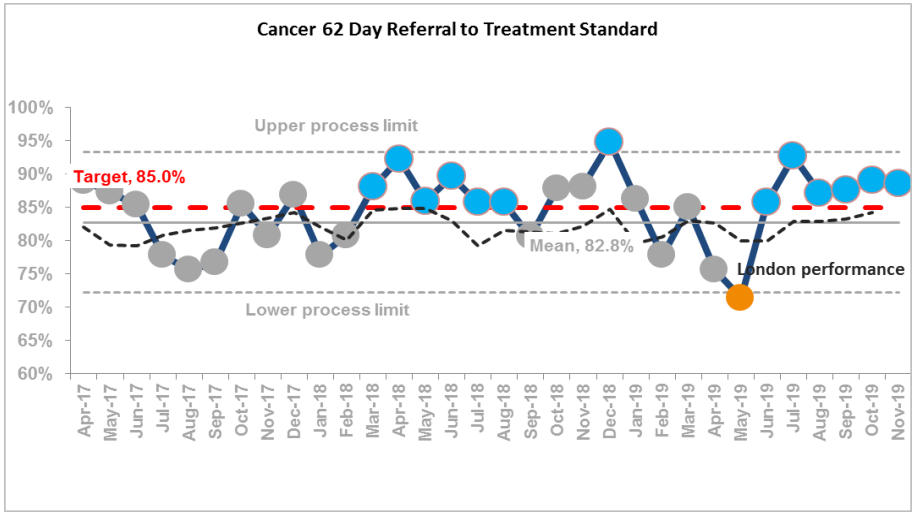


2

Our Process Perspective

Cancer





What the information tells us

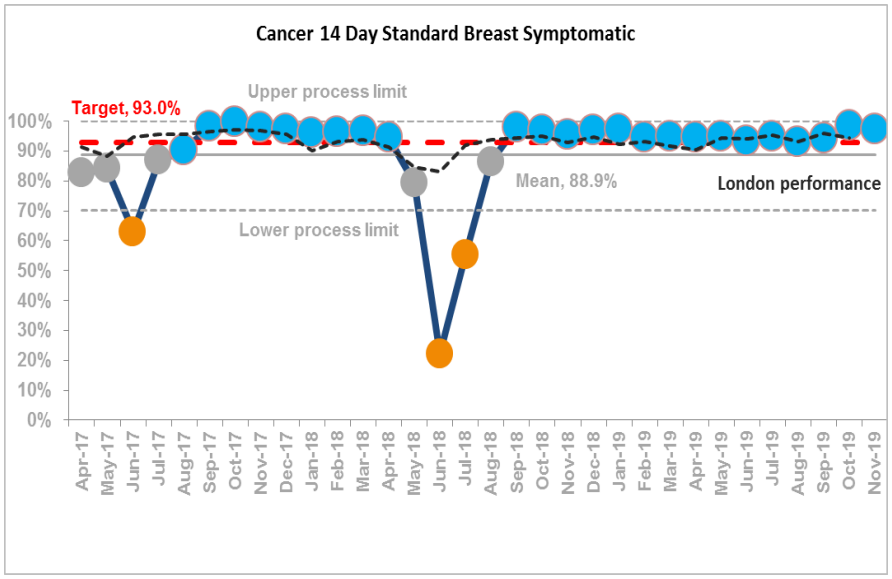
- The Trust achieved six of the seven cancer standards for the month of November, remaining compliant against the 14 Day Standard and 62 Day Standard.
- Within the 14 Day Standard, three tumour groups were non-compliant against the 93% national target, these were Lower Gastrointestinal, Skin and Upper Gastrointestinal. Overall Trust performance was 94% and remains within the upper and lower control limits and in line with London performance. All tumour groups remain within upper and lower control limits with the exception of Upper Gastrointestinal where 14 day performance remains below the lower control limit showing special cause variation.
- Performance against 62 days from referral was 88.6% in the month of November 2019 against the target of 85% with three tumour groups non-compliant (Head & Neck, Lung and Upper Gastrointestinal). All tumour groups remain within upper and lower control limits with no special cause variation seen. Urology has seen a sustained increase in performance reporting above the mean for the sixth consecutive month.
- In the month of November the Trust did not achieve the Cancer 62 Day Referral to Treatment Screening target of 90%, reporting 87.7% although performance remains within the upper and lower control limit.

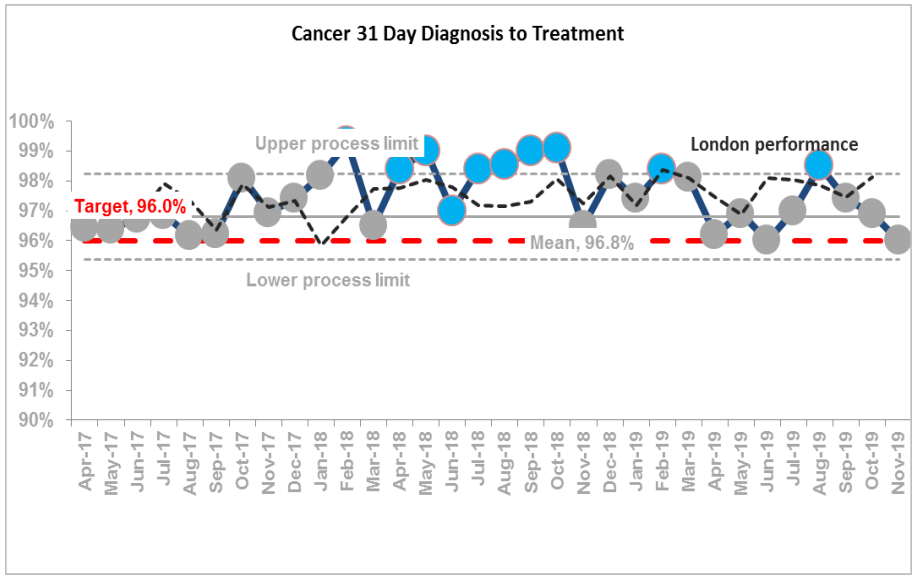
Actions and Quality Improvement Projects

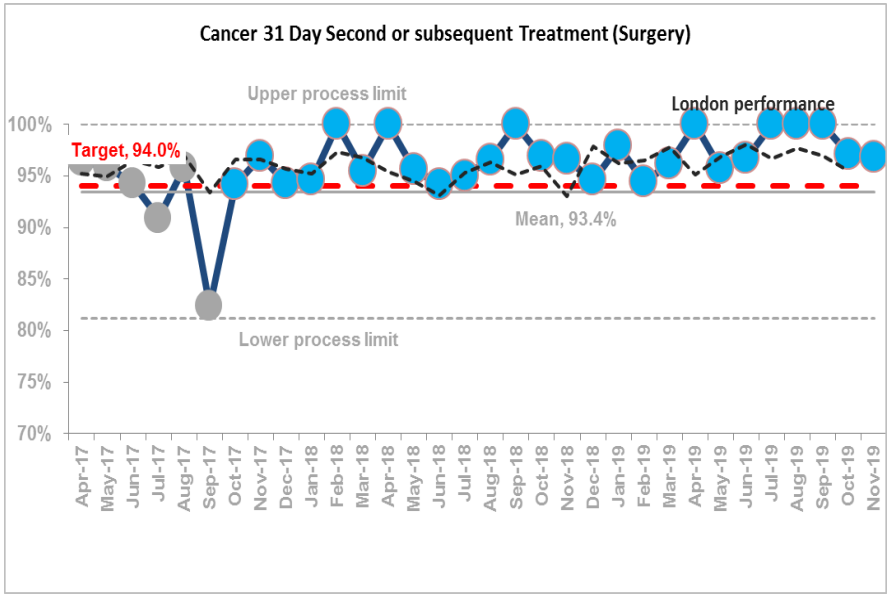
- Two Week Rule - Demand and capacity modelling continues with all services to ensure the right capacity is in place to meet the demand. Plans for services to review further demand and capacity planning to meet this requirement. The focus remains on the Appointment Slot Issue (ASI) list due recent increase in total numbers due to Electronic Referral Service (ERS) down time. Whilst this is moving back down, work is on going to bring all services 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.

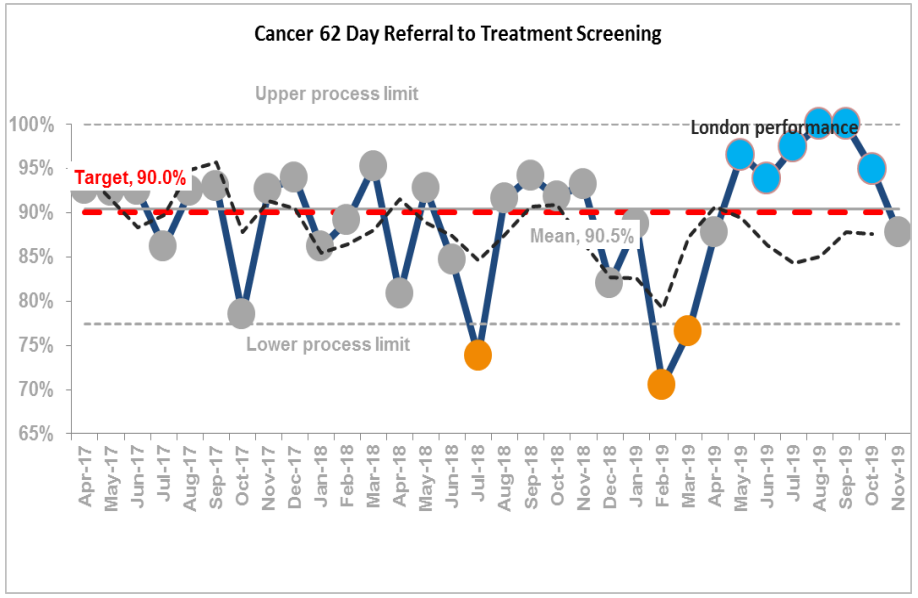
Cancer

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









2

Our Process Perspective

Cancer

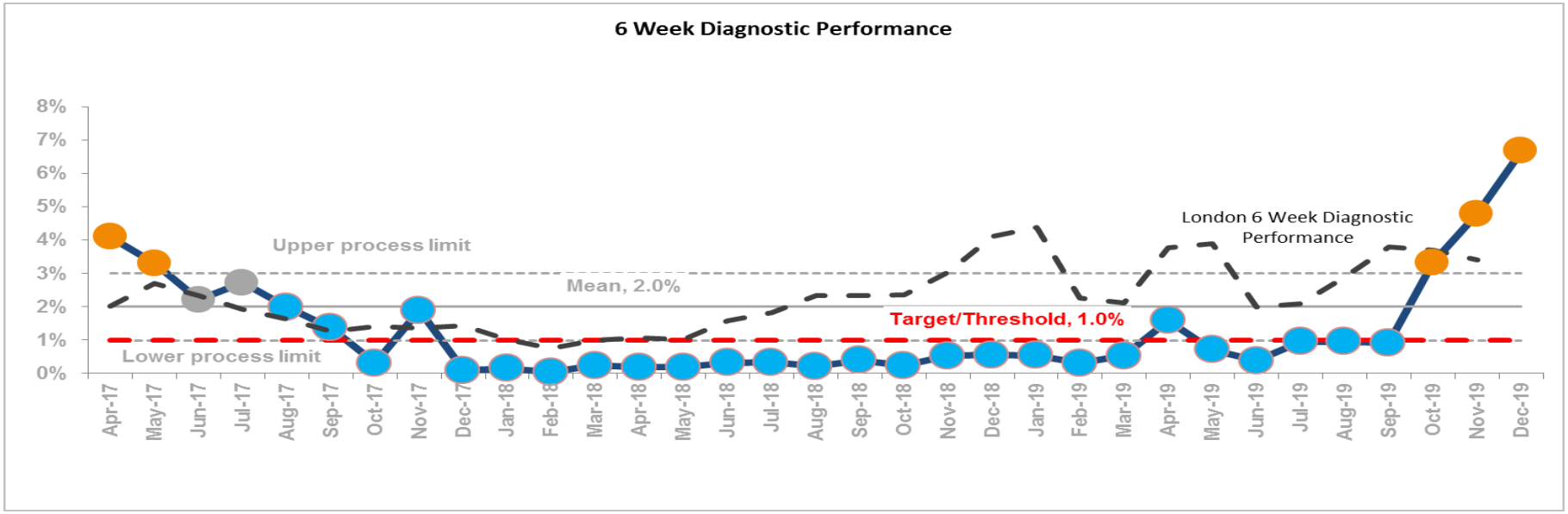
14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	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	No of Patients
Brain	93%	-	100.0%	100.0%	100.0%	-	100.0%	-	100.0%	-	100.0%	100.0%	-	-	0
Breast	93%	97.4%	98.8%	97.4%	98.6%	97.9%	99.5%	96.3%	96.9%	95.4%	94.9%	95.9%	100.0%	97.0%	237
Children's	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	3
Gynaecology	93%	87.5%	95.9%	69.5%	65.3%	80.0%	75.0%	59.3%	78.0%	95.5%	97.2%	95.4%	97.6%	99.2%	119
Haematology	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	86.7%	95.2%	100.0%	16
Head & Neck	93%	98.1%	96.0%	98.5%	100.0%	99.3%	98.0%	97.8%	100.0%	98.9%	96.4%	96.6%	99.0%	96.6%	148
Lower Gastrointestinal	93%	95.8%	94.5%	97.2%	92.1%	94.5%	85.6%	91.1%	87.9%	93.7%	93.1%	92.8%	89.7%	91.5%	270
Lung	93%	100.0%	100.0%	93.3%	100.0%	96.9%	100.0%	95.6%	96.8%	95.7%	100.0%	97.1%	97.7%	100.0%	39
Skin	93%	97.4%	97.6%	97.1%	95.9%	97.6%	96.9%	95.5%	94.8%	96.0%	98.0%	91.8%	95.9%	91.0%	345
Upper Gastrointestinal	93%	95.4%	94.1%	91.8%	90.9%	83.5%	87.9%	70.2%	90.9%	95.1%	88.9%	87.2%	82.5%	88.1%	109
Urology	93%	93.4%	96.6%	94.5%	94.2%	92.2%	90.1%	95.4%	92.1%	93.8%	93.0%	97.0%	88.4%	95.6%	137

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	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	No of Treatments
Brain	85%	100.0%	100.0%	-	-	-	-	-	-	-	-	-	-	-	0
Breast	85%	100.0%	100.0%	100.0%	82.4%	90.9%	83.3%	80.0%	87.5%	73.3%	88.6%	100.0%	100.0%	100.0%	17
Children's	85%	-	-	-	-	-	-	-	-	-	100.0%	-	-	-	0
Gynaecology	85%	100.0%	83.3%	88.9%	50.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%	60.0%	100.0%	4
Haematology	85%	100.0%	100.0%	100.0%	100.0%	100.0%	30.0%	33.3%	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	5.5
Head & Neck	85%	86.7%	87.5%	46.2%	85.7%	80.0%	77.8%	40.0%	28.6%	80.0%	80.0%	75.0%	76.5%	76.9%	6.5
Lower Gastrointestinal	85%	100.0%	100.0%	100.0%	81.8%	66.7%	41.7%	100.0%	69.2%	83.3%	63.6%	90.0%	100.0%	87.5%	8
Lung	85%	70.0%	72.7%	80.0%	75.0%	70.0%	71.4%	100.0%	100.0%	91.7%	89.5%	60.0%	100.0%	66.7%	6
Skin	85%	100.0%	100.0%	92.3%	100.0%	89.7%	100.0%	75.8%	95.7%	100.0%	100.0%	78.9%	100.0%	89.5%	10
Upper Gastrointestinal	85%	100.0%	100.0%	0.0%	50.0%	60.0%	100.0%	20.0%	75.0%	100.0%	53.8%	66.7%	80.0%	50.0%	2
Urology	85%	77.8%	95.0%	89.5%	71.1%	88.9%	83.0%	75.8%	93.9%	100.0%	94.4%	100.0%	83.8%	87.8%	20.5
Other	85%	100.0%	-	0.0%	-	100.0%	-	-	100.0%	-	-	-	100.0%	-	0

Diagnostics



What the information tells us

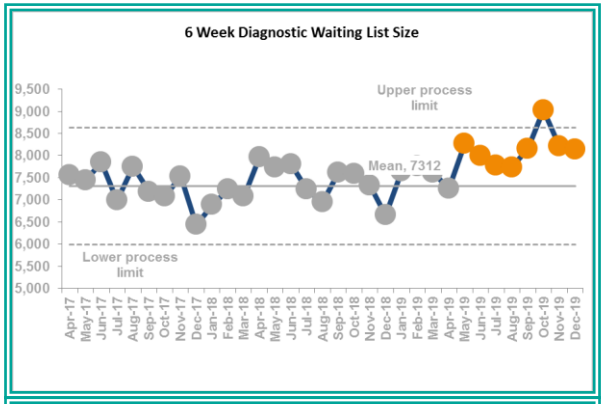
- In December, the Trust did not achieve the six week diagnostic standard with an adverse performance of 6.7% against a National Threshold of 1% and London performance of 3.4%. The total number of patients waiting greater than six weeks was 544, 38% more than the previous month.
- The diagnostic waiting list continues to be above the upper process limit and is 22% higher than the same period last year.
- Compliance has not been achieved within eight modalities, with Echocardiography being the most challenged and performing above the upper control limit. Echocardiography have also seen an increase in the waiting list numbers, this is due to primarily work reviewing the patient waiting list and ensuring any planned and non planned waits are being recorded appropriately.
- In the month of December, Neurophysiology have continued to be challenged both in staffing and an increase in demand resulting in a number of patients waiting above six weeks. Performance was at 9.9% and significantly above upper control limit.
- Endoscopy performance have seen a deterioration in performance in recent months with longer waits reported. However, all modalities are within their upper and lower control limits except colonoscopies which are above its upper control limit.

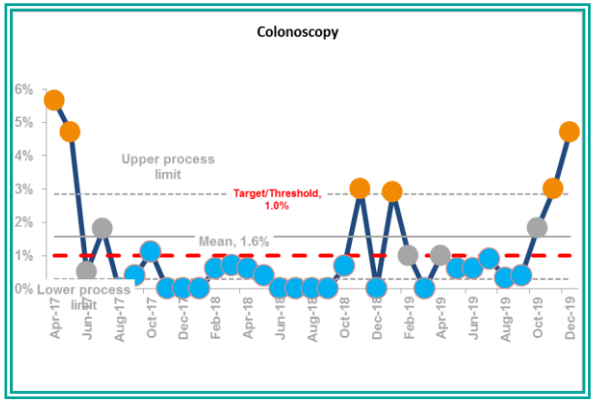
Actions and Quality Improvement Projects

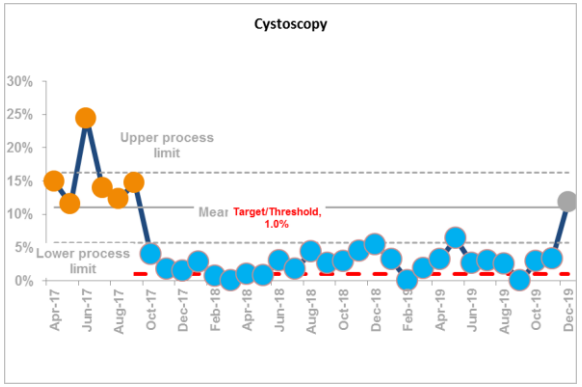
- **Echocardiography** - Performance trajectory for Echocardiography has been submitted to the Executive team with recommendations for long term impact and sustainability for the service including demand management projects. The patient waiting list continues to be reviewed and validated to ensure accurate reporting of planned and non planned patients. A service manager post will be dedicated to Diagnostics and RTT performance. Additional administrative resource has been requested to ensure that booking processes are robust and to ensure adequate capacity. A dedicated resource from transformation will lead on reviewing the current administrative and booking process. Insourcing has begun to bridge echocardiography capacity gap.
- **Endoscopy** - A dedicated resource from transformation will lead on reviewing workforce with a focus on nursing and a review on capacity.
- **Neurophysiology** – Reviewing staffing capacity with a shared Consultant post being appointed.

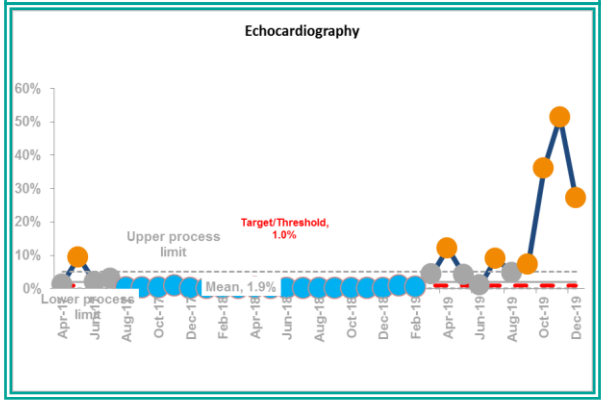
Diagnostics

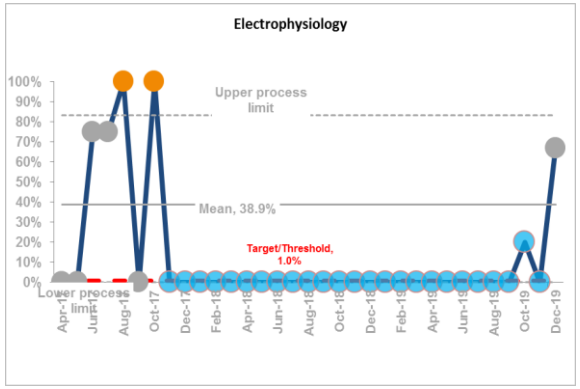
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

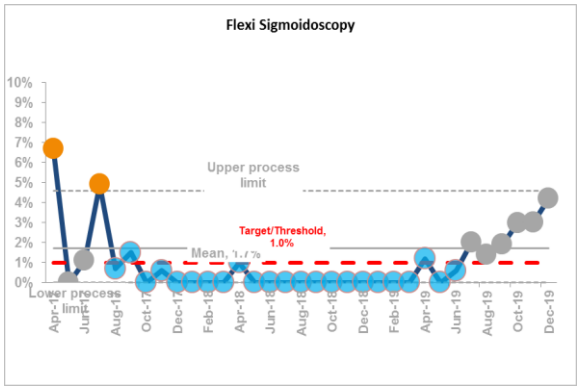


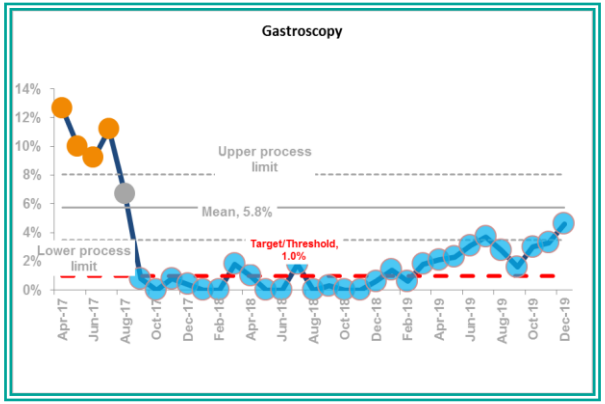


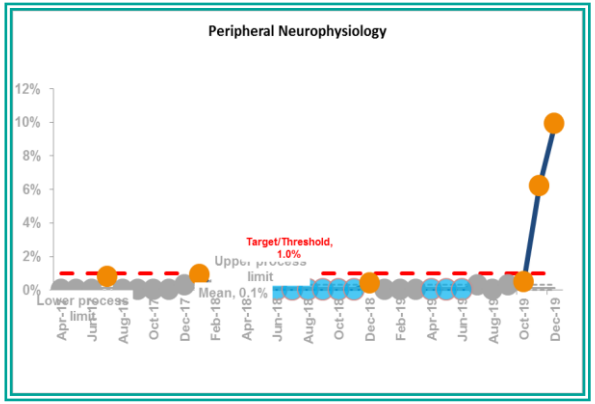


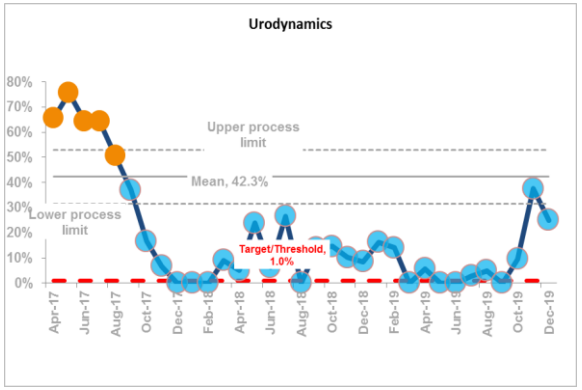




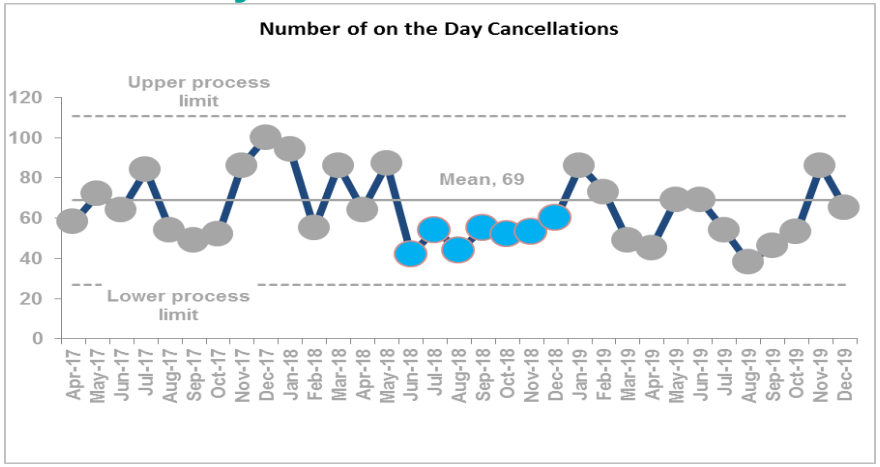


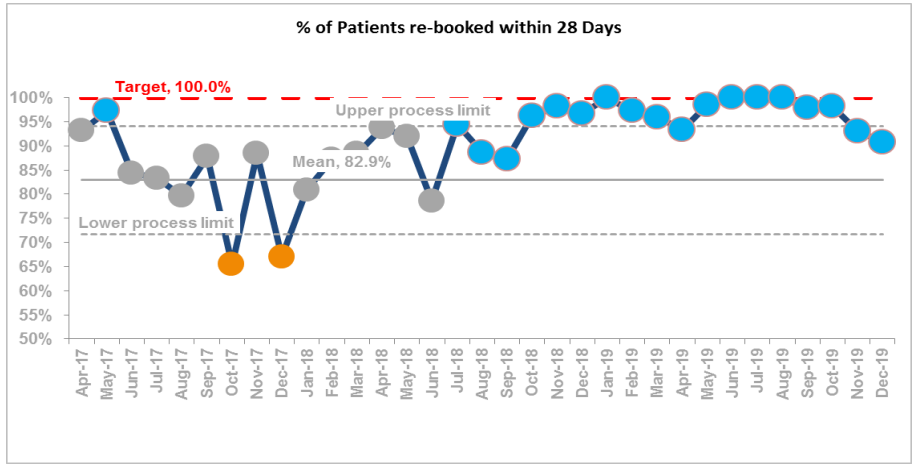






On the Day Cancellations for Non Clinical Reasons





What the information tells us

- Performance remains within expected levels staying within the upper and lower control limits in both the number of on the day cancellations and the percentage of patients re-booked within 28 days.
- In Q3, the Trust has seen an increase in the number of on the day cancellations compared to the same period last year, however with a larger amount of elective activity going through our theatres, the number of cancelled operations as a percentage of activity has dropped.
- The top three reasons for cancellations in the month of December were; Complication previous case, no critical care beds available and emergency cases taking priority.

Actions and Quality Improvement Projects

- Two way text reminders have been rolled out for DSU surgery dates, this will also include a firmer message to encourage patients to attend
- The Trust Directory is being updated to ensure the correct numbers for the PPCs are listed to support switchboard putting patients through to the right person
- Partial Bookings are being sent out to all patients added to the IP, and DSU waitlist, which asks patients if they are available at short notice (1 day, to 1 week before TCI) so we have a pool of patients to pull from when other patients cancel at short notice (for DSU, 65% of our total cancellation are patients cancelling at short notice)
- Information is now being entered on Theatreman (IP scheduling system) which highlights if a patient is on a cancer pathway, and their breach date, to mitigate the risk of these patients being cancelled because of bed flow challenges
- The PPC team are designing a 'Friends and Family test' for scheduling which will help us understand why patients cancel, so we can look to put actions in place to stop DNA's/short notice cancellations
- Non clinical on the day cancellations are discussed daily at the PPC huddle to ensure patients are dated within 28 days

Referral to Treatment

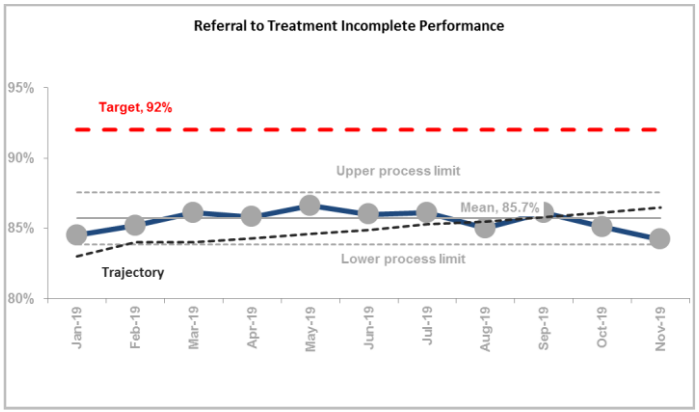
Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RTT Incomplete Performance	92%	84.5%	85.2%	86.1%	85.8%	86.6%	86.0%	86.1%	85.0%	86.1%	85.1%	84.2%				
RTT Incomplete Trajectory		83%	84%	84%	84.3%	84.6%	84.9%	85.3%	85.5%	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	48,640				
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	7,701				
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	7				
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%	63.7%				
Total waits greater than 18 weeks - Admitted		1,563	1,563	1,428	1,511	1,459	1,494	1,523	1,655	1,643	1,686	1,719				
Total waits greater than 52 weeks - Admitted	0	62	63	18	7	8	4	1	2	4	0	2				
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%	86.4%				
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	5,982				
Total waits greater than 52 weeks - Non Admitted	0	56	53	9	15	8	3	4	4	2	1	5				

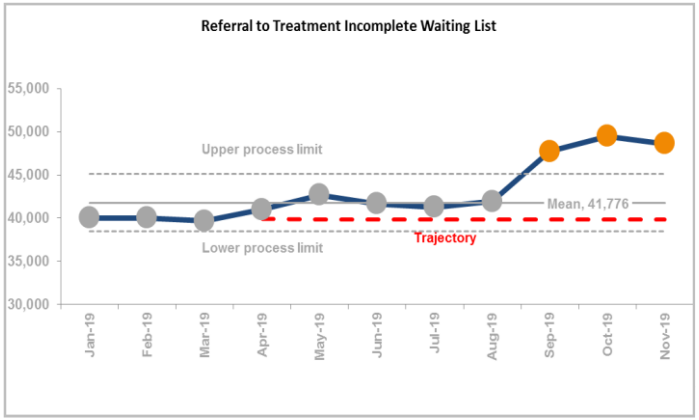
What the information tells us

- The Trust remains behind trajectory for incomplete Referral To Treatment (RTT) performance in November 2019. The submitted performance was 84.2% against a trajectory of 86.5%.
- The Total Patient Tracking List (PTL) size reported in November 2019 was 48,640 (inclusive of QMH pathways) against a trajectory of 39,820. The trajectory of PTL size was not adjusted to take into account the QMH patients migrated in September 2019. The QMH PTL size remains higher than planned.
- The Trust 52 week breach position deteriorated in November 2019 from reporting only one breach in October 2019 to seven in November 2019 (six General Surgery and one Plastic Surgery).

Actions and Quality Improvement Projects

- Focused work on the management of patients on the continuing PTL (follow up waiting list). On 16th December 2019 there were a total of 15,035 patients on the continuing PTL, 7,150 (47.3%) did not have a next event booked. Service specific reviews have been taking place and continue throughout January 2020 to focus and action un-booked patients, this includes consultant, management and validation resource to either discharge or book patients. As of 15th January 2020 the continuing PTL position is now a total of 13,291 patients on the continuing PTL, 5230 patients (40%) remain un-booked. In short, it demonstrates that the Trust can reduce its overall PTL size by 1,744 patients in less than 4 weeks with targeted work to actually review each patient on its PTL.
- As a result of reviewing all un-booked patients on the continuing PTL (over and under 18 weeks) there will be a drop in performance for December 2019 however this will lead to longer term improvement and ensures our patients are appropriately being followed up.
- Revised RTT documentation circulated twice weekly to all operational teams.
- Revised access meeting structure from weekly to fortnightly offering more time to review report in detail.





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	275	57.1%	980	74.9%	891	364	1,255	71.0%	70	3
Urology	295	51.5%	1,639	92.4%	1,666	268	1,934	86.1%	13	0
Trauma & Orthopaedics	161	50.9%	2,182	86.9%	1,978	365	2,343	84.4%	4	0
Ear, Nose & Throat (ENT)	514	36.8%	2,579	85.2%	2,386	707	3,093	77.1%	26	0
Ophthalmology	0	-	446	93.7%	418	28	446	93.7%	0	0
Oral Surgery	3	0.0%	513	86.5%	444	72	516	86.0%	3	0
Neurosurgery	139	59.0%	2,149	80.9%	1,821	467	2,288	79.6%	17	0
Plastic Surgery	590	54.2%	1,182	88.3%	1,364	408	1,772	77.0%	27	1
Cardiothoracic Surgery	0	-	0	-	0	0	0		0	0
General Medicine	0	-	53	94.3%	50	3	53	94.3%	0	0
Gastroenterology	512	89.3%	2,417	88.7%	2,600	329	2,929	88.8%	7	0
Cardiology	884	75.7%	3,179	84.6%	3,360	703	4,063	82.7%	16	0
Dermatology	10	80.0%	3,456	88.1%	3,053	413	3,466	88.1%	3	0
Thoracic Medicine	16	100.0%	1,809	84.9%	1,552	273	1,825	85.0%	0	0
Neurology	32	87.5%	2,851	88.6%	2,555	328	2,883	88.6%	0	0
Rheumatology	0	-	1,131	83.9%	949	182	1,131	83.9%	3	0
Geriatric Medicine	2	100.0%	130	96.2%	127	5	132	96.2%	0	0
Gynaecology	283	53.0%	2,379	88.6%	2,258	404	2,662	84.8%	7	0
Other	1,023	69.2%	14,826	86.1%	13,467	2,382	15,849	85.0%	78	3
Total	**4,739**	**63.7%**	**43,901**	**86.4%**	**40,939**	**7,701**	**48,640**	**84.2%**	**274**	**7**

- 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 seven 52 week breach patients reported were General Surgery (6) and Plastic Surgery (1). Trajectory was 0.

Balanced Scorecard Approach

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

Key

Current Month

A Previous Month

Workforce

Indicator Description	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Trust Level Sickness Rate	3.2%	3.8%	4.3%	4.0%	3.4%	3.1%	3.5%	3.8%	3.8%	3.5%	3.4%	3.7%	3.8%	4.0%
Trust Vacancy Rate	10%	9.4%	9.4%	9.3%	9.6%	9.1%	10.3%	10.5%	11.9%	12.8%	12.8%	9.3%	9.9%	11.2%
Trust Turnover Rate* Excludes Junior Doctors	13%	16.9%	17.1%	17.1%	17.5%	17.1%	17.4%	17.4%	17.5%	17.7%	17.7%	17.8%	17.6%	17.6%
Total Funded Establishment		9,196	9,229	9,238	9,248	9,112	9,241	9,251	9,365	9,432	9,534	9,280	9,294	9,403
IPR Appraisal Rate - Medical Staff	90%	Data Unavailable					85.4%	84.5%	84.4%	85.7%	81.5%	83.9%	81.5%	83.6%
IPR Appraisal Rate - Non Medical Staff	90%	71.5%	70.9%	71.3%	70.4%	71.6%	72.5%	73.6%	73.3%	71.3%	70.4%	70.9%	72.3%	72.3%
Overall MAST Compliance %	85%	89.1%	89.3%	89.1%	89.4%	89.8%	90.6%	91.1%	91.2%	91.3%	90.6%	89.7%	90.0%	89.7%
Ward Staffing Unfilled Duty Hours	10%	6.1%	6.6%	6.7%	7.2%	5.7%	5.9%	6.1%	6.3%	5.4%	6.5%	6.1%	3.8%	5.3%

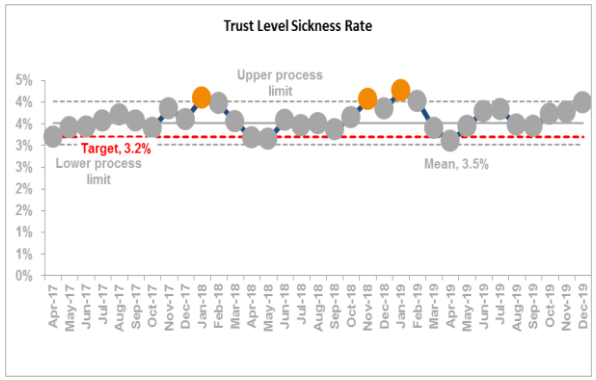
What the information tells us

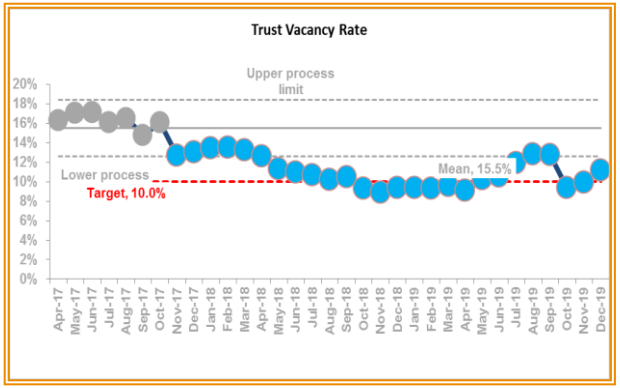
- Mandatory and Statutory Training figures for December were recorded at 89.7% with a mean of 86.2%, a slight reduction in compared to last month.
- Medical appraisal rates currently stands at 83.6% against a target of 90%.
- Non-medical appraisal performance remains unchanged in December at 72.3% against a 90% target and is below the lower control limits.
- The Trust's Total Funded Establishment and Trust Vacancy rate are both below the lower control limits.
- The Trust was within their monthly agency cost in December for the first time this year with agency costs of £1.22m against a target of £1.25m
- Consultant agency usage was below target for the first time in eleven months and Interim spend fell below target for the second successive month.

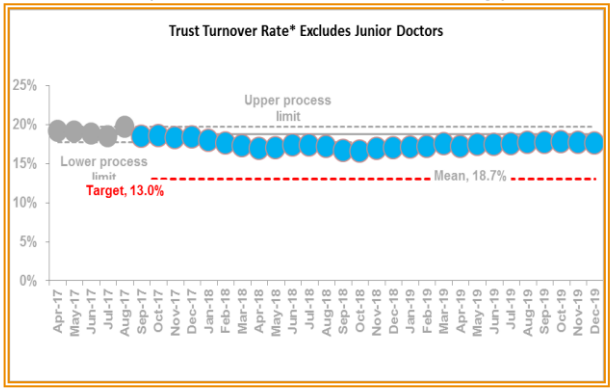
Actions and Quality Improvement Project
HR Managers will be meeting with Divisional Directors of Operations to discuss remedial actions to control agency costs.

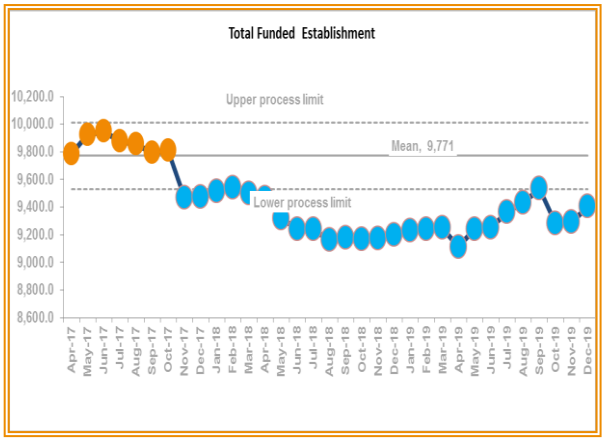
Workforce

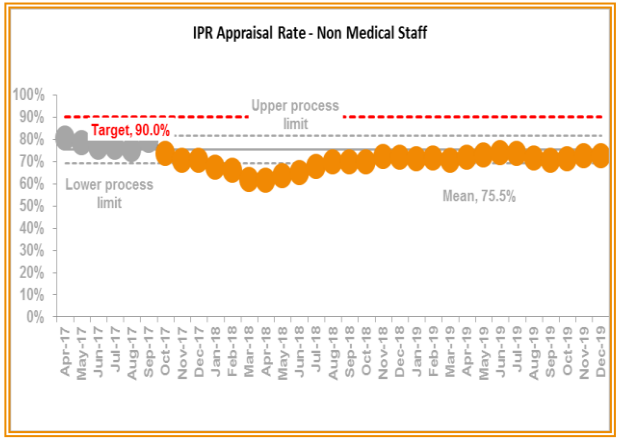
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

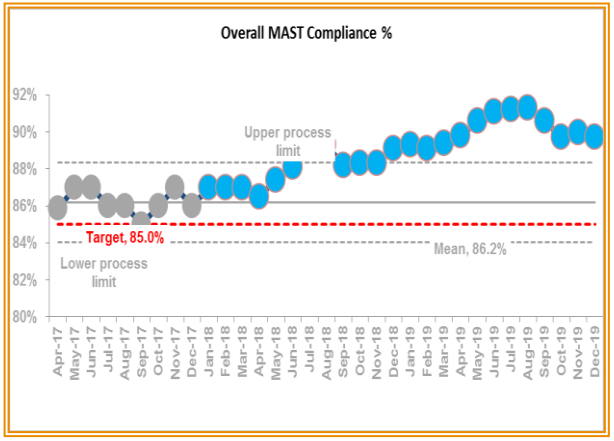


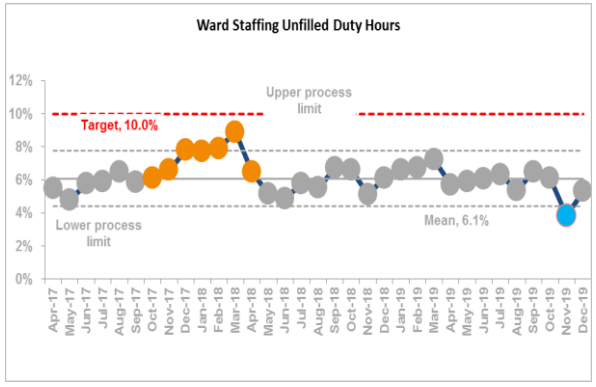




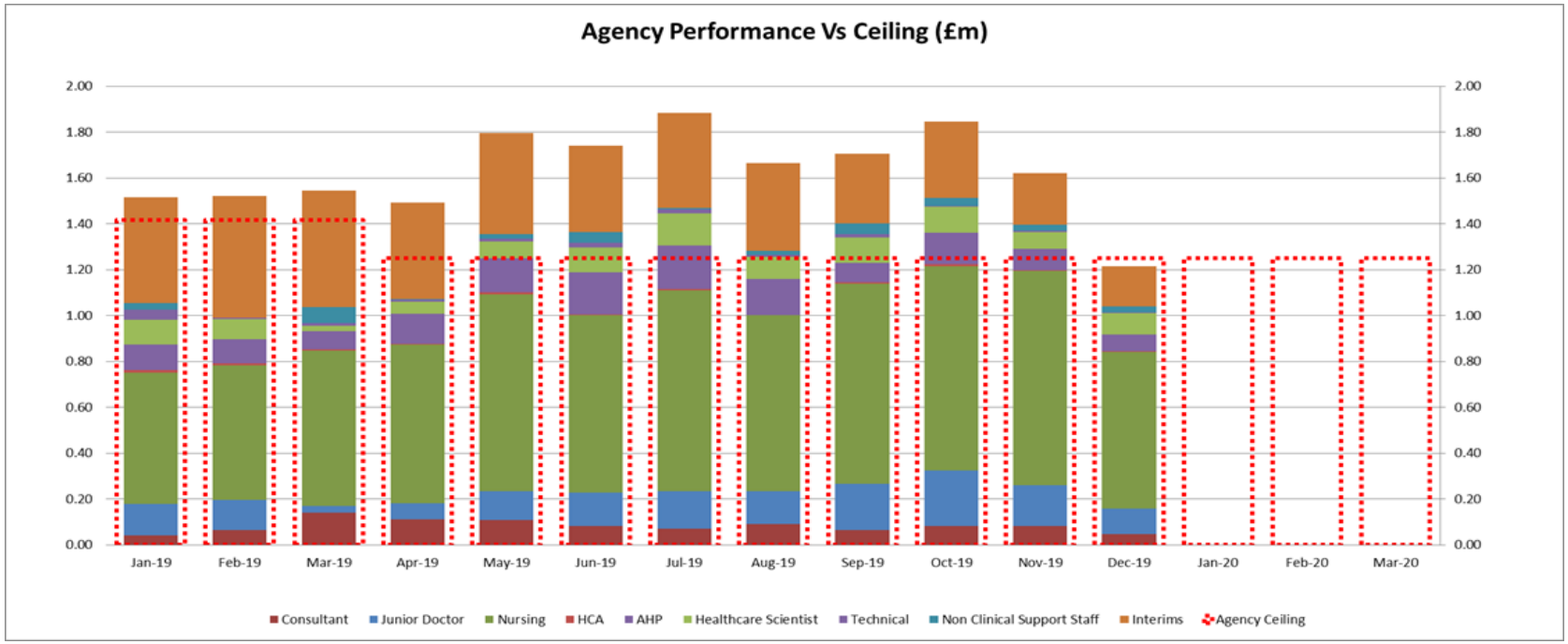








Agency use



- The Trust's total pay for December was £43.73m. This is £0.68m adverse to a plan of £43.05m.
- The Trust's 2019/20 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.
- Agency cost in December was £1.22m or 2.8% of the total pay costs. For 2018/19, the average agency cost was 3.2% of total pay costs.
- For December, the monthly target was £1.25m. The total agency cost was below target by £0.03m.
- Agency cost is £0.41m lower compared to November. This is in line with the forecast. There have been decreases mainly in Nursing (£0.25m), Junior Doctor (£0.07m), Interims (£0.05m) and Consultant (£0.03m).
- The biggest area of overspend was Nursing (£0.10) and Junior Doctor (£0.04m). The biggest areas of underspend were Interims (£0.12m).

Agency use

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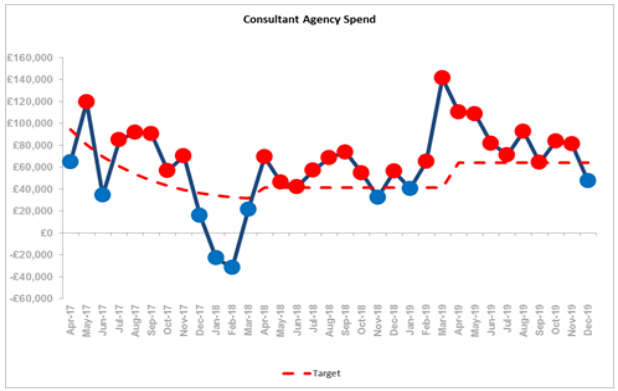
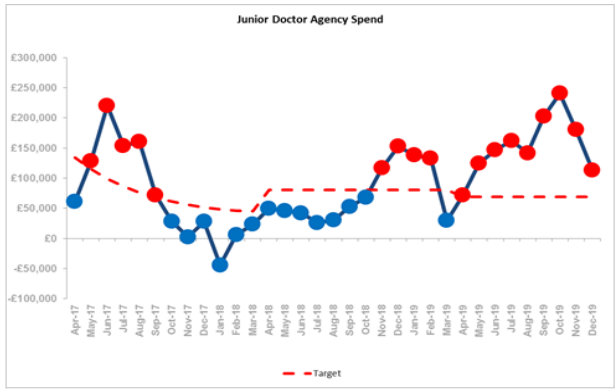
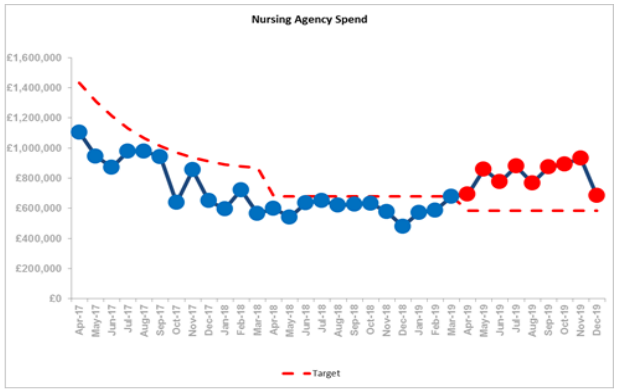
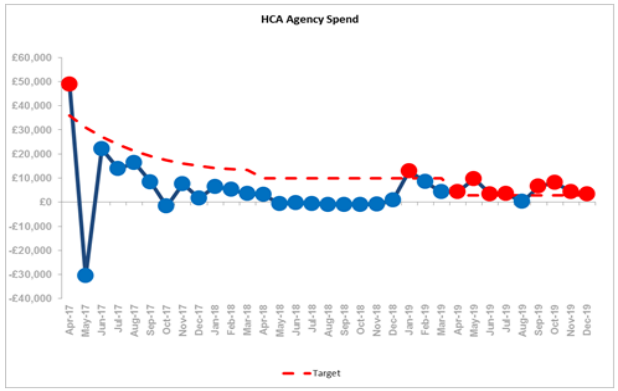
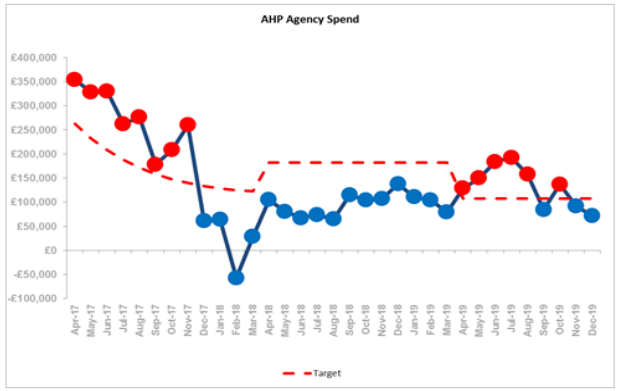
Above cap

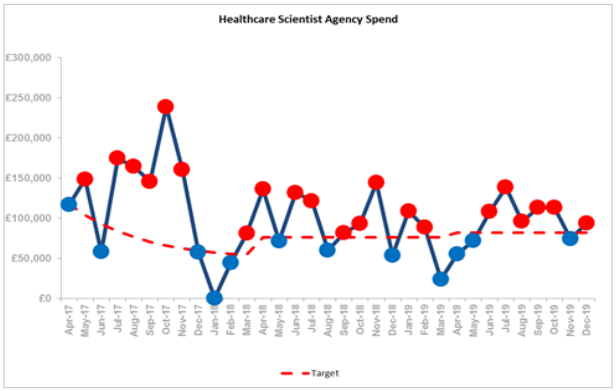


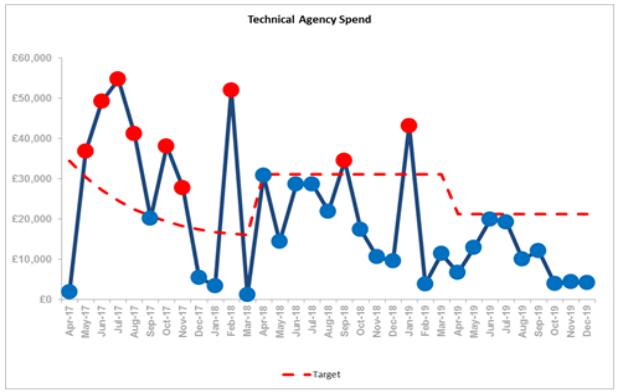


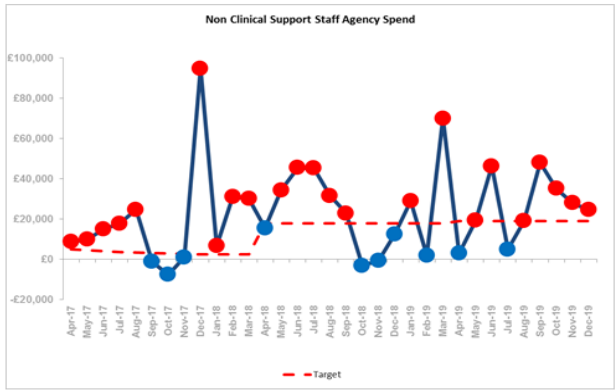


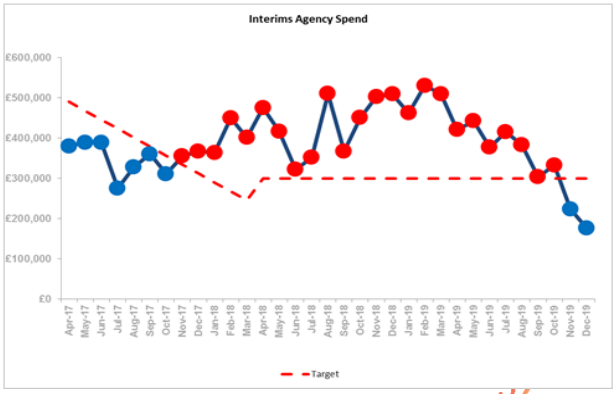






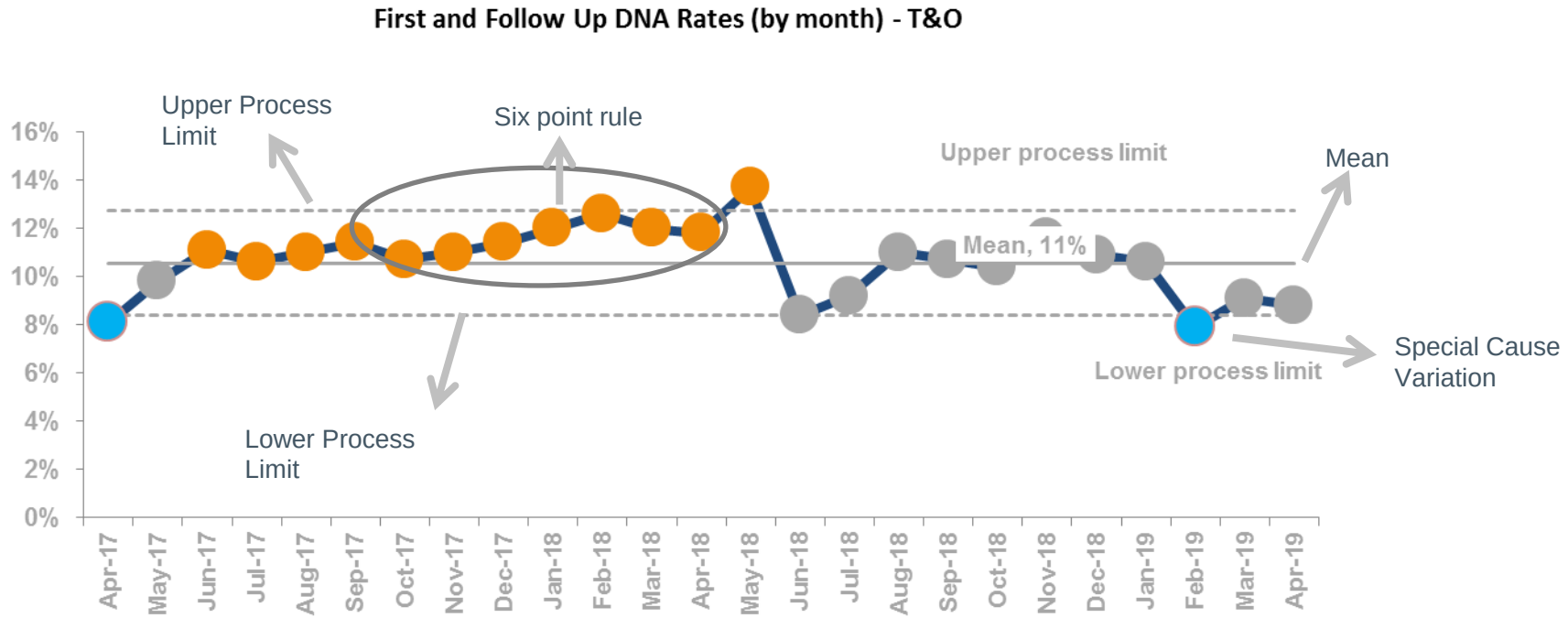






Appendix
Additional Information and Data Tables

Interpreting SPC (Statistical Process Control) Charts



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

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

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

Productivity Tables

First Outpatient Attendances (average per working day)

Directorate	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Attendances in the last month	First Outpatient Attendances per working day			
															2018-19 YTD	2019-20 YTD	Variance	Variance
Cardiology, Cardiothoracic & Vascular Services	51	59	58	59	58	68	64	58	54	57	57	58	46	916	59	58	-1	-2.3%
Children's Services	38	50	47	46	42	50	45	43	39	44	46	51	37	742	45	44	-1	-3.0%
Neurosciences	74	94	81	75	86	82	88	82	72	77	86	92	73	1,468	80	82	2	2.2%
Renal & Oncology	23	26	25	24	25	25	27	25	24	26	24	26	22	442	26	25	-1	-2.2%
Specialist Medicine	126	148	147	148	148	158	159	155	131	147	144	163	143	2,864	142	150	7	5.2%
Surgery	257	268	264	278	250	252	269	253	243	235	228	262	218	4,356	270	246	-25	-9.2%
Womens Services	78	88	92	82	91	78	82	87	83	78	83	77	70	1,409	86	81	-5	-6.0%
T&O	48	53	54	51	52	51	54	53	42	56	51	55	46	917	55	51	-4	-6.8%
Other	36	39	33	32	60	60	62	59	52	66	78	81	67	1,341	37	65	28	75.1%
Total	**731**	**826**	**801**	**791**	**812**	**823**	**850**	**813**	**740**	**787**	**797**	**865**	**723**	**14,455**	**801**	**801**	**0**	**-0.01%**

Follow-up Outpatient Attendances (average per working day)

Directorate	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Attendances in the last month	FollowUp Outpatient Attendances per working day			
															2018-19 YTD	2019-20 YTD	Variance	Variance
Cardiology, Cardiothoracic & Vascular Services	104	113	106	96	100	100	105	94	92	109	99	109	89	1,787	112	100	-12	-11.0%
Children's Services	73	83	84	70	78	82	78	72	70	73	81	86	57	1,147	79	75	-4	-4.6%
Neurosciences	104	124	118	101	121	118	122	107	103	99	114	131	102	2,043	113	113	-1	-0.5%
Renal & Oncology	229	238	223	230	242	229	221	219	211	222	235	240	202	4,044	229	225	-5	-2.1%
Specialist Medicine	481	528	537	526	573	538	544	528	483	504	534	616	544	10,889	507	540	34	6.7%
Surgery	331	382	350	335	317	331	327	321	291	306	325	363	291	5,827	352	319	-33	-9.5%
Womens Services	64	69	65	52	58	61	65	53	59	53	70	70	42	849	63	59	-4	-6.6%
T&O	76	86	85	76	82	79	81	75	70	77	77	86	68	1,355	83	77	-6	-6.7%
Other	77	91	92	87	119	121	125	125	104	109	132	142	107	2,972	91	120	29	31.6%
Total	**1,539**	**1,713**	**1,661**	**1,574**	**1,689**	**1,659**	**1,668**	**1,593**	**1,483**	**1,550**	**1,666**	**1,843**	**1,504**	**30,083**	**1,630**	**1,628**	**-2**	**-0.1%**

First to Follow-up Ratio

Directorate	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	First to FollowUp Ratio			
														2018-19 YTD	2019-20 YTD	Variance	Variance
Cardiothoracic & Vascular Services	2.04	1.92	1.83	1.63	1.72	1.46	1.65	1.62	1.69	1.89	1.74	1.88	1.93	1.90	1.73	-0.16	-8.6%
Children's Services	1.89	1.66	1.79	1.52	1.85	1.64	1.73	1.69	1.82	1.64	1.76	1.69	1.54	1.74	1.71	-0.04	-2.1%
Neurosciences	1.40	1.32	1.46	1.35	1.40	1.44	1.39	1.30	1.43	1.29	1.33	1.42	1.40	1.42	1.38	-0.04	-3.0%
Renal & Oncology	10.13	9.15	8.92	9.58	9.68	9.17	8.06	8.76	8.70	8.45	9.79	9.23	9.18	9.05	9.00	-0.04	-0.5%
Specialist Medicine	3.81	3.57	3.65	3.55	3.87	3.41	3.41	3.42	3.67	3.42	3.71	3.78	3.80	3.57	3.61	0.04	1.2%
Surgery	1.29	1.43	1.33	1.21	1.27	1.31	1.21	1.27	1.20	1.30	1.43	1.39	1.33	1.31	1.30	0.00	-0.3%
Womens Services	0.82	0.78	0.71	0.63	0.64	0.78	0.79	0.61	0.72	0.67	0.84	0.91	0.60	0.73	0.73	0.00	-0.6%
T&O	1.59	1.62	1.57	1.49	1.58	1.55	1.51	1.43	1.65	1.38	1.51	1.56	1.48	1.52	1.52	0.00	-0.1%
Other	2.16	2.33	2.79	2.72	1.98	2.02	2.03	2.11	1.99	1.65	1.69	1.75	1.60	2.47	1.87	-0.60	-24.4%
Total	**2.10**	**2.07**	**2.07**	**1.99**	**2.08**	**2.02**	**1.96**	**1.96**	**2.00**	**1.97**	**2.09**	**2.13**	**2.08**	**2.04**	**2.03**	**-0.01**	**-0.25%**

Productivity Tables

First and Follow-up DNA Rate

Directorate	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	DNA patients in the last month	Patients not attending rate 2018-19 YTD	Patients not attending rate 2019-20 YTD	Variance
Cardiothoracic & Vascular Services	10.5%	10.9%	10.3%	10.1%	9.0%	9.6%	9.8%	9.6%	8.5%	8.3%	8.5%	9.0%	9.3%	222	10.6%	9.1%	⇩ -1.5%
Children's Services	10.9%	10.9%	10.9%	10.2%	10.9%	12.3%	10.4%	11.1%	12.4%	11.1%	9.3%	10.4%	9.9%	219	12.5%	10.9%	⇩ -1.6%
Neurosciences	10.2%	10.3%	10.6%	11.0%	11.8%	11.9%	11.2%	10.1%	11.1%	10.2%	10.1%	9.4%	9.5%	346	9.9%	10.6%	⇧ 0.6%
Renal & Oncology	10.2%	9.7%	10.1%	9.4%	9.2%	9.9%	10.1%	8.2%	7.6%	7.9%	7.6%	8.3%	8.2%	262	10.4%	8.6%	⇩ -1.9%
Specialist Medicine	11.5%	12.3%	11.2%	10.8%	11.0%	12.8%	12.1%	10.2%	11.4%	11.1%	10.7%	12.0%	10.6%	1,336	12.3%	11.3%	⇩ -1.0%
Surgery	10.8%	10.4%	10.5%	10.4%	10.2%	10.3%	10.0%	8.8%	9.8%	8.8%	8.8%	9.2%	8.5%	998	11.0%	9.4%	⇩ -1.7%
Womens Services	7.4%	6.6%	7.4%	6.8%	8.0%	7.8%	7.8%	6.7%	7.4%	7.4%	6.6%	7.9%	8.1%	399	8.4%	7.5%	⇩ -0.8%
T&O	10.9%	10.6%	7.9%	9.1%	8.8%	10.7%	9.4%	9.3%	9.0%	10.5%	10.0%	9.8%	9.7%	263	10.9%	9.7%	⇩ -1.2%
Other	14.2%	12.9%	12.9%	14.3%	14.2%	13.4%	12.8%	12.6%	14.3%	14.8%	15.3%	17.6%	17.7%	1,520	12.7%	14.7%	⇧ 2.0%
Total	**10.9%**	**10.8%**	**10.5%**	**10.6%**	**10.7%**	**11.2%**	**10.7%**	**9.7%**	**10.6%**	**10.4%**	**10.1%**	**11.1%**	**10.7%**	**5,565**	**11.0%**	**10.6%**	⇩ -0.5%

Elective & Daycase activity (average per working day)

Months	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	2018-19 YTD	2019-20 YTD	Variance	Discharges for month
Cardiology & Cardiac Surgery	13.8	14.7	17.2	16.2	12.0	13.3	15.4	13.7	13.6	15.6	14.3	16.5	11.7	15.5	14.0	-9.4%	235
Clinical Haematology	1.8	1.0	1.3	1.4	0.8	0.8	0.7	1.4	1.1	0.4	0.7	0.5	0.8	1.8	0.8	-55.5%	17
Diabetes & Endocrinology	1.2	2.0	1.6	1.8	1.8	2.7	1.9	1.6	1.6	1.9	1.3	2.6	1.4	1.8	1.9	3.1%	28
Endoscopy & Gen Med	49.7	57.3	56.4	61.6	57.4	68.5	70.8	65.3	61.7	61.4	68.2	71.9	60.7	56.4	65.1	15.3%	1,215
Ear, Nose & Throat	7.1	9.5	7.9	7.9	8.5	8.3	8.9	8.3	7.5	9.4	8.5	8.0	6.9	8.1	8.3	1.4%	138
General Surgery	10.4	10.7	10.5	12.8	8.1	7.1	8.5	7.2	6.7	7.6	9.0	7.0	6.6	9.9	7.5	-23.9%	132
Gynaecology and Obstetrics	8.8	11.0	10.8	10.4	9.9	10.8	10.5	10.3	8.8	11.0	10.0	11.0	8.2	10.4	10.1	-3.0%	165
Max Fax & Dental	5.5	6.7	7.2	5.4	6.1	7.3	7.2	6.5	5.8	6.8	5.8	5.8	3.8	6.5	6.1	-5.3%	77
Neurosurgery	8.9	8.2	9.3	10.5	8.8	10.3	9.1	8.1	8.5	8.0	9.0	8.3	7.8	9.2	8.6	-5.9%	156
Neurology	24.2	28.7	34.3	31.0	32.4	33.3	32.1	31.9	27.8	30.5	32.2	29.4	24.5	26.2	30.5	16.3%	490
Oncology	1.5	2.8	2.7	1.8	4.0	3.4	3.6	3.8	4.1	4.1	4.6	5.0	3.1	1.7	4.0	138.3%	62
Paediatric Medicine	10.9	10.5	12.5	11.9	12.9	12.3	12.6	11.2	10.5	13.0	11.8	10.6	12.8	10.1	12.0	18.2%	255
Paediatric Surgery	8.4	9.6	10.0	10.0	8.9	10.3	8.2	8.9	9.0	8.4	8.8	9.5	6.6	8.9	8.7	-1.7%	133
Pain Clinic	5.2	5.1	5.3	5.3	4.5	3.1	5.2	3.3	2.3	4.9	3.8	5.2	4.1	5.3	4.1	-23.8%	82
Plastic Surgery	15.9	17.1	17.4	16.5	15.0	19.3	18.5	15.1	16.6	17.5	18.0	17.0	14.7	17.7	16.9	-4.6%	294
Renal Medicine	4.4	3.2	5.2	3.7	4.3	6.5	5.1	4.3	5.5	5.2	5.6	7.0	4.6	4.9	5.3	8.2%	92
Trauma & Orthopaedics	6.0	7.7	8.5	6.4	7.3	8.0	9.2	6.0	6.1	6.0	5.6	8.8	5.7	7.0	7.0	-0.4%	114
Urology	12.9	13.4	14.8	13.2	15.8	13.0	13.7	14.1	12.6	15.8	13.6	14.3	10.5	12.8	13.7	6.8%	210
Thoracic Surgery	2.7	2.3	3.2	3.1	2.2	3.0	3.3	2.9	3.2	3.0	2.4	3.1	2.5	2.8	2.8	0.9%	51
Vascular Surgery	4.3	5.1	3.9	4.4	4.4	4.8	4.1	4.5	3.7	5.2	4.2	4.5	3.6	4.8	4.3	-10.5%	73
Other	5.5	6.5	6.6	4.2	7.5	7.4	8.6	9.3	9.4	11.2	10.5	10.7	8.1	5.6	9.2	63.1%	162
Grand Total	**209.4**	**233.1**	**246.3**	**239.4**	**232.3**	**253.7**	**256.7**	**237.8**	**226.0**	**246.9**	**248.0**	**256.7**	**209.1**	227.5	240.8	**5.8%**	**4,181**
Daycase as a percentage of all Elective Activity	75.0%	77.7%	77.1%	74.8%	77.0%	77.7%	77.2%	78.8%	76.8%	77.7%	79.5%	79.1%	78.0%				

Productivity Tables

Percentage of Daycase Activity

Months	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	2018-19 YTD	2019-20 YTD	Variance
Cardiology & Cardiac Surgery	50%	51%	54%	54%	50%	49%	49%	50%	50%	56%	56%	55%	52%	53%	52%	-0.7%
Clinical Haematology	51%	57%	77%	45%	27%	17%	43%	52%	52%	0%	13%	10%	0%	62%	24%	-38.7%
Diabetes & Endocrinology	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	89%	96%	100%	98%	-1.9%
Endoscopy & Gen Med	99%	99%	99%	98%	99%	97%	98%	97%	96%	97%	97%	98%	99%	99%	98%	-1.1%
Ear, Nose & Throat	31%	43%	39%	28%	39%	49%	37%	51%	42%	45%	47%	54%	46%	45%	46%	0.7%
General Surgery	30%	52%	51%	31%	42%	40%	36%	42%	42%	43%	53%	46%	59%	46%	45%	-1.2%
Gynaecology and Obstetrics	76%	75%	73%	74%	72%	72%	69%	68%	70%	76%	73%	76%	80%	74%	73%	-1.2%
Max Fax & Dental	51%	63%	55%	57%	56%	62%	62%	58%	52%	57%	57%	57%	48%	55%	56%	1.0%
Neurosurgery	32%	34%	30%	31%	26%	31%	28%	33%	32%	30%	25%	36%	27%	34%	30%	-4.7%
Neurology	96%	94%	95%	95%	96%	96%	95%	96%	95%	96%	97%	95%	96%	94%	96%	1.3%
Oncology	62%	79%	76%	65%	82%	79%	82%	82%	81%	67%	87%	87%	89%	58%	82%	23.9%
Paediatric Medicine	98%	94%	96%	94%	95%	96%	96%	98%	95%	94%	97%	95%	95%	91%	96%	4.6%
Paediatric Surgery	84%	84%	81%	84%	80%	85%	77%	80%	79%	85%	81%	78%	81%	82%	81%	-1.1%
Pain Clinic	94%	91%	93%	100%	92%	88%	92%	92%	100%	92%	99%	100%	96%	93%	95%	1.9%
Plastic Surgery	81%	78%	80%	75%	79%	79%	83%	85%	81%	85%	81%	80%	83%	79%	82%	3.1%
Renal Medicine	81%	81%	81%	73%	77%	81%	84%	72%	73%	75%	79%	81%	61%	78%	76%	-2.5%
Trauma & Orthopaedics	60%	75%	71%	72%	63%	61%	69%	68%	66%	75%	78%	75%	67%	64%	69%	5.0%
Urology	55%	56%	52%	47%	58%	51%	50%	61%	54%	58%	55%	60%	50%	52%	55%	3.5%
Thoracic Surgery	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%	0%	0%	0%	0%	2%	0%	-1.5%
Vascular Surgery	61.0%	52.7%	52.6%	48.9%	43%	52.5%	48%	48%	31%	57%	48%	47%	21%	45%	44%	-1.4%
Other	84%	92%	93%	84%	77%	76%	79%	86.9%	75%	74%	85%	70%	70%	89%	77%	-11.7%
Grand Total	**75%**	**78%**	**77%**	**75%**	**77%**	**78%**	**77%**	**79%**	**76%**	**78%**	**79%**	**79%**	**78%**	76%	78%	1.8%

Productivity Tables

Theatre Utilisation

Main List Specialty	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Number of Patients in the last month
Cardiothoracic	72%	72%	80%	74%	70%	70%	75%	70%	73%	75%	71%	81%	75%	55
ENT	78%	80%	76%	74%	75%	78%	72%	73%	82%	82%	75%	83%	76%	118
General Surgery	84%	78%	78%	82%	81%	80%	88%	80%	72%	76%	79%	76%	78%	76
Gynaecology	81%	79%	88%	74%	81%	71%	78%	84%	81%	84%	85%	77%	67%	98
Neurosurgery	80%	82%	78%	75%	79%	78%	78%	79%	79%	81%	76%	77%	82%	135
Oral and Maxillo Facial Surgery	78%	84%	67%	91%	61%	72%	84%	87%	67%	65%	84%	70%	74%	12
Paediatric Dentistry	62%	65%	68%	65%	58%	80%	64%	59%	74%	68%	48%	55%	51%	17
Paediatric Surgery	75%	76%	82%	74%	77%	79%	79%	80%	78%	80%	77%	81%	76%	84
Plastic Surgery	78%	74%	75%	69%	76%	87%	72%	74%	74%	69%	74%	72%	62%	133
Renal Medicine & Surgery	60%	66%	67%	83%	66%	88%	69%	79%	77%	77%	67%	64%	67%	9
Trauma & Orthopaedics	90%	81%	83%	90%	83%	81%	84%	88%	84%	74%	78%	77%	77%	95
Urology	81%	86%	82%	80%	79%	78%	79%	82%	77%	79%	78%	79%	83%	132
Vascular Surgery	74%	76%	82%	75%	68%	73%	74%	72%	67%	75%	73%	66%	75%	48
Grand Total	**80%**	**79%**	**79%**	**77%**	**77%**	**77%**	**78%**	**78%**	**77%**	**77%**	**76%**	**76%**	**76%**	**1,012**

Theatre Average Cases per Session

Main List Specialty	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Cardiothoracic	1.5	1.5	1.7	1.4	1.5	1.6	1.6	1.6	1.6	1.6	1.3	1.6	1.5
ENT	1.6	1.9	1.6	1.6	1.7	1.9	1.9	1.8	2.0	2.0	1.9	1.8	1.9
General Surgery	1.6	1.8	1.7	1.6	1.8	1.8	1.6	1.5	1.7	1.4	1.4	1.2	1.4
Gynaecology	2.9	2.7	2.6	2.3	2.5	2.2	2.4	2.5	2.4	2.7	2.6	2.4	2.5
Neurosurgery	1.2	1.1	1.0	1.1	1.1	1.1	1.1	1.1	1.1	0.9	1.0	0.9	1.1
Oral and Maxillo Facial Surgery	3.8	3.7	3.1	4.0	2.7	3.1	3.4	3.2	3.0	3.0	3.6	2.6	2.8
Paediatric Dentistry	4.7	4.4	4.3	4.1	3.9	4.9	4.2	3.8	3.8	3.8	2.8	3.3	2.7
Paediatric Surgery	2.7	2.6	2.5	2.6	2.4	2.7	2.2	2.5	2.2	2.8	2.5	2.6	2.3
Plastic Surgery	2.0	1.9	2.0	2.1	1.8	1.8	1.7	1.8	2.0	1.9	1.6	2.0	1.7
Renal Medicine & Surgery	1.4	1.2	1.8	1.5	1.9	2.0	1.2	1.1	1.0	1.4	1.3	2.4	1.1
Trauma & Orthopaedics	1.8	1.9	1.9	1.9	1.8	1.8	2.0	1.7	1.8	1.7	1.7	1.7	1.7
Urology	2.1	2.0	2.0	2.0	2.0	2.1	2.1	2.1	1.8	1.9	1.9	2.0	1.7
Vascular Surgery	1.1	1.0	1.0	1.1	1.0	1.1	1.4	1.4	1.3	1.5	1.3	1.4	1.2
Grand Total	1.8	1.8	1.8	1.7	1.7	1.8	1.8	1.8	1.7	1.7	1.6	1.7	1.6

Productivity Tables

Elective Length of Stay

Directorate	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Discharges in the last month	2018-19 YTD	2019-20 YTD	Variance
Cardiothoracic	3.7	3.5	4.2	3.6	3.0	3.5	3.9	3.7	3.6	3.6	3.3	3.0	3.3	171	3.9	3.4	⇩ -11%
Children's & Women	2.1	3.8	2.7	3.0	2.4	1.9	2.0	2.2	1.9	3.8	5.1	1.6	4.7	77	2.5	2.8	⇧ 13%
Neurosciences	10.6	10.2	8.4	5.9	10.1	7.8	6.9	11.1	9.4	8.9	7.5	11.8	9.9	152	9.2	9.3	⇧ 1%
Surgery & Trauma	4.6	4.5	3.9	3.5	2.6	2.5	2.6	2.4	2.9	2.0	2.6	2.5	2.7	440	3.8	2.5	⇩ -34%
Grand Total	**5.3**	**5.4**	**4.7**	**4.7**	**3.8**	**3.5**	**3.5**	**4.1**	**4.0**	**3.4**	**3.9**	**3.9**	**4.3**	**840**	**4.7**	**3.8**	⇩ -19%

Non-Elective Length of Stay

Directorate	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Discharges in the last month	2018-19 YTD	2019-20 YTD	Variance
Acute Medicine	2.7	2.9	2.8	2.8	2.7	2.7	2.5	2.6	2.9	3.1	2.9	2.9	4.1	2,223	2.7	2.9	⇧ 10.55%
Cardiothoracic	8.8	7.6	9.7	11.7	10.2	12.3	9.1	11.2	8.1	10.7	10.3	9.4	9.3	1580	8.5	10.1	⇧ 18%
Children's & Women	2.4	2.4	2.9	3.1	3.4	3.6	3.7	3.7	3.2	3.3	3.6	3.1	2.9	845	2.4	3.4	⇧ 39%
Neurosciences	9.8	10.8	13.5	9.3	9.5	11.9	6.8	9.9	10.3	8.6	11.2	12.4	9.3	221	9.4	10.0	⇧ 6%
Senior Health	11.4	12.5	11.1	11.2	12.7	12.6	10.2	12.6	10.6	16.6	18.4	23.1	13.5	66	9.8	14.5	⇧ 48%
Specialist Medicine	7.5	8.3	6.8	8.5	9.5	11.1	11.2	7.9	9.4	10.1	8.3	9.5	7.5	122	7.3	9.4	⇧ 28%
Surgery & Trauma	4.2	5.3	5.0	4.0	4.3	4.2	4.1	4.8	4.1	4.3	4.1	4.5	5.4	714	4.5	4.4	⇩ -1.6%
Therapeutics	21.1	12.3	25.3	11.3	11.0	22.5	23.0	14.1	7.6	12.6	18.0	10.1	17.7	35	12.1	15.2	⇧ 25%
Grand Total	**3.8**	**4.0**	**4.3**	**4.0**	**4.1**	**4.3**	**3.9**	**4.2**	**4.1**	**4.4**	**4.4**	**4.4**	**4.8**	**4,376**	**3.8**	**4.3**	⇧ 13%

Maternity

Definitions	Format	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Total number of women giving birth (per calendar day)	Number	14 per day	13.3	13.6	13.1	12.9	13.6	14.0	13.6	13.2	12.6	13.4	14.4	12.9	14
Caesarean sections (Total Emergency and Elective by Delivery date)	%	<28%	23.7%	29.2%	28.5%	31.4%	30.4%	25.9%	25.9%	25.9%	25.6%	27.4%	25.7%	24.2%	26.7%
% deliveries with Emergency C Section (including no Labour)	%	<8%	1.9%	4.5%	4.6%	3.7%	4.7%	2.8%	3.2%	3.9%	2.6%	5.2%	4.5%	1.5%	4.0%
% Time Carmen Suite closed	%	0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%	6.7%	0.0%	4.8%	1.7%	19.4%	11.7%	8.1%
% of all births in which woman sustained a 3rd or 4th degree tear	%	<5%	1.5%	2.1%	1.4%	2.0%	1.5%	2.8%	1.2%	1.5%	3.3%	3.5%	4.0%	2.6%	5.3%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	%	<4%	2.7%	2.6%	1.9%	3.0%	2.7%	1.8%	2.0%	3.4%	2.1%	2.0%	2.3%	3.4%	3.0%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit	Number		10	12	6	8	10	9	12	7	6	9	5	12	7
Supernumerary Midwife in Labour Ward	%	>95%	100.0%	98.4%	96.4%	95.2%	96.7%	98.4%	98.3%	100.0%	96.8%	96.7%	96.8%	96.7%	96.8%
% women booked by 12 weeks and 6 days	%	90%	86.2%	84.7%	86.6%	87.3%	83.3%	86.6%	88.4%	85.3%	84.9%	81.5%	81.7%	84.1%	85.7%

Patient Safety

Indicator Description	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Number of Never Events in Month	0	0	1	0	0	1	0	0	1	0	0	1	0	1
Number of SIs where Medication is a significant factor	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Number of Serious Incidents	=<8 month	6	6	6	4	3	7	7	2	4	1	3	1	6
Serious Incidents - per 1000 bed days	N/A	0.26	0.25	0.27	0.16	0.13	0.29	0.30	0.08	0.17	0.04	0.12	0.04	0.25
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.6%	95.9%	96.5%	96.0%	96.1%	96.1%	94.6%	95.4%	95.3%	96.0%	96.8%	98.1%	96.3%
Safety Thermometer - % of patients with harm free care (new harm)	95%	97.6%	98.4%	98.6%	98.3%	98.3%	98.9%	98.0%	97.8%	98.7%	98.2%	98.3%	98.7%	98.0%
Percentage of patients who have a VTE risk assessment	95%	95.5%	95.9%	95.7%	95.5%	87.8%	88.2%	87.6%	93.8%	93.8%	93.9%	94.0%	94.7%	
Number of Patient Falls	N/A	148	128	147	135	143	135	133	123	158	142	131	137	140
Falls (Moderate and Above Severity)	N/A	1	3	1	2	2	2	1	0	3	0	2	2	4
Number of patient falls- per 1000 bed days	N/A	6.32	5.31	6.57	5.38	6.08	5.63	5.75	4.99	6.58	6.03	5.25	5.57	5.87
Acquired Category 2 Pressure Ulcers	N/A	13	10	16	6	4	17	20	10	15	15	13	11	21
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.56	0.42	0.72	0.24	0.17	0.71	0.86	0.41	0.63	0.64	0.52	0.45	0.88
Acquired Category 3 Pressure Ulcers		7	7	4	11	8	5	8	8	2	3	5	5	10
Acquired Category 3 Pressure Ulcers per 1000 bed days		0.30	0.29	0.18	0.44	0.34	0.21	0.35	0.32	0.08	0.13	0.20	0.20	0.42
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Complaints

Indicator Description	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Complaints Received		78	92	84	101	108	102	96	96	88	81	88	79	55
% of Complaints responses to within 25 working days	85%	78%	66%	55%	80%	72%	79%	78%	95%	100%	100%	100%	100%	100%
% of Complaints responses to within 40 working days	95%	48%	30%	64%	44%	56%	46%	57%	72%	96%	100%	100%	100%	
% of Complaints responses to within 60 working days	95%	None Due	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PALS Received		252	369	334	280	249	247	218	177	259	232	316	283	218

Patient Priorities

Indicator Description	Threshold/Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Number of 2222 calls / 1000 adult ordinary IP admissions		11.3	11.0	11.2	8.8	7.1	8.9	10.2	12.2	8.3	7.0	7.4	11.1	12.9
Number of Cardiac Arrests / 1000 adult ordinary IP admissions (to become avoidable cardiac arrests)		2.6	3.8	3.3	2.8	4.0	2.9	1.8	3.6	0.9	1.6	1.2	2.2	3.2
% of patients in ED with Red Flag sepsis receiving antibiotics within an hour (adults)	90%	93.5%	94.5%	93.2%	88.3%	90.6%	91.4%	93.5%	87.2%	83.4%	90.3%	86.4%	89.5%	83.5%
Compliance with appropriate response to EWS (adults)	100%	93.3%	95.8%	87.3%	89.6%	92.7%	94.2%	92.9%	90.6%	93.9%	87.6%	86.8%	89.6%	89.0%
Resuscitation BLS	85%	69.8%	70.5%	71.5%	74.1%	76.2%	75.2%	76.0%	75.5%	75.9%	76.4%	77.8%	79.8%	81.3%
Resuscitation ILS	85%	68.5%	70.2%	69.3%	71.3%	72.1%	72.7%	72.0%	72.5%	69.2%	67.9%	67.7%	68.3%	71.7%
Resuscitation ALS	85%	51.2%	64.2%	67.0%	70.4%	72.7%	73.0%	73.5%	74.8%	59.1%	62.7%	64.4%	63.9%	66.9%

Indicator Description	Threshold/Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	83.4%	83.9%	86.3%	88.6%	89.8%	91.8%	90.8%	92.2%	92.1%	90.5%	89.6%	89.3%	90.0%
Mental Capacity Act & Deprivation of Liberties - Level 2	85%		21.7%	32.2%	42.0%	53.2%	62.9%	70.9%	74.3%	73.0%	72.7%	72.2%	73.6%	75.1%
%-age Staff knowledge of Mental Capacity Act - Fully Compliant					76.7%	100.0%	85.0%	75.0%	76.9%	100.0%	90.5%	94.7%	88.2%	85.7%
Staff knowledge of Mental Capacity Act - Number of staff interviewed					30	15	20	12	13	8	21	19	17	14
Total Datix incidents reported in month		1,174	1,333	1,215	1,208	1,096	1,329	1,332	1,413	1,544	1,442	1,410	1,310	
Monthly percentage of incidents of low and no harm						97.0%	97.0%	99.0%	97.0%	98.0%	97.0%	96.0%	data one months in arrears	
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%					100.0%	92.0%	100.0%	97.0%	93.0%	97.0%	data two months in arrears		
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	78%	67%	62%	Compliance timeframe changed from 10 working days to 20 working days									

Emergency Flow

Indicator Description	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
4 Hour Operating Standard	95%	85.6%	84.2%	82.2%	83.1%	85.4%	86.5%	87.0%	86.4%	83.3%	82.3%	83.2%	79.4%	79.4%
Patients Waiting in ED for over 12 hours following DTA	0	2	0	0	1	1	0	1	2	3	1	4	9	7
Admitted patients with a length of stay 7 Days or Greater		291	315	321	315	298	301	290	314	302	315	320	336	309
Ambulance Handover - % under 15 minutes	100%	37.0%	33.9%	33.0%	33.0%	35.1%	35.2%	36.0%	32.9%	32.4%	31.1%	31.3%	28.0%	24.3%
Ambulance Handover - % under 15 minutes (London Average)	100%	44.7%	41.6%	43.1%	45.4%	43.5%	44.4%	42.3%	43.9%	45.0%	44.7%	41.7%	38.9%	36.8%
Ambulance Handover - number of patients not handed over within 30 minutes	0	135	145	87	94	76	112	119	134	171	163	176	238	271
Ambulance Handover - % under 30 minutes	100%	93.6%	92.3%	95.1%	93.6%	95.5%	94.3%	93.5%	92.9%	90.8%	90.8%	90.2%	86.4%	83.8%
Ambulance Handover - % under 30 minutes (London Average)	100%	90.5%	88.2%	90.3%	92.7%	91.7%	92.2%	90.6%	92.4%	92.3%	92.0%	89.6%	86.6%	84.1%
Ambulance Handover - number of patients not handed over within 60 minutes	0	1	13	6	8	6	0	4	2	1	4	11	16	22

Diagnostics

Indicator Description	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
6 Week Diagnostic Performance	1%	0.6%	0.5%	0.3%	0.5%	1.6%	0.7%	0.4%	0.95%	0.96%	0.92%	3.3%	4.8%	6.7%
6 Week Diagnostic Breaches	N/A	37	41	24	40	115	59	31	74	74	75	300	393	544
6 Week Diagnostic Waiting List Size	N/A	6,652	7,649	7,754	7,622	7,247	8,274	7,992	7,772	7,737	8,153	9,025	8,205	8,142

Indicator Description	Threshold	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
MRI	1%	0.6%	0.4%	0.6%	0.1%	0.3%	0.3%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.2%
CT	1%	0.7%	0.6%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.6%
Non Obstetric Ultrasound	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	1.0%	0.1%	0.0%	0.0%	0.2%
Barium Enema	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dexa Scan	1%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Audiology Assessments	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Echocardiography	1%	0.0%	0.8%	0.4%	4.3%	12.1%	4.2%	1.0%	9.0%	4.7%	7.3%	36.1%	51.4%	27.1%
Electrophysiology	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	66.7%
Peripheral Neurophysiology	1%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.3%	0.5%	6.2%	9.9%
Sleep Studies	1%	2.4%	1.1%	0.8%	2.7%	4.6%	4.8%	1.4%	1.0%	0.9%	4.0%	3.0%	1.6%	0.5%
Urodynamics	1%	8.5%	16.3%	14.0%	0.0%	5.7%	0.0%	0.0%	2.9%	4.9%	0.0%	9.5%	37.5%	25.0%
Colonoscopy	1%	0.0%	2.9%	1.0%	0.0%	1.0%	0.6%	0.6%	0.9%	0.3%	0.4%	1.8%	3.0%	4.7%
Flexi Sigmoidoscopy	1%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	0.6%	2.0%	1.4%	1.9%	3.0%	3.0%	4.2%
Cystoscopy	1%	5.4%	3.2%	0.0%	1.9%	3.2%	6.4%	2.6%	3.0%	2.6%	0.0%	3.0%	3.3%	11.8%
Gastroscopy	1%	0.6%	1.4%	0.6%	1.8%	2.1%	2.3%	3.1%	3.7%	2.8%	1.6%	3.0%	3.3%	4.6%

Data tables

On the Day Cancellations

Indicator Description	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Number of on the Day Cancellations		60	86	73	49	45	69	69	54	38	46	53	86	65
Number of on the Day cancellations re-booked within 28 Days		58	86	71	47	42	68	69	54	38	45	52	80	59
% of Patients re-booked within 28 Days	100%	96.7%	100.0%	97.3%	95.9%	93.3%	98.6%	100.0%	100.0%	100.0%	97.8%	98.1%	93.0%	90.8%

Cancer

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	No of Patients
Cancer 14 Day Standard	93%	95.9%	96.6%	94.4%	93.3%	94.4%	92.4%	90.2%	92.5%	95.6%	95.4%	93.8%	94.3%	94.0%	1,423
Cancer 14 Day Standard Breast Symptomatic	93%	95.4%	96.9%	97.4%	94.6%	94.7%	94.4%	94.9%	93.2%	94.9%	93.0%	94.3%	98.4%	97.4%	195
Cancer 31 Day Diagnosis to Treatment	96%	96.5%	98.2%	97.4%	98.4%	98.1%	96.2%	96.9%	96.0%	97.0%	98.5%	97.4%	96.9%	96.0%	201
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	96.6%	94.6%	97.9%	94.4%	96.2%	100.0%	95.7%	96.7%	100.0%	100.0%	100.0%	97.1%	96.8%	31
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	111
Cancer 62 Day Referral to Treatment Standard	85%	88.1%	94.8%	86.2%	77.8%	85.0%	75.6%	71.4%	85.8%	92.7%	87.1%	87.6%	89.0%	88.6%	79
Cancer 62 Day Referral to Treatment Screening	90%	93.2%	82.0%	88.7%	70.5%	76.6%	87.7%	96.5%	93.8%	97.4%	100.0%	100.0%	94.9%	87.7%	28.5

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	**30 January 2020**	**Agenda No**	**2.4 (Public)**
Report Title:	**Cardiac Surgery Update**		
Lead Director	**Richard Jennings, Chief Medical Officer**		
Report Author(s):	**Steve Livesey, Associate Medical Director for Cardiac Surgery & Cardiac Surgery Care Group Lead**		
Presented for:	**(1) Assurance and (2) Information**		
Executive Summary	This paper was considered at the Trust's Quality and Safety Committee held on 23 January 2020. It provides assurance on the quality and safety of the Cardiac Surgery Service, and the on-going steps being taken to improve the service following the NICOR safety alerts (2018) and the findings of the independent review (Professor Bewick, July 2018). Since the last update to Trust Board (19 December 2019): • The most recent NHSE/I Single Item Quality Surveillance Group Meeting was held on 13 January 2020 and no new quality concerns were raised. • The Trust has been invited by NHSE/I to provide clinician responses on any substantial matters of factual accuracy in the Structured Judgement Reviews produced by the external mortality review panel, and these have been provided. The External Mortality Review Panel report is awaited. • The Trust continues to communicate 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. • The risks rated as moderate and above on the Cardiac Surgery Service Risk Register have not changed.		
Recommendation:	The Board is asked to note the updated information on safety assurance and on-going actions.		
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.		
Equality and Diversity:	N/A		
Previously Considered by:	Trust Executive Committee Quality and Safety Committee	**Date**	22.01.20 23.01.20
Appendices:	None		

CARDIAC SURGERY UPDATE; JANUARY 2020

1. PURPOSE

1.1 To update the Board on the information that provides assurance on the quality and safety of the Cardiac Surgery Service, and the on-going steps being taken to improve the service, since the last report received to Trust Board on 19 December 2019.

2 EXTERNAL ASSURANCES

2.1 The most recent NHSE/I Single Item Quality Surveillance Group Meeting was held on 13 January 2020 and no new quality concerns were raised.

3. INTERNAL ASSURANCES: SAFETY UPDATE

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

3.2 As was reported to the Trust Board in December 2019, there have been no deep sternal wound infections in 2019. The Trust's Cardiac Surgery Steering Group is overseeing the Care Group's development of an action plan to maintain this good performance, but also to further reduce the risk of *any* post-surgical site infections, and this plan will be reviewed in February 2020.

3.3 Since the last Trust Board paper received on 19 December 2019 there have been 5 inpatient post-operative deaths. In accordance with the Trust's Standard Operating Procedure for post-operative deaths in Cardiac Surgery, the care provided in these cases is 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 investigation relating to post-operative deaths within Cardiac Surgery are independently reviewed by a Cardiac Surgery expert at another Trust in South London.

4. EXTERNAL MORTALITY REVIEW

4.1 The Trust has been invited by NHSE/I to provide clinician responses on any substantial matters of factual accuracy in the Structured Judgement Reviews produced by the external mortality review panel, and these have been provided. The External Mortality Review Panel continues to draft its report.

5. EXTERNAL GOVERNANCE; UPDATE

5.1 The Trust continues to communicate 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.

6. CARDIAC SURGERY RISK REGISTER; UPDATE

6.1 The risks rated as moderate and above on the Cardiac Surgery Service Risk Register have not changed since the last Trust Board meeting.

7. RECOMMENDATION

Trust Board is asked to note the updated information on safety assurance and on-going actions.

Meeting Title:	**TRUST BOARD**		
Date:	30 January 2020	**Agenda No.**	**2.5**
Report Title:	Emergency Preparedness Resilience and Response - Annual EPRR Assurance Submission to NHS England (London)		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer and Authorised Executive Officer (AEO)		
Report Author:	Kristel McDevitt, Emergency Preparedness Manager		
Presented for:	Assurance		
Executive Summary:	This report provides an update on the outcomes of the 2019-20 NHS England EPRR Assurance process. The main points: • Trust achieved **SUBSTANTIALLY COMPLIANT** with the EPRR Core Standards. • Trust has agreed an action plan to achieve full compliance.		
Recommendation:	The Board is asked to note the NHS England EPRR assurance findings and the 'substantial' rating.		
Supports			
Trust Strategic Objective:	Ensure the Trust has unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Operational performance		
Implications			
Risk:	If the work is not maintained, there is a risk that the trust will not be prepared in the event of a Major Incident or a significant Business Continuity disruption.		
Legal/Regulatory:	Emergency Preparedness, Resilience and Response standards are a requirement under the NHS England EPRR Framework 2015 which are aligned to the statutory duties under the Civil Contingencies Act 2004, and the Health and Social Care Act 2012.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix 1 - Action plan for areas of 'substantially compliant' Appendix 2 - 2018 EPRR Assurance Report from NHS England		

EPRR Assurance Report 2019 - AEO response

As required by the EPRR 2019-20 assurance process initiation letter dated 9 July 2019, this response:

- confirms the EPRR RAG scores agreed at the 8 October review meeting
- outlines the action plan required to remedy identified weaknesses
- agrees our overall level of compliance with the EPRR core standards.

1 LEVEL OF COMPLIANCE

I am pleased to note that NHS England felt that 'overall, the trust demonstrated its commitment to EPRR'. However, I also accept that the assurance process identified some weaknesses in our arrangements and agree that this year; our overall level of compliance is **SUBSTANTIALLY COMPLIANT**.

To move the trust towards full compliance with the EPRR core standards I have agreed an action plan with the Emergency Preparedness Manager focusing on the priorities outlined below.

Full details of the action plan, including timescales and lead officers, can be found in the updated self-assessment tool (appendix 1).

2 PRIORITIES FOR 2019/20

The trust will prioritise the following tasks during the year ahead:

- Undertake annual reviews of the following plans (now deemed dated as no evidence of a recent review);
    - Mass Countermeasures plan
    - Pandemic influenza plan
    - Evacuation plan
- The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s)
- Assurance of commissioned providers / suppliers BCPs
- CBRNe staff awareness, specifically the Emergency Department Major incident training to include more detail on identification and decontamination guidance

3 NEXT STEPS

The results of the 2019 EPRR assurance process and the action plan to address areas of weakness will be submitted at the Board meeting in January 2020 to ensure that the Board is sighted on the assurance result and to receive Board-level sign off.

Ellis Pullinger

Chief Operating Officer,

AEO for St George's University Hospitals NHS Foundation Trust

Appendix 1 - Action plan for areas of 'substantially compliant'

EPRR core standard	Description of core standard	Actions to be taken	Lead officer(s)	Timescale
15	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register	Review Pandemic Influenza Plan	Business Continuity Steering group / Infection Control Committee	Spring / Summer 2020. (Review of plan to start January 2020)
17	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, e.g. mass prophylaxis or mass vaccination	Review Mass Countermeasures Plan. Discussed reviewing against trust infrastructure and internal process, to ensure plan can be validated to 'Green' rating in 2020.	Business continuity Steering group / Pharmacy	March / April 2020. (Review of plan started December 2020)
20	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation	Review Evacuation Plan - requires further exercising and plan review.	Business continuity Steering group	TBC – depending on the outcome of the Fire Strategy review of all inpatient areas.

EPRR core standard	Description of core standard	Actions to be taken	Lead officer(s)	Timescale
49	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s)	Critical services have not all completed BIAs, however it is recognised that there have been significant improvements over the last 12 months.	Business continuity Steering group. All services	COMPLETED. November 2019
55	Assurance of commissioned providers / suppliers BCPs - The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers' arrangements work with their own.	Needs review as point from last year's assurance may not have been implemented yet	Emergency Preparedness Manager	TBC – Met with Procurement early 2020 to confirm if BREXIT planning covers these requirements?
68	Staff training – decontamination. Training issue – staff need to appreciate the importance of initial improvised wet decontamination with caustic agents.	Improve: message in ED communication folder, monthly walk through and scenarios. Discuss further in Major incident training day	Tim Hardiman	COMPLETED. October 2019- included in training. Review effectiveness before 2020 assurance.

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

2

Meeting Title:	Trust Board		
Date:	30 January 2020	**Agenda No**	**2.6**
Report Title:	Seven-Day Services: An update report for achieving compliance with national standards		
Lead Director/ Manager:	Richard Jennings, Chief Medical Officer		
Report Authors:	Mark Hamilton, Associate Medical Director for Quality Improvement		
Presented for:	Assurance		
Executive Summary:	There is a national expectation that Trusts should be complaint with the four key clinical standards for seven-day services by April 2020, although national data indicates that many Trusts are not yet fully compliant with all four standards. A paper outlining the Trust's compliance with the clinical standards was received to Trust Board in December 2019. The Trust Board requested that: 1) The Chief Medical Officer (CMO) bring an interim update report on a plan for compliance to Quality and Safety Committee (QSC) and Trust Board. 2) The Chief Nurse (CN) put the risk onto the Board Assurance Framework 3) The Chief Transformation Officer (CTO) include weekend mortality in the integrated quality and performance report This report outlines the background to seven-day services, how they are reported and the Trusts current performance. The Trust does not currently fully comply with consultants seeing >90% of emergency patients within 14 hours of admission (Standard 2) at weekends. The Trust also does not yet fully comply with the national standard (Standard 5) with regard to magnetic resonance imaging (MRI) at the weekend. MRI is available at the weekend for critical and urgent indications, but the arrangements for this are not as streamlined as they should be, and MRI is not currently available for non-urgent indications within 24 hours at the weekend. The paper contains a detailed plan (the compliance plan) to improve our performance against these standards by April 2020 and recommends a series of actions to take that will increase the likelihood of compliance being achieved. This paper was considered at the Trust's Quality and Safety Committee held on 23 January 2020.		
Recommendation:	The Board is asked to: 1) To receive and approve the action plan for compliance; and 2) To endorse the recommendations for the governance and reporting of seven-day services.		
Supports			
Trust Strategic Objective:	Outstanding care every time		

CQC Theme:	Well led		
Single Oversight Framework Theme:			
Implications			
Risk:	As outlined in the report		
Legal/Regulatory:	As outlined in the report		
Resources:	As outlined in the report		
Previously Considered by:	Trust Board Trust Executive Committee Quality and Safety Committee	**Date**	19.12.19 22.01.20 23.01.20
Appendices:	1 - November BAF submission 2 – Action Plan 3 – Suggested Governance & Reporting Structure		

Seven-Day Services:

An update report for achieving compliance with national standards

1.0 Purpose

1.1 In December 2019 the Trust Board felt it could not be assured that there was a clear plan to improve our performance against the national standards for seven-day services in view of the national expectation that Trusts should be fully compliant by April 2020.

1.2 This paper sets out that plan to improve our performance against these standards by April 2020.

1.3 As part of that plan it also sets out the governance and reporting changes that are needed for ongoing assurance now and beyond April 2020.

1.4 After April 2020 it is likely that six further standards will become national expectations, so ensuring these changes are made effectively will provide better ongoing assurance.

2.0 Background for seven-day service standards

2.1 What is seven-day services?

2.1.1 Since 2016, NHSE have led a programme of work to deliver a better service for patients across the full seven days of the week by introducing a number of clinical standards it expects Trusts to achieve.

2.2 What are the clinical standards?

2.2.1 There are ten standards overall, four of which have been prioritized for delivery by April 2020. These apply to the admission of emergency patients only with a threshold for compliance set at >90% of all emergency admissions.

2.2.2 These four standards are set out below:

Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.
Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week.
Standard 6: Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.
Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

2.3 How have they been reported and how has the Trust performed?

2.3.1 It should be noted that the advice given on the reporting and meaning of these clinical standards has changed over the last few years, resulting in NHSE tightening up many of their definitions and processes. This has created some ambiguity for organisations in interpreting what is needed.

2.3.2 From 2016 until 2018

2.3.2.1 Services were audited by an internal team at St. George's and the results were collated by NHSE at a national level to allow for comparative benchmarking. The Trust performed well against its peers and made steady progress.

2.3.2.2 Nationally the achievement of standard 2 was seen as the most challenging for all organisations.

2.3.2.3 In 2017 an additional standard for specialist services (Stroke, STEMI, Vascular Emergencies, Major Trauma, and PICU) was added for specialised commissioning. Performance analysis was undertaken, and the Trust was assured by NHSE of >90% compliance and was one of the first to achieve that standard.

2.3.3 From 2019 until 2020

2.3.3.1 NHSE stopped collecting data for benchmarking through its data submission portal and trialled the use of local reporting through a Board Assurance Framework, with an additional focus on weekday and weekend performance. The guidance was not specific with some Trusts choosing to do this at Board level and others allowing a sub-committee of the board to oversee the assurance process. On advice from the Director of Quality Governance, assurance through a sub-committee of the Board was adopted.

2.3.3.2 Feedback from NHSE suggested the splitting out of performance between weekday and weekend performance meant some Trust's compliance had reduced. This did not appear to be the case with St. George's.

2.3.3.3 Over the course of 2019 St. George's continued to improve its performance and submitted two self-assessments to NHSE, but failed to gain full compliance for standards at weekends. Work was undertaken with the individual care groups to help them improve their performance. (See Appendix 1)

2.3.4 Which services still need to improve their performance against standard 2?

2.3.4.1 Although the Trust is compliant with the weekday standard overall there is still a need for the specialities of Urology and ENT to improve their performance. Both have job plans to support the delivery of the standard but need to improve their operational delivery of the standard.

2.3.4.2 For performance at the weekend the following specialties need to improve their performance. General surgery, ENT, Haematology and infectious diseases. Due to the number of patients seen by General surgery, if they could improve their performance by 5%, then the Trust is likely to become compliant overall with the standard at weekends, and so this may be an area to prioritise.

2.3.4.3 Working on standardising clinical pathways of care for specialties that see common conditions has helped other organisations achieve compliance and should be considered by Divisions.

3.0 Compliance plan

A number of key steps are needed for the Trust to be assured that it will be complaint with the four national standards for seven-day services by April 2020. Taking these steps will also allow the Trust to be better assured for the six further standards beyond April 2020. These are laid out below and detailed in the attached action log in Appendix 2:

3.1 **Improve the governance of seven-day services provision at Divisional, Directorate and Care Group level**

3.1.1 Divisions ideally need to have better integrated visibility of their current performance and gaps in performance by Directorate and Care Group for all specialities that admit emergency patients.

3.1.2 Each non-compliant speciality (as outlined in section 2.3.4) will need to develop an action plan at care group level to describe how they propose to achieve the April 2020 compliance date.

3.1.3 These action plans should be scrutinised at Divisional Governance boards and assessed for the risk of non-delivery. It may be necessary to have more frequent reporting to the Division for plans that are considered high risk.

3.1.4 Divisions need to have clear oversight of action plans against gaps in performance and a way of reporting and monitoring these action plans through an integrated governance structure that places discrete emphasis on where and when seven-day services are reported.

3.1.5 Divisions need to develop a way of escalating and dealing with the risk of non-compliance either because of resource limitations or a failure of the current operating model of the speciality.

3.2 **Agree a reporting structure to support the monitoring and delivery of services against the seven-day services framework from Care Group through to Board**

3.2.1 The Trust will need to agree and be confident that the suggested governance and reporting structure outlined in the attached diagram will provide floor to board oversight of seven-day services (See Appendix 3).

3.2.2 Divisions, Directorates and Care Groups will also have to agree and comply with the suggested governance and reporting structure for this assurance to be effective.

3.3 Agree a rolling self-audit programme for services from April 2020 to ensure ongoing compliance that is integrated into the reporting architecture

3.3.1 The change in national reporting now places the emphasis on Trusts to self-report their performance and report this in their Board Assurance Framework. It is not possible to get this data from our iClip system currently, despite multiple attempts to do that. As a result, each speciality will need to complete an audit of their performance regularly.

3.3.2 For those specialities that are known to be compliant this could be on a yearly basis. For those specialities that are not compliant this should be more frequent and potentially done on a quarterly basis to support progress against the appropriate action plan for that speciality.

3.3.3 Directorates and Divisions should agree on a rolling programme of self-audit for specialties they are responsible for and publish that annually via a report to their Divisional Governance Boards. It is also recommended that the audit department have sight of these plans to ensure a connected audit function in the Trust.

3.4 Ongoing monitoring of this compliance plan

3.4.1 Divisions should ensure that they have monthly oversight of the action plan for non-compliant specialties and be able to escalate risks that arise to the CMO and CN.

3.4.2 Quality and Safety Committee (QSC) should receive a report from each Division via the CMO up to and including April 2020 for those specialties that remain non-compliant, with a view of reporting to Trust Board in April 2020. This should include details of the actions being taken to help evaluate any risk of non-compliance by April 2020 and identify any enabling decisions that may need to be made.

3.4.3 These processes should be reviewed after April 2020 against the expected ongoing need to progress against the additional six standards if NHSE continues to set standards against them. It is likely that Trusts will need to continue to show their compliance against these and the existing four standards. It is proposed that Divisions review the above recommendations after April 2020 for their fitness for purpose to continue to monitor and implement these standards and make any necessary changes.

4.0 Summary and Conclusion

The Trust has made good progress on the clinical standards for seven-day services since 2016 but needs to take further steps to optimise our performance against these quality standards by April 2020, and to have clear action plans for any areas of non-compliance.

These actions include improving the governance, reporting, action planning, risk assessment and auditing of services at Divisional, Directorate and Care Group level. They also include creating a better floor to Board governance function.

There remains a risk that this Trust, like many other Trusts, will not be fully complaint with the four core standards for seven-day services by April 2020, but this paper sets out the plan to minimise that risk, and to ensure that we optimise our performance against these core standards as quickly as possible.

7 Day Hospital Services Self-Assessment

Organisation	St. George's University Hospitals NHS Foundation Trust
Year	2019/20
Period	Autumn

St George's University Hospitals NHS Foundation Trust: 7 Day Services Self-Assessment - Spring 2019

Priority 7DS Clinical Standards

Clinical standard	Self-assessment of performance	Weekday	Weekend	Overall score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Appended is a paper that was reviewed by the Quality and Safety Comittee on November 21st 2019. It highlighs the significant improvement the Trust has made against standard 2 for which it is now complaint for weekday admissionsa and very close to compliance for weekedn admissions. Specialities that see low numbers of pateints or repeating patterns of clinical admissions have worked on standardising pathways of care and wokring in larger teams to see patients in a timely fashion. These include ENT, Haematology and Infctious Dieseases. The speciaiilities of General and Colorectal surgery have made progress with a 89% weekday and 70% weekend performance against the standard. They are continuing to work with their Division to improve this performance and will re-audit their performance in Q3 this year.	Yes, the standard is met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

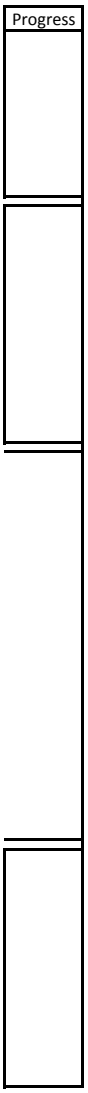
Clinical standard	Self-assessment of performance		Weekday	Weekend	Overall score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • within 1 hour for critical patients • within 12 hours for urgent patients • within 24 hours for non-urgent patients.	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	The Trust has 24/7 access to MRI for regional neurology and neurosurgical patients. For other patients, MRI at the weekends is only available via informal arrangement. A business case is being formulated to provide the capacity to deliver a formal and robust arrangement for weekend MRI.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic resonance imaging (MRI)	Yes available on site	No the test is only available on or off site via informal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-assessment of performance		Weekday	Weekend	Overall score
Clinical Standard 6: Hospital inpatients must have timely 24-hour access, seven days a week, to key	Q: Do inpatients have 24-hour access to the following consultant-directed interventions seven days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	
		Interventional radiology	Yes available on site	Yes available on site	

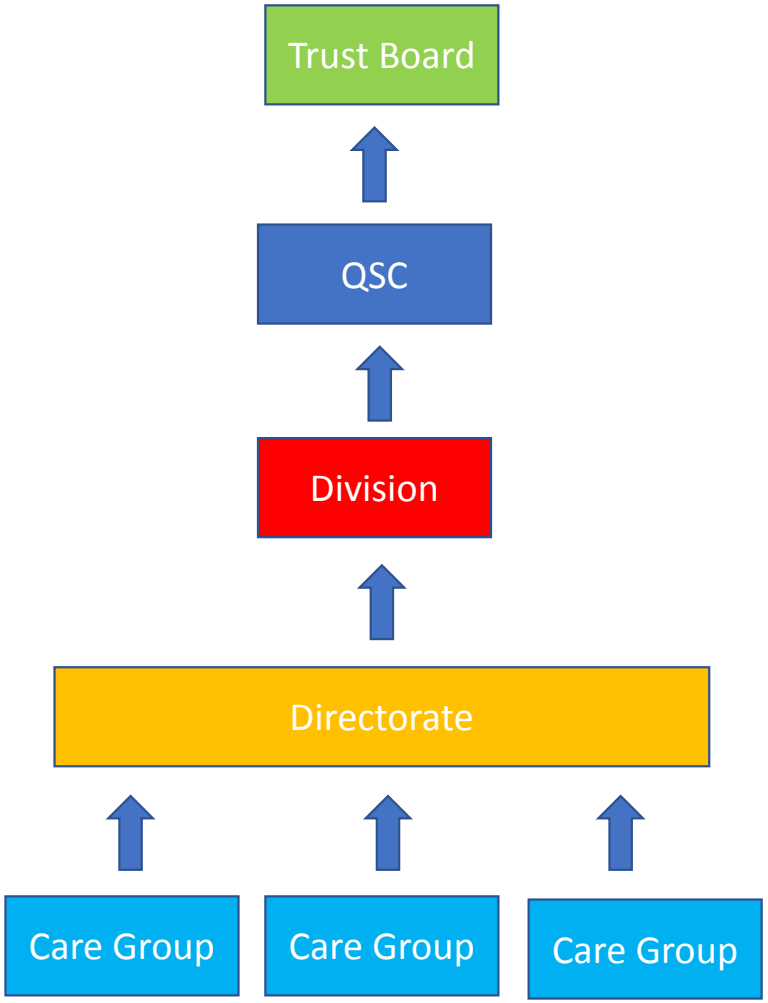
consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear written protocols.	[illegible]	Interventional endoscopy	Yes available on site	Yes available on site	Standard Met
		Emergency surgery	Yes available on site	Yes available on site	
	No change	Emergency renal replacement therapy	Yes available on site	Yes available on site	
		Urgent radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous coronary intervention	Yes available on site	Yes available on site	
		Cardiac pacing	Yes available on site	Yes available on site	

Clinical standard	Self-assessment of performance	Weekday	Weekend	Overall score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Once daily reviews: Weekday - 100%, weekend 100% Twice daily reviews: Weekday - 98%, weekend - 94%	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

			Action	Owner	Due Date
Corporate		c1	Include seven day services risk on Board Assurance Framework	CNO	Jan
		c2	Interim report to Board via QSC January 2020	CMO	Jan
		c3	Weekend mortality data to be included in the integrated quality and performance report	CTO	Jan
		c4	Write to Divisions outlining the suggested steps they need to take for compliance	CMO	Jan
		c5	Receive feedback from Divisions and make any modifications necessary to the compliance plan and report any significant changes to QSC	CMO	Feb
		c6	Ensure audit department are connected to audits of performance done at care group level	CNO	Feb
Divisions	MedCard	m1	Create an action plan for seven day services for non-compliant specialities that is reported and monitored through their Divisional Governance Board	DDO	Jan
		m2	Create and approve appropriate clinical pathways for common presenting conditions in Haematology and Infectious diseases and sign these off at DGB	DC	Feb
		m3	Understand and describe the need for additional resource to fund consultant expansion in haematology and infectious diseases if necessary	DDO	Jan
		m4	Provide an update report and action plan to QSC in February 2020 for non-compliant services	DDO	Feb
		m5	Create an on-going monitoring plan and audit programme for all specialties against the seven day standards from April 2020 onwards to ensure on-going compliance	DDO	April
		m6	To agree the compliance plan in the report to QSC and take the necessary steps to implement it	DDO	Jan
	SNCT	s1	Create an action plan for seven day services for non-compliant specialities that is reported and monitored through their Divisional Governance Board	DDO	Jan
		s2	Create and approve appropriate clinical pathways for common presenting conditions in ENT to improve compliance and sign these off at DGB	DC & CGL	Feb
		s3	To work with Urology care group lead to improve current performance from 75% to 90% by understanding the barriers and taking appropriate action	DC & CGL	Feb
		s4	To work with the General Surgery care group lead to improve current performance from 85% to 90% by understanding the barriers and taking appropriate action	DC & CGL	Feb
		s5	Improve documentation of consultants seeing patients in neurosurgery to fully assess the performance of Neurosurgery against standard 2	DC & CGL	Feb
		s6	Provide update on the business plan for additional consultant posts in neurosurgery, including timescale for signing off and appointment of new posts	DC & CGL	Feb
		s7	Provide an update report and action plan to QSC in February 2020 for non-compliant services	DDO	Feb
		s8	Create an on-going monitoring plan and audit programme for all specialties against the seven day standards from April 2020 onwards to ensure on-going compliance	DDO	April
		s9	To agree the compliance plan in the report to QSC and take the necessary steps to implement it	DDO	Jan
	CWDT	cw1	Create an action plan for seven day services for non-compliant specialities that is reported and monitored through their Divisional Governance Board	DDO	Jan
		cw2	Complete an audit of paediatric surgery services against standard 2	DC & CGL	Jan
		cw3	Create and action plan for paediatric surgery based on audit results	DC & CGL	Feb
		cw4	Include plan for MRI compliance including communication plan to stakeholders and expected implementation dates in seven day services action plan	DDO	Jan
		cw5	Provide an update report and action plan to QSC in February 2020 for non-compliant services	DDO	Feb
		cw6	Create an on-going monitoring plan and audit programme for all specialties against the seven day standards from April 2020 onwards to ensure on-going compliance	DDO	April
		cw7	To agree the compliance plan in the report to QSC and take the necessary steps to implement it	DDO	Jan


Progress

Suggested Governance & Reporting of Seven-Day Services



Reporting Frequency	Reporting Items
6 monthly update or more frequently if needed	• Trust Wide Assurance • Escalation of risk
Quarterly update or more frequently if needed	• Trust Wide Assurance • Escalation of risk
Quarterly update or more frequently if needed	• Divisional Assurance • Progress against action plans • Escalation of risk
Quarterly update or more frequently if needed	• Directorate Assurance • Rolling cycle of specialty self-audit • Progress against action plans • Escalation of risk
Monthly update via standing item under Quality	• Current performance • Progress against action plan • Escalation of risk

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St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 January 2020	**Agenda No.**	2.7
Report Title:	Quality Improvement Academy (Q3) Report		
Lead Director	James Friend, Chief Transformation Officer		
Report Authors:	Martin Haynes, Improvement Methodology Director		
Presented for:	Noting		
Executive Summary:	This report provides an update Quality Improvement Academy's headline activities over the period October to December 2019 and is structured around our 4 key improvement themes: • Coaching the organisation to change • Structures to sustain change • Creating conditions for change • Building capability to lead change In the quarter the three improvement leads have started working with divisional leadership teams to map improvement capability across care groups and support projects that help address quality and financial priorities. The accompanying trust improvement maturity matrix will help leaders prioritise where specialist coaching and support is most needed to deliver critical operational, quality and financial targets. At the same time the Quality Improvement Academy has worked alongside teams from finance and business intelligence to develop a joint analytics and improvement support services for care group teams. This will be launched in early in quarter 4. The Flow Coaching Academy team launched a further 3 'big rooms' which involve multi-disciplinary teams leading weekly improvement / coaching sessions. With support from St George's Hospital Charity, we also had the opportunity to award £20,000 between 6 successful teams who competed in the Quality Improvement week Dragons' Den competition. The report also includes examples of recently completed projects.		
Recommendations:	The Board is asked to note the intentions and progress of the Academy to date.		
Supports			

Trust Strategic Objectives:	Right Care, Right place, Right Time Balance the Books, Invest in the Future Build a Better St George's Champion Team St George's Develop Tomorrow's Treatments Today		
CQC Themes:	Safe and Effective - Well Led		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources		
Implications			
Risk:	None in this paper.		
Legal / Regulatory:	N/A		
Resources:	None requested in this paper.		
Previously considered	At Trust Executive Committee as part of Monthly Transformation Report and Quality & Safety Committee	Date:	January 2020
Appendices:			

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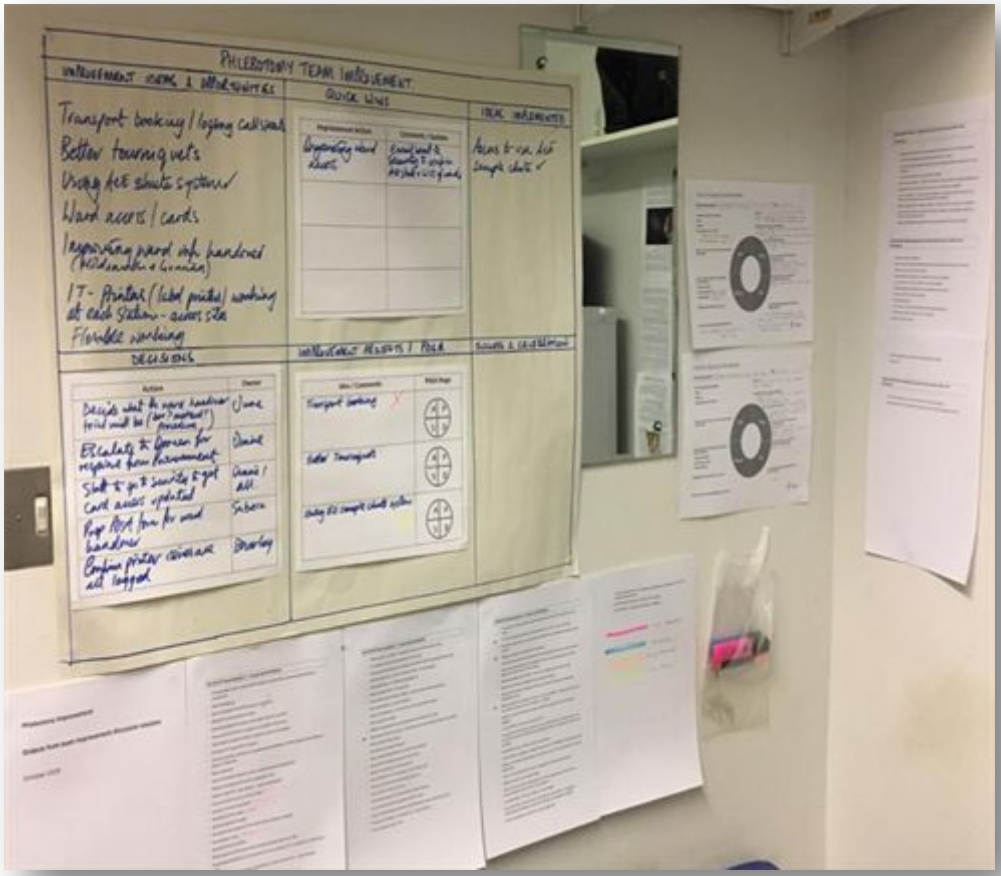
St George's University Hospitals
NHS Foundation Trust

Quality Improvement Academy



Board Update
30th January 2020

James Friend,
Chief Transformation Officer

Report format

- Executive summary
- Selected activity updates by core improvement themes
- Key actions for Q4
- Trust improvement maturity matrix & dashboard
- Appendices: examples current / recently completed projects

Outstanding care every time

Executive Summary

During the quarter we have continued to focus on the 4 key improvement themes: creating conditions for change, building capability to lead change, coaching the organisation to change and the structures to sustain change

- Completed third annual Quality Improvement week with activities at both Tooting & QMH sites and in the front line with ward teams
- QI team members have directly engaged with c750 staff over the quarter in a series of 70 workshops, training and coaching sessions
- Launched three new ‘big room’ coaching workshops using flow coaching improvement methodology (pre-op, hand therapy & paediatric surgical pathway on Nicholls ward)
- Embedded QI leads into divisions to help assess levels of QI capability and prioritise / lead improvement activities agreed by the divisional leadership teams
- With support from St George’s Hospital charity, awarded £20,000 between six Dragons’ Den winners to promote innovative projects, including: a mobile phone app to improve flow within emergency department, a programme to support staff well-being and a film about induction of labour for expectant mothers
- Developed and launched first version of our trust improvement maturity matrix which is being used to target divisional project & capability development activities
- Successfully integrated improvement training into the Trust Enhanced Leadership development programme

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Selected activity summaries by key improvement theme

Creating conditions for change

- Facilitated business planning workshop with paediatrics leadership team and leadership development workshop with senior therapist / allied health professional leads
- Completed 8 new GIRFT reviews and quarterly meeting with London GIRFT team.
- Collaborated with members of finance and business intelligence teams to create a combined data, analytical and improvement support service for care group teams
- Continued support for acute provider collaborative pathway improvement projects including kidney stones and mothers & babies
- Collaborated with Deputy CPO in support of organisation development programme

Building capability to lead change

- Extended training delivery for junior doctors including foundation year foundation years 1 & 2 and ST 3-7
- Completed lessons learned review of ward managers leadership programme and enhanced approach and improvement content to for 2020 programme
- Provided advisory support and workshop facilitation for team leading the emergency floor business case
- Commence work with the medical school to create a short quality improvement training programme that will enable newly qualified doctors to lead / support QI projects as they join our care groups teams
- Trained & supported 30 staff in ‘Plot the Dots’ SPC chart analysis

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Selected activity summaries by key improvement theme

Coaching the organisation to change

- Continued to embed the structures and rhythm of ‘big rooms’ to support improved patient flow

- Continued support and coaching for all adults ward teams to enable delivery of our corporate objectives
- Delivered training to newly established Outreach team to help embed improvement as part of their work processes
- Established echo pathway re-design project to address breach issues and identified range of improvement opportunities to implement from Jan 2020 (see appendix 2)

Structures to sustain improvements

- Completed further 10 post implementation review posters to embed systematic learning from recent improvement projects
- Completed quarterly review of weekly communication (comm) cell meetings which has highlighted improvement opportunities for the year ahead

- Collaborated with the Trust Communications team to support design workshops for the trust’s new intranet site
- Created first version of the trust improvement maturity matrix to help plan and manage capability development
- Reviewed, updated & agreed GIRFT governance process

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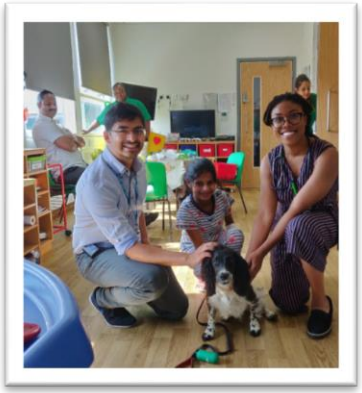
Dragons' Den Winners - December 2019



Title	The pitch…	Amount Funded
Improving communications for induction of labour in maternity	Production of a short film for expectant mothers to help them better understand and reduce concerns about the induction of labour process	£2,000
Who cares for the carers	Better provision of preventative wellbeing strategies for our staff - to aid staff engagement, retention and care for one another.	£2,500
Say my name, say my name	Provision of personalised theatre hats (stitched with staff member's name) which improves communication within the team, with patients and helps create a happier environment	£5,000
Making the most of waiting	Opportunity for patients to provide helpful information for doctors (via a mobile phone application), whilst in the ED waiting room. Reduces repetition and admin time – "think improved ED check-in processes for c450 patients per day"	£5,000
Home diagnosis in neurology	Use of artificial intelligence powered epilepsy diagnostics in patients' homes.	*£5,000
Making pet therapy at St George's a household brand	Pets as Therapy (PAT) branded dog jackets for the team of existing team and the growing list of potential volunteers	£500

* Funded with thanks to St George's Hospital Charity

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Key actions Q4 2020

- Roll out first round of improvement training programme for paediatric nursing teams (which will eventually cover c200 staff)
- Implement Heartflow improvement product (part of Health Innovation Network portfolio)
- Develop & agree options for enhanced communications (comm) cell infrastructure across the three clinical divisions (and to executive level)
- Support divisional teams to deliver priority projects including: maternity improvement programme, echo pathway re-design, theatres improvement programme
- Facilitate & support engagement /development workshops for the following teams: Children's, Women's, Diagnostics & Therapies (CWDT) divisional leaders, allied health professionals / therapy leaders, paediatric respiratory team
- Complete the Sheffield Flow Coaching Academy development programme and continue planning for launch of our own South West London Flow Coaching Academy
- Facilitate acute provider collaborative (APC) neurology pathway re-design workshop and related support activities
- Complete review and enhance improvement training provision aligned to divisional priorities
- Development of improvement intranet "hub"

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Improvement maturity matrix, dashboard

The following slides include the latest versions of the trust improvement maturity matrix and dashboard.

Please note some elements are still in development and will be updated in the next quarterly report (March 2020)

Future additions:

– Maturity matrix: divisional trajectory plans
– Dashboard: including input, output and outcome measures

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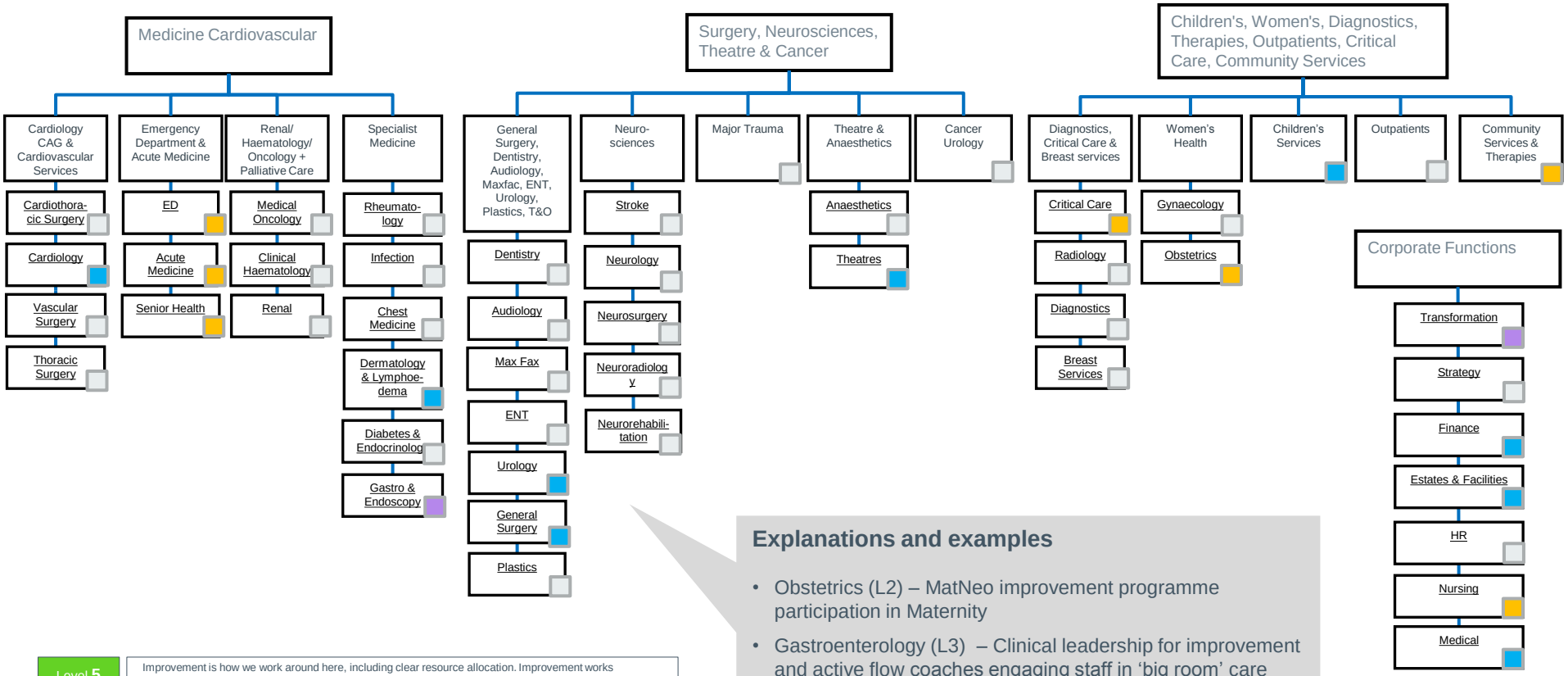
Improvement maturity matrix

The first version of this matrix was produced in November 2019, since which time, cardiology has moved from unknown to blue to reflect work planned work on echo pathway re-design project and general surgery has been assessed as blue to reflect work from the flow coaching big room. The matrix will be updated on a quarterly basis



Level 5	Improvement is how we work around here, including clear resource allocation. Improvement works seamlessly across divisional boundaries and into the wider health system
Level 4	Improvement is proactive and data driven, including benefits evaluation & use of visual management / learning boards. Aligned to division/corporate objectives
Level 3	Improvement is proactive and organised with alignment to team objectives
Level 2	Improvement is reactive but managed using core methodology, including clear objectives
Level 1	Improvement is largely reactive and sporadic with some use of core methodology
Unknown	Review underway with teams to assess evidence

Explanations and examples

- Obstetrics (L2) – MatNeo improvement programme participation in Maternity
- Gastroenterology (L3) – Clinical leadership for improvement and active flow coaches engaging staff in ‘big room’ care pathway sessions
- Acute Medicine & Senior Health (L2) - active use of plan, do, study, act (PDSA) improvement method, Darzi fellow involvement in improvement

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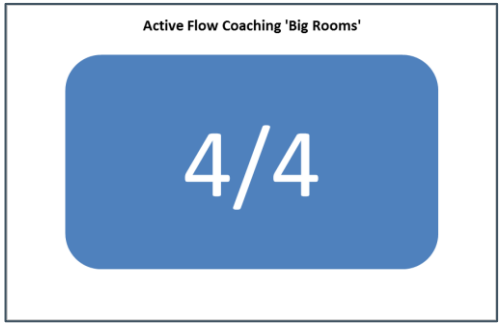
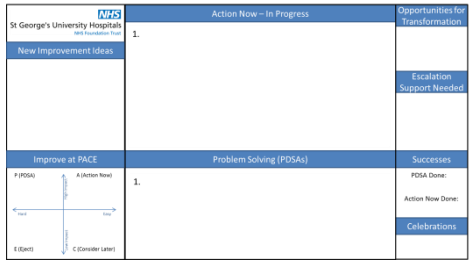
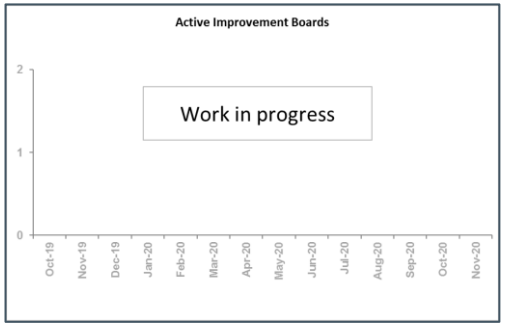
Creating the Conditions for Change

Inputs

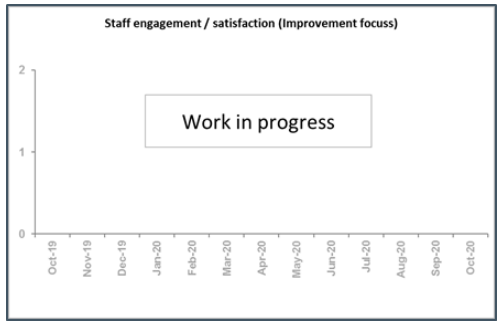




Outputs



Outcomes



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

Comments / actions in response to performance:

Inputs - Creating conditions for change focuses on having the specialist knowledge and skills to establish improvement as part of how we work at St George's. This covers a very broad array of activities, but the initial reporting focus covers the number of Flow Coaches to lead the big rooms as a core part of our improvement methodology.

Outputs - Many ward teams already have some form of learning board which they use to improve process, but the output chart will be updated as we implement more structured improvement boards that cover learning, culture and leadership themes.

Outcomes - work is in its early stages to establish a simple and repeatable way to capture staff engagement / satisfaction in respect of improvement / implementation

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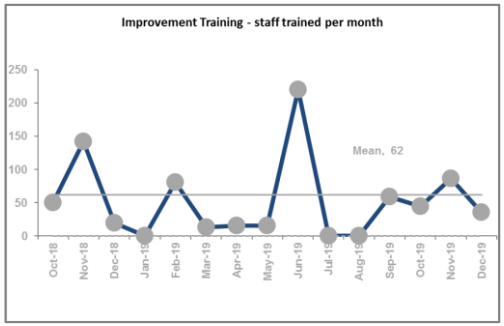
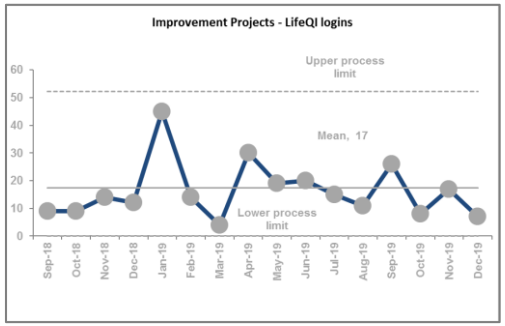
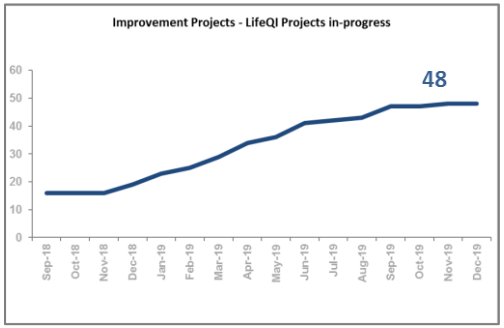
Build our internal capability

Inputs





Outputs



Outcomes

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

Comments / actions in response to performance:

- To date training activity has been largely open access, but we are working with divisions to proactively plan training interventions in line with improvement priorities and current levels of improvement maturity within teams.
- More work is needed to encourage use of the Life QI application as a core management tool for teams. We are seeing steady levels of sign ups, but subsequent login numbers remain low which limits visibility of project progress across the trust
- We do not yet have the infrastructure and data to populate the 'training confidence' outcomes box but, although recent feedback from the Ward Managers training programme gave a satisfaction score 4.5/5 across the three rounds of workshops

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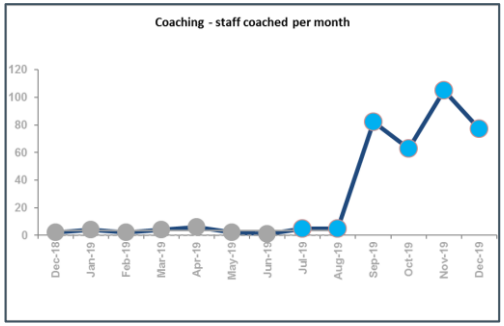
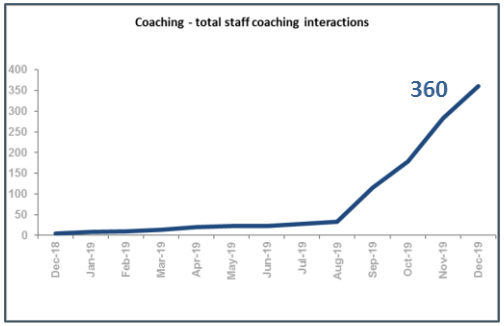
Coaching the Organisation through Change

Inputs

Outputs





Outcomes

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

Comments / action in response to performance

- Work on developing the trust improvement maturity matrix is expected to highlight additional staff with improvement skills who we can encourage to lead projects within their care groups.
- We have also worked with members of finance and business intelligence to build a joint improvement approach for care group leadership teams.
- The output measure of staff coached per month was positively impacted by the 4 flow coaching based 'Big Rooms' and more active engagement of the three divisional improvement leads
- Work is in its early stages to establish a simple and repeatable way to capture staff engagement / satisfaction in respect of improvement. This may be aligned with the OD programme

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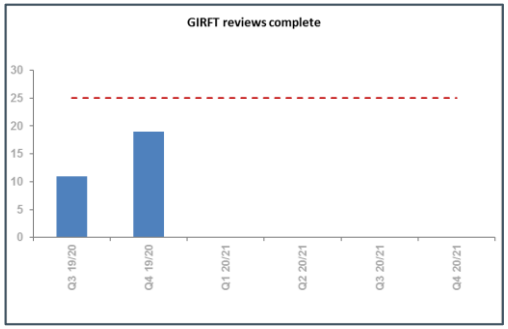
Building a Sustainable Infrastructure

Inputs



Supported APC / STP Workstreams

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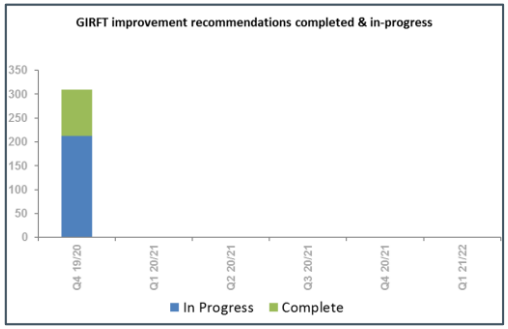
Outputs



Supported APC / STP Workshops

8

Outcomes

Please refer to example projects in appendix 1 of this report

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

Comments / actions in response to performance:

- Inputs – the quarter shows a positive growth in the number of GIRFT reviews meetings as teams continue to explore improvement actions in response to GIRFT / Model Hospital recommendations.
- Outputs – This is the first quarter we have started to track the number of completed GIRFT improvement actions and establish the baseline (but do include actions completed prior to Oct 2019). Through our work with the finance and business intelligence teams, we expect that over time we will be able to add financial and qualitative output measures to augment this report.
- Outcomes – appendix 1 of this report includes examples of GIRFT improvement projects completed during the reporting period.

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Appendices

This section outlines examples of current / recently completed improvement projects:

Appendix 1 – GIRFT project updates

Appendix 2 – Flow coaching ‘big rooms’

Appendix 3 - Echo pathway re-design

Appendix 4 – Improvement board in phlebotomy

Appendix 5 – Championing St George’s unique ‘Minestrone Soup’ improvement approach

Appendix 6 – Learning improvement skills at Queen Mary’s Hospital

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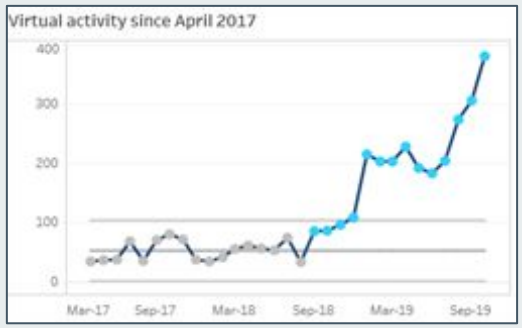
Appendix 1 - GIRFT – selected updates

Gastroenterology

The gastroenterology Clinical Assessment Service, co-designed by consultants and GPs has been opened to all GP practices as of October 2019.



Results to date have shown a 12 day (18%) reduction in waiting times for first appointment, an 11% improvement in RTT clock stop performance, whilst managing a 17% increase in demand for services from GPs.

INTENSIVE & CRITICAL CARE

In Novemeber-19 the service launched an outreach team. The service aims to identify deteriorating adults more effectively, meaning patients will need to stay for less time in ICU. However it is also anticipated that the number of patients being admitted to critical care may increase, so the impact on capacity will be evaluated in 6 months time.

RENAL

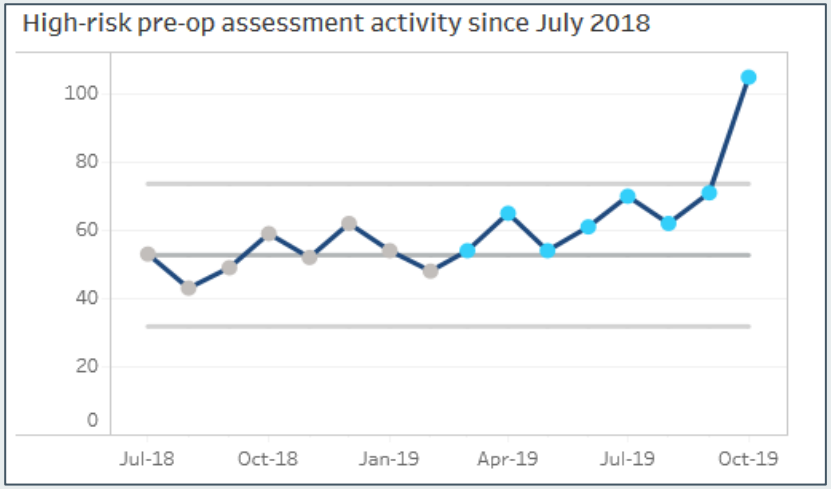
The service has introduced a home therapy percutaneous PD catheter service being delivered by three medical consultants. The number of patients now keeping these patients out of hospital and improving overall patient experience has provided an annual cost saving of circa £180,000

IMAGING

The service has introduced 'radiologist of the day' offering a continuous service to protect reporting times. Benefits include, fewer interruptions to reporting sessions, more effective appropriate escalation routes, whist increasing daily reporting by circa 9%

Pre-operative Assessment

The graph illustrates how improvements to the high risk pre-operative assessment pathway has enabled higher volumes of activity



Appendix 2 - Flow coaching ‘Big Rooms’

Pre operative assessment (POA) pathway:

- Appointment slots in DSU have been extended to 40 minutes to allow sufficient time for staff to carry out a more comprehensive assessments for patients.
- Patient experience data and a real patient story was shared in the Big Room. Further patient stories will be collected
- Communications of POA outcome information has been clarified to patient pathway co-ordinators which will reduce the number of emails between teams. Additionally, the 2 teams held a joint meeting on 12th December 2019 which was the first time they have met face to face.

- A meeting was held between the day surgery unit and Willows annex teams which enabled a better understanding of how they work, allowed sharing of ideas and helped build enthusiasm for the planned merger of the two services.
- High Risk Anaesthetic clinic slot lengths have been reduced to allow for one additional slot per clinic. Changes agreed to POA pro-forma to make it fit for purpose, saving time for POA nurses and patients. The plan is to have IT changes within iClip by the end of January 2020.

- **Digestive health pathway**
- A half day training session has been set up for one of the surgeons to train the nurse endoscopists. Patients will leave their appointments with advice and information rather than wait for their surgical follow-up.
- A member of the IT team spent a morning observing an outpatient clinic. Redesign of the iClip application is underway to make it more user-friendly for consultants in clinic.

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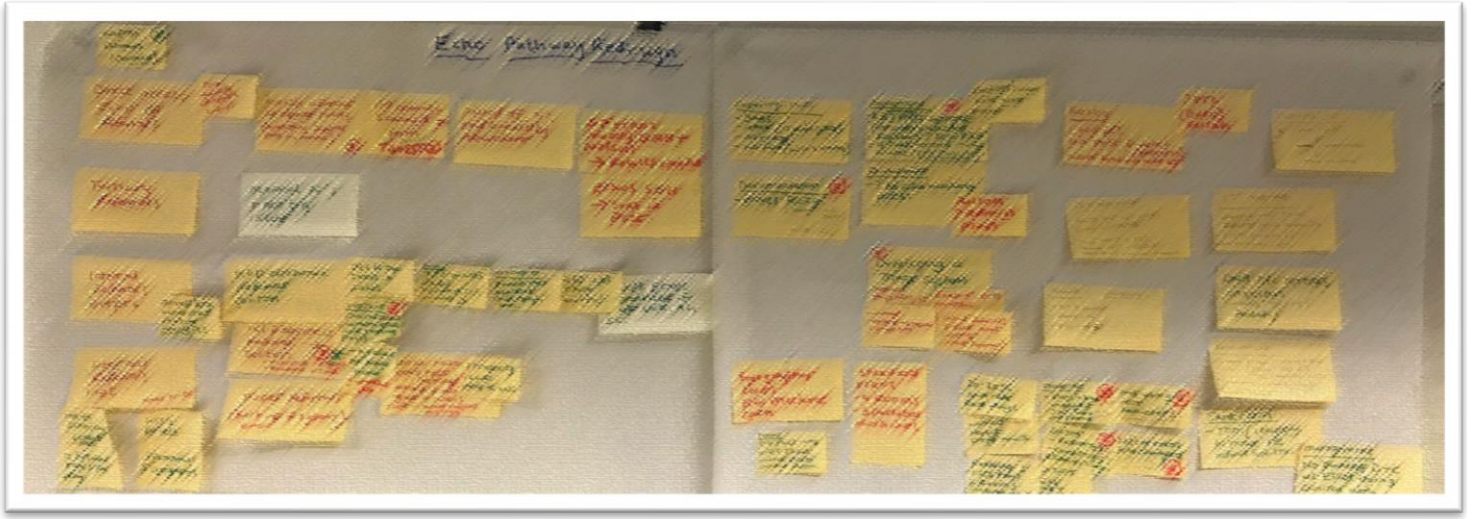
Appendix 3 - Echo pathway redesign



"**It has been really helpful to be given time to think and support to identify solutions"**

Echo bookings administrator

Two workshops were facilitated by the MedCard QI lead in December 2019 with core members of the Echo team to identify:

1. The key pathway / process issues contributing to the echo breaches
2. The solutions the team could work to implement in January 2020. These include:
    - A clinical triage system (Approx. 20-30% referrals are of poor quality and are inappropriate)
    - A text reminder service (current did not attend [DNA] rate is 30%)
    - Amendments to patient letters (letter is unclear and patients often arrive late)
3. A process whereby the team are empowered to continuously improve

Please note, the process map text is blurred to protect patient sensitive information

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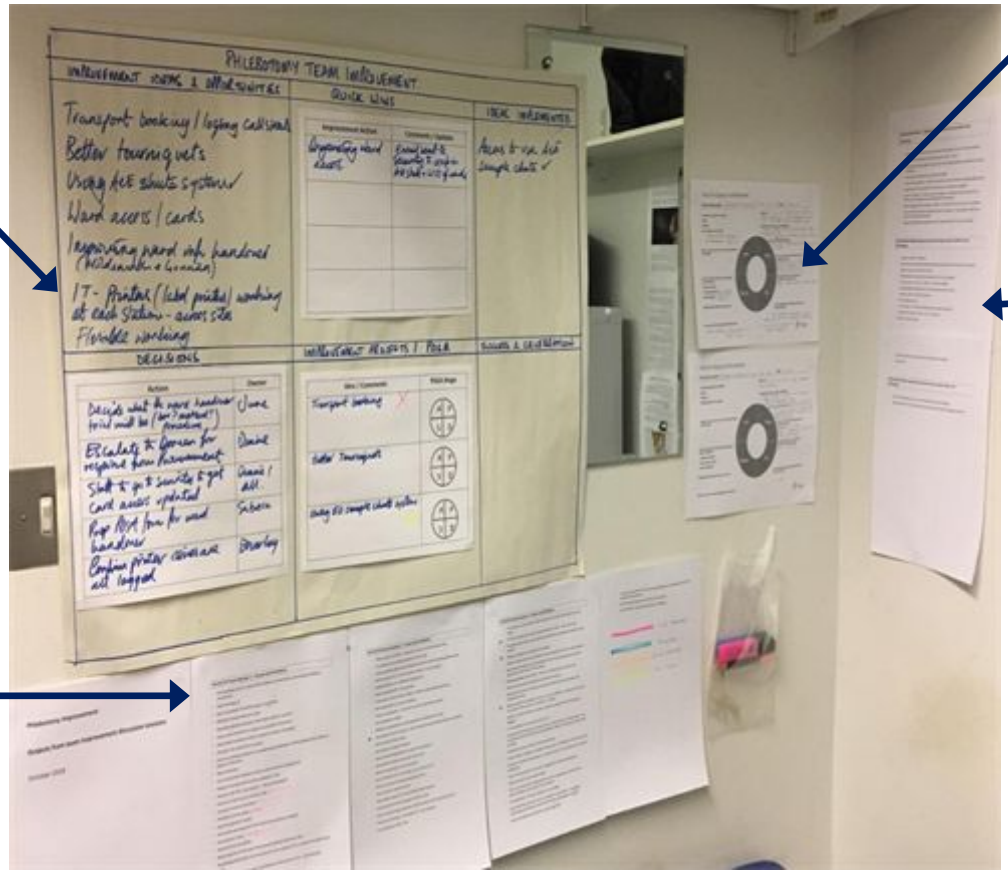
Appendix 4 - A developing Improvement board & improvement culture in phlebotomy

Structure to sustain improvements

Improvement / Gemba board showing Ideas, Actions, 'Just-do-it' improvements and PDSA projects



PDSA templates capturing progress of improvement work

Lists of the improvement ideas captured in original workshops

Lists of the issues & opportunities from workshops (now being colour coded for priority)

Phlebotomy improvement group (team lead & 4 x improvement ambassadors meeting on a weekly basis to discuss and update)

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Appendix 5 - Championing St George's innovative QI initiative with health leaders

Bernadette Kennedy QI Coach and Head of Therapies was invited by the Institute of Healthcare Improvement (IHI) to share her unique take on an established improvement methodology with an international network of health leaders.

Learning and experience was shared with IHI members, on Twitter and will be fed back through further activities and events in 2020

Creating balanced leadership teams using a minestrone soup model

St George's University Hospitals NHS
NHS Foundation Trust

Bernadette Kennedy, Head of Community Directorate Therapies @BernadetteKenn0

Description

In December 2018 I started a new role and was struck by the divisions between professions and teams. The poor staff cohesion was impacting on patient care and staff well-being resulting in complaints and high staff sickness. I wanted to explore this using the working styles framework[1] to rebalance the leadership structure and depersonalise conflicts. The framework identifies four working styles (analyst, driver, amiable, expressive) which I renamed as the vegetables in minestrone soup (tomato, leek, onion, carrot) to avoid preconceptions and to work in a fun and creative way (figure 1).

Fig 1: The minestrone version of the working styles framework[1]

Aim

To create balanced leadership teams to improve care through a new shared minestrone soup language.

Actions taken

Staff assessed their own working style and an experiential workshop enabled understanding to foster a constructive way for embracing difference. The leadership profile of teams was re-balanced using these insights. The minestrone soup language was shared across the organisation via training days and social media (figure 2).

Fig 2: Social media promotion of the minestrone model

Summary of results

A more balanced profile of working styles was achieved in three teams (see Fig 3).
Staff are now using the minestrone language in their every day work, eg:

- Leadership meeting using the vegetable format to frame anxieties.
- Identifying the need for diverse thinking such as a Consultant requesting "a tomato" to help
- Teams recognising the differences in language of vegetable styles and need for translation.

Signs of improved team cohesion.
Harvest festival October 2019 –a celebration of individual and crop growth within teams and working up a plan for next seasons growth

Fig 3: Working styles profile of 3 teams before and after the introduction of the minestrone model

Reference: 1. Bolton DG and Bolton R *People Styles at Work...and Beyond: Making Bad Relationships Good and Good Relationships Better* 2nd edition, New York, Amacom

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Appendix 6 - Quality Improvement Week

Learning QI skills at QMH

As part Quality Improvement Week 2019, we took QI on the road to ward teams. Here we're teaching plan, do, study, act (PDSA) model for improvement to therapist on Gwyn Holford ward at Queen Mary's Hospital

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3

Meeting Title:	**Trust Board**		
Date:	30 January 2020	**Agenda No**	**3.1**
Report Title:	**Finance and Investment Committee (Core) Report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 23rd January 2020.		
Recommendation:	The Board is asked to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee (Core) – January 2020

The Committee met on 23 January and in addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on Costing, the MRI business case, SWL PACS Procurement, the 2020/21 Financial Plan, a policy update and a Procurement Report.

Committee members discussed the BAF risks on finance and ICT. A paper on ICT risk led to discussion on the expectation the overall rating would move from 'limited' to 'partial' assurance at Q4. 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, as well as the different implications of the current Trust forecast. **The Committee wishes to bring the following items to the Board's attention:**

1.1 ICT Risks – the Chief Information Officer (CIO) noted that there were no material changes to the ICT risks and the committee discussed whether the current position required a further forward look on potential changes to each risk. In view of the improving position on ICT risks, the committee agreed to maintain the limited assurance rating at Q3 for the Board Assurance Framework, while noting that it was expected to move to 'partial' assurance for Q4.

1.2 Diagnostics Performance – the Chief Operations Officer (COO) observed the challenge in Diagnostics performance in December, where 6.7% of patients had a Diagnostic wait over 6 weeks compared with a target of 1%. He noted particular work required in Echocardiography waits, and the intended recovery plan to move to compliance by May 2020. The Committee noted this update.

1.3 Cancer Performance – the COO noted that a provisional closing position for the two week rule and breast symptomatic standard for December will show non-compliance, owing to challenges in booking patients over the Christmas period that were not managed as actively as they could have been. The Committee noted this update.

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 79.4% in December, which is adverse to the Trust's 87% trajectory in the month. The Trust continues to develop its Rapid Assessment Zone (RAZ) and the COO noted the improvements seen through this development. The Committee were encouraged by this while noting that more focus was needed, especially on patients admitted to the hospital from the ED.

1.5 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance of 84.2% was below the incomplete target trajectory of 86.5%, and the number of 52 week waits of 7 was more than the trajectory of 0. The size of the waiting list (including QMH patients) was 48,640 patients. The committee noted the balance in performance between the three metrics above and the COO agreed to set out the implications for the three metrics under certain scenarios through to the financial year end.

1.6 Financial Performance – Tom Shearer, the Acting Chief Financial Officer (ACFO) noted performance to date at Month 9 was in line with plan showing a £38.4m Pre-PSF/FRF/MRET deficit. The Committee noted the current cash requirements in view of the expected year end

position and the potential availability of capital funding in 2019/20 (and the Trust's plan to spend it should this be confirmed).

1.7 Financial Forecast – the ACFO provided an update for the Committee on the Trust's financial forecast, which shows a £9m adverse variance against the £37.7m pre-PSF/FRF/MRET plan at year end. The ACFO explained actions being taken and also implications from the change in year-end deficit. The Committee expressed disappointment on this position and noted the importance of achieving this new forecast at year end.

1.8 PLICS/Costing update – the Director of Financial Planning (DFP) provided an update for the Committee on the latest Costing information for the Trust. He noted that the reference costing index score of 101 for 2018/19 was a further improvement on previous years which was welcomed by the committee, although more work was still required to improve this further.

1.9 2020/21 Planning Update – the DFP introduced the Committee to the paper providing an update on the financial plan for 2020/21. The DFP noted that the national planning guidance was still to be disseminated, and the Committee observed the increase in reliance on external factors in developing plans for future years.

1.10 MRI Business Case – the DFP introduced an Outline Business Case (OBC) exploring options for the replacement of aged MRI equipment at the trust. The Committee recommended the preferred option being approved at Trust Board subject to a clearer understanding being given on the need to have a larger Estates footprint in the preferred option in the Full Business Case (FBC).

1.11 SWL PACS Business Case – the DFP introduced an Outline Business Case (OBC) which sets out the case and options to deliver a collaborative radiology image sharing platform across the four acute Trusts within South West London (SWL). The Committee recommended the preferred option for approval at Trust Board.

1.12 Policies Update – the Committee reviewed policy updates on Financial Planning and Procurement. The Committee agreed to the updates on both policies while governance arrangements were checked with respect to executive oversight.

1.13 Procurement Update – David Main, Associate Director of Procurement (ADP), noted further progress in the procurement function, in terms of breaches and waiver and departmental recruitment. The Committee welcomed this further progress.

2.0 Recommendation

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

Ann Beasley
Finance & Investment Committee Chair,
January 2020

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Meeting Title:	**Trust Board**		
Date:	30 January 2020	**Agenda No**	**3.2**
Report Title:	**Finance and Investment Committee (Estates) Report**		
Lead Director/ Manager:	Tim Wright, Lead Non-Executive Director, Estates		
Report Author:	Tim Wright, Lead Non-Executive Director, Estates		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 23 January 2020.		
Recommendation:	The Board is asked to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	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) – January 2020

This Part 2 Finance and Investment Committee (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 January meeting was shortened as the Part 1 FIC (Core) meeting had been extended to allow more time to discuss the Trust's financial position.

The January 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 a verbal update on overall Estates risk. 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 that the committee was continuing to develop and may benefit from a more abridged set of Estates reports, which may come from the committee returning to being part of the main FIC (Core) in the coming months.

The Committee welcomed updates from the ADs that included information on the Procure-22 (P22) contract, 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 Deputy Director of Estates & Facilities (DDE&F) noted the update on Estates risks as part of the Divisional Overview paper. The Committee agreed that associated BAF risks 9 and 10 related to Estates were assessed as 'Limited' for Q3, with potential to move to 'Partial' assurance for Q4.

1.2 AD Report – Divisional Overview - the DDE&F highlighted the key updates from the division, including the PFI review, the Cath Labs upgrade, Premises reviews, and MAST/appraisal compliance. Andrew Grimshaw, Acting Chief Executive Officer (ACEO) noted that the executive team agreed the indemnities for the Cath Lab upgrade at low risk as per the current trust scheme of delegation. The Committee welcomed the divisional update.

1.3 AD Report - Estates - the Assistant Director of Estates (ADE) introduced a paper on current performance in Estates which included key incidents that have taken place in the last month. Discussion was held on the skills matrix used for Estates work required.

1.4 AD Report - Facilities - the Assistant Director of Facilities (ADF) introduced an update on the Mitie contract, the HATs CQC inspection, Waste services and Security services. The CFO noted the recent industrial action by university staff and the assurance that the associated disruption would not happen again.

1.5 AD Report – Capital Projects - the Assistant Director of Capital Projects (ADCP) introduced an update on Capital Projects, including the work on the P22 project. The Committee discussed the resourcing associated with these projects.

1.6 AD Report- Medical Physics & Clinical Engineering – the Assistant Director of Medical Physics & Clinical Engineering (ADMPCE) introduced the paper reporting on this domain. He highlighted some of the key metrics, and the committee discussed the statutory compliance on radiation detection that required support from other organisations.

1.7 AD Report- Health & Safety/Fire –The AD Health & Safety (ADHS) introduced the paper updating the committee on Health & Safety. He noted the progress in setting up the Fire Safety Management Strategy Group among other developments in this area.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Estates) on 23 January 2020 for information and assurance.

Tim Wright
Lead Non-Executive Director, Estates
January 2020

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Meeting Title:	**TRUST BOARD**		
Date:	**30 January 2020**	**Agenda No.**	**3.3**
Report Title:	**M09 Finance Report 2019/20**		
Lead Director/ Manager:	Tom Shearer, Acting Chief Financial Officer		
Report Author:	Michael Armour, Financial Strategy		
Presented for:	Note/Update		
Executive Summary:	The Trust has reported a deficit to date in M9 of £38.4m which is equal to the Pre-PSF/FRF/MRET plan. Within the position, income is favourable to plan by £7.4m, and expenditure is overspent by £7.3m. CIP performance to date is £28.4m which is in line with plan. The Trust has recognised £23.2m of PSF/FRF/MRET funding YTD to Month 9 in line with plan. The Trust also recognised £0.5m of prior year PSF as discussed at the Finance & Investment Committee in June. The financial forecast submitted at M9 shows an expected £9.0m adverse variance to the Pre-PSF/FRF/MRET plan.		
Recommendation:	The Trust Board is asked to note the Trust's financial performance to M9 and expected financial forecast.		
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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Financial Report Month 09 (December 2019)

Trust Board - January 2020

Chief Finance Officer

30th January 2020

Executive Summary – Month 09 (December)

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The Trust is reporting a Pre-PSF/MRET/FRF deficit of £38.4m** at the end of December, which is **on plan**. Within the position, income is favourable to plan by £7.4m, and expenditure is overspent by £7.3m. **M09 YTD PSF/MRET/FRF income of £23.2m** in the plan has **been achieved** in the Year-to-date position. **£5.0m of this is MRET which is expected to be received in all scenarios, and the remaining £18.2m 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 £7.4m favourable to plan year to date. SLA income is £5.5m over plan, mainly due to decreased Challenges and excluded Drugs and Devices which are offset in non-pay. Non-SLA income is £1.9m favourable to plan, which is mainly owing to Private Patients and R&D income.	£7.4m Fav to plan	£5.5m Fav to plan
Expenditure	Expenditure is £7.3m adverse to plan year to date in December. This is caused by Non-Pay adverse variance of £3.9m, related to pass-through income, and Pay adverse variance of £3.5m across all clinical staff groups.	£7.3m Adv to plan	£5.5m Adv to plan
CIP	The Trust planned to deliver £28.4m of CIPs by the end of December. To date, £28.4m of CIPs have been delivered; which is on plan. Income actions of £6.6m and Expenditure reductions of £21.8m 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 £32.3m has been incurred year to date. This is to plan. The current month YTD position is £32.3m and the previous month YTD position is £29.0m.	£32.3m To plan	£29.0m To plan
Cash	At the end of Month 9, 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	£0.1m Fav to plan
Use of Resources (UOR)	At the end of December, the Trust's UOR score was 4 as per plan.	UOR score 4	UOR score 4

Financial Report Month 09 (December 2019)
St George's University Hospitals NHS Foundation Trust

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Financial Report Month 09 (December 2019)
St George's University Hospitals NHS Foundation Trust

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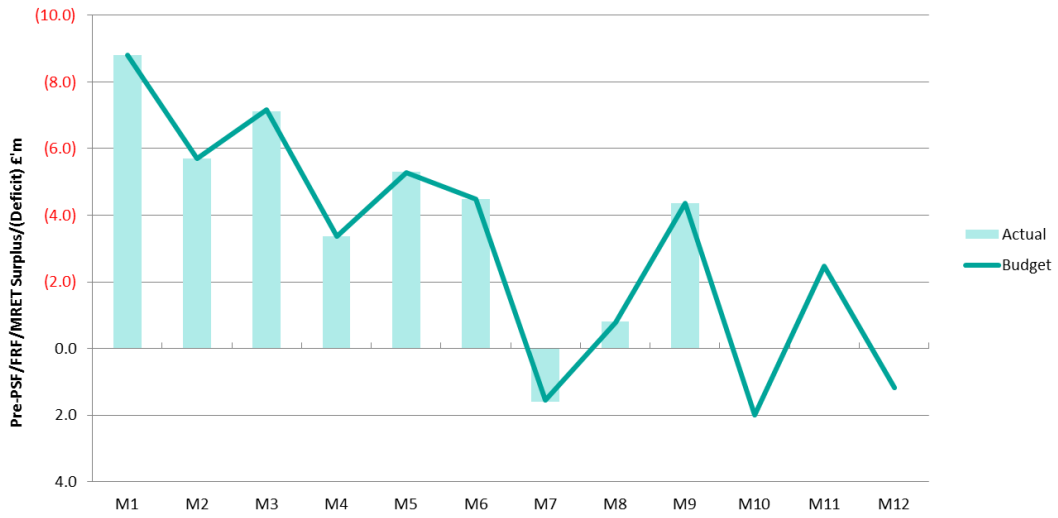
1. Month 09 Financial Performance

			Full Year Budget (£m)	M9 Budget (£m)	M9 Actual (£m)	M9 Variance (£m)	M9 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF/FRF/MRET	**Income**	SLA Income	677.4	53.0	53.9	0.9	1.7%	503.2	508.7	5.5	1.1%
		Other Income	159.9	13.5	14.4	0.9	6.8%	120.6	122.5	1.9	1.5%
	Income Total		**837.3**	**66.5**	**68.3**	**1.8**	**2.8%**	**623.8**	**631.1**	**7.4**	**1.2%**
	Expenditure	Pay	(532.6)	(43.0)	(43.7)	(0.7)	(1.6%)	(403.5)	(407.0)	(3.5)	(0.9%)
		Non Pay	(306.6)	(24.8)	(26.1)	(1.2)	(4.9%)	(231.8)	(236.0)	(4.2)	(1.8%)
	Expenditure Total		**(839.2)**	**(67.9)**	**(69.8)**	**(1.9)**	**(2.8%)**	**(635.3)**	**(643.0)**	**(7.6)**	**(1.2%)**
	Post Ebitda		(35.8)	(3.0)	(2.9)	0.1	2.5%	(26.9)	(26.6)	0.3	1.2%
Pre-PSF/FRF/MRET Total			**(37.7)**	**(4.4)**	**(4.4)**	**0.0**	**0.2%**	**(38.4)**	**(38.4)**	**0.0**	**0.1%**
PSF/FRF/MRET			34.7	3.4	3.4	0.0	0.0 %	23.2	23.2	0.0	0.0 %
Total			**(3.0)**	**(1.0)**	**(1.0)**	**0.0**	**0.7%**	**(15.2)**	**(15.1)**	**0.0**	**0.3%**
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)**	**(1.0)**	**(1.0)**	**0.0**	**0.7%**	**(15.2)**	**(14.6)**	**0.5**	**3.6%**



Trust Overview

- Overall the Trust is reporting a Pre-PSF/FRF/MRET deficit of £38.4m at the end of Month 09, which is on plan.
- The **financial forecast** submitted at M9 shows an expected £9.0m adverse variance to the Pre-PSF/FRF/MRET plan.
- **SLA Income** is £5.5m ahead of plan, after adjustment for block contract values. There remains a large level of estimation within the M09 income position due to delays in coding in some specialties.
- **Other income** is £1.9m over plan, which is owing to Private Patient and R&D income.
- **Pay** is £3.5m overspent across all clinical staff groups.
- **Non-pay** is £3.9m overspent, mainly related to pass-through income.
- **PSF/FRF/MRET Income** is on plan at M09 YTD, at £23.2m. The Trust has met the pre-PSF/FRF/MRET control total target of a £38.4m 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 £28.4m is on plan. Delivery to plan is:
  - Non-pay £1.1m favourable
  - Income £0.8m favourable
  - Pay £2.0m adverse

Financial Report Month 09 (December 2019)
St George's University Hospitals NHS Foundation Trust

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2. Month 09 YTD Analysis of Cash Movement

	M09 YTD Plan £m	M09 YTD Actual £m	YTD Variance £m
Opening Cash balance	**3.2**	**3.2**	**(0.0)**
Income and expenditure deficit	(15.6)	(15.1)	0.5
Depreciation	18.4	18.4	(0.0)
Interest payable	9.0	9.0	0.0
PDC dividend	0.0	0.0	0.0
Other non-cash items	(0.1)	(0.1)	0.0
Operating surplus/(deficit)	**11.7**	**12.2**	**0.5**
Change in stock	1.3	(1.0)	(2.3)
Change in debtors	13.6	16.3	2.7
Change in creditors	(36.4)	(16.8)	19.6
Change in provisions	(1.2)	(0.4)	0.8
Net change in working capital	**(21.5)**	**(1.5)**	**20.0**
Capital spend (excl leases)	(19.7)	(18.5)	1.2
Interest paid	(8.1)	(8.1)	0.0
PDC dividend paid/refund	0.0	0.0	0.0
Other	0.0	0.0	0.0
Investing activities	**(27.8)**	**(26.6)**	**1.2**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	23.6	2.0	(21.6)
Capital loans	21.3	21.3	0.0
Loan/finance lease repayments	(7.5)	(7.5)	0.0
Cash balance 31.12.19	**3.0**	**3.1**	**0.1**

M01-M09 YTD cash movement

- The cumulative M9 I&E deficit is £15.1m, £0.5m better than plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £15.1m, depreciation (£18.4m) does not impact cash. The charges for interest payable (£9.0m) 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 £12.2m.
- The operating surplus variance from plan is £0.5m.
- Working capital is better than plan by £20.0m. This favourable variance comprises of £2.7m higher on debtors and £19.6m lower on creditors. The change of stock level is £2.3m better than the plan.
- The Trust has borrowed £11.6m to fund the YTD deficit and repaid £9.6m.
- The Trust has received £21.3m for capital loan. The working capital borrowing is £17.8 lower than the YTD plan. The Trust has requested a drawdown of capital loan in January of £1.9m with an interest rate of 1.55%. Although the Trust can borrow up to £23.6m, however due to the phasing of the I&E at month 9, we have not requested any loans since June. The Trust would have had to repay any excess as the maximum loan cannot exceed £12.8 at the yearend. The previous slide outlines the expected working capital drawdowns before the end of the year.

December cash position

- The Trust achieved a cash balance of £3.1m on 31st December 2019, £0.1m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 13 week cash flow submitted last month.

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3. Balance Sheet as at Month 09

Balance Sheet	Mar-19 Audited Account (£m)	M09 YTD Revised Plan (£m)	M09 YTD Actual (£m)	M09 YTD Variance to Plan (£m)
Fixed assets	**390.5**	**403.4**	**404.5**	**1.1**
Stock	7.8	6.5	8.8	2.3
Debtors	101.9	88.7	86.0	(2.7)
Cash	3.2	3.0	3.1	0.1
Creditors	(126.7)	(101.3)	(122.1)	(20.8)
PDC div creditor	0.0	0.0	0.0	0.0
Int payable creditor	(1.2)	(2.3)	(2.3)	0.0
Provisions< 1 year	(0.5)	0.0	(0.4)	(0.4)
Borrowings< 1 year	(57.6)	(243.0)	(178.2)	64.8
Net current assets/-liabilities	**(73.1)**	**(248.4)**	**(205.1)**	**43.3**
Provisions> 1 year	(1.0)	(0.4)	(0.8)	(0.4)
Borrowings> 1 year	(284.3)	(138.2)	(181.6)	(43.4)
Long-term liabilities	**(285.3)**	**(138.6)**	**(182.4)**	**(43.8)**
Net assets	**32.1**	**16.4**	**17.0**	**0.6**
Taxpayer's equity				
Public Dividend Capital	133.4	133.4	133.4	0.0
Retained Earnings	(213.4)	(229.1)	(228.5)	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**	**16.4**	**17.0**	**0.6**

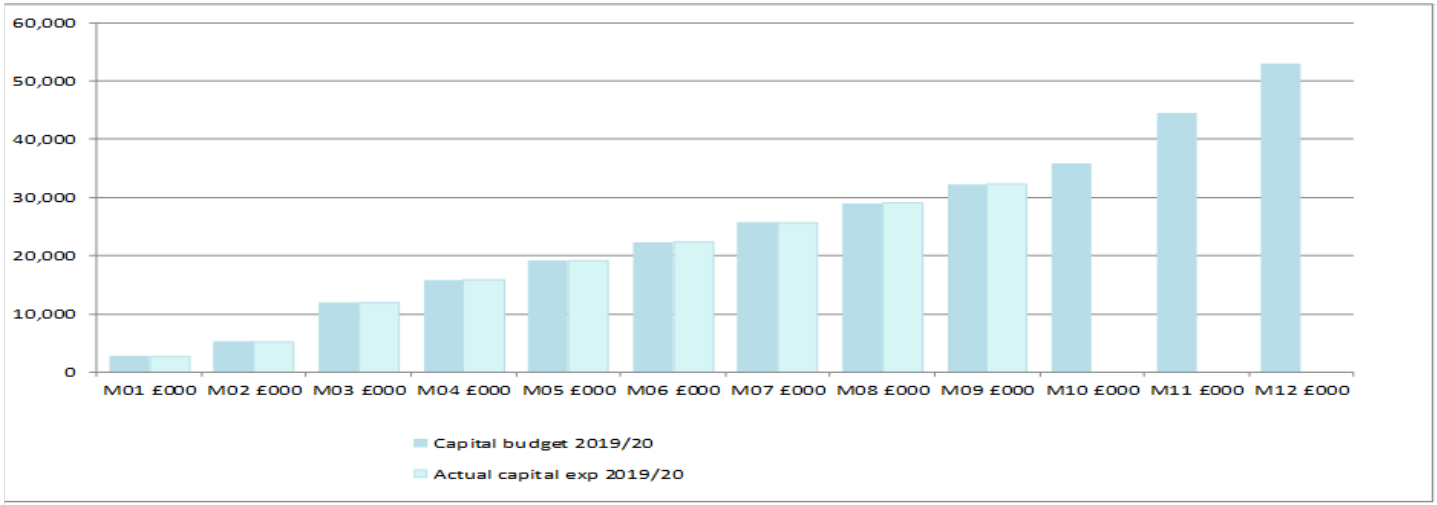
M09 YTD Balance Sheet

- **The previous slide explains the variance between the previous and the revised plan, in this slide we are using the revised YTD plan as a comparison to YTD actual.**
- 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. Fixed assets are £1.2m higher than the plan. This includes depreciation charges and capital spend to month 9.
- Stock is £2.3m higher than plan, mainly due to an increase in pharmacy area, as well as increased capture of stock.
- Debtors is £2.7m better than plan in month and has reduced by £15.9m 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 £20.8m higher than plan in month 9, this includes capital creditors. However they have been reduced by £4.6m since March 2019.
- £21.3m of capital loan was received as at December subject to an interest rate of 1.55%. The Trust has requested drawdown of capital loan in January of £1.9m with the same interest rate as in December.
- Borrowings less than a year are less than plan by £64.8m owing to NHSI confirming that the £48.7m IRS facility due for repayment in March 2019 and the £15m due for repayment in March 2020 will be re-scheduled and extended to September 2020 at similar interest rates. There is a large offset of £43.4m on borrowings more than a year for the former.
- 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, although more is expected in February and March.
- The deficit financing borrowings are subject to an interest rate 3.5%

4. Capital programme 2019/20 - M09 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 £52.889m for 2019/20.
- The Trust has spent £32.3m YTD as at M09, which is to plan and includes a £8.9m 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.
- The Trust received notification of the possibility of receiving an Emergency Loan funding of £5.4m by the end of the year. As the loan is not confirmed the Trust has been advised not to commit expenditure until approval is received. The Trust has shown these funds in the annual budget as advised by NHSI.
- Budgets have been allocated to cost centres with reviews continuing each month of the actual spend against the forecast.



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Meeting Title:	**Trust Board**		
Date:	30 January 2020	**Agenda No**	**4.1**
Report Title:	**Audit Committee Report**		
Lead Director/ Manager:	Sarah Wilton, Chair of the Audit Committee		
Report Author:	Sarah Wilton, Chair of the Audit Committee		
Presented for:	Assurance/Approval		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on 21 January 2020.		
Recommendation:	**The Board is asked to:** • **Note the update in the report; and** • **Approve the audit plan and audit fees for the financial and quality accounts audit for the period 01 April 2019 – 31 March 2020.**		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Audit Committee Report – January 2020
Trust Board, 30 January 2020

Matters for the Board's attention:

1. Annual Reporting and External Audit Reports

1.1. External Audit Reports

The Committee received the External Auditors' progress report, the annual audit plan for 2019-20 and the audit fees letter. The scope of the audit 2019-20 is largely in line with previous years. Similarly, the External Auditors will focus on key risks areas pertaining to management override of controls, revenue recognition, valuation of land and buildings and going concern. All organisations will be required to make a declaration against the new financial regulations standard, International Financial Reporting Standard (IFRS) 16 (Leases) in 2020-21 financial reports. This represents a significant change for the Trust, and other public sector organisations. The standard comes into force on 01 April 2020 and the Trust would be required to assess the degree to which all its contracts and arrangements amount to an operating lease this represents a complete change to the balance sheet and the Trust will need to conduct a significant amount during the year in readiness to make the declaration. NHS Improvement/England (NHSI/E) also plans to conduct an audit in autumn 2020 of organisations' readiness to make the declaration for year ending 31 March 2021. The Committee will continue to monitor progress and agreed that the management team will provide an assurance report to the next Committee meeting setting out plans to complete the work to analyse its contracts and arrangements. The Committee was assured by the plans for completing the audit work for the financial and quality accounts in the period 2019/20 and endorsed the proposed audit fees which the Board is now asked to approve (see Appendix 1).

1.2. Annual Report, Financial Accounts and Quality Accounts Plan and Annual Policies 219/20

The Committee also considered and endorsed the internal reports which outlined the plan and timetable for completing the annual report, financial accounts and the quality accounts/report. The Committee approved the draft accounting policies and notes which need to be incorporated in the financial accounts for 2019/20. There was no substantive change in approach from previous years, and only minor amendments had been made to the Foundation Trust Annual Reporting Manual published by NHSE&I.

2. Internal Audit Report

The Committee considered the following reports from the Internal Auditor:

- Progress Report against the Refreshed Internal Audit Plan 2019/20
- Internal Audit Review Recommendation Tracker
- Draft Internal Audit Plan 2020-21 and 2020-30 Audit Strategy
- Final Internal Audit Report:
  - Learning from Incidents (Substantial Assurance) and Complaints (Reasonable Assurance)
  - Diversity & Inclusion (Reasonable Assurance)
  - ICT Review of Data Quality – Roll-out of iClip to Queen Mary's Hospital (Substantive Assurance)
  - General Data Protection Regulation (GDPR) Compliance (Reasonable Assurance)

The Committee welcomed the good progress made on the internal audit plan for 2019-20. Likewise, good progress continued to be made on completing internal audit recommendations with only six recommendations outstanding.

The Committee approved the draft internal audit plan (2020-21) and strategy (2020-23). In light of recent work to improve governance across the Trust the Committee asked the management team to look at either bringing forward the divisional governance review to 2021/22 (scheduled for 2022/23) or finding a mechanism, via another internal review (such as the scheduled 2022/22 governance framework review), to take a temperature check of progress to improve divisional governance.

The Committee was very pleased to note the reasonable and substantial assurance ratings for the aforementioned internal reviews. The learning from incidents and complaints review rating was split to reflect that there was more evidence that learning from serious incidents was routinely documented which was not the case in relation to complaints. The Committee heard that management are strengthening the mechanisms to track actions and learning from complaints and processes for management of complaints at divisional levels. The Committee recognised the significant progress on diversity and inclusion work which culminated in the reasonable assurance rating. Management reassured the Committee that by delivering its diversity and inclusion strategy and the action plan the Trust would meet its regulatory requirements. The internal audit review findings and substantive assurance rating in relation to the ICT Review of Data Quality: Roll-out of iClip at Queen Mary's Hospital was aligned to the findings from the independent external audit which was conducted as part of the project. Whilst it was good that the project had gone well, management is cognisant of the need to continue to embed the system and provide continuous training for staff. In 2018, internal auditors gave a no assurance rating on the Trust's GDPR Compliance. The recent review was rated reasonable assurance and reflects the significant level of work and focus given to this area and the Committee was assured that once the Trust had completed the four recommendations from the review the Trust would be complaint and on par with other similar organisations. The Committee also noted that information governance training had been organised for board members in January 2020.

3. Internal Compliance and Assurance

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

3.1. Data Security and Protection Toolkit

The Committee was assured by the plans in place to ensure the Trust is compliant with the National Data Guardian's 10 data security standards. Significant focus would be given to completing the actions to meet the mandatory standards with key emphasis being on attaining training targets, cyber security and updating the policy framework.

3.2. Counter Fraud Report

The Committee considered the quarter three Counter Fraud report and welcomed the enhanced report. There had been 18 new issues raised to the counter fraud team in the quarter and there are four cases under review. The Committee would consider the lessons learnt in the next report.

3.3. Risk Management and Board Assurance Framework Update

The Committee received the update on Risk Management and Board Assurance Framework (BAF) in response to previous actions raised at the Committee and by the Board. The Committee noted that the Trust had commissioned a review of its risk management

processes to address know challenges with scrutiny and management of risks across the organisation. The review would be undertaken by the internal auditors, TIAA, and NHSI&E would support the development of the scope and terms of reference. The Committee would receive the terms of reference ahead of the review being undertaken. The Committee also noted that the executive responsibility for the BAF would move, with adequate supporting resources, from the Chief Nurse to the Chief Corporate Affairs Officer who would lead on the planning for the 2020/21 BAF.

3.4. Freedom Speak Up Guardian

The Committee considered the Freedom to Speak Up (FTSU) Guardian report which outlined the number FTSU concerns raised during the period October - December 2019. The Committee noted the report and reflected that given the Workforce and Education Committee was also reviewing the detail of the issues raised future reports to the Audit Committee would focus on assurance around the internal controls, processes and mechanisms to manage and deliver an effective FTSU function at the Trust. The Committee took reasonable assurance from the report and noted that the Board in December 2019 had requested that arrangements for executive sponsorship of FTSU be reviewed.

3.5. Updates on Trust-wide Policies and Declarations of Interests (Managing Conflict of Interest)

The Committee welcomed the good progress made on improving the internal controls, systems and mechanisms for the management of trust-wide policies and managing conflicts of interest. There are now robust mechanisms in place to manage policies and notifying policy owners when policies are due for review and ensuring that the correct policies are available centrally. The Committee flagged the number of patient care and ICT policies due to be reviewed. It was noted that the Quality and Safety Committee would consider the progress made against patient care policies at its next meeting. The Committee also heard that 40% of 1300 decision making staff had made the required declarations in line with the Trust's Managing Conflict of Interest policy and national guidance. These declarations are captured in the self-declaration system Declare and available on the Trust's website. Focussed communication is sent out to staff and more work is being done to ensure other hard to reach staff groups are making the required declarations. The Committee welcomed the progress made and agreed to receive update reports on both areas at its next meeting.

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

The Committee were pleased to note the continued grip on the management of the Trust's losses and compensations and breaches and waivers processes with marked improvement in both areas. The Committee was reasonably assured by processes to manage aged and bad debts. The Committee also noted the debt write-off of overseas patient income and requested further assurance on management of overseas patients' debt going forward.

3.7. Committee Effectiveness Review

The Committee also reviewed the results from its effectiveness review and was pleased to note that 86% of respondents (12/14) reported that the Committee was very effective. The Committee would progress the actions to further improve the Committee and more information would be provided in the Committee's Annual Report to the Board.

3.8. Committee Chair

The January 2020 meeting was my last as Committee Chair before I step down as a non-executive director after nine years at the Trust. As Audit Chair, I have seen a very significant improvement both in the operation of the Committee and in the financial and governance business it has considered it in recent years, and I am pleased to hand over my role as Committee Chair to Elizabeth Bishop, who takes up her role as non-executive director at the Trust next month.

Recommendation

The Board is asked to:

- **Note the update in the report; and**
- **Approve the audit plan and audit fees for the financial and quality accounts audit for the period 01 April 2019 – 31 March 2020.**

Sarah Wilton
Audit Committee Chair, NED
January 2020

Grant Thornton

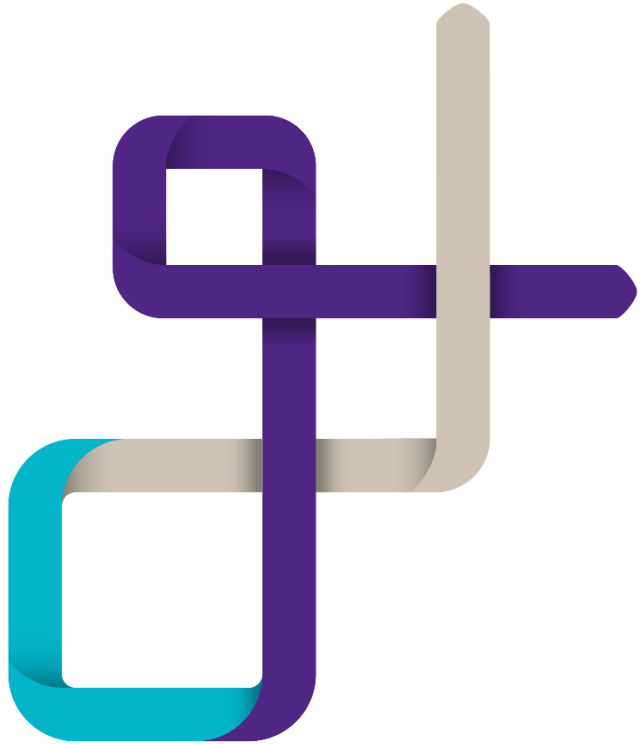
External Audit Plan

Year ending 31 March 2020

4

St George's University Hospitals NHS Foundation Trust

21 January 2020



Contents

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Introduction & headlines

Purpose

This document provides an overview of the planned scope and timing of the statutory audit of St George's University Hospitals NHS Foundation Trust ('the Trust') for those charged with governance.

Respective responsibilities

The National Audit Office ('the NAO') has issued a document entitled Code of Audit Practice ('the Code'). This summarises where the responsibilities of auditors begin and end and what is expected from the audited body. Our respective responsibilities are also set out in the agreed engagement letter. We draw your attention to both of these documents.

Scope of our audit

The scope of our audit is set in accordance with the Code and International Standards on Auditing (ISAs) (UK). We are responsible for forming and expressing:

- An opinion on the financial statements that have been prepared by management with the oversight of those charged with governance (the Audit Committee); and
- A conclusion on the Value for Money arrangements in place at the Trust for securing economy, efficiency and effectiveness in your use of resources.

The audit of the financial statements does not relieve management or the Audit Committee of your responsibilities. It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business, and that public money is safeguarded and properly accounted for. We have considered how the Trust is fulfilling these responsibilities.

Our audit approach is based on a thorough understanding of the Trust's business and is risk based.

Significant risks	Those risks requiring special audit consideration and procedures to address the likelihood of a material financial statement error have been identified as: • Management override of controls • Revenue recognition • Valuation of land and buildings • Going concern We will communicate significant findings on these areas as well as any other significant matters arising from the audit to you in our Audit Findings (ISA 260) Report.
Materiality	We have determined planning materiality to be £13m (PY £12.95m) for the Trust, which equates to 1.48% of your prior year gross operating costs for the year. We are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. Clearly trivial has been set at £0.3m (PY £0.3m).
Value for Money arrangements	Our risk assessment regarding your arrangements to secure value for money have identified the following VFM significant risks: • Financial outturn and financial sustainability • Care Quality Commission (CQC) inspection
Audit logistics	Our interim visit takes place in January 2020 and our final visit will take place in April and May. Our key deliverables are this Audit Plan and our Audit Findings Report. Our fee for the audit will be £78,750 plus £8,000 for the Quality Report audit (PY: £68,500 plus £8,000 for the Quality Report audit) for the Trust, subject to the Trust meeting our requirements in relation to financial statements and working papers as detailed in this Audit Plan.
Independence	We have complied with the Financial Reporting Council's Ethical Standard and we as a firm, and each covered person, confirm that we are independent and are able to express an objective opinion on the financial statements..

Key matters impacting our audit

Factors			
The wider health economy and political uncertainty NHS funding continues to be stretched with increasing cost pressures and patient demand. For St George's University Hospitals Foundation Trust, the Trust agreed a budgeted deficit in 2019/20 of £3 million with NHS Improvement which is a challenging target following a deficit of £45.4 million in 2018/19. As a result of the Trust's poor financial performance, in March 2017 NHS Improvement placed the Trust into Financial Special Measures and this remains the case in 2019/20. At a national level, the government continues its negotiation with the EU over Brexit, and future arrangements remain clouded in uncertainty. The Trust will need to ensure that it is prepared for all outcomes, including in terms of any impact on contracts, on service delivery and on its support for local people and businesses.	**Financial reporting and audit – raising the bar** The Financial Reporting Council (FRC) has set out its expectation of improved financial reporting from organisations and the need for auditors to demonstrate increased scepticism and challenge, and to undertake more robust testing, as detailed in Appendix A. Our work in 2018/19 has highlighted areas where health sector financial reporting, in particular, property, plant and equipment, needs to be improved, with a corresponding increase in audit procedures. We have also identified an increase in the complexity of financial transactions in the health sector which require greater audit scrutiny.	**CQC performance** An inspection by the Care Quality Commission in June 2016 rated the Trust as requiring significant improvement. A follow-up CQC inspection in May 2017 and March - April 2018 identified that progress and the rating was changed from 'inadequate' to 'requires improvement' in July 2018. A further inspection in 2019 reported in December 2019 and retained the 'requires improvement' rating. The Trust currently remains in quality special measures.	**IFRS 16 Implementation** IFRS 16 *Leases* is being implemented for NHS providers in 2020/21 with disclosure required in the 2019/20 financial statements.
Our response			
• We will consider your arrangements for managing and reporting your financial resources as part of our work in reaching our Value for Money conclusion. • We will consider whether your financial position leads to material uncertainty about the going concern of the Trust and will review related disclosures in the financial statements.	• As a firm, we are absolutely committed to meeting the expectations of the FRC with regard to audit quality and financial reporting in the health sector. Our proposed work and fee, as set out further on page 13, has been agreed with the Chief Financial Officer.	• We will discuss preparations with the client and their assessment of the risk • We will review any related disclosures in the financial statements to ensure these are sufficient.	• We will discuss preparations with the client and their assessment of the risk • We will review any related disclosures in the financial statements to ensure these are sufficient.

Significant risks identified

Significant risks are defined by ISAs (UK) as risks that, in the judgement of the auditor, require special audit consideration. In identifying risks, audit teams consider the nature of the risk, the potential magnitude of misstatement, and its likelihood. Significant risks are those risks that have a higher risk of material misstatement.

Risk	Reason for risk identification	Key aspects of our proposed response to the risk
Revenue recognition	Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. In this environment, we have considered the rebuttable presumed risk under ISA (UK) 240 that revenue may be misstated due to the improper recognition of revenue. We have rebutted this presumed risk for the revenue streams of the Trust that are principally derived from contracts that are agreed in advance at a fixed price. We have determined these to be income from: • Block contract income element of patient care revenues We have not deemed it appropriate to rebut this presumed risk for all other material streams of patient care income and other operating revenue. We have therefore identified the occurrence and accuracy of these income streams of the Trust and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement and a key audit matter.	We will: • evaluate the Trust's accounting policy for recognition of income from patient care activities and other operating revenue for appropriateness and compliance with the DHSC Group Accounting Manual 2018/19 • update our understanding of the Trust's system for accounting for income from patient care and other operating revenue, and evaluate the design of the associated controls <u>Patient Care Income</u> • using the DHSC mismatch report, we will investigate unmatched revenue and receivable balances over the NAO £0.3m threshold, corroborating the unmatched balances used by the Trust to supporting evidence; • agree, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from the Trust's commissioners • evaluate the Trust's estimates and the judgments made by management with regard to corroborating evidence in order to arrive at the total income from contract variations recorded in the financial statements. <u>Other Operating Revenue</u> • agree, on a sample basis, income and year end receivables from other operating revenue to invoices and cash payment or other supporting evidence • PSF only – agree income recognised in Q1 – Q3 to NHS Improvement notifications; • PSF only – obtain supporting evidence that confirms the Trust has met NHS Improvement requirements for recognising Q4 income;

Significant risks identified

Significant risks are defined by ISAs (UK) as risks that, in the judgement of the auditor, require special audit consideration. In identifying risks, audit teams consider the nature of the risk, the potential magnitude of misstatement, and its likelihood. Significant risks are those risks that have a higher risk of material misstatement.

Risk	Reason for risk identification	Key aspects of our proposed response to the risk
Management over-ride of controls	Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities. The Trust faces external pressures to meet agreed targets, and this could potentially place management under undue pressure in terms of how they report performance. We therefore identified management override of control, in particular journals, management estimates and transactions outside the course of business as a significant risk, which was one of the most significant assessed risks of material misstatement.	We will: • evaluate the design effectiveness of management controls over journals • analyse the journals listing and determine the criteria for selecting high risk unusual journals • test unusual journals made during the year and after the draft accounts stage for appropriateness and corroboration • gain an understanding of the accounting estimates and critical judgements applied made by management and consider their reasonableness • evaluate the rationale for any changes in accounting policies, estimates or significant unusual transactions.
Valuation of land and buildings (Annual revaluation)	The Trust revalues its land and buildings on an annual basis to ensure that the carrying value is not materially different from the current value at the financial statements date. This valuation represents a significant estimate by management in the financial statements. Management have engaged the services of a valuer to estimate the current value as at 31 March 2019. The valuation of land and buildings is a key accounting estimate which is sensitive to changes in assumptions and market conditions. We therefore identified valuation of land and buildings, particularly revaluations and impairments, as a significant risk, which was one of the most significant assessed risks of material misstatement, and a key audit matter.	We will: • evaluate management's processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts and the scope of their work • evaluate the competence, capabilities and objectivity of the valuation expert • write to the valuer to confirm the basis on which the valuations were carried out • challenge the information and assumptions used by the valuer to assess completeness and consistency with our understanding • engage our own valuer to assess the instructions to the Trust's valuer, the Authority's valuer's report and the assumptions that underpin the valuation • test, on a sample basis, revaluations made during the year to ensure they have been input correctly into the Trust's asset register • evaluate the assumptions made by management for any assets not revalued during the year and how management has satisfied themselves that these are not materially different to current value.

Significant risks identified

Risk	Reason for risk identification	Key aspects of our proposed response to the risk
Going concern material uncertainty disclosures	As auditors, we are required to "obtain sufficient appropriate audit evidence about the appropriateness of management's use of the going concern assumption in the preparation and presentation of the financial statements and to conclude whether there is a material uncertainty about the entity's ability to continue as a going concern. entity's ability to continue as a going concern The Trust are facing significant financial challenges and have forecast a deficit position for 2019/20 and 2020/21. The Trust will therefore require further cash support to pay its expenses in these years. The source and value of this support has yet to be confirmed. We therefore identified the adequacy of disclosures relating to material uncertainties that may cast doubt on the Trust's ability to continue as a going concern in the financial statements as a significant risk. Given the sensitive nature of these disclosures, this is one of the most significant assessed risks of material misstatement, and a key audit matter for the audit.	We will: ▪ discuss the financial standing of the Trust with officers ▪ review management's assessment of going concern assumptions and supporting information, e.g. 2020/21 and 2021/22 budgets and cash flow forecasts and associated sensitivity analysis to corroborating evidence ▪ examine the terms of available cash support facilities ▪ consider the arrangements for the refinancing of loans that fall due ▪ evaluate the completeness and accuracy of disclosures on material uncertainties with regard to going concern in the financial statements.

We will communicate significant findings on these areas as well as any other significant matters arising from the audit to you in our Audit Findings Report in May 2020.

Other risks identified

Risk	Reason for risk identification	Key aspects of our proposed response to the risk
International Financial Reporting Standard (IFRS) 16 Leases – (issued but not adopted)	The public sector will implement this standard from 1 April 2020. It will replace IAS 17 Leases, and the three interpretations that supported its application (IFRIC 4, Determining whether an Arrangement contains a Lease, SIC-15, Operating Leases – Incentives, and SIC-27 Evaluating the Substance of Transactions Involving the Legal Form of a Lease). Under the new standard the current distinction between operating and finance leases is removed for lessees and, subject to certain exceptions, lessees will recognise all leases on their balance sheet as a right of use asset and a liability to make the lease payments. In accordance with IAS 8 and paragraph 1.2.5 of the Group Accounting Manual 2019/20, disclosures of the expected impact of IFRS 16 should be included in the Trust's 2019/20 financial statements.	We will: • Evaluate the processes the Trust has adopted to assess the impact of IFRS16 on its 2020/21 financial statements and whether the estimated impact on assets, liabilities and reserves has been disclosed in the 2019/20 financial statements. • Assess the completeness of the disclosures made by the Trust in its 2019/20 financial statements with reference to the DHSC Group Accounting Manual - IFRS 16 Supplement , HM Treasury IFRS 16 Lease - Application guidance and further guidance issued by NHS England and NHS Improvement. •

We will communicate significant findings on these areas as well as any other significant matters arising from the audit to you in our Audit Findings Report in May 2020.

Other matters

Other work

In addition to our responsibilities under the Code of Practice, we have a number of other audit responsibilities, as follows:

- We audit parts of your Remuneration and Staff Report in your Annual Report and check whether these sections of your Annual Report have been properly prepared.
- We read the sections of your Annual Report which are not subject to audit and check that they are consistent with the financial statements on which we give an opinion.
- We carry out work to satisfy ourselves that disclosures made in your Annual Governance Statement are in line with requirements set out in the NHS foundation trust annual reporting manual 2019/20.
- We issue a separate "consistency with" opinion on your summarisation schedules which confirms whether the schedules are consistent with the audited financial statements.
- We carry out work on your summarisation schedules for the Whole of Government Accounts process in accordance with group audit instructions.
- We consider our other duties under legislation and the Code, as and when required, including:
    - referral of matters to the regulator under schedule 10 of the National Health Service Act 2006;
    - issue of a report in the public interest.
- We certify completion of our audit.

Other material balances and transactions

Under International Standards on Auditing, "irrespective of the assessed risks of material misstatement, the auditor shall design and perform substantive procedures for each material class of transactions, account balance and disclosure". All other material balances and transaction streams will therefore be audited. However, the procedures will not be as extensive as the procedures adopted for the risks identified in this report.

Materiality

The concept of materiality

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to the monetary misstatements but also to disclosure requirements and adherence to acceptable accounting practice and applicable law. Misstatements, including omissions, are considered to be material if they, individually or in the aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

Materiality for planning purposes

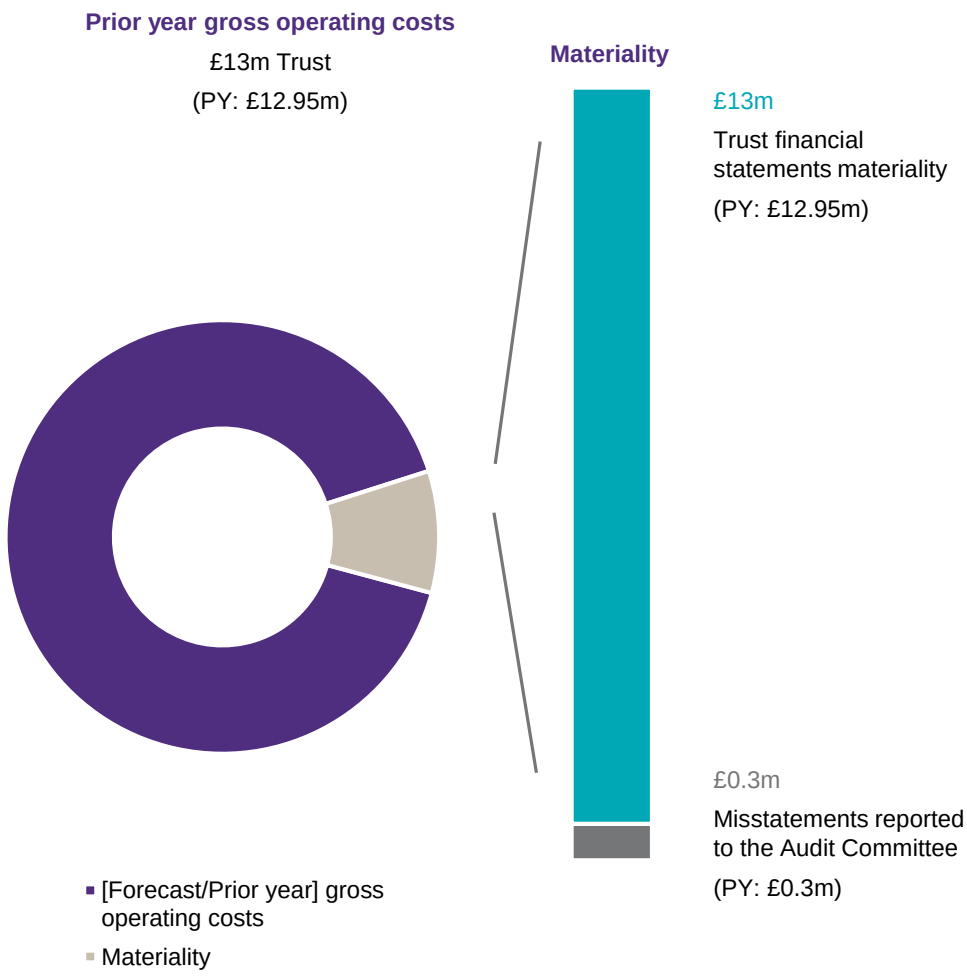
We have determined financial statement materiality based on a proportion of the gross operating costs of the Trust for the financial year. In the prior year we used the same benchmark. Materiality at the planning stage of our audit is £13m (PY £12.95m) for the Trust, which equates to 1.48% of your prior year gross operating costs for the year. We design our procedures to detect errors in specific accounts at a lower level of precision which we have determined to be £0.1m for the Remuneration Report and related party disclosures.

We reconsider planning materiality if, during the course of our audit engagement, we become aware of facts and circumstances that would have caused us to make a different determination of planning materiality.

Matters we will report to the Audit Committee

Whilst our audit procedures are designed to identify misstatements which are material to our opinion on the financial statements as a whole, we nevertheless report to the Audit Committee any unadjusted misstatements of lesser amounts to the extent that these are identified by our audit work. Under ISA 260 (UK) 'Communication with those charged with governance', we are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. ISA 260 (UK) defines 'clearly trivial' as matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria. In the context of the Trust, we propose that an individual difference could normally be considered to be clearly trivial if it is less than £0.3m (PY £0.3m).

If management have corrected material misstatements identified during the course of the audit, we will consider whether those corrections should be communicated to the Audit Committee to assist it in fulfilling its governance responsibilities.



Value for Money arrangements

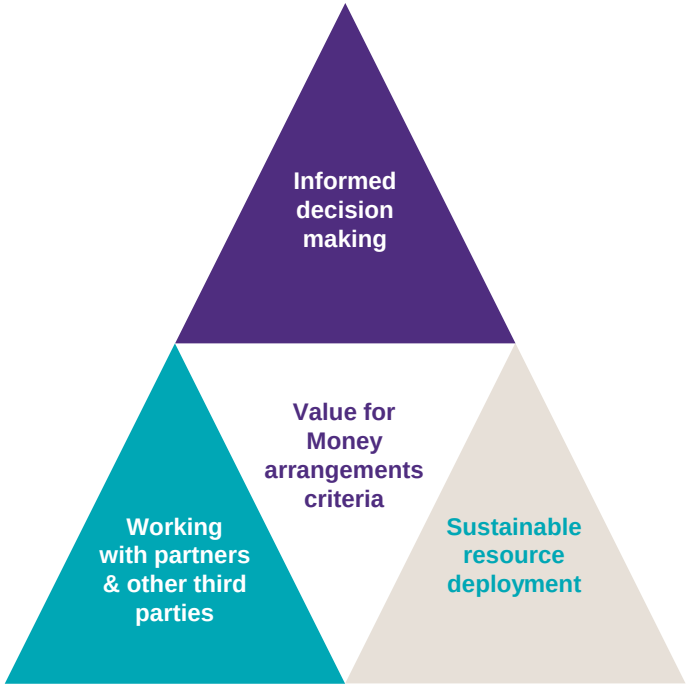
Background to our VFM approach

The NAO issued its guidance for auditors on Value for Money work in November 2017. The guidance states that auditors are only required to report by exception where they are not satisfied that NHS bodies have proper arrangements in place to secure value for money. However, we are required to carry out sufficient work to satisfy ourselves that proper arrangements are in place at the Trust.

The guidance identifies one single criterion for auditors to evaluate:

"In all significant respects, the audited body takes properly informed decisions and deploys resources to achieve planned and sustainable outcomes for taxpayers and local people."

This is supported by three sub-criteria, as set out below:



Significant VFM risks

Those risks requiring audit consideration and procedures to address the likelihood that proper arrangements are not in place at the Trust to deliver value for money.

Financial outturn and financial sustainability

The Trust's audited financial statements for the year ended 31 March 2019 reported a deficit of £45million. The Trust agreed a budgeted deficit in 2019/20 of £3 million with NHS Improvement. This is a challenging target. As a result of the Trust's poor financial performance, in March 2017 NHS Improvement placed the Trust into Financial Special Measures and this remains the case in 2019/20.

The current scale of the deficit will not be sustainable in the longer term and as such there is a risk that the Trust does not have sufficient arrangements in place to ensure medium term financial stability.

We will review the Trust's arrangements for putting together and agreeing its budget, including identification of savings plans; and its arrangements for monitoring and managing delivery of its budget and savings plans for 2020/21, including the impact on service delivery. We will also meet with key officers to discuss and review arrangements for returning the Trust to a position of financial stability.

Care Quality Commission (CQC) inspection

An inspection by the Care Quality Commission in June 2016 rated the Trust as requiring significant improvement. A follow-up CQC inspection in May 2017 and March - April 2018 identified that progress had been made in addressing their findings but that areas for improvement remain. The rating was changed from 'inadequate' to 'requires improvement' in July 2018. A further inspection was undertaken in July to September 2019 which reported in December 2019 and retained the rating of 'requires improvement'. The Trust currently remains in quality special measures

There is a risk that the Trust will not be able to adequately respond to areas identified by the CQC as requiring improvement.

We will review how the Trust is implementing and monitoring delivery of the action plan agreed to address the findings of the CQC inspection. We also review correspondence from the CQC in relation to their findings from inspection visits during the year.

Audit logistics and team

Paul Dossett, Key Audit Partner and Engagement Lead

Responsible for overall quality control; accounts opinions; final authorisation of reports; liaison with the Trust.

Tina James, Audit Manager

Responsible for overall audit management, quality assurance of audit work and liaison with the Trust.

Lisa Lee, Audit Incharge

Lisa will lead the onsite team and will be the day to day contact for the audit. Lisa will monitor the deliverables, manage the query log with your finance team and highlight any significant issues and adjustments.

Client responsibilities

Where clients do not deliver to the timetable agreed, we need to ensure that this does not impact on audit quality or absorb a disproportionate amount of time, thereby disadvantaging other clients. Where the elapsed time to complete an audit exceeds that agreed due to a client not meeting its obligations we will not be able to maintain a team on site. Similarly, where additional resources are needed to complete the audit due to a client not meeting their obligations we are not able to guarantee the delivery of the audit to the agreed timescales. In addition, delayed audits will incur additional audit fees.

Our requirements

To minimise the risk of a delayed audit, you need to ensure that you:

- produce draft financial statements of good quality by the deadline you have agreed with us, including all notes, the Annual Report and the Annual Governance Statement
- ensure that good quality working papers are available at the start of the audit, in accordance with the working paper requirements schedule that we have shared with you
- ensure that the agreed data reports are available to us at the start of the audit and are reconciled to the values in the accounts, in order to facilitate our selection of samples
- ensure that all appropriate staff are available on site throughout (or as otherwise agreed) the planned period of the audit
- respond promptly and adequately to audit queries.

Audit fees

Planned audit fees 2019/20

Across all sectors and firms, the FRC has set out its expectation of improved financial reporting from organisations and the need for auditors to demonstrate increased scepticism and challenge and to undertake additional and more robust testing. Within the public sector, where the FRC has recently assumed responsibility for the inspection of local audit, the regulator requires that all audits achieve a 2A (few improvements needed) rating.

Our work across the sector in 2018/19 has highlighted areas where financial reporting, in particular in respect of property, plant and equipment, needs to be improved. We have also identified an increase in the complexity of financial transactions. Combined with the FRC requirement that 100% of audits achieve a 2A rating this means that additional audit work is required. We have set out below the expected impact on our audit fee. The table overleaf provides more details about the areas where we will be undertaking further testing.

As a firm, we are absolutely committed to meeting the expectations of the FRC with regard to audit quality and public sector financial reporting. Our proposed work and fee at the audit planning stage, as set out below, has been agreed with the Director of Finance.

	Actual Fee 2017/18	Actual Fee 2018/19	Revised fee 2019/20
NHS Trust Audit	£66,000	£68,500	£78,750
Audit of Quality Report	£10,000	£8,000	£8,000
Total audit fees (excluding VAT)	**£76,000**	**£76,500**	**£86,750**

Assumptions

In setting the above fees, we have assumed that the Trust will:

- prepare a good quality set of accounts, supported by comprehensive and well presented working papers which are ready at the start of the audit
- provide appropriate analysis, support and evidence to support all critical judgements and significant judgements made during the course of preparing the financial statements
- provide early notice of proposed complex or unusual transactions which could have a material impact on the financial statements.

Relevant professional standards

In preparing our fee estimate, we have had regard to all relevant professional standards, including paragraphs 4.1 and 4.2 of the FRC's Ethical Standard which stipulate that the Engagement Lead (Key Audit Partner) must set a fee sufficient to enable the resourcing of the audit with staff of appropriate skills, time and abilities to deliver an audit to the required professional standard.

Audit fee variations – Further analysis for the Trust audit

Planned audit fees

The table below shows the planned variations to the original contracted fee for 2019/20 based on our best estimate at the audit planning stage. Further issues identified during the course of the audit may incur additional fees.

	£	
Original contract fee	68,500	
Raising the quality bar	3,000	There is a general raising of the quality bar following the concerns around the financial performance of some recent high profile companies and the criticism of the Financial Reporting Council's role (FRC). Alongside the FRC, other key stakeholders including the Department for Business, Energy and Industrial Strategy (BEIS) have expressed concern about the quality of audit work and the need for improvement. The FRC has raised the threshold of what it assesses as a good quality audit. Previously, on a four point scale (1;2a;2b;3) it considered a '2b' to represent a quality audit. Now it has set a 100% target for all audits to achieve a '2a'. Its threshold for achieving a '2a' is challenging and failure to achieve this level is reputationally damaging for individual engagement leads and their firm. Inevitably, this results in a need to increase the managerial oversight to manage this risk.
PPE Valuation – work of experts	5,750	The FRC has determined that auditors need to improve the quality of audit challenge on PPE valuations across the sector. We have therefore engaged our own audit expert – (Wilks Head Eve) and increased the volume and scope of our audit work to ensure an adequate level of audit scrutiny and challenge over the assumptions that underpin PPE valuations. The increase includes an estimate for the fee payable to the auditor's expert. We estimate that the cost of the auditors expert will be in the region of £3,500.
IFRS 16 - Leases	£1,500	IFRS 16 requires a leased asset, previously accounted for as an operating lease off balance sheet, to be recognised as a 'right of use' asset and corresponding liability on the balance sheet from 1 April 2020. There is a requirement, under IAS8, to disclose the expected impact of this change in accounting treatment in the 2019/20 financial statements. We estimate the cost of auditing this disclosure to be in the region of £1,500. **Please note that this does not include the cost of any separate work mandated by NHSI. We will scope and agree a separate fee for such work with you, should work be required.**
Revised fee	**78,750**	

Independence & non-audit services

Auditor independence

Ethical Standards and ISA (UK) 260 require us to give you timely disclosure of all significant facts and matters that may bear upon the integrity, objectivity and independence of the firm or covered persons. relating to our independence. We encourage you to contact us to discuss these or any other independence issues with us. We will also discuss with you if we make additional significant judgements surrounding independence matters.

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention. We have complied with the Financial Reporting Council's Ethical Standard and we as a firm, and each covered person, confirm that we are independent and are able to express an objective opinion on the financial statements. Further, we have complied with the requirements of the National Audit Office's Auditor Guidance Note 01 issued in December 2017 which sets out supplementary guidance on ethical requirements for auditors of local public bodies.

We confirm that we have implemented policies and procedures to meet the requirements of the Ethical Standard. For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust.

Other services provided by Grant Thornton

The following services provided by Grant Thornton were identified.

Service	Fees £	Threats	Safeguards
Audit related			
Review of the Trust's Quality Report	8,000	Self-Interest (because this is a recurring fee)	The level of this recurring fee taken on its own is not considered a significant threat to independence as the fee for this work is £8,000 in comparison to the total fee for the audit of £77,000 and in particular relative to Grant Thornton UK LLP's turnover overall. Further, it is a fixed fee and there is no contingent element to it. These factors all mitigate the perceived self-interest threat to an acceptable level.

The amounts detailed are fees agreed to-date for audit related and non-audit services to be undertaken by Grant Thornton UK LLP in the current financial year. These services are consistent with the Trust's policy on the allotment of non-audit work to your auditors. Any changes and full details of all fees charged for audit related and non-audit related services by Grant Thornton UK LLP and by Grant Thornton International Limited network member Firms will be included in our Audit Findings report at the conclusion of the audit.
None of the services provided are subject to contingent fees.

The firm is committed to improving our audit quality – please see our transparency report - https://www.grantthornton.ie/about/transparency-report/

Appendix A: Audit Quality – national context

What has the FRC said about Audit Quality?

The Financial Reporting Council (FRC) publishes an annual Quality Inspection of our firm, alongside our competitors. The Annual Quality Review (AQR) monitors the quality of UK Public Interest Entity audits to promote continuous improvement in audit quality.

All of the major audit firms are subject to an annual review process in which the FRC inspects a small sample of audits performed from each of the firms to see if they fully conform to required standards.

The most recent report, published in July 2019, shows that the results of commercial audits taken across all the firms have worsened this year. The FRC has identified the need for auditors to:

- improve the extent and rigour of challenge of management in areas of judgement
- improve the consistency of audit teams' application of professional scepticism
- strengthen the effectiveness of the audit of revenue
- improve the audit of going concern
- improve the audit of the completeness and evaluation of prior year adjustments.

The FRC has also set all firms the target of achieving a grading of '2a' (limited improvements required) or better on all FTSE 350 audits. We have set ourselves the same target for public sector audits from 2019/20.

Other sector wide reviews

Alongside the FRC, other key stakeholders including the Department for Business, energy and Industrial Strategy (BEIS) have expressed concern about the quality of audit work and the need for improvement. A number of key reviews into the profession have been undertaken or are in progress. These include the review by Sir John Kingman of the Financial Reporting Council (Dec 2018), the review by the Competition and Markets authority of competition within the audit market, the ongoing review by Sir Donald Brydon of external audit, and specifically for public services, the Review by Sir Tony Redmond of local authority financial reporting and external audit. As a firm, we are contributing to all these reviews and keen to be at the forefront of developments and improvements in public audit.

What are we doing to address FRC findings?

In response to the FRC's findings, the firm is responding vigorously and with purpose. As part of our Audit Investment Programme (AIP), we are establishing a new Quality Board, commissioning an independent review of our audit function, and strengthening our senior leadership at the highest levels of the firm, for example through the appointment of Fiona Baldwin as Head of Audit. We are confident these investments will make a real difference.

We have also undertaken a root cause analysis and put in place processes to address the issues raised by the FRC. We have already implemented new training material that will reinforce the need for our engagement teams to challenge management and demonstrate how they have applied professional scepticism as part of the audit. Further guidance on auditing areas such as revenue has also been disseminated to all audit teams and we will continue to evolve our training and review processes on an ongoing basis.

What will be different in this audit?

We will continue working collaboratively with you to deliver the audit to the agreed timetable whilst improving our audit quality. In achieving this you may see, for example, an increased expectation for management to develop properly articulated papers for any new accounting standard, or unusual or complex transactions. In addition, you should expect engagement teams to exercise even greater challenge management in areas that are complex, significant or highly judgmental which may be the case for accounting estimates, going concern, related parties and similar areas. As a result you may find the audit process even more challenging than previous audits. These changes will give the audit committee – which has overall responsibility for governance - and senior management greater confidence that we have delivered a high quality audit and that the financial statements are not materially misstated. Even greater challenge of management will also enable us to provide greater insights into the quality of your finance function and internal control environment and provide those charged with governance confidence that a material misstatement due to fraud will have been detected.

We will still plan for a smooth audit and ensure this is completed to the timetable agreed. However, there may be instances where we may require additional time for both the audit work to be completed to the standard required and to ensure management have appropriate time to consider any matters raised. This may require us to agree with you a delay in signing the announcement and financial statements. To minimise this risk, we will keep you informed of progress and risks to the timetable as the audit progresses.

We are absolutely committed to delivering audit of the highest quality and we should be happy to provide further detail about our improvement plans should you require it.

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Meeting Title:	**Trust Board**		
Date:	**30 January 2020**	**Agenda No**	**4.2**
Report Title:	**Quality and Safety Strategy 2019-2024 (DRAFT)**		
Lead Director	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control** **Richard Jennings, Chief medical officer**		
Report Author:	Alison Benincasa, Director of Quality Governance and Compliance Kath Brook, Strategy and Planning Manager		
Presented for:	Approval		

Executive Summary:

The quality and safety strategy 2019-2024 is one of a number of supporting strategies being developed by the Trust in order to support delivery of the ambitions set out in the Trust Strategy 2019-2024, *Delivering outstanding care every time.*

The development of the quality and safety strategy has been shaped by engagement with staff, patients and the public and via a working group with representatives from professional staff groups. Particular note should be taken of the following information in appendix 1 which has informed the quality and safety strategic priorities for 2019-24:

- Slide 8: feedback from our staff and patients
- Slide 9: National quality and safety strategy and local implications
- Slides 10-12: Progress to date with reference to the 2019-20 quality priorities and key developments/ remaining issues
- Slide 15: Our strengths, weaknesses, opportunities and threats

A Board seminar was held In December 2019 and the feedback provided has been incorporated:

Board seminar feedback	Slide number
Increase the aspirations of the strategic priorities	14
Include quality and safety governance in strategic priority 6	14
Emphasis what success will look like	15-22
Include the health and well-being strategy in strategic priority 4	18
Quality improvement needs to be a core part of our 5 year journey	20
Simplify the narrative for our approach to quality improvement	21

Given the breadth of issues, challenges and opportunities facing the Trust now and in the future, the quality and safety strategy has focussed on seven strategic priorities areas which are within the Trust's gift to deliver and have the potential for the biggest impact on quality and safety, see slides 19-25 for detail. These are:

1. We will **minimise avoidable harm across** our organisation, utilising the developments in technology, reducing unwarranted variation and embedding further, robust quality assurance and learning processes
2. We will **improve outcomes for patients** through timely diagnosis, exceptional care and treatment and by working with our partners to ensure we contribute to developing the whole pathways of care for our

	patients 3. We will **provide patients with an excellent experience** through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients 4. We will improve **staff experience**, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology 5. We will **provide patients with an equitable access and quality** by proactively improving access and care for vulnerable groups 6. We will **embed a culture** in which **quality, safety and learning** is embraced across the organisation, and is supported by robust systems of safety governance 7. We will be at the forefront of **providing and developing pioneering and leading edge treatments** for today and for the future To support the delivery of strategic priority 6 (embed a culture in which quality, safety and learning is embraced across the organisation, and is supported by robust systems of safety governance) the Executive team has agreed investment in additional staff resources which was confirmed by the Trust Board in December 2019. Any further investment needed will be addressed through the annual business planning cycle.
Recommendation:	The Board is asked to: 1. Review the draft quality and safety strategy 2019-2024 and suggest any amendments/additions which they would like to be included prior consideration by the Trust Board on the 30 December 2. Note the dependency of the Education, Workforce, Digital and Research Strategies to deliver the expected outcomes 3. Note that as the strategy relates to quality and safety there is no requirement to undertake a Quality Impact Assessment
Supports	
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring:** staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources

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	▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	▪		
Legal/Regulatory:	N/a		
Resources:	N/a		
Previously Considered by:	Trust Executive Committee Quality and Safety Committee	**Date:**	22 January 2020 23 January 2020
Appendices:	Appendix 1: Quality and Safety Strategy 2019-2024 Appendix 2: Equalities Impact Assessment Appendix 3: Stakeholder Engagement		

Appendix 3 - Stakeholder Engagement

The following groups were engaged in developing the quality and safety strategy

Stakeholder	How have contributed
Staff Groups: • Allied Health Professionals • Advanced Clinical Practitioners • Physician Associates • Nursing and Midwifery • Pharmacists • Healthcare Scientists • Medical • Clerical and Administration • Divisional representation	Stakeholder events and online staff engagement survey has contributed to: • Scoping the quality and safety strategy • Identify current, future challenges for their relevant staff group • Identifying potential solutions • Review and testing of the emerging strategy
Partnership Forum	Presentation 29th October
Trust Board	Board Seminar 4th December
Trust staff	Staff engagement event 16th and 24th September, 15th November (SGUH and QMH sites) Staff engagement on-line survey launched November - January
Public and Patient Groups	Engagement event 23rd October
GP Engagement	18th September and 10th October
Council of Governors	Presentation at the 17th December meeting
Patient Safety Quality Group	Circulated to group members 23rd January
Quality and Safety Committee	Regular updates on strategy development, final presentation 23rd January

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Quality and Safety Strategy 2019 – 2024

January 2020

Contents

Outstanding care every time

Introduction

Quality and safety is a key part of the **Trust Strategy for 2019 – 2024**, *delivering outstanding care, every time*.

Delivering outstanding care, every time

Our strategy for 2019-2024

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

Strong foundations

To provide outstanding care, every time

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

Excellent local services

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

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

Closer collaboration

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

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

Leading specialist healthcare

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

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

This quality and safety strategy recognises the challenges we face now and sets out the ambitions for the future.

It harnesses the opportunities to maximise what we do well, learn from patient safety incidents and to embed a culture of quality, safety and learning culture

It identifies areas where we will prioritise our efforts to ensure we can address our challenges and maximise the opportunities.

What do we mean by quality?

A single definition of quality for the NHS was first set out in ***High Quality Care for All in 2008*** and has since been embraced by staff throughout the NHS and enshrined in legislation through the ***Health and Social Care Act 2012.***

This definition sets out ***three dimensions of quality***: ***clinical effectiveness, patient experience*** and ***patient safety*** which has been expanded by the ***World Health Organisation*** to cover six dimensions of healthcare quality and states that healthcare must be:

1. Safe: Avoiding harm to patients from care that is intended to help them

2. Timely: Reducing waits and sometimes harmful delays

3. Effective: Providing services based on evidence and which produce a clear benefit

4. Efficient: Avoiding waste

5. Person-centred: Establishing a partnership between practitioners and patients to ensure care respects patients' needs and preferences

6. Equitable: Providing care that does not vary in quality because of a person's characteristics.

Sources:
High Quality Care for All: NHS Next Stage review Final Report, Department of Health, June 2008. Available at: http://www.dh.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_0858255
Health and Social Care Act 2012. Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
World Health Organisation, quality definition: accessed via: https://www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/

Engaging with our staff and patients

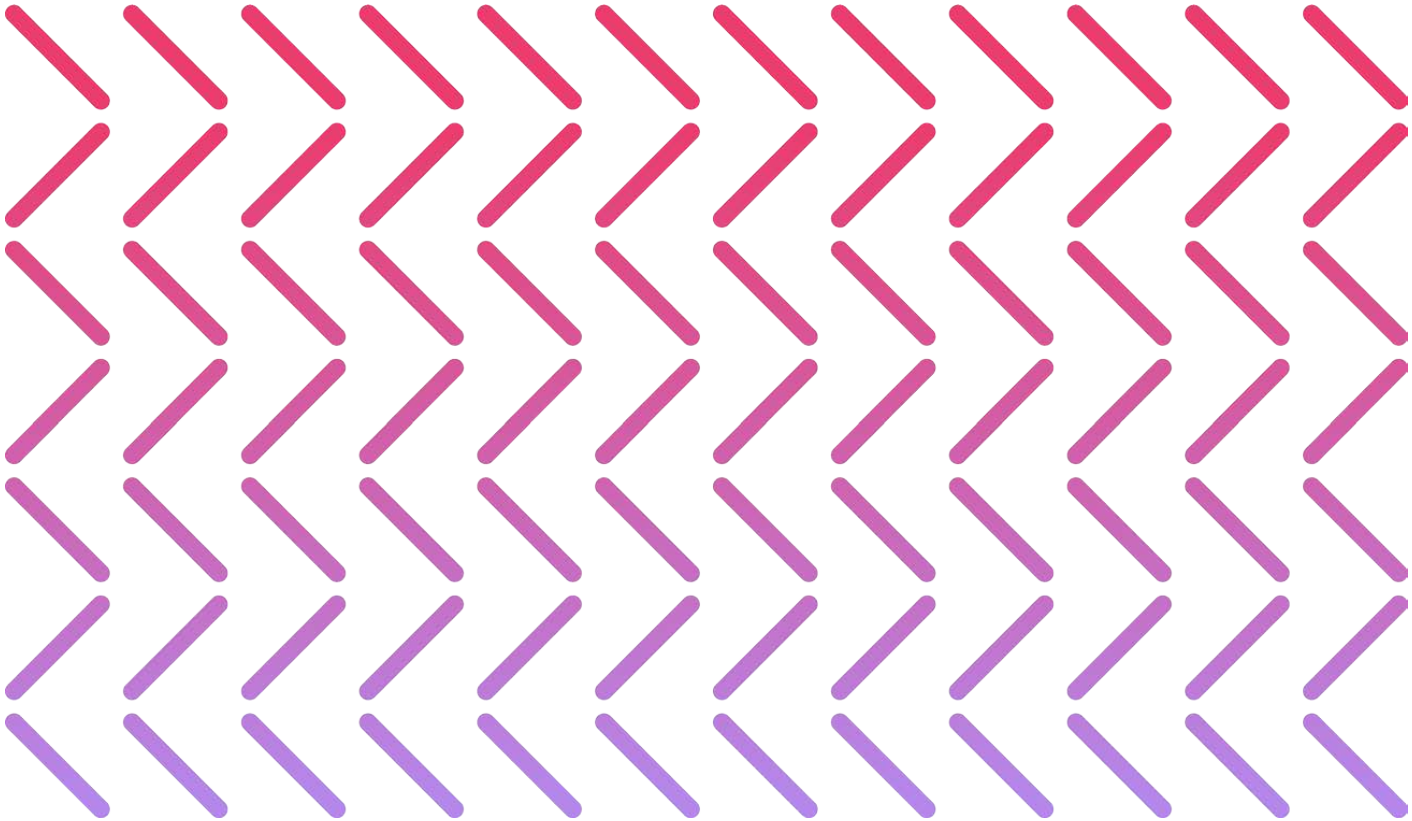
In developing this strategy we held a number of engagement events with a range of staff, patients and the public. We also conducted a Trust wide electronic staff survey.

In addition we reviewed the following:

- NHS Staff Survey results for 2017/18 and preliminary results for 2019
- Findings of inpatient patient survey July 2018
- Findings of ward and departmental accreditations 2019
- Care Quality Commission inspection report 2019
- Trust's Quality Improvement Programme 2018-19 and aligned Quality Account priorities for 2019-20
- Medical Engagement Scale (MES) Survey November 2019

The feedback we received and the review of key reports helped shape our plans for the future.

Where we have come from, and where we are now



Our quality and safety journey so far:

Treat the patient, treat the person is a key organisational objective within the Trust's strategic priority **Strong Foundations**.

To fulfil our ambition to deliver outstanding care every time for 2019-20 we identified three clinical priorities and one non-clinical priority:

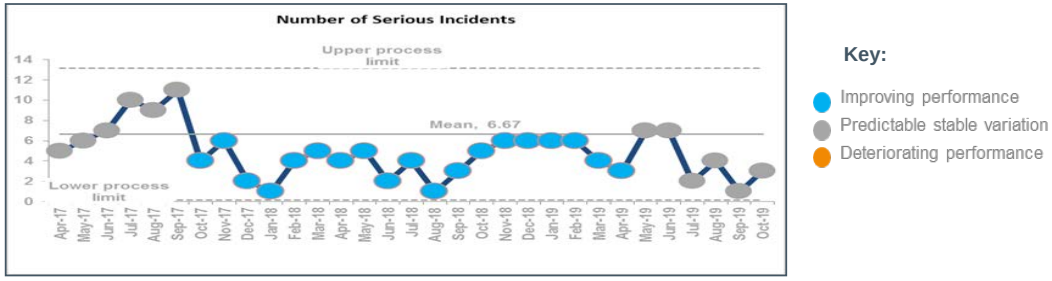
- all non elective adults to have a ***treatment escalation plan*** within 24 hours of admission
- Appropriate response and treatment for the ***deteriorating patient***
- Proper protection and care for patients who lack ***mental capacity***

- Standardise ***quality governance***, safety and learning

We also have a Quality Improvement programme to drive improvements in a further eight areas: team working; fundamentals of care; complaints; mental health; dementia; acute pain; staffing; and reducing variations in care.

Our focus on improving quality and safety has seen our Care Quality Commission inspection rating improve from ***Inadequate in 2016 (placed in quality special measures)*** to ***Requires Improvement in 2019 (with a recommendation to be removed from quality special measures)***

Progress against our quality and safety priorities 2019-20

Priorities 2019-20	Key progress to date	Remaining areas to address
Our clinical priorities		
Emergency patients will have treatment escalation plans (TEP) within 24 hours of admission	• Treatment Escalation Plan developed (paper format) and implementation commenced • Electronic Treatment Escalation Plan built in test domain of iClip (electronic patient records)	• Trust wide roll out of iClip TEP at pace supported by education and training of staff
Patients who lack mental capacity will have proper protection and care	• Developed staff reference cards – information and guidance at a glance to support staff making evidence based treatment decisions on a range of key topics e.g. Mental Capacity Assessment and Depravation of Liberty assessment, safeguarding children and adults • Achieved compliance with level 1 training and saw improvement in level 2 • Developed South West London audit/ staff knowledge survey to understand the baseline knowledge in our staff groups, benchmark our position with other trusts and assess the impact of our level 1 and 2 training programmes	• Improve and sustain compliance in level 1 and level 2 training • Implement South West London audit/ staff knowledge survey to inform targeted training and support
Inpatients who deteriorate will be recognised and treated promptly	• The updated national early warning score assessment process (NEWS2) implemented in iClip • Critical Care Outreach team launched December 2019 to improve quality of care provision and patient outcomes • Improved compliance across all staff groups for the 3 resuscitation modules. However, the Trust target of 85% compliance was not met, as of January 2020 Trust performance was 73.6%	• Completion of recruitment to critical care outreach team • Improve and sustain compliance in resuscitation training modules • Provide on-going training and education of our clinical staff • Explore further IT solutions for patient observations
Our non-clinical priority		
We will map, standardise, support and improve our departmental-level governance of quality, safety and learning	• Completed 2 external governance reviews • Developed an action plan to capture the recommendations and commenced implementation • Investment secured for additional staff to strengthen governance processes • The number of serious incidents has reduced from in 2019/20 and the general trend over the last 2 years has been a significant reduction (see figure 1 below) Figure 1. Number of Serious Incidents 2017-2019 	• Increase pace of delivery against review recommendations e.g. recruit to the enhanced governance team structures and mortality monitoring meeting coordinators • Review and embed optimal governance reporting systems from ward/ department to board

The local and national environment is changing bringing new opportunities:

National Patient Safety Strategy 2019

- New national standards and guidance published July 2019 to support continuous improvement in patient safety
- The strategy builds on 2 foundations: ***a patient safety culture*** and ***a patient safety system***
- ***Three strategic aims*** are detailed in the strategy:

  - **INSIGHT:** adopt and promote ***key safety measurement principles and use culture metrics*** to better understand how safe care is; and use ***new digital technologies*** to support learning from what does and does not go well, by replacing the National Reporting and Learning System with a ***new safety learning system***; and introduce the ***Patient Safety Incident Response Framework*** to improve the response to and investigation of incidents.

  - **INVOLVEMENT**: the ***whole healthcare system*** is involved in the safety agenda; create the first ***system-wide and consistent patient safety syllabus, training and education framework*** for the NHS; establish ***patient safety specialists*** to lead safety improvement across the system; and ***equip people to learn*** from what goes well as well as to respond appropriately to when things go wrong

  - **IMPROVEMENT:** designing and supporting programmes that ***deliver effective and sustainable change*** in the most important areas. Commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population

St George's University NHS Foundation Trust

- Delivery of the Trust's Clinical Strategy 2019-2024
- Our focus on improving quality and safety has seen our Care Quality Commission inspection rating improve from ***Inadequate in 2016 (placed in quality special measures)*** to ***Requires Improvement in 2019 (with a recommendation to be removed from quality special measures)***
- Workforce and Digital strategy approved by Board in 2019, Education Strategy to be approved by Board in January 2020, all driving improved quality of care provision which is key to the delivery of outstanding care every time
- Readiness to adopt the new ***Patient Safety Incident Response Framework*** in Autumn 2020 with full implementation from summer 2021

Quality and safety matters to our staff, patients and partners

In developing this strategy we have engaged with a range of staff, patients and the public. The detail in the strategy is informed through bottom-up engagement with professional staff groups

Staff Feedback

- Want to see a **quality and safety culture** and a change towards **'Always Events'**
- **Reduce avoidable harm**
- Improve patient flow **to improve patient safety and experience**
- **Health and wellbeing initiatives** need to be **more accessible for** staff
- Enable provision of high standard **compassionate consistent care**
- Enable **consistent communication** which is clear and timely both internally and externally for patients and colleagues that we work with
- Provide **suitable environments** to care for our patients
- **Improve care through learning**
- Enable **patient centred care** and shared decision making
- Want **all staff groups** to be included
- Want to get the **basics right**
- Want **more visibility of the Quality Improvement Academy** and how it can support us to make improvements
- Want to improve care through learning and to **exploit external opportunities for system learning**
- Need the right staff at the right time with the right skills
- Want improved systems for triage **and responsiveness** to referrals

Patients and Public Feedback

- Want to see **safety first** and a clear commitment **to reduce avoidable harm**
- Want **easily available and clear information** for staff and patients on known risks and what help is available to reduce incidences
- Want to see **continual learning,** make SGUH more resilient to risks and clinical incidents
- Want to extend the reported **outcome measures, co-produced with patients**
- Want **honest and transparent interaction**/ Duty of Candor
- Want a **culture in which staff never hesitate to raise a concern** if they feel safety is compromised
- Want **compassionate care provision**
- Need to get the **workforce right**, in terms of the numbers and skills required
- Need an **estates strategy- fundamental to safety and quality ambitions**

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

Strengths:

- We established ***a Quality Improvement Academy***
- We have ***strong governance processes for reporting, declaring and investigating serious incidents***
- We can demonstrate good promotion of privacy and dignity
- We have improved infection control management
- We have improved the experience for our patients
- We have improved our discharge arrangements
- We have a high performing major trauma centre
- We have stroke and renal services which are the best in London
- We have improved our complaints response rate

Opportunities:

- We can deliver the recommendations from the ***Clinical governance reviews*** to improve our ***quality and safety governance***
- We can strengthen our current processes for the management of falls, pressure ulcers, Venous Thrombosis Embolism (VTE) and learning from deaths to ***reduce avoidable harm***
- We can further ***improve patient experience***
- We can develop a ***culture for learning, quality and safety***
- We can develop the ***role of our business intelligence service to inform our Quality Improvement***
- We can further develop our ***mentorship & career development programme***
- We can ***improve staff satisfaction*** and NHS Staff Survey results
- We can ***engage in innovative practices with links to research*** and develop networks/centres of excellence with clinical and academic partners to ***to improve patient outcomes***
- We can bring ***health and wellbeing initiatives for staff*** to the wards and departments
- progress with improvement plan
- We can **improve our CQC rating**
- We can improve our financial efficiency and productivity
- We can improve the condition of our estate supported by NHSI capital investment

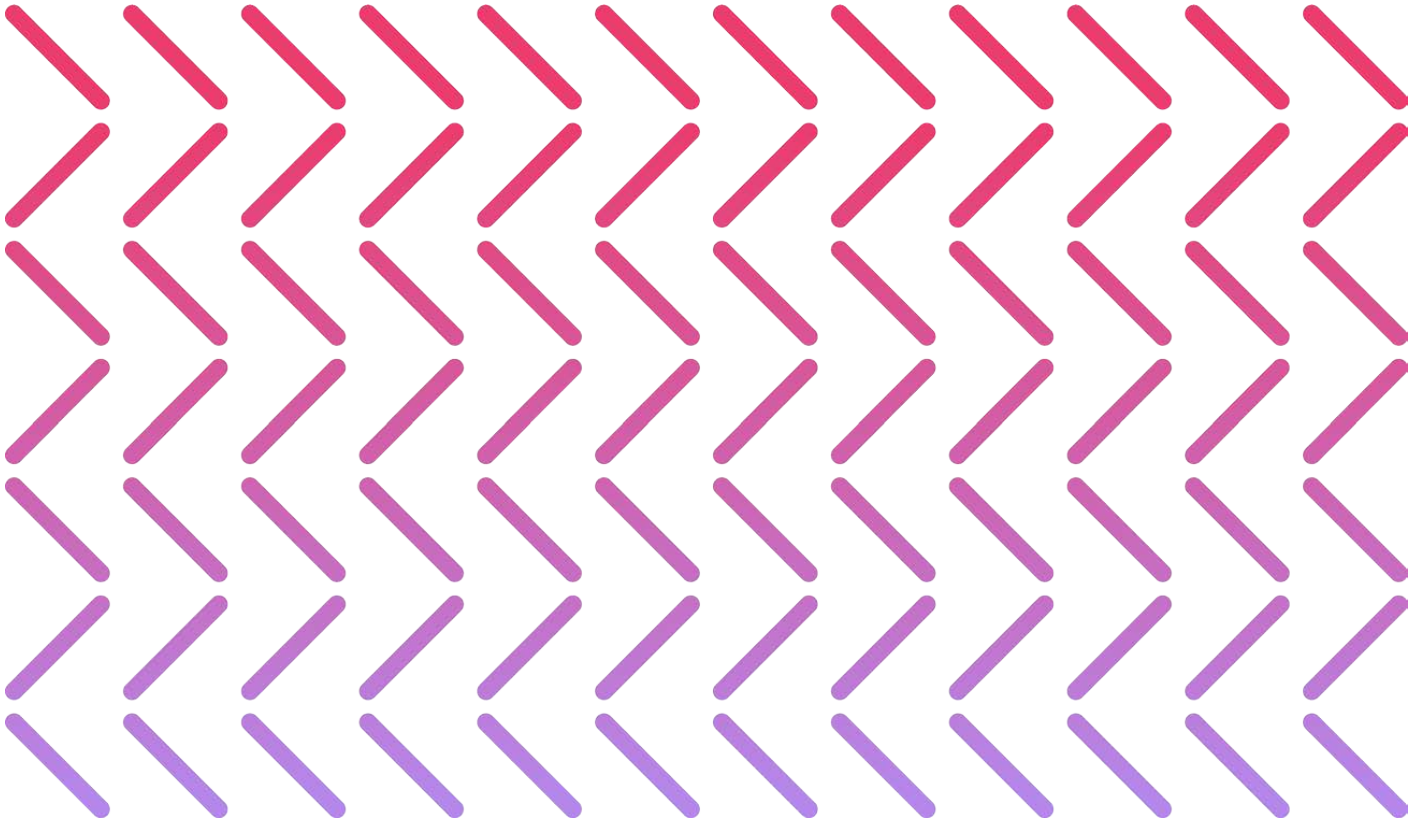
Weaknesses:

- We need a stronger ***quality and safety culture***
- We need to improve ***quality and safety governance***
- We need to **improve flow** to improve patient safety and experience
- We need to **triangulate quality and safety information** and own, understand and use data more systematically to achieve better patient outcomes and results
- We need to achieve ***parity of esteem*** and safe care of our mental health patients
- We need to improve our outpatient services
- We need to improve our NHS Staff Survey results, in particular reduce bullying and harassment, improve staff engagement and our focus on diversity and inclusion for staff
- We need to improve our capacity to implement change as part of usual business
- We need to improve the visibility of our quality improvement academy
- We need to monitor and report on the completion of actions from complaints investigations
- We need to improve our evidence of compliance with National Institute of Clinical Excellence guidance
- We need to improve the condition of our estates and health and safety

Threats:

- Our financial constraints
- Our workforce constraints
- The expected ***cultural shift*** does not happen, or does not happen quickly enough

Where we go next :quality and safety priorities 2019-24



Our vision for quality and safety at St George's 2019-2024:

Quality is at the heart of our Trust Strategy 'Delivering outstanding care every time' and by 2024 St George's will be an outstanding Trust delivering the best experience and outcomes for patients, with happy staff who are fully equipped to provide high quality and safe services , within a culture of continuous quality and safety improvement

Strategic quality and safety priorities for 2019 – 2024

1. We will **minimise avoidable harm across** our organisation, utilising the developments in technology, reducing unwarranted variation and embedding further, robust quality assurance and learning processes

2. We will **improve outcomes for patients** through timely diagnosis, exceptional care and treatment and by working with our partners to ensure we contribute to developing the whole pathways of care for our patients

3. We will **provide patients with an excellent experience** through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients

4. We will improve **staff experience**, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology

5. We will **provide patients with an equity of access and quality** by proactively improving access and care for vulnerable groups

6. We will **embed a culture** in which **quality, safety and learning** is embraced across the organisation, and is supported by robust systems of safety governance

7. We will be at the forefront of **providing and developing pioneering and leading edge treatments** for today and for the future

Strategic priority 1: We will minimise avoidable harm across our organisation

Why are we focussing on this?
Patients are safer when there is a safety culture that is fully embedded in our everyday business. All staff have a responsibility to identify and intervene to prevent an event or chain of events that may cause patient harm.

Proposal: Everyone will have responsibility to take all necessary steps to avoid harm to our patients, to learn from best practice, deliver the best possible outcomes and reduce unwarranted variation.

- We will focus on the ***key priorities*** of ***falls, pressure ulcers, infection control, Venous Thromboembolism (VTE), learning from deaths, patient flow and consent***
- We will drive improved performance through ***existing processes*** e.g. safety thermometer, ward and departmental accreditation scheme, quality observatory and through the introduction of the ***new patient safety incident response framework*** and ***new medical examiner system***
- We will ***review each year*** as we make progress to ensure we are sighted on emerging risks of avoidable harm
- We will also monitor the impact of ***clinical systems*** and our ***estate*** on our ability to deliver safe care

What will success look like?
We will see a **year on year improvement** against our agreed Key Performance Indicators.

Strategic priority 2: We will improve outcomes for patients through timely diagnosis, exceptional care and treatment and by working with our partners to ensure we contribute to developing the whole pathways of care for our patients

Why are we focussing on this?
We want to be an organisation that supports continuous learning and drives through healthcare innovations and improvement.

Proposal: We want to make it easier to do the right thing, to demonstrate measurable improvement in patient outcomes, to reduce unwarranted variation and to participate in research.

- We will use **our data** to focus on improving access and quality of care where evidence shows patients are disadvantaged e.g. Black and Minority Ethnic patients, homeless patients, vulnerable older people and those living with mental health issues, dementia or a learning disability

- We will engage with the **national patient safety improvement programme**, building on the existing focus of preventing avoidable deterioration and adopting and spreading safety innovations

- We will drive improved performance through ***existing processes*** e.g. safety thermometer, ward and departmental accreditation scheme, quality observatory, through the introduction of the ***new patient safety incident response framework*** and through the learning derived from collaboration with other healthcare providers in the local system

- We will implement a strengthened **corporate quality and safety governance structure**

What will success look like?
Our **clinical audit programme** and the **external quality surveillance programme** will demonstrate a year on year improvement in patient outcomes and unwarranted variation. We will sustain our improved recruitment of patients to clinical research trials.

Strategic priority 3: We will offer patients an excellent experience through their journey with us by monitoring and acting on feedback to ensure continual improvements in the areas that matter most to our patients

Why are we focussing on this?
We want to provide the fundamentals of care that matter to our patients meeting both their emotional and physical needs - communication, privacy, dignity, safety, nutrition and hydration, comfort and warmth.

Proposal: We will use patient feedback for continuous improvement.

- We will focus on tracking the delivery of actions in response to complaints investigations and on improving the dissemination of learning from complaints and feedback from the Friends and Family Test
- We will build on our existing patient partnerships to ensure that patients are involved in improvement projects from the earliest stage
- We will focus on improving the experiences of care to our most vulnerable patients and their carers, including children, our homeless patients and those living with dementia, a learning disability, mental health issues
- We will focus on improving shared decision making and consent
- We will focus on engaging all staff in the Trust on improving patient flow
- We will drive improved performance through ***existing processes*** and through the introduction of the ***new patient safety incident response framework***

What will success look like?
We will see year on year improvement in Friends and Family Test, inpatient survey results and a reduction in formal complaints.

Strategic priority 4: We will develop further our approach to improving staff experience, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology

Why are we focussing on this?
We want our staff to feel valued, supported and safe and equipped to deliver high quality safe care.

Proposal: We will ensure all staff have the training, development and resources needed to deliver outstanding care every time, and we will take positive action to encourage and celebrate the diversity of our workforce.

- We will drive this through the **deliver of the Trust's workforce, education and the diversity and inclusion strategy**
- We will support our staff through the delivery of the key objectives of the **health and well being strategy 2018**
- We will continue **to embrace the diversity of our workforce and embed staff networks**

What does success look like?
We will see improved scores in the NHS Staff Survey, improved feedback from Friend and Family Test, improved engagement with staff networks and increased uptake of training.

* *Workforce Strategy launched November 2019, Education Strategy to be launched February 2020,* Diversity and Inclusion Strategy launched January 2019

Strategic priority 5:We will provide patients with equitable access and quality by proactively improving access and care for vulnerable groups

Why are we focussing on this?
We serve a diverse population and we want our patients and communities to have equal access to our services which we are currently not achieving.

Proposal: We will improve our use of data to understand where issues with patient access exist and utilise this to optimise equitable provision.

- We will **increase patient participation**, including dedicated initiatives to engage with our seldom heard patient groups
- We will focus on **improving the experiences of care to our most vulnerable patients and their carers**, including children, our homeless patients and those living with dementia, a learning disability and mental health issues

What will success look like?
We will reduce incidents relating to patient access to care and reduce avoidable incidents in vulnerable patient groups.

Strategic priority 6: We will work to embed a culture where governance of quality, safety and learning is embraced across the organisation

Why are we focussing on this?
We want our patients and staff to recognise that quality and safety comes first and is at the heart of everything we do. Patients are safer when there is a safety culture that is fully embedded in our everyday business. All staff have a responsibility to identify and intervene to prevent an event or chain of events that may cause patient harm.

Proposal: We will respond to the findings of our external reviews and maximise new investment by developing and embedding a culture of quality and safety to enable our staff to deliver outstanding care every time, and we will take positive action to encourage our staff to report and learn from patient safety incidents.

- We will **raise the level awareness of psychological safety** and encourage staff to speak about their concerns, and we will improve in our responsiveness to their concerns
- We will continue our bespoke human factors training and support increasing numbers of staff to train and **coach our staff in quality improvement**
- We will **recruit culture champions** and work differently to develop new initiatives
- We will **equip our staff with skills in critical thinking to drive improvement**, support them to get the time and space to create the conditions for change, encouraging our staff to develop quality and safety improvement projects and to access our quality improvement academy for support
- We will drive this by ensuring 'quality and safety first' is seen as everyone's responsibility, through **increasing the visibility of our Freedom to Speak up Guardian** and staff champions, surrounding our patients and staff with quality and safety messages Trust wide, implementing the patient safety incident response framework and developing quality improvement plans at care group level aligned to the clinical outcomes in our quality and safety strategy
- We will **upgrade our current ward and departmental accreditation scheme** to include a platinum rating in addition to our current ratings of bronze, silver and gold and we will extend the programme to include finance and performance

What does success look like?
We will see increased incident reporting, with a decrease in the proportion of incidents causing harm, increased use of the Freedom To Speak Up Guardian and Champions, and year on year improvement in our agreed metrics. We will see a high level of visibility and transparency of quality and safety issues at Board level.

How we will develop a culture where governance of quality, safety and learning is embedded across the organisation

Our approach to Quality Improvement is to help teams solve problems at their own level:

To embed a culture where governance of quality, safety and learning **we will create the conditions for change**. Our staff will continue to develop a **culture of continuous improvement** where staff are empowered to identify issues in their own area of work and are skilled to make improvements that enable them to provide better and safer care for patients. Our experience, supported by our colleagues in the Institute of Health Innovation, is that we will best achieve this by continuing to use a simple yet effective improvement model to bring about changes.

Our **method for improvement** is simple – plan, do, study, act (**PDSA**):

Staff undertaking improvement initiatives will be able to draw on support from our **Quality Improvement Academy** with particular emphasis on the leadership support, accountability and culture and reliability and sustainability

Strategic priority 7: We will be at the forefront of providing and developing pioneering and leading edge treatments for today and in the future

Why are we focussing on this?
We want to extend our national and international reputation as a leading edge Trust and provide the most up to date care and treatment to maximise outcomes for patients.

Proposal: We will be at the forefront of providing and developing pioneering and leading edge treatments for today and in the future.

- We will pursue and encourage **new and novel procedures** e.g. more day case surgery, provision of virtual clinics, use of virtual reality in clinical settings
- We will **integrate our medical devices with the hospital electronic systems** e.g. monitoring vital signs to be sent directly to the electronic patient record
- We will be a **research active organisation** encouraging our patients to participate in research trials and develop our staff to embrace research and evidence based practice
- We will extend our successful **surgical school** 'Get set for Surgery' for our cancer patients to other surgical specialities
- We will communicate our success and share learning locally, nationally and internationally

What does success look like?
We will be able to demonstrate pioneering and leading edge treatments across a wide range of services and our patients will report positive experience and outcomes.

Summary: Our vision for Quality and Safety at St George's 2019-2024

Quality is at the heart of our the Trust Strategy '*Delivering outstanding care every time*' and by 2024 St George's will be an outstanding Trust delivering the best experience and outcomes for patients, with happy staff who are fully equipped to provide high quality and safe services within a culture of continuous quality and safety improvement

By 2024 we will know we have met our ambition because our:

- Patients will receive outstanding care every time
- Staff will have the training, development and resources needed to deliver outstanding care every time
- Trust will have an outstanding record of patient safety
- Trust will be soundly governed and compliant with the requirements of our regulators
- Trust will be rated Outstanding by the Care Quality Commission

Above all:
Our communities will have equal access to the best care and treatment when they need it and St George's will be among the best and safest places in the country to receive care.

Next step:
Implementation plans will be produced for each of the seven priority areas, setting out in detail the actions needed, clear targets, Key Performance Indicators and an accountable owner. The governance of the plans will rest with the Patient Safety Quality Group, the Trust Executive Committee, and the Quality and Safety Committee reporting up to Trust Board.

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EQUALITY IMPACT ASSESSMENT FORM

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Quality and Safety Strategy 2019-2024	Strategy	Alison Benincasa, Director of Quality Governance and Compliance Kath Brook Strategy and Planning Manager	New strategy	14/01/2020

1.1 Who is responsible for this service / function / policy?

Avey Bhatia, Chief Nursing and Director of Infection Prevention and Control
Richard Jennings, Chief Medical Officer

1.2 Describe the purpose of the service / function / policy?

The purpose of the Quality and Safety Strategy 2019-2024 is to set out how the Trust will ensure it provides high quality, effective and safe services whilst delivering the best experience and outcomes for patients with happy staff working within a culture of continuous improvement.

The strategy identifies the key priority areas which will be the focus of action over the next 5 years to ensure the Trust achieves its purpose.

1.3 Are there any associated objectives?

The strategy has been drafted to be consistent and aligned with national priorities (e.g. the NHS Long Term Plan and the National Patient safety Strategy), local priorities (e.g. the SWL Health and Care Partnership and the Acute Provider Collaborative) and the Trust's vision (Outstanding Care, Every Time) and corporate priorities (Treat the patient, treat the person)

Out of the strategy will be seven key areas of focus for 2019/24:

1. Minimise avoidable harm
2. Improve outcomes for patients
3. Provide patients with an excellent experience
4. Improve staff experience
5. Provide patients with an equitable experience
6. Embed a quality, safety and learning culture
7. Provide and develop pioneering and leading edge treatments

1.4 What factors contribute or detract from achieving intended outcomes?

There are a range of factors which could contribute or detract from achieving the ambitions set out in the strategy. These include:

- Digital infrastructure – for enhanced care and treatment technology
- Estates – impact on patient and staff experience
- Ability and capacity for staff to be released for quality improvement development opportunities
- The pace of cultural change towards being a learning organisation
- Availability of further investment (£0.75M invested in additional staff resource in 2020)

1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights?

The proposed Quality and Safety strategy should have a positive impact on equalities. For example, the strategy:

- Commits to providing patients with an equitable experience by proactively reaching out with system partners to our communities and our vulnerable groups
- Commits to providing patients with an excellent experience through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients
- Commits to improving staff experience, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology
- As part of the plan the Trust will ensure that processes for applying for opportunities to engage in quality and safety improvement initiatives are equitable and transparent

Without some changes, there remain negative impacts:

- We serve a diverse population and we want our patients and communities to have equal access to our services which we are currently not achieving
- We do not use of data effectively to understand where issues with patient access exist and utilise this to optimise equitable provision

1.6 If yes, please describe current or planned activities to address the impact.

These positive impacts will be pursued through implementation of the strategy, which will be driven forward by implementation plans with progress reported to Trust Board.

The areas identified with negative impact can be addressed by:

- Investment linked to the Quality and Safety Strategy
- The associated implementation plan will seek to enhance opportunities for better understanding and use of our data to identify hard to reach groups

1.7 Is there any scope for new measures which would promote equality?

As the Trust moves into implementing the Quality and Safety Strategy, it may decide there is scope

for new measures to further promote equality through on-going engagement with staff and patient groups who have contributed to developing the Quality and Strategy and also with existing staff and patient networks.

1.8 What are your monitoring arrangements for this policy/ service

The impact of the key areas of focus will be monitored and reported to the Patient Safety Quality Group, the Trust Executive Committee, and the Quality and Safety Committee reporting up to Trust Board

1.9 Equality Impact Rating [low, medium, high]

Low.

2.0. Please give you reasons for this rating

The proposed strategy should have a positive impact on equalities, as set out in this assessment. There will be further opportunities to ensure that this potential positive impact is delivered as the Trust moves into implementing the Quality and Safety strategy, and monitoring progress.

The process of drawing up more detailed implementation plans, and then monitoring progress against them, will also afford further opportunities to identify and prevent/ mitigate any unintended negative impact on equalities.

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Meeting Title:	Trust Board		
Date:	30 January 2020	**Agenda No**	**4.3**
Report Title:	2019/20 Corporate Objectives – Quarter 3 Report		
Lead Director	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Sarah Brewer, Head of Business Planning		
Presented for:	Assurance		
Executive Summary:	In April 2019 the Trust Board approved a new suite of Corporate Objectives for 2019/20, based on the domains of "Outstanding Care, Every Time." Progress against the objectives and their associated quarterly milestones is reported to Trust Board on a quarterly basis. As at the end of Quarter 3, of the 18 objectives, 11 have been rated green, 6 amber, and 1 red. Progress has been made on those milestones not completed in Quarter 2, with only 4 remaining amber at Quarter 3 and 1 remaining red. In summary those delays which are linked to the BAF strategic risks are**:** • 1.1 Reduce harm to patients (BAF risk SR1) • 1.2 We will map, standardise, support and improve our departmental-level governance of quality, safety and learning (BAF risk SR4) • 2.1 Patients will not wait long for treatment (BAF risk SR3) • 3.1 We are in financial balance (BAF risk SR7)) • 3.2 Our cost structures are understood and defines (BAF risk SR7) • 3.4 Improve management of commercial relationships (BAF risk SR8) • 4.1 We have a clear estates strategy (BAF risk SR10) • 5.3 A zero tolerance approach to bullying and harassment (BAF risk SR13) • 5.5 Empowering our staff to make real change (BAF risk SR11)		
Recommendation:	The Trust Board is asked to note the progress being made in delivery of the corporate objectives and the mitigations for those which are not on track.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring:** staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it		

	promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	▪ Any risks associated with the corporate objectives are covered within the BAF, Trust Risk Register or local risk registers		
Legal/Regulatory:	As legal/regulatory issues associated with the Corporate Objectives are covered by the governance underpinning that particular area of delivery of the trusts work programme		
Resources:	Delivery core business as usual of the trust, and supported by trust leadership cohort		
Previously Considered by:	Trust Executive Committee	**Date:**	22/01/2020
Appendices:			

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2019/20 Corporate Objectives – Quarter 3 Report

Trust Board 30th January 2020

1.0 Purpose

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

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

2.0 Progress against objectives in Quarter 3

2.1 Corporate objectives for Q3 have been RAG rated on progress, as has each of the domains into which they are divided. Annex B sets out the methodology for arriving at RAG-ratings, which was previously agreed by Trust Board.

2.2 The overall rating for Q3 is amber, no change from Q2; however more objectives were rated green in Q3 than Q2 which reflects an improvement in the progress against the objectives (see RAG table below):

- 11 objectives have been rated green, an increase of 7 from Q2
- 6 amber, a decrease of 5 from Q2
- 1 red, a decrease of 1 from Q2.

Progress has been made on those milestones not completed in Q2 with only 4 remaining amber at Q3 and 1 remaining red.

2.3 The update to Objective 4 'Build a better St George's' reflects the revised timescales following Board discussion of the Q2 update.

Organisational Objective	Green	Amber	Red	N/a (for quarter)	Update outstanding	Consolidated Quarterly Position	YTD position (and change on previous Q)
Treat the patient, treat the person		2					-
Right care, right place, right time	1	1					-
Balance the books, invest in our future	1	2	1				↓
Build a better St. George's	1	1					↑
Champion Team St. George's	6						↑

Develop tomorrow's treatments today	2						↑
OVERALL	**11**	**6**	**1**				↑

3.0 Objectives not being met in Q3

Objective	Assurance
1 Treat the patient, treat the person 1.1 Reduce harm to patients: • emergency patients will have treatment escalation plans (TEP) • patients who lack mental capacity will have proper protection and care • inpatients who deteriorate will be recognised and treated promptly 1.2 We will map, standardise, support and improve our departmental-level governance of quality, safety and learning	Quality and Safety Committee
2. Right care right time, right place 2..1 Patients will not wait long for treatment	Quality and Safety Committee Finance and Investment Committee
3. Balance the Books Invest in the Future 3.1 We are in financial balance 3.2 Our cost structures are understood and defined 3.4 Improve management of commercial relationships	Finance and Investment Committee
4. Build a Better St George's 4.1 We have a clear estates strategy	Finance and Investment Committee

4.0 Risks and mitigating actions

4.1 All deliverables not met as at Q3 are set out in Annex A, which includes a progress update, mitigation, and assessment of the extent to which not meeting the objective poses a material risk.

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

- 1.1 Reduce harm to patients (BAF Risk SR1)

- 1.2 We will map, standardise, support and improve our departmental-level governance of quality, safety and learning (BAF risk SR4)
- 2.1 Patients will not wait long for treatment (BAF risk SR3)
- 3.1 We are in financial balance (BAF risk SR7)
- 3.2 Our cost structures are understood and defined (BAF risk SR7)
- 3.4 Improve management of commercial relationships (BAF risk SR8)
- 4.1 We have a clear estates strategy (BAF risk SR10)
- 4.2 Our environment is safe for our patients and our staff (BAF risk SR10)
- 5.5 Empowering our staff to make real change (BAF risk

5.0 Recommendations

5.1 The Trust Board is asked to:

- Note the progress being made in delivery of the corporate objectives and the mitigations for those which are not on track

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Annex A – Deliverables not met YTD

Objective	Deliverables not delivered & causing amber or red RAG rating	Progress update	Mitigation	Material risk? (Link to BAF)	Q3 - Overall RAG Position On Delivery of Objective
Treat the patient, treat the person					
1.1 Reduce harm to patients	IT will produce an electronic audit facility based on the iClip TEP Launch of the electronic documentation for MCA and DoLs Developing management level and monthly audit data with IT for NEWS2 in iCLIP in readiness for electronic audit facility anticipated by end of Q3	Not delivered: no test function was included in iClip during Trust upgrade (Nov/Dec) which delayed the planned roll out in Q3.	No additional actions being taken as this has been addressed iClip will have full functionality to allow rollout in Q4.	Potentially a material risk as linked to the BAF (SR1)	
	The Trust will achieve over 85% compliance for level 2 Mental Capacity Assessment training. Achieve 85% compliance for Early Warning Score mandatory training Achieve 85% compliance for resus training across all levels.	Not Achieved- compliance at 74% in Q3 Not Achieved: compliance at 82% Q3 Not achieved: compliance 73.6% at Q3	To have on-going focus at Divisional level to drive improvement is achieving compliance. Staff recruited to resus team Additional training slots established	Potentially a material risk as linked to the BAF (SR1)	
1.2 We will map, standardise, support and improve our departmental-level governance of quality, safety and learning	Deliver relevant actions in Mortality and morbidity, MDT and Clinical Governance action Deliver relevant actions in Mortality and	Partially delivered**.** Work underway but delayed due to capacity constraints Partially achieved: Work	Medical Directorate Business Manager now in post and actions expected to be delivered by the end of Q4 A more detailed	Potentially a material risk as linked to the BAF (SR2)	

	morbidity, MDT and Clinical Governance action plan agreed by Trust Board in June 2019 (namely: action 3.5)	underway with some actions delivered and some delayed.	update on progress against these actions was received by Trust Board in December (and as above)		
Right care, right place, right time					
2.1 Patients will not wait long for treatment	Accident and Emergency 87% at the end of month 9. Referral to treatment 87.2% at the end of month 9 Diagnostics Testing 1.0% at the end of month 9	The Trust achieved 79.4% against the 87.5% A&E trajectory in December. The Trust achieved 84.2% against a trajectory of 86.5% in November 2019 The Trust achieved 6.7% against a trajectory of 1.0% in December	An improvement programme is in place and being delivered through the internal Emergency Care Delivery Board. Focused work is taking place on the management of patients on the patient tracking list and service specific reviews are taking place. Recovery plans are in place for those areas facing the longest waiting times and additional capacity is being provided to support recovery.	Yes – this is a BAF risk (SR3)	
2.2 Our IT is easier to use and supports our staff to provide the best care for patients	The emergency department will be able to prescribe electronically.	**Not delivered -** due to concern in ED department about moving to new electronic system without assurance over the speed of new infrastructure.	CIO is working with relevant GMs to provide assurance and agree a plan for roll-out	Yes – this is a BAF risk (SR4)	

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Balance the books, invest in our future					
3.1 We are in financial balance	E&I is currently on plan CIP delivery on plan (not delivered)	The E&I is not to plan in M10 The full year quantum of CIPS has yet to be found	Weekly meetings with divisional teams continue to explore opportunities to reduce spend and increase income. Corporate initiatives are also underway Services continue to look for opportunities to identify CIP opportunities. Service development for 2019/20 not agreed until CIP target reached	Yes - this is a BAF risk (SR7)	
3.2 Our cost structures are understood and defined	CIP programme for 2020/21; target areas identified.	Partially achieved – Potential schemes are being identified by divisions	This will progress as part of the business planning process. Risk to the process are being highlighted to TEC monthly	Yes - this is a BAF risk (SR7)	
3.4 Improve management of commercial relationships	Commercial strategy for service offers developed. To include milestone plan for key areas of improvement. Commercial opportunities/offers identified for development Supplier contract management framework developed. Reporting in place on key supplier contracts.	Partially delivered: Draft commercial strategy has been developed. Commercial opportunities are being explored Partially delivered: Delay to supplier contract management framework approval has meant a delay to all reporting mechanisms being put in place	Draft commercial strategy will go to FIC for approval in January and action plans will then be developed No mitigating actions s this work is now progressing albeit it delayed from the original plan.	Although linked to BAF risk (SR8) it is not a material risk due to progress made	

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Build a better St George's					
4.1 We have a clear estates strategy	Option appraisal and costing exercise, including capital and revenue. Review preferred options against emerging SWL Health Economy plans	Partially delivered – the work has commenced as part of the scoping work for the estates strategy.	Following Q2 update to Board – the timescale for delivering the estates strategy has been put back to the end of Q4	Yes – BAF risk (SR(10)	
Champion team St George's					
5.2 Developing outstanding leaders and effective teams	Roll-out of Master class schedule	Partially delivered -.A plan has been put together which needs formal sign-off	No mitigating actions as this will be rolled out once it has been signed off.	No	
5.5 Empowering our staff to make real change	Carry out Go Engage survey 25% of the workforce) on 10 areas of staff engagement to identify concerns	Not delivered: The Go Engage survey has been delayed as the timing is too close to the national staff survey.	Survey time lines under review post staff survey closure. Planned launch in Q4	Linked to BAF risk (SR11) but not a material risk due to planned launch in Q4	

Annex B - Approach to RAG-rating

1. The RAG ratings for Q3 derived as follows. Each objective is shown as:

- Green for Q3 if all its Q3 milestones have been delivered, or if the position is overwhelmingly close to that (e.g. 5 milestones delivered, 1 partially delivered but due for completion in early April).
- Amber for Q3 if some of the associated Q3 milestones have been delivered, and some not, or if the milestones are partially delivered.
- Red if the milestones for Q3 have not been delivered.

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

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

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Meeting Title:	**Trust Board**		
Date:	**30 January 2020**	**Agenda No**	**4.4**
Report Title:	**Board Assurance Framework (BAF) – Quarter 3 Assurance Rating**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	**Alison Benincasa, Director of Quality Governance and Compliance**		
Freedom of Information Act (FOIA) Status:	**Unrestricted**		
Presented for:	**Decision/Assurance/Discussion**		

Executive Summary:

This paper brings to the Board the summary page of the Board Assurance Framework. The summary sheet of the BAF (appendix 1) gives an overview of the risk profile of the Trust and enables the Board to ensure its agenda is directed to improving control of these strategic risks.

The BAF has been updated with the quarter 3 assurance rating and statements from the committees of the Board.

Quarter 3 Assurance rating

In quarter 3 there has been no change to the overall assurance ratings for the strategic risks.

Nine of the sixteen strategic risks have a 'partial' assurance rating and seven risks have a 'limited' assurance rating (see appendix 2 for definitions).

Risk scores

The risk score has changed for the following strategic risks:

- SR3 has been increased to 16 (from 12). The decision was made following discussion in Committee to add three new risks to the corporate risk register relating to echocardiography diagnostic capacity for adults, and paediatrics and 7 day services standards.

- SR7 has been increased to 25 (from 20). The decision was made following discussion in Committee to reflect the current financial forecast which indicates the target deficit for 2019/20 will not be delivered, see slide 26.

There has been no change to the risk scores for other strategic risks.

Strategic Risks for the Board – SR5 and SR6

The Board is asked to agree the assurance level for these risks based on the assurances from reports to the Board, see summary BAF at appendix 1.

When considering the risk score for these risks the Board's attention is drawn to:

- SR5: Board approval of the workforce and research strategies in December 2019 with reference to SR5 and assurance that the remaining supporting strategies will be delivered by the end of March 2020
- SR6: The Trust remains an active partner in the SWL Health and Care Partnership meetings which are focussed on developing the Integrated Care System and is engaged in the Acute Provider Collaborative. There

	is further work required at borough level (for Merton and Wandsworth) to establish the workstreams to drive the clinical priorities. This will happen in quarter 4.
	The Board is asked: 1. For strategic risks reserved to itself (SR5 and SR6) to: • Note the risk rating • Agree the proposed assurance rating • Agree the proposed assurance statement 2. For the 14 risks assigned to its assuring committees to: • Note the risk score, assurance rating and statement from the relevant assuring committee.
Supports	
Trust Strategic Objective:	All
CQC Theme:	Well led
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability
Implications	
Risk:	The strategic risk profile
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence
Resources:	N/A
Previously Considered by:	Workforce and Education Committee Quality and Safety Committee Finance and Investment Committee – Finance Finance and Investment Committee – Estates
Date	05.12.2019 23.01.2020 23.01.2020 23.01.2020
Equality Impact Assessment:	N/A
Appendices:	1. Summary Board Assurance Framework (BAF) 2. Assurance ratings - definitions

Appendix 2 **Assurance ratings – definitions**

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

BOARD ASSURANCE FRAMEWORK OVERVIEW QUARTER 3 2019-2020										
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
				Q1	Q2	Q3	Q4				
1. Treat the patient, treat the person	Low	SR1	There is a risk that we do not create an environment and embed an approach to Quality Improvement which minimise the occurrence of harm to our patients					The committee has received assurance on the performance metrics within the IQPR, the progress of the implementation of the Critical Care Outreach service and use of Treatment Escalation Plans for adults. A progress report was received demonstrating the on-going work of the Quality Improvement Academy supporting the use of improvement methodology for service improvement initiatives. CQC inspection report was received in December 2019 and identified two regulatory requirements (MUST dos) related to consent and storage and accuracy of medical records. Improvement actions will commence in Q4. Although the committee received assurance on progress in some areas the assurance rating is currently partial to reflect the need for further work and improvement	Chief Nurse	Quality & Safety Committee	12
	Low	SR2	There is a risk that our clinical governance structures and how we implement them are neither clear nor robust and inhibit our ability to provide outstanding care.					The committee has received assurance from the Cardiac Surgery update reports on progress. The CQC inspection report December 2019 noted improvements in governance processes for Cardiac Surgery Services. In December 2019 Board supported the recommendation for additional investment to take forward the recommendations from the two external reviews. The assurance rating is currently partial as the implementation of the recommendations from the external governance reviews has recently commenced and further assurance with reference to delivery is required	Chief Medical Officer	Quality & Safety Committee	15
2. Right care, right place, right time	Low	SR3	There is a risk that our patients wait too long for treatment					The committee has received assurance on the 4 hour operating standard and noted that performance continues to be variable. Assurance was provided on the management of patient pathways at QMH following data migration to iClip.The review of the risk relating to an aging MRI scanner resulted in a reduction in the risk score from 20 to 12 based on the assurance provided as current mitigations were reported to be impact positively. Three new risks were added to the corporate risk register relating to echocardiography diagnostic capacity for adults and paediatrics and 7 day services standards. The assurance rating is currently partial to reflect the need for further work and improvement	Chief Operating Officer	Quality & Safety Committee	16
	Low	SR4	There is a risk that our staff cannot provide outstanding care as IT does not become more reliable, easier to use and more integrated					The committee has received assurance on the successful risk mitigation of fragmented medical records as the implementation of iClip at QMH addresses the most material issue. This risk has now been closed. Assurance was also provided for three contributing risks resulting in reduced risk scores following the completion of planned mitigations. The committee noted the substantial progress and recognised the material individual risks that remain. The committee requested an extended forward look in relation to the risk reduction schedule to consider the timescales associated with risk mitigation. While improvement was noted in these areas the overall assurance rating remains limited reflecting the need to complete the remainder of the planned works	Chief Information Officer	Finance and Investment Committee	20
	Moderate	SR5	There is a risk that we fail to make progress in delivering our clinical services strategy					For Decision after discussion at Trust Board: The Board has received assurance on the progress of supporting strategies and remaining supporting strategies will be delivered by the end of March 2020. The Board has received assurance of commissioners' support for the five year clinical services strategy. Board has overview of the year 1 implementation plan and received assurance on the development of implementation plans for year 2 as part of the business planning process for 2020/21.The assurance rating remains limited to reflect the need for further work	CEO (Chief Strategy Officer)	Board	16
	Moderate	SR6	There is a risk that we do not make progress in increasing integrated and transformed services as a system across SW London in line with the SWL Health and Care Partnership priorities.					For Decision after discussion at Trust Board: The Board has received assurance that the Trust remains an active partner in the SWL Health and Care Partnership meetings focussed on developing the Integrated Care System and is engaged in the Acute Provider Collaborative. The Board is reasonably assured that controls are adequate but indicates a partial assurance rating to remain for Q3 to reflect the need for further progress at borough level (for Merton and Wandsworth the workstreams to drive the clinical priorities will be established in Q4)	CEO (Chief Strategy Officer)	Board	9
3. Balance the books, invest in our future	Low	SR7	There is a risk that we do not develop plans to achieve unsupported financial balance within 3* years (*to be confirmed with regulators in conjunction with national planning guidance)					The risk score was reviewed and increased to reflect the current financial forecast which indicates the target deficit for 2019/20 will not be delivered. This has increased the challenge of returning to unsupported balance. The risks associated with the process aspects of this risk remain largely unchanged from Q1. The assurance rating remains limited	Chief Financial Officer	Finance and Investment Committee	25
	Low	SR8	There is a risk that the Trust is unable to source sufficient capital funds to support investment in areas of material risk					The committee has received assurance on the plans in place in relation to 2019/20 funding; for later years work is on-going. The assurance rating remains limited as a consequence, with further guidance anticipated in from NHSI/E in February, on the capital regime going forward	Chief Financial Officer	Finance and Investment Committee	16
4. Build a better St George's	Low	SR9	There is a risk that we are unable to deliver an estates strategy that supports the delivery of our clinical services strategy					The assurance rating remains limited however the committee expects to receive assurance and be able to evidence actions and their impact at the end of Q4	Chief Finance Officer	Finance and Investment Committee	16
	Low	SR10	There is a risk that we do not improve our estate to provide a safe and compliant environment for our patients and staff					The assurance rating remains limited however the committee expects to receive assurance be able to evidence actions and their impact at the end of Q4	Chief Finance Officer	Finance and Investment Committee	20
5. Champion team St George's	Low	SR11	There is a risk that we are unable to achieve a significant shift in culture whereby staff feel engaged, safe to raise concerns and are empowered to deliver outstanding care					The committee has received assurance on the progress achieved to date in the development of the 2019-2020 Staff Engagement Plan, implementation of the new engagement methodology Go-Engage and revised Raising Concerns at Work Policy. The assurance rating remains partial, controls are generally adequate but the committee continues to seek further assurance that the controls will deliver demonstrable progress particularly with reference to the Staff Engagement Strategy and implementation of the new engagement methodology	Chief People Officer	Workforce and Education Committee	12
	Low	SR12	There is a risk that we are not seen as a diverse and inclusive employer by our staff					The committee has received assurance that additional resource has been brought in to the Trust to support the delivery of the D&I strategy and that the staff groups have been re-launched. Assurance is further supported a D&I focussed Board workshop. The assurance rating remains partial, controls are generally adequate but the committee requires further assurance with reference to visibility of agreed performance metrics	Chief People Officer	Workforce and Education Committee	9
	Low	SR13	There is a risk that we are unable to sufficiently address issues of harassment and bullying					The committee has received assurance that the raising Concerns Policy has been revised and re-launched in the Trust supported by communications. The assurance rating remains partial, controls are generally adequate but the committee requires further assurance with reference to visibility of agreed performance metrics	Chief People Officer	Workforce and Education Committee	12
	Low	SR14	There is a risk that we are unable to recruit, train and sustain (retain) an engaged and effective workforce					The committee has received assurance about the Trust vacancy rate. The assurance rating remains limited to reflect the concerns related to some staff groups and the need for further work	Chief People Officer	Workforce and Education Committee	16
	Low	SR15	There is a risk that we are unable to develop new and innovative roles/ways of work to deliver our Trust clinical strategy					The committee has received assurance on the developing Workforce Strategy, with the workforce strategy approved at Trust Board in December 2019. The assurance rating remains partial to reflect the need for further work	Chief People Officer	Workforce and Education Committee	12
6. Develop tomorrow's treatments today	High	SR16	There is a risk that we cannot compete against other key NHS organisations delivering large programmes of research, with a consequence that we lose research funding, are less able to attract high calibre staff and lose our reputation for clinical innovation.					The committee has received assurance that there continues to be improvement in the numbers of patients recruited to clinical trials. The Research Strategy was approved by the Board in December 2019.The assurance rating is currently partial to reflect the need to sustain the position and receive further updates at committee	Chief Medical Officer	Quality & Safety Committee	9