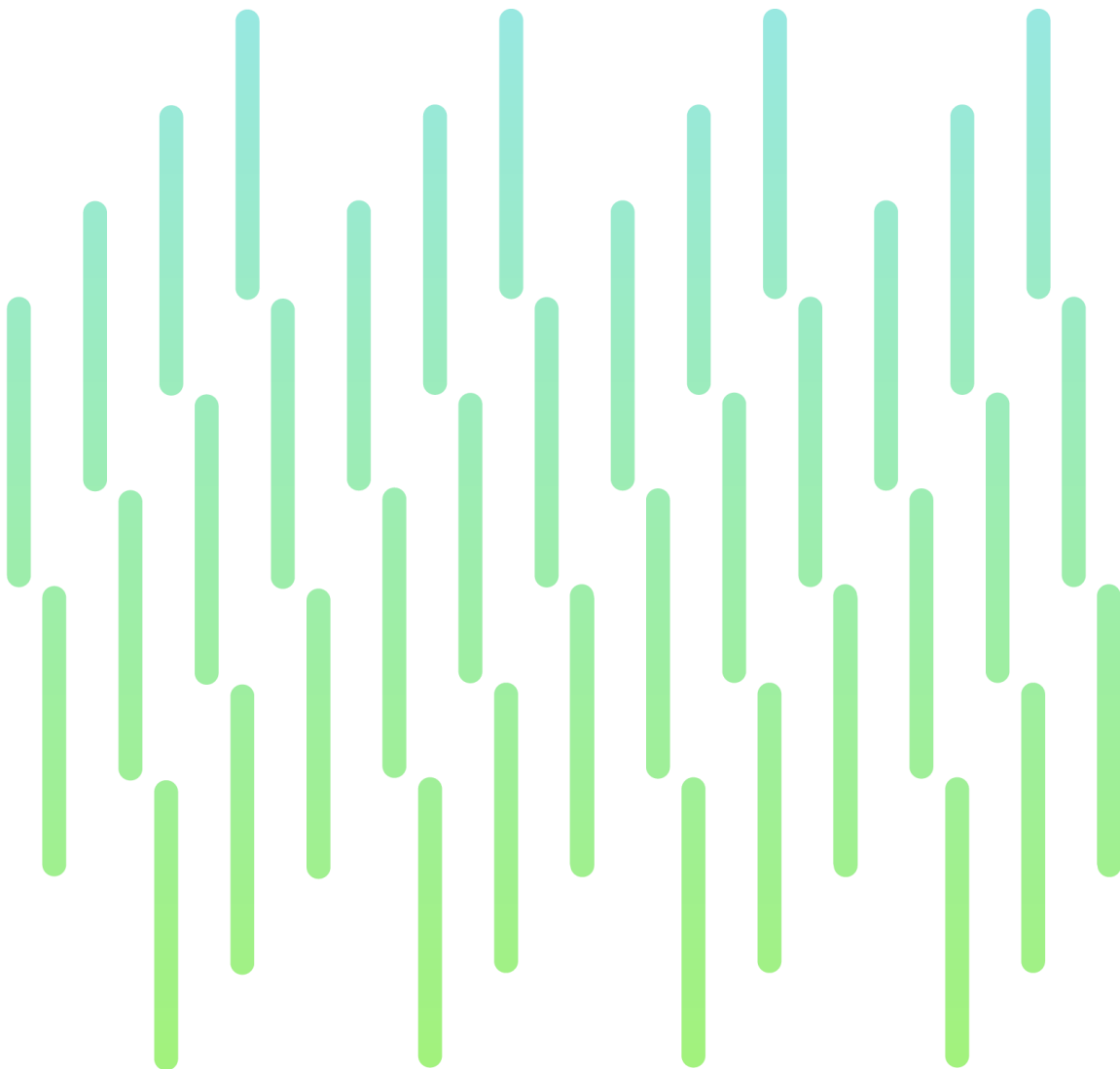




Trust Board Meeting

Thursday 30 April 2020

Agenda and papers



Trust Board Meeting (Part 1) Agenda

Date and Time: Thursday, 30 April 2020, 09:00-11:00

Venue: WebEx and For Internal Staff Room 52, 1st Floor Grosvenor Wing

Time	Item	Subject	Lead	Action	Format
1.0 OPENING ADMINISTRATION					
09:00	1.1	Welcome and apologies	Chairman	Note	Oral
	1.2	Declarations of interest	All	Assure	Oral
	1.3	Minutes of meeting – 26 March 2020	Chairman	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
09:05	1.5	Chief Executive Officer	Chief Executive	Inform	Report
2.0 COVID-19					
09:15	2.1	Covid-19 Overview and Safety Dashboards: <ul style="list-style-type: none">Capacity, Demand and EquipmentOther Activities and Risks AssessmentWorkforce Updates & Staff TestingEthical Decision Making	Chief Executive/ Acting Chief Nurse	Assure	Report
3.0 QUALITY & PERFORMANCE					
10:00	3.1	Quality and Safety Committee Report	Committee Chairman	Assure	Report
10:10	3.2	Integrated Quality & Performance Report and Emergency Care Update	Chief Operating Officer	Assure	Report
10:25	3.3	Cardiac Surgery Update	Chief Medical Officer	Assure	Report
4.0 FINANCE					
10:35	4.1	Finance & Investment Committee Report	Committee Chair	Assure	Report
10:45	4.2	Finance Report (Month 12) – Financial Outturn	Acting Chief Finance Officer	Update	Report
5.0 CLOSING ADMINISTRATION					
10:55	5.1	Questions from Governors/Public	Chairman	Note	Oral
	5.2	Any new risks or issues identified	All	Note	
	5.3	Any Other Business		Note	
11:00	CLOSE				

Thursday, 28 May 2020, 09:00-11:00

WebEx and For Internal Staff Room 52, 1st Floor Grosvenor Wing



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.
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Membership and In Attendance Attendees		
Members	Designation	Abbreviation
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Vice Chairman	NED
Elizabeth Bishop	Non-Executive Director	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
Tim Wright	Non-Executive Director	NED
Andrew Grimshaw	Deputy Chief Executive Officer	CFO/DCEO
Avey Bhatia	Chief Operating Officer	COO
Robert Bleasdale	Acting Chief Nurse & Director of Infection, Prevention & Control	ACN
Richard Jennings	Chief Medical Officer	CMO
Tom Shearer	Acting Chief Financial Officer	ACFO
In Attendance		
Harbhajan Brar	Chief People Officer	CPO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Secretariat		
Tamara Croud	Head of Corporate Governance/Board Secretary	HOCG-BS
Apologies		
James Friend	Chief Transformation Officer	CTO
Quorum:	<i>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.</i>	



**Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 26 March 2020
Room 52, 1st Floor Grosvenor Wing, St George's Hospital, Tooting**

Name	Title	Initials
PRESENT (* attendees joining the meeting via videoconferencing)		
Gillian Norton*	Chairman	Chairman
Jacqueline Totterdell*	Chief Executive Officer	CEO
Andrew Grimshaw	Deputy Chief Executive Officer	DCEO
Ann Beasley*	Non-Executive Director	NED
Elizabeth Bishop*	Non-Executive Director	NED
Stephen Collier*	Non-Executive Director	NED
Prof Jenny Higham*	Non-Executive Director	NED
Prof Parveen Kumar*	Non-Executive Director	NED
Dr Pui-Ling Li*	Associate Non-Executive Director	ANED
Tim Wright*	Non-Executive Director	NED
Avey Bhatia	Chief Operating Officer (<i>for agenda item 2.1 only</i>)	COO
Robert Bleasdale	Acting Chief Nurse and Director of Infection Prevention & Control	ACN/DIPC
Dr Richard Jennings	Chief Medical Officer	CMO
Tom Shearer*	Acting Chief Finance Officer	ACFO
IN ATTENDANCE		
Harbhajan Brar	Chief People Officer (<i>for agenda item 2.1 only</i>)	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
SECRETARIAT		
Tamara Croud	Head of Corporate Governance/Board Secretary	HCG
APOLOGIES		
Sally Herne	NHSI Quality Improvement Director	NHSI-QID

	Action
1.0 OPENING ADMINISTRATION	
1.1 Welcome, Introductions and apologies	
The Chairman welcomed everyone to the meeting and noted that due to the COVID-19 pandemic non-executive directors were joining the meeting by videoconference.	



		Action
1.2	<p>Declarations of Interest</p> <p>The Board noted that Elizabeth Bishop was also a non-executive director (NED) at Epsom and St Helier University Hospitals NHS Trust. The Board noted that the Trust's Constitution, and the provisions of the NHS Act 2006 on which it was based, permitted directors to have conflicts of interest where these were authorised by the Board. The Board recognised that Elizabeth's role across the two Trusts did represent a potential conflict of interest, but agreed that this could exist on the basis that her role across the two Trusts would assist with facilitating closer collaboration between two major hospitals in South West London, with potentially significant benefit to the patients of both organisations. This was subject to Elizabeth Bishop formally declaring any explicit conflicts of interest in matters to be discussed and agreed by the Board or its Committees.</p>	
1.3	<p>Minutes of the meetings held on 27 February 2020</p> <p>The minutes of the meeting held on 27 February 2020 were approved as an accurate record.</p>	
1.4	<p>Action Log and Matters Arising</p> <p>The Board reviewed and noted the action log and agreed to defer the majority of the actions that were due as a result of the current and anticipated operational demands of managing the impact of the COVID-19 pandemic at the Trust. The Board noted those actions not yet due and the following update:</p> <ul style="list-style-type: none"> • Action Item TB30.01.20/03 (Estates Data in the Integrated Quality and Performance Report): The CTO reported that the data for estates had not yet been built into the integrated quality and performance report and this was unlikely to be done in the short term given other immediate priorities, Covid-19. 	
2.0	CARDIAC SURGERY	
	<p>The Trust Chairman reported that NHS England and NHS Improvement had at 4 pm that day (26 March 2020) published two independent reports into cardiac surgery at St George's University Hospitals NHS Foundation Trust. Alongside this, the Trust had published a report setting out the actions it had taken to ensure the safety of and improve the service. The Chairman emphasised that while the Board and Quality and Safety Committee had given considerable attention to the issues affecting cardiac surgery since the Trust had received the first mortality report in May 2017, the independent reports nevertheless made for very sobering reading and it was essential the Board carefully reflected on their findings and recommendations, and ensured it had on-going assurance as to the safety and effective operation of the service. The Chairman expressed regret for the failings in care identified and for the fact that as a result of the social distancing guidance issued by the Government as a result of the COVID-19 pandemic, the Board had been unable to hold this important discussion on cardiac surgery with members of the public present. As a result, a full minute of the Board's discussions would be prepared so that the public could understand the Board's consideration of the reports and the steps being taken to improve the service.</p>	



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<p><u>Statement from the Chief Executive:</u></p> <p>The Chairman invited the Chief Executive to make a statement in response to the publication of the reports on behalf of the Board.</p> <p>The CEO stated that: <i>"When a family member or loved one dies we often have great feelings of distress, loss and pain. However when a loved one has died because of poor care, as 67 patients did at St George's, that pain can only intensify. Whilst we can point to many improvements in the care we give at St George's, we need to give, and do give, those relatives and friends of those that died an unreserved full apology for what has happened".</i></p> <p>The Chairman thanked the Chief Executive for her statement. The Board endorsed the unreserved apology on behalf of the Board and the Trust as a whole to the families and loved ones of the patients who had died under the care of the Trust in the period examined by the independent panel.</p> <p><u>Presentation of the independent reports:</u></p> <p>The Chairman invited the Chief Medical Officer (CMO) to present to the Board the findings and recommendations of the independent reports on cardiac surgery. The CMO explained that the Board had been presented with four documents:</p> <ul style="list-style-type: none"> – The report of the Independent External Mortality Review into Cardiac Surgery at St George's University Hospitals NHS Foundation Trust, which had been chaired by Mr Mike Lewis; – The report to NHS England and NHS Improvement and St George's University Hospitals NHS Foundation Trust of the Independent Scrutiny Panel for Cardiac Surgical Services at St George's University Hospitals NHS Foundation Trust, chaired by Sir Andrew Cash; – The Trust's response to reports into Cardiac Surgical Services at St George's University Hospitals NHS Foundation Trust (in the form of a letter and appended report from the Trust Chief Executive to Sir David Sloman, London Regional Director, NHS England and NHS Improvement); and – A summary of the recommendations of the two independent reports into Cardiac Surgery Services at St George's University Hospitals NHS Foundation Trust against which the Trust's actions and progress in implementing the recommendations had been mapped. <p>The CMO started by endorsing the unreserved apology to the bereaved families. The CMO explained that he and colleagues had met in person and spoken directly by telephone to six families of the patients who had died under the care of the cardiac surgery service during the period reviewed by the mortality review panel. The degree of distress these families had been through and the distress this brought back to them in talking about the death of their loved ones had been very striking, powerful and profoundly sad. On hearing the outcomes of the reviews of the care provided to their loved ones, families had responded with a range emotions. Some had expressed anger at the failings in care and at the fact the Trust had previously been unwilling to</p>	



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<p>acknowledge these failings or to listen to their concerns. Some expressed the view that, while difficult to hear, it was reassuring that their longstanding concerns had belatedly been taken seriously. The CMO added that the Board should also be cognisant of the fact that this sadness was no less profound for those families where the independent panel had not identified failings in care. For almost a year, the families had known that a review was being conducted into the death of their loved ones and this was inherently challenging and stressful for them.</p> <p>The CMO provided an overview of the key findings and recommendations of the reports and highlighted the following points:</p> <ul style="list-style-type: none"> • The Independent External Mortality Review had been led by Mr Mike Lewis and supported by a panel of independent medical and surgical experts. The panel had examined the deaths (most of which were post-operative) of 202 patients who were looked after by the cardiac surgery service at the Trust between April 2013 and December 2018. The review had concluded that there were failings in the care provided to 102 of those patients and in 67 cases those failings either definitely, most likely or probably contributed to their deaths. The review identified a number of themes around pre-operative care, operative care, post-operative care, and professionalism. The Trust fully accepted the findings of the report. While the review did find examples of good care, it concluded that there were “many cases in which the evidence observed in the case note review suggested that the death of patients was avoidable, or that care was of a poorer standard than would have been expected”. The CMO explained that the Trust had written to the families of those who had died under the care of the Trust during the period under review to set out the findings of the panel in relation to the care provided to their loved one. In so doing, the Trust had been committed to being open and doing the right thing by the families, and had also thereby discharged its responsibilities in relation to duty of candour. • The Independent Scrutiny Panel, led by Sir Andrew Cash, had been established to act as a ‘critical friend’ to the Trust in October 2018 to support the improvements to safety, leadership, governance and culture of the service. The report made a total of 19 recommendations, which the Trust again had accepted in full. A number of the recommendations had already been implemented by the Trust including the appointment of a new, externally-appointed clinical lead for the cardiac surgery service, the establishment of new protocols for overseeing the safety of the service, and enhancing governance processes around the operation of multidisciplinary team meetings and morbidity and mortality meetings. <p>The CMO explained that although the Trust only recently received the final reports, the Trust had been taking a range of actions to improve the safety and governance of the service since it had received the first cardiac surgery mortality alerts in May 2017. In addition, both reviews had ensured the Trust was sighted on any areas of concern in real time so that any further improvements could be made ahead of the completion of the reviews. The Trust had strengthened the day-to-day operational processes, the oversight of the service and the visibility of what happens within it, internal safety governance mechanisms and leadership. The CMO concluded by saying that the Board could take assurance as to the safety of the service from external sources as well as the Trust’s own internal measures. These included the</p>	



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<p>improvements documented by the CQC in its inspection report published in December 2019 and by the fact that the National Institute for Cardiovascular Outcomes Research (NICOR) had found that the latest data demonstrated the Trust was no longer an outlier for mortality.</p> <p>The Chairman thanked the CMO for the overview of the reports and of the actions taken by the Trust to ensure safety and oversight of the service, and invited questions from Board members.</p> <p>Professor Dame Parveen Kumar, Chair of the Trust's Quality and Safety Committee, asked why the issues identified in the review had not been identified by the Trust at the time and escalated through its governance structures and processes. The CMO responded that the current Board and Executive team had been in place largely since Spring 2017 and it was clear that the problems affecting cardiac surgery were longstanding and dated back at least a decade. The Wallwork report of April 2010 had highlighted a number of concerns regarding culture and behaviours within the service and a lack of effective governance, and the potential impact of this on safety. The first mortality alert regarding cardiac surgery had been received from NICOR in May 2017 and related to deaths in the service between 1 April 2013 and 31 March 2016. Following the receipt of the first NICOR alert, the Trust had undertaken a proactive and comprehensive programme of actions, overseen by a Cardiac Surgery Task Force, the Trust Executive Committee, Quality & Safety Committee and the Board, to improve the safety, leadership and governance of the service. New and robust governance structures and processes had been introduced to ensure more effective oversight of the service and the service was now led by a well-respected and externally-appointed cardiac surgeon who had been appointed as Care Group Lead and Associate Medical Director for cardiac surgery. Multi-disciplinary team meetings had been strengthened and all deaths in the service were reviewed by the Trust's Serious Incident Decision Making Group (SIDM). The details of these improvement actions were set out in detail in the Chief Executive's letter to Sir David Sloman as well as being referenced in the independent reports themselves. The CMO acknowledged that it was undoubtedly the case that, historically, there were weaknesses in the Trust's clinical and corporate governance and this had been documented by the CQC in November 2016 when it had placed the Trust in quality special measures. With better governance systems and processes, the issues should have been escalated and addressed at an earlier stage.</p> <p>Professor Kumar asked what assurances the Board could take that the cardiac surgery service was genuinely safe, particularly given that the composition of the surgical team had not changed. The CMO reported that there was a range of both internal and external assurance around the safety of the service. The key pieces of evidence on which the Board could rely as assurance that the service was safe were presented to the Board in December 2019. Externally, the key sources of assurance were the findings of the Care Quality Commission inspection report, published in December 2019, which had noted significant improvements in the service and the latest data from NICOR which demonstrated that cardiac surgery at the Trust was no longer an outlier for mortality. Since September 2018, there had been robust external scrutiny of the service with NHS England and NHS Improvement holding regular Quality Summits with the Trust, CQC, and the General Medical Council and neighbouring Trusts to oversee the safety of the service.</p>	



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<p>In relation to the appointment of Mr Steve Livesey as Care Group Lead for cardiac surgery, Professor Kumar asked whether his leadership in improving the service was evident and what succession planning was in place to ensure that the improvements made would be sustained in the event he was to leave the Trust. The CMO explained that Mr Livesey's influence was clearly evident and he had had a profound effect on the safety, governance and operation of the service since his appointment in December 2018. At present, the CMO acknowledged that there was no one in the cardiac surgery service who could take over the role of Care Group Lead in the event that Mr Livesey were to leave. However, succession planning was inherently linked to the emerging plans to develop a cardiac surgery network across South London.</p> <p>Professor Kumar asked about how the Trust managed complex cardiac surgery cases. The CMO explained that, in consultation with the regulator, since September 2018 the Trust had decided that complex and high risk cardiac surgery should be performed by neighbouring Trusts to allow the service at St George's the space required to make improvements to the service. Initially, cardiac surgery with a EUROCORE of higher than 2 (in effect, a risk of death greater than 2%) should be performed elsewhere. This was subsequently raised to surgery with a EUROSCORE of greater than 5. The exception to this was Mr Livesey who was the only cardiac surgeon permitted to perform complex surgery above this risk rating. The Trust had recently contacted the Chief Medical Officer at Spire, where most of the cardiac surgeons conducted their private cases, to advise of the limitations set on the complexity of cases that could be undertaken by the Trust's cardiac surgery service, and he had agreed that similar limitations to the complexity of procedures should be implemented in private practice.</p> <p>Ann Beasley, Vice Chair of the Trust and Senior Independent Director, asked what assurance the Board could have that other services at the Trust were not affected by similar issues that had been evident within the cardiac surgery service, and in addition asked how the Board would know and be informed should any other services develop mortality or other safety concerns.</p> <p>The CMO explained that there had been very significant weaknesses in the governance and oversight of cardiac surgery over many years. These would have been more clearly evident had the Trust reviewed the internal governance of the service at an earlier stage. In light of this, the current Board and Executive team had commissioned an independent review of clinical governance across the Trust, to look at how effective service level governance was operating, including the effectiveness of multi-disciplinary team meetings and morbidity and mortality meetings, and the arrangements and resource available to support effective clinical governance at service level. The Trust had also reviewed corporate level support to Trust-wide clinical governance. The Board had received these reviews, which demonstrated that there was good practice in many areas but had also highlighted areas for improvement and steps were being taken in response to strengthen this. The Board could note recent examples of where behavioural challenges within teams had led to timely escalation to the Board and to the commissioning of external reviews where this was appropriate. This demonstrated that issues were spotted early and that they were escalated from the ward to the Board.</p> <p>Jenny Higham asked what external measures the Trust had to ensure the</p>	



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<p>Trust and the Board had oversight of key performance areas and in addition asked what systems were in place so that the Trust could track and act on early warning or soft signals that there could be fundamental issues within a service.</p> <p>The CMO acknowledged that the Trust did not always have robust sources of external data to rely upon. NICOR data relating to cardiac surgery was a key source of intelligence regarding mortality and receipt of a NICOR alert had prompted the Trust to take action to improve the service. However, not all services had sources of externally validated data of this kind. Some care groups regularly submitted clinical data externally but this was not routinely done across the Trust. It was recognised that there needed to be stronger systems in place to ensure governance leads across all services and care groups were able to provide the correct data and correlate early soft signals of underlying issues. With implementation of the recommendations from the clinical governance review the Trust had begun moving in the right direction. It would be important to ensure that key sources of soft intelligence could be brought together to identify any emerging issues within a service.</p> <p>Asked whether the Board and the Trust management looking at the right sources of information, the CMO explained that the Trust now more effectively triangulated key data from Patient Advice and Liaison services, complaints and freedom to speak up with performance data. It may be possible to have a look back at these data sets at the time that the cardiac issues first arose to ascertain whether these would have yielded information that may have enabled earlier intervention. Culture was a key issue in cardiac surgery and it was essential that staff felt empowered to speak up where they had concerns and were able to escalate issues and concerns effectively.</p> <p>Stephen Collier asked about the support being provided both to the staff working in and with the cardiac surgery service and other staff not directly implicated in the findings of the independent review. The CMO explained that support was available to all staff, and particularly those affected by the review. Pastoral support was available to staff in cardiac surgery and the broader members of the care group team including nurses, allied health professionals, and anaesthesiologists. The Trust had held engagement events with affected staff prior to the publication of the report and these had been well attended. Work had been undertaken to strengthen and reinforce the freedom to speak up processes within the Trust and to encourage staff to escalate issues.</p> <p>In response to a question regarding the Coroner's engagement with the Trust on the review, the CMO stated that he had met with the Coroner on a number of occasions during the development of the report. At no point had the Coroner expressed a lack of confidence in the current systems and outcomes now in place. The Coroner had received the report and all of the Structured Judgement Reviews compiled by the independent panel and would decide which cases warranted a further review.</p> <p>The Chairman thanked Board members for their questions and the CMO for his detailed responses. The Chairman reiterated that the mortality review made for very difficult reading and it was clear there had been significant failings in care that must not happen again. Significant work had been undertaken since the Trust had received the first NICOR alert in May 2017 and the Board could take assurance from the external sources of assurance</p>	



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	<p>regarding the safety of the service. The external clinical governance reviews commissioned by the Trust in 2019 and the actions being taken as a result provided further assurance that similar issues would be identified early and would be reported to the Board. She thanked the executive for the work they had done to date and the Board for its ongoing scrutiny of the safety, governance and operation of the service, which would continue.</p> <p>The Board:</p> <ul style="list-style-type: none"> • Received the reports of the Independent External Mortality Review and the Independent Scrutiny Panel into cardiac surgery at St George's and accepted their findings and recommendations in full; • Recognised the serious failings in care identified in the reports and endorsed the unreserved apology by the Trust to the families of patients who died under the Trust's care; and • Noted the actions that had been taken by the Trust to improve the safety, leadership, governance and culture of the cardiac surgery service at St George's since the first NICOR mortality alert was received in May 2017; • Noted that the cardiac surgery service was safe, and in particular noted the independent external assurance on this provided by both the Care Quality Commission's inspection report of December 2019 and the latest data from NICOR which demonstrated that the Trust was no longer an outlier for mortality in cardiac surgery; and • Agreed that it would require ongoing assurance as to the safety of the service, the implementation of the recommendations of the reviews, and the wider improvements to cardiac surgery at the Trust. The Board agreed it would continue to receive regular reports on the safety and performance of the cardiac surgery service. 	
3.0	NOVEL CORONAVIRUS (Covid-19)	
3.1	<p>Update on Novel Coronavirus (Covid-19)</p> <p>The Board was provided with a comprehensive report on the Trust's preparations, operations, governance and wider system issues in light of the developing COVID-19 pandemic.</p> <p>The CEO reported that the NHS had not experienced such a crisis in peace time. Modelling conducted by the system had predicted that, on current estimates, around 7,000 people across London may require ventilation during the pandemic, which was way in excess of the number of ICU beds available in the region. The new field hospital at the Excel Centre in East London, the NHS Nightingale Hospital, was designed to provide additional ICU capacity and was being developed to have up to 4,000 ICU beds. The Trust could expect the number of cases to rise dramatically up in the coming days and weeks, though it was hard at present to know when the peak of infections and hospital admissions may come. Given these pressures, Trusts across London were having to look across the range of their operations, consider what additional ICU capacity could be created, and what activity could be postponed or stopped to free up that additional capacity. These pressures applied equally to staffing; as ICU capacity was scaled-up so the pressures</p>	



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<p>on staffing increased. This would mean revising staffing ratios in ICU, for example. NHS England and NHS Improvement had agreed that the nurse-patient ratio in ICU would be changed from 1:1 to 1:6 with additional supporting staff assisting.</p> <p>The DCEO reported that in order to manage the challenges facing the Trust in the current crisis and to ensure that there were robust systems for when the Trust returned to 'a new normal', several workstreams had been established to work through the scaling up of ICU and other resources to care for patients infected with COVID-19, the safe stepping down of other activity, the workforce implications for the Trust, the estates, procurement and IT aspects, and the ethical dimensions of managing a surge in very ill patients with limited ICU capacity. Additional workstreams had been established to oversee the management of gifts and offers of help from the community and to begin the planning for the 'new normal'. An executive director had been appointed to lead each workstream. There were daily staff communications across the Trust as well as daily operational meetings.</p> <p>The ACN/DIPC reported that there were robust systems in place for the isolation and care of patients who had tested positive for COVID-19. The Trust had created a system for streamlining patients that required screening at the emergency department. The Trust had been reporting tests within 24 hours by completing three-to-four runs each day. More patients were being cohorted and the Trust was using its influenza business continuity plan to manage operationally. The Trust had identified cohort wards and surge ICU capacity. There was understandable anxiety among the Trust's intensive care team regarding personal protective equipment, but the Trust was adhering to national guidance on PPE from the Department of Health. The Trust was currently working to identify staff who could be deployed to support the critical care units and other areas of the Trust, as well as identifying staff to support NHS Nightingale. There was also an improved clinical rota to ensure that there was sufficient senior leadership support and guidance available seven days a week. The Trust was now contemplating how it could provide up to 575 intensive care beds to support the wider system however this would be predicated on the system being able to provide respirators and equipment. To date, there had been a total of 38 deaths from COVID-19 at the Trust and 33 patients had been admitted to its level three critical care function.</p> <p>The following key points were raised and noted by the Board in discussion:</p> <ul style="list-style-type: none"> • Jenny Higham noted that St George's University of London, which shared the site with the Trust, had closed and was now conducting its curriculum online. The research laboratories remained open with clinicians focusing on supporting the work around COVID-19. Other clinicians had been released to support the NHS frontline. Students in their final year had also been released into the workforce to support the NHS. The University had also produced a number of guidance and information resources. • The DCEO explained that, at present, the Trust had 110 critical care beds. Any empty beds were available to support neighbouring trusts and some Trusts had already transferred patients requiring ICU support to St George's. • In response to Ann Beasley's query about how mental health patients could safely attend the emergency department, it was reported that the 	



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<p>Trust had redesigned the emergency department pathway so that patients were cohorted into 'green' and 'red' zones. The red zone was for those patients who may have COVID-19. The rooms for mental health patients were located within the red zone footprint but were in separate side rooms. These beds were specifically designed with reduced ligature risks. There were also robust protocols in place to support mental health patients and ensure they were not at risk. In addition, the Chief Executive Officer of South West London & St Georges Mental Health Trust had visited the psychiatric liaison team and was assured by the protocols in place which included faster response from the liaison team when a mental health patient attended the emergency department.</p> <ul style="list-style-type: none"> • NHS England and NHS Improvement (NHSE&I) had asked the Trust to identify staff who could support the new NHS Nightingale Hospital. The Trust had emailed all clinical staff to gauge which staff would like to volunteer. The CPO and COO were considering how the Trust could release staff to the Nightingale while ensuring that the Trust could manage the demand on site. • Elizabeth Bishop enquired what the Trust was doing with regards to step down facilities for patients who were medically fit for discharge. It was reported that the Trust had been working with social care and community organisations to ensure that medically fit patients were discharged into appropriate care settings. • In response to a question from Stephen Collier, the CMO reported that the Trust was working with the wider NHS system to ensure that there were robust systems for ethical decision making should demand for respirators outstrip capacity. These ethical decisions would be based on rigorous protocols and any assessments would be made on a case by case basis. It was also recognised the impact such decisions would have on clinicians and there would be mechanisms put in place to support staff. Tim Wright added that the Clinical Ethics Committee, of which he was a member, was engaged in this work. • The Chairman enquired about the resilience of staff and plans to ensure that there would be continued executive leadership for the duration of the pandemic. It was reported that at present there were no firm resilience plans for executive directors and the executive team had been working hard to ensure that there was senior support on site seven days per week and ensure that staff on the frontline feel supported. At a basic level the plan would be for the next level of senior manager to step up in the event that an executive director gets COVID-19. The Chairman asked that a resilience plan for the Executive team be developed and shared with the Board. • Pui-Ling Li asked about the extent to which the Trust was able to track the number of staff infected by COVID-19 and who were self-isolating either due to being infected themselves or as a result of a family member displaying symptoms. It was reported that the Trust had started testing certain staff for COVID-19. The Trust had also organised local hotel accommodation for staff who had members of their household in the 'shielding' category as defined by the Government. Occupational Health had been keeping in contact with staff who were self-isolating. The Trust was also considering which staff could be redeployed into other functions 	<p>CEO/ DCEO</p>



	Action
<p>across the Trust to support work on COVID-19 either directly or indirectly.</p> <p>The Board noted the update and recorded thanks to all Trust staff for everything they were doing during the Covid-19 pandemic.</p> <p>The Board also considered proposals for managing Board and Committee, and other Governance meetings, during the pandemic. Due to the operational demands of COVID-19, it was essential that the Trust focused on dealing with the pandemic and providing safe and effective care to patients. The Board would continue to play an essential role during this period, both in terms of providing oversight of the Trust's response to COVID-19 and in providing support and challenge to the Executive team. At the same time, usual Board business during this period needed to be reconsidered to ensure that staff were freed up to deal with and respond to these pressures. Although the Board had planned to move to bi-monthly meetings from April 2020, the Board would now meet monthly by videoconference focusing on key matters of business. The Quality and Safety Committee (QSC) and Finance and Investment Committee (FIC) would continue to meet each month albeit with shorter and more focused agendas. The Workforce and Education Committee would be suspended for the time being with key workforce business escalated to the Board or to FIC and QSC. The Audit Committee would meet to consider key year-end and urgent business, although it was anticipated that the year-end deadlines would be extended and therefore the scheduled meeting of the Committee on 14 April may well be postponed. Provisions would be made to ensure that attendees could join the meetings virtually. In lieu of meetings being held in public, a summary of the key matters discussed and decisions made by the Board would be published on the Trust's website and be made available to Governors. Public Board papers would also be published in advance of meetings and Governors and members of the public would have an opportunity to ask questions in advance. It was also noted that meetings of the Council of Governors had been paused for the time being and that the May Council meeting had been cancelled.</p> <p>The Board:</p> <ul style="list-style-type: none"> • Approved the proposed arrangements for Board and Committee meetings during the period of intense operational pressure during the pandemic. • Noted the arrangements put in place to ensure continued transparency and public accountability of the Board during this period. • Noted the arrangements put in place regarding the Council of Governors and membership engagement. • Delegated authority to the Chairman, on the advice of the Chief Executive and in consultation with the Chairs of the relevant Board Committees, to approve temporary amendments to the Trust's Standing Orders and Standing Financial Instructions where these are required, in order that the Trust could respond rapidly and in an agile way to a rapidly changing situation. 	



		Action
4.0 QUALITY AND PERFORMANCE		
4.1	<p>Quality and Safety Committee Report</p> <p>Professor Parveen Kumar, Chair of the Committee, presented the report of the meeting held on 19 March 2020, which set out the key matters raised and discussed. The Board endorsed the Committee's concerns about COVID-19 risks and the need to ensure it was adequately reflected as a key risk for the Board and, as such, should be reflected on the Board Assurance Framework. Due consideration should be given not only to the short-term implications but the long-term impact of COVID-19 and the risks to the Trust, its patients and the delivery of its strategy. It was noted that given the scale of the pandemic and its impact COVID -19 inevitably impacted across all aspects of the Board Assurance Framework risks to varying degrees but it was accepted that this should be clearly articulated in the Board Assurance Framework.</p> <p>It was also reported that the Committee had considered a deep dive on maternity services and was encouraged by the progress made but intended to closely monitor this over the coming months. The Committee had observed that the Trust was close to its full year threshold for cases of clostridium difficile and had had a case of MRSA. The Committee had considered a paper on serious incidents and was assured that there were no particular themes from the incidents that were closed which signalled underlying performance issues. Ongoing SI investigations were also discussed and the Board noted that these would be reported formally once the investigations had been completed.</p> <p>The Board noted the report and agreed that a risk related to COVID-19 should be reflected in the Board Assurance Framework.</p> <p>The Board agreed that executive team should ensure that both the short and long term risks associated with COVID-19 and its impact and implications for other service provision should be considered by the relevant executive workstreams responsible for managing the Trust's response to the pandemic.</p>	<p>CCAO</p> <p>DCEO</p>
4.2	<p>Integrated Quality and Performance Report (IQPR)</p> <p>The Board received and noted the IQPR at Month 11 (February 2020), which had been scrutinised at both the Finance and Investment and the Quality and Safety Committees. Outside the matters raised in the Board Committee reports and the issues discussed elsewhere on the agenda there were no other key performance issues to highlight.</p> <p>The Board received and noted the report.</p>	
5.0 FINANCE		
5.1	<p>Finance and Investment Committee Report</p> <p>Ann Beasley, Chair of the Committee, provided an update on the meeting held on 19 March 2020. The Trust's financial performance was in line with revised forecast of £9m deficit. Cash remained well managed based on current requirements, but COVID-19 was expected to have an impact here which would need to be carefully monitored. The decision of NHS England</p>	



		Action
	<p>and NHS Improvement to provide block contract funding for months one and two of 2020/21 in April 2020 was welcome. The Committee recognised the challenges COVID-19 posed to the current planning round and it noted the suspension of this by NHS England and NHS Improvement. Effective forward planning for 2020/21 also presented a challenge in the current climate.</p> <p>The Board noted the report.</p>	
5.2	<p>Finance and Investment Committee (Estates) Report (FIC(E))</p> <p>Tim Wright, NED Estates Lead, provided an update on the meeting held on 19 March 2020. The estates team had made significant improvements and there was now greater transparency and scrutiny of estate issues. There were also robust governance systems in place. As such, it was agreed that the group, which had been set up on a temporary basis to oversee enhanced assurance on estates, should be disestablished and estates matters be reincorporated into the core FIC meetings with an estates dashboard presented each month.</p> <p>The Board noted the report, acknowledge the good work of the estates team, and agreed that estates issues would be re-integrated within the core Finance and Investment Committee meetings.</p>	
5.3	<p>Month 11 Finance Report</p> <p>The Board noted the Month 11 finance report. The ACFO reported that the Trust was £7.5m off plan and expected to end the year with a £9m deficit in line with the reforecast position. The COVID-19 pandemic was impacting on the Trust's ability to manage its finances with decisions focused on ensuring that the Trust could continue to care for patients effectively. NHS England and NHS Improvement (NHSE&I) had indicated that Trusts would be reimbursed for COVID-19 related expenditure. A key consideration for the Trust was cash and as Ann Beasley had reported NHSE&I had confirmed that the Trust would be provided with the months one and two 2020/21 block contract payments in April 2020.</p> <p>The Board noted the report.</p>	
6.0	CLOSING ADMINISTRATION	
6.1	<p>Questions from the public</p> <p>The Board also addressed a question from Sandhya Drew, Public Governor in the Rest of England constituency, about the sufficiency of the Trust's personal protection equipment (PPE). It was noted that the Trust continues to operate within the guidance and instructions set out by Public Health England and the Department of Health in relation to the use of PPE. The Trust currently had sufficient stocks of PPE and had put in place a regime whereby staff were proactively topping up stocks in each clinical area of the Trust. It was also noted that NHS England and NHS Improvement was providing all Trusts with supplies of PPE and these were being procured at a national level.</p>	
6.2	Any other risks or issues identified	



		Action
	There were no other risks or issues identified.	
6.3	Any Other Business There were no matters of any other business raised for discussion.	
Date of next meeting: Thursday, 30 April 2020, Room 52 and videoconference		

Trust Board Action Log Part 1 - April 2020

Action Ref	Section	Action	Due	Lead	Commentary	Status
TB26.03.20/01	Novel Coronavirus (COVID-19)	The Chairman asked that a resilience plan for the Executive team be developed and shared with the Board.	30/04/2020	CEO/DCEO	Update to be provided at the meeting.	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.	26/03/2020-28/05/2020	CN/CTO	Deferred to accommodate focused March agenda and developing national health crisis.	OPEN/DEFERRED
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.	26/03/2020-28/05/2020	ACEO	ACEO reported that the Health & Safety Report Action Plan would be discussed at the FICE meeting and a report provided to Board.	OPEN/DEFERRED
TB30.01.20/04	Seven Day Services Implementation Update	The Board noted the report and asked that the programme of work be integrated into the development of the annual plan for 2020-21, with the Trust Executive Committee providing oversight and scrutiny of progress.	26/03/2020-28/05/2020	CMO	Deferred to accommodate focused March agenda and developing national health crisis.	OPEN/DEFERRED
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.	26/03/2020-28/05/2020	CSO/CCAO	Deferred to accommodate focused March agenda and developing national health crisis.	OPEN/DEFERRED
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 FTSU to escalate non-engagement.	26/03/2020-28/05/2020	TEC	Deferred to accommodate focused March agenda and developing national health crisis.	OPEN/DEFERRED
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.	26/03/2020-28/05/2020	CEO	Deferred to accommodate focused March agenda and developing national health crisis.	OPEN/DEFERRED
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
TB30.01.20/02	Integrated Quality and Performance Report (IQPR)	Non-Medical Appraisals Deep Dive at WEC: The Board agreed that the Workforce and Education Committee (WEC) would conduct a deep dive into non-medical staff appraisals and the executive team could learn from the work carried out in the estates team to improve the department's appraisal rates.	28/05/2020	CPO	Not yet due.	NOT DUE
TB30.01.20/05	Patient Story: Sickie Cell Patients in the Emergency Department	The Board thanked Ms Vitalis for sharing her story and agreed that a follow-up report would be presented to the Board setting out the actions that had been taken to ensure that her poor experiences would not be repeated either for herself or for others.	30/06/2020	CN	Not yet due.	NOT DUE
TB27.02.20/01	Learning from Deaths Quarter Three 2019/20 Report	The Board noted the report and it was agreed that an item on the Medical Examiner system would be included in the Board development programme in the first half of 2020/21.	30/06/2020	CMO	Not yet due.	NOT DUE
TB27.02.20/02	Outpatients Strategy	The Board approved the strategy subject to a robust business case being undertaken and the Board given the opportunity to scrutinise the financial investment envelop and the key risks and next steps.	28/05/2020	COO	Not yet due.	NOT DUE
TB26.03.20/02	Quality & Safety Committee Report	The Board agreed that executive team should ensure that both the short and long term risks associated with COVID-19 and its impact and implications for other service provision should be considered by the relevant executive workstreams responsible for managing the Trust's response to the pandemic.	28/05/2020	DCEO	Not yet due. The Quality & Safety Committee discussed this risk rating at its meeting on 23 April 2020 and the executive team have been tasked with looking at BAF risk which would be considered at the May 2020 Board meeting.	NOT DUE
TB26.03.20/03	Quality & Safety Committee Report	The Board noted the report and agreed that a risk related to COVID-19 should be reflected in the Board Assurance Framework.	28/05/2020	CCAO	Not yet due. The Quality & Safety Committee discussed this risk rating at its meeting on 23 April 2020 and the executive team have been tasked with looking at BAF risk which would be considered at the May 2020 Board meeting.	NOT DUE



Meeting Title:	Trust Board		
Date:	30 April 2020	Agenda No.	1.5
Report Title:	Chief Executive Officer’s Update		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is asked to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	Date:	N/A



Chief Executive's report to the Trust Board – April 2020

Introduction

It would be an understatement to say that a huge amount has happened in the two months since my last report to the Trust Board.

Since early March, and as a direct result of the Covid-19 pandemic, our focus has shifted almost entirely to making sure we continue to provide urgent and emergency care for our patients; as well as those admitted to hospital as a result of Covid-19 infection.

The last six weeks have been challenging, and the impact of Covid-19 on staff - and the communities we serve - has been significant. The way we deliver hospital care over the next 12-18 months will be very different to what we are all used to; and we need to find a new 'steady state' to get us through the short-medium term period.

The response from staff has been truly heroic, both in terms of their commitment to the cause, but also everybody's willingness to take on new roles, and to work with different teams.

I would also like to extend a huge thank you to St George's Hospital Charity, and the many other smaller hospital and community charities that support us. The tide of goodwill from local communities has made a huge difference; and will continue to over the weeks and months to come.

Covid-19

As stated above, many parts of the organisation have been transformed in a matter of weeks.

We now have the ability to open as many as 150 ITU beds at St George's, from an original ITU bed base of just over 70. Fortunately, we have not yet had to open all 150 ITU beds - and we are cautiously optimistic that the first surge in Covid-19 cases has now passed. However, we mustn't be complacent, and this is something we are stressing to staff on a daily basis.

Like all hospitals, we have suspended all non-urgent, planned operations, and patients will only attend hospital for outpatient appointments if absolutely essential - with the majority undertaken virtually.

Sadly, 220 patients have so far died at St George's and tested positive for Covid-19 - and our teams are doing their best to support relatives who can't attend hospital because of the restrictions on visiting we've had to put in place.

Since early March, nearly 600 patients who tested positive for Covid-19 have been discharged from our hospitals. The vast majority of these patients have gone home, with many now reunited with families and loved ones; whilst a much smaller number have been transferred to other hospitals and/or care homes for ongoing care.

We are currently planning for the future as best as we can. We are very aware of the desire to re-start activity (such as planned operations) as soon as we possibly can; but we need to match this with the need to be ready for a further surge in Covid-19 cases. We also need to ensure that, by bringing some activity back on site, we don't in any way expose otherwise healthy people to unnecessary infection; and we are in regular discussions with colleagues in south west London and nationally about this.



Performance

Covid-19 has changed both the way we deliver services, and also led to a reduction in demand in some areas.

During March, 79% of patients were either seen, admitted or discharged from our Emergency Department at St George's within four hours.

Attendances to ED are significantly down, particularly during April, and this is reflected in other urgent and emergency care services: such as our heart attack centre and stroke services, for example.

This is a concern, and we are working hard to ensure patients know that our urgent and emergency care services are operating largely as normal, and ready to care for people who need us.

The number of patients seen and treated within 18 weeks during March was also 79%. Unfortunately, the number of patients waiting longer than 52 weeks for treatment has increased - this is a concern and something we need to urgently address, even if the number of patients waiting more than a year for treatment represents a small fraction of our overall waiting list.

Finance

In January, the Trust Board agreed a revised year end forecast deficit for 2019/20 of £12 million.

This represented a £9 million adverse position to the £3 million target deficit we set ourselves at the start of the financial year in March 2019.

In light of Covid-19, the projected year end deficit was reset to £13.3 million earlier this month - and we can confirm that this has been delivered.

Going forward, we will need to factor the impact of Covid-19 into our financial planning for 200/21, including support from the centre. We also need to reduce our run-rate, which remains a concern.

We have reduced the deficit over the past 12 months, but the run-rate has not shifted significantly enough to enable us to deliver the month by month, year on year efficiencies we can and need to make.

Patient safety

We are continuing to focus on keeping our patients safe, which also means factoring in the additional challenges presented by Covid-19.

We have created a new patient safety dashboard - set out in these papers - which details the key additional metrics we will track and measure as the Covid-19 pandemic continues.

I also wanted to touch briefly in this section of my report on the independent cardiac surgery mortality review published on the day of the last Trust Board meeting in March.

The findings of the review were upsetting to all of us, although the service is now safe, which has been confirmed by the latest published NICOR data and CQC inspection. Dr Jennings has met with a number of the families affected, and providing relatives with the information and answers they need remains a priority for us, although our ability to meet families in person is restricted as a result of Covid-19.



I would like to reassure the Trust Board that we remain completely focussed on delivering further improvements to the cardiac surgery service at St George's - and maintaining a safe and effective service for our patients. This will mean ongoing monitoring and scrutiny of the service, in conjunction with our regulators.

Community support

To conclude, I just wanted to touch briefly again on the fantastic support we've had from local communities.

Anyone who works in the NHS cannot help but be moved by the national round of applause every Thursday evening at 8am - and I know how big a lift it gives our staff.

We've had so many generous donations, and the support from St George's Hospital Charity, plus many, many others has been truly humbling.

The impact on staff of recent events - and the weeks and months to come - is naturally a concern, and this is the point on which I want to conclude my report to the Trust Board.

We have put a lot of initiatives in place to support our staff emotionally, psychologically and practically during the Covid-19; but the impact on many staff should not be under-estimated, and we must remember this over the coming months.

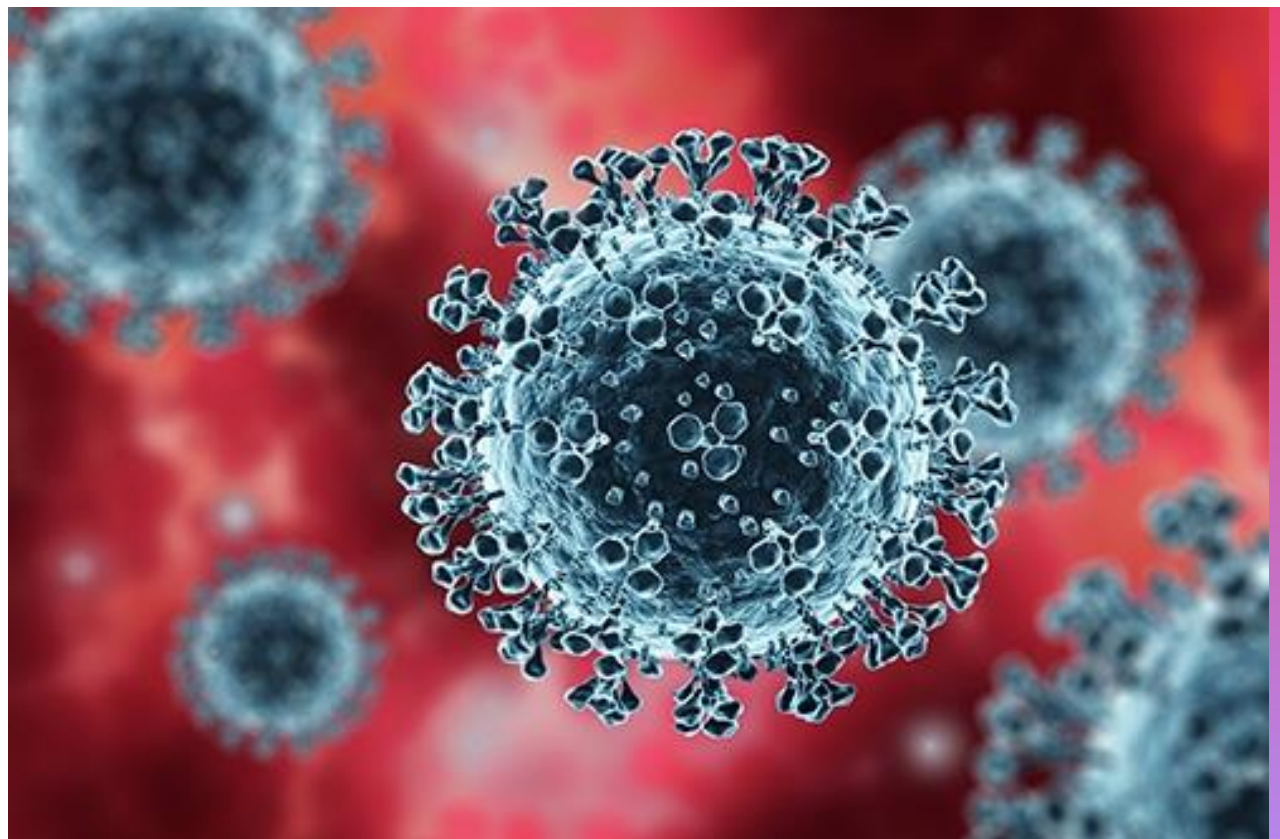
We need to support our staff now more than ever; and this is probably our greatest and most important challenge over the coming weeks and months.



Trust Board Covid-19 Update

Jacqueline Totterdell – Chief Executive
Officer

30th April 2020



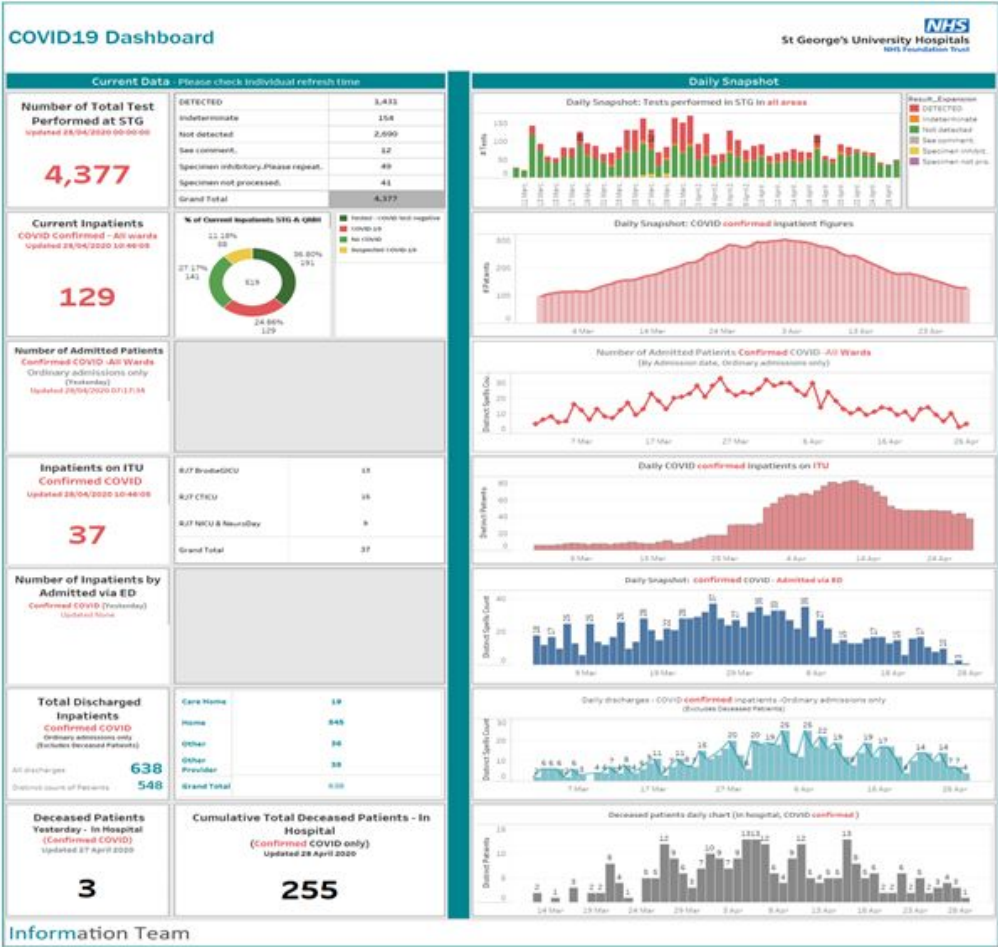
Executive Summary

- Since the last Board update, the Trust has continued to operate with more capacity than demand for COVID 19 patients needing our care and support in ITU and general medical beds. In addition, we have continued to run a range of retained services, such as: trauma, maternity, neonatal, cancer, stroke, heart attack, medical and surgical take, paediatrics, imaging and pathology.
- We have seen a marked reduction in all non- COVID 19 referrals. Allied to the cessation of most elective procedures, this has resulted in surplus theatre and bed capacity which has either been repurposed or supported the staff redeployment needed for ITU, medical and retained services capacity, to safely manage our response to the first phase of COVID 19.
- Demand for COVID 19 inpatient beds peaked on 2nd April and for ITU peaked on the 12th April. Since then we have plateaued at a lower level of COVID 19 demand and this is forecast to continue into May 2020.
- Our staff have continued to be truly amazing and we will continue to recognise and build upon this in the second phase of our response, which will require us to be flexible and agile in relation to both COVID and non COVID 19 patient needs. We will continue to work collaboratively with partners across SW London and NHS London to achieve this.
- We are now entering into the second phase of our response, with revised governance arrangements being finalised by the executive for implementation from next week. This will position us well to respond at pace to the NHS London and SW London pandemic strategy.
- We are working with our partners to look at re-starting the treatment of the non-cancer urgent patients, with adoption of the Royal Marsden policies and aim to have this signed off by the Regional Office by the end of next week.
- St. George's University of London has dedicated its laboratory based research programme to support the national COVID research priorities, with patients and volunteer staff already entered on to clinical trials. We will update as progress is made.

Work stream Summary

Work stream	Priorities/ key actions since last meeting	Lead
Surge and Sustain	<ul style="list-style-type: none"> Delivered the ITU, medical and retained service capacity needed to safely manage the Trusts COVID 19 response in the first phase. Priority now is to plan and commission ITU and medical capacity needed going forwards for different levels of COVID 19 response, in support of the SWL pandemic response strategy. 	COO
Safely Standing Down	<ul style="list-style-type: none"> Delivered the retained services needed to safely manage the Trusts COVID 19 response in the first phase. A new care pathway for the management of urgent and benign cancer has been agreed and is being implemented, which aims to create a 'clean non-COVID ward' environment to mitigate the risk of nosocomial transmission to patients who need this urgent planned surgery at the St. George's, Tooting site. 	CTO/ COO/ CMO
Workforce	<ul style="list-style-type: none"> Delivered the workforce changes needed from existing staff and rotas to safely manage the Trusts COVID 19 response in the first phase, including consultant delivered care 24/7 and the increase of virtual outpatient clinics. Providing psychological support to frontline teams and linking this to our communications and well-being plans. Reviewing ITU, surgical and medical mega rota's to achieve the optimum balance between COVID 19 support and speciality training. Developing a workforce modelling capability to forecast the staff needed for various demand scenarios in the second phase. 	CPO
Support Activities	<ul style="list-style-type: none"> Delivered the stock and PPE needed to safely manage the Trusts COVID 19 response in the first phase. Building the stock levels needed to support our phase 2 response, with a focus on gowns and protective masks. 	DCFO
Ethics and Palliative Care	<ul style="list-style-type: none"> Agreed and implemented Treatment Escalation Plans to support new ways of working required by our COVID 19 response. Agreed the 'decision making framework' to triage patients to and from ITU Developing the COVID elements of the Quality and Safety dashboard to provide assurance regards standards of care and clinical outcomes 	CMO
Support to Staff	<ul style="list-style-type: none"> Delivered 'well being' hubs across the St. George's Tooting site, supported by the St. George's Charity, British Airways and Virgin Atlantic Extended staff testing for COVID 19 to all staff groups that have the symptoms on site and through the Chessington drive-in centre 	CCA
Returning to Normal	<ul style="list-style-type: none"> Planning the Trusts response to the second phase, for COVID and non-COVID 19 patients, in line with NHS London and NHS SW London's pandemic response strategy. 	COO

COVID 19 Demand and Activity at 28th April 2020



- We appear to have passed our first peak and stepped down to a plateau of demand in relation to COVID 19
- COVID 19 inpatients reduced to 129, down from a peak of 304 on 2nd April
- COVID 19 inpatients on ITU at 37, down from a peak of 83 on 12th April
- A total of 4,377 COVID 19 tests on patients have been completed, with 1,431 identified as positive
- A total of 638 patients with confirmed COVID 19 have been discharged, of which there have been 255 diagnosed COVID 19 deaths
- There are currently 481 (54%) inpatient G&A beds open and 406 (46%) closed
- Our forecast into May 2020 is that we will continue on the current plateau, with demand for COVID 19 ITU in the range of 30-60 beds and medical COVID 19 of 120-160 beds.
- The following slide illustrates the capacity plan for Covid 19 ITU beds. This illustrates that plans were developed for circa 500 beds; although only 123 were actually mobilised.

COVID 19 Capacity Plan

ITU

ITU Surge Plan



33 x 7.50 in



COVID 19

Staff testing

- To date, total number of St George's staff tested for Covid-19 is 999. Of the 999 staff tested, 450 tested positive. 540 of the staff were clinical, 145 non clinical and remaining 306 staff members did not have their job titles registered.
- SWL Pathology, based at St George's has processed 780 of the 999 tests, as the first 219 tests were sent to Collindale.
- In total, SWL Pathology has processed 14,619 Covid-19 tests to date of which 4,846 tested positive.
- Update since TEC briefing on 15th April:
 - Process agreed with CCG to expand staff testing at St George's POD to include staff (and household members) from CLCH, Your Healthcare, SWLStGs, Primary Care and Pharmacy Staff.
 - CCG to co-ordinate the referral of staff from the above units to St George's POD.
 - Staff and household members of HRCH, Social Care, Care Homes, emergency services and any other NHS or social care organisation to continue to be processed at Chessington site for now.
 - Testing of the above staff could potentially be moved to St George's POD subject to agreement, and this will be reviewed as part of Phase 2 in coming days/ weeks.
 - Following a decision from NHSE/I last week, all non-elective hospital admissions should now be screened for Covid-19, regardless of whether or not they have any suggestive signs or symptoms. This is to facilitate early detection of mild or pre-symptomatic cases and prevent nosocomial transmission.
 - Actual tests processed by SWL Pathology continue to run significantly below capacity.
- Next Steps:
 - The five London Pathology networks (including SWLP) are working with NHSI and NHSE to align the national staff testing agenda with existing pathology network infrastructure.
 - Work with NHSI/NHSE to implement Phase 2 of national testing strategy, including all staff at work and community testing.
 - Continue to message that testing is available for all staff
 - Continue to monitor stock levels, demand and capacity.



COVID 19

Ethics Framework and Safety Dashboard

Decision Making Framework to Triage Patients To and From ITU – This framework was discussed at TEC on 28th April 2020, feedback will be incorporated into the final version for TEC approval next week, on 5th May.

- Fortunately, social distancing and the national lockdown have flattened the curve of Covid-19 cases to such an extent that we have not had to face a mismatch between demand and supply of intensive care bed capacity. This has provided time for this piece of work to be considered thoroughly before being finalised, but this decision-making framework is still necessary to have in place in order to be prepared for any future eventuality should there be further waves occur. This framework sets out the ethical principles by which difficult decisions may be made, but importantly, it also sets out the operational way in which that decision making will be distributed among senior clinicians who are not directly involved in the individual patients' care.

COVID 19 Safety Dashboard – this work is being led by the CMO and CNO with support from the CTO and is forecast to be completed and in use within the next two weeks.

- The purpose of the dashboard is to give assurance that during the COVID-19 response, the Trust is delivering safe, high quality care. The proposed metrics are shared on the next page of this update. The indicators are split into the seven priority areas, in line with our Quality and Safety Strategy 2019-2024. Work is well under way to agree, refine and populate the metrics into the dashboard format.

COVID 19 Safety Dashboard - Proposed Metrics

Priority	Name
minimise avoidable harm	The absolute numbers and percentages of Covid cases that are nosocomial/hospital-acquired
	The absolute numbers and percentages of Covid deaths that are nosocomial/hospital-acquired
	ITU Medication errors
	ITU Pressure Ulcer rate
improve patient outcomes	Our % mortality (ITU & G&A)
	Our % of patients who go to ITU
	Our % of patients who receive CPAP/NIV
	Our % of patients who are intubated
	Renal replacement therapy rate
	72 hour ITU readmission rate
excellent patient experience	Metric TBC - family experience, especially experience of bereaved families, possibly including the number and % of deceased patients who were visited, virtually or physically, before their death

Priority	Name
improved staff experience	Staff absence due to COVID, separated into absence due to illness and absence due to household contact illness
	Staff testing
	Absolute numbers
	turnaround time
equitable patient access and quality	%-age positive
	staff support/wellbeing metric – TBC pending feasibility
	G&A beds and their occupancy
	ITU beds and their occupancy
embed quality, safety and learning culture	Length of Stay (ITU and G&A)
	The deaths that the Medical Examiner office flagged for further attention because of concerns
	The absolute number and % of Datix reports related to Covid (separated in possible into Covid positive incidents and non-Covid incidents related to service changes)
	Unplanned extubations
provision and development of pioneering treatments	Our absolute numbers and % of patients who are recruited into treatment trials
	Our absolute numbers of staff and volunteers who are recruited into vaccine trials (and other trials)

COVID 19

Workforce Modelling

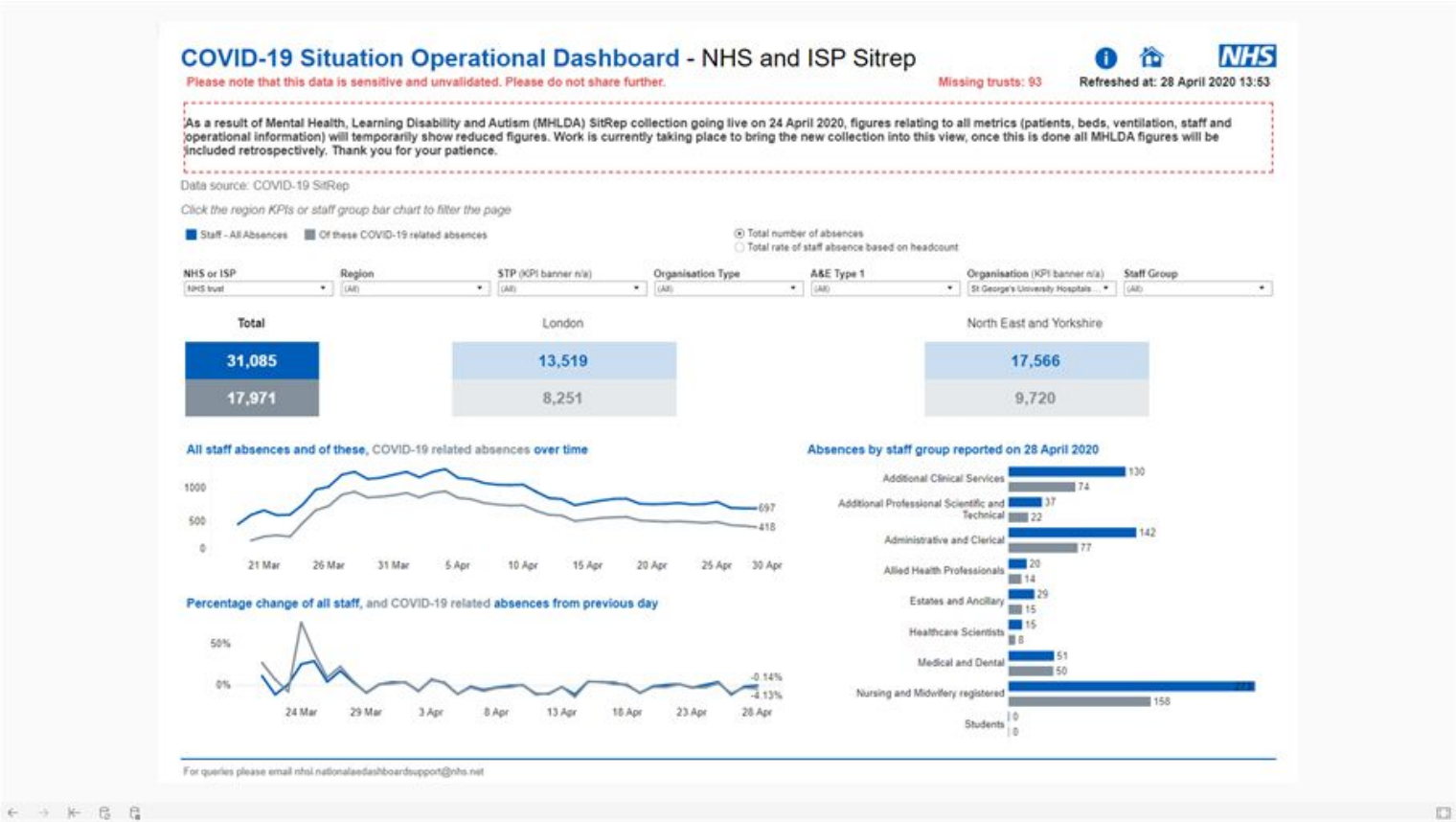
- The Workforce group has developed and delivered plans to safely staff the Trusts first phase COVID 19 response, including the continuation of an agreed range of 'retained services.'
- This has required many staff to be redeployed from their care groups and usual place of work to support the COVID 19 ITU and medical capacity plans.
- Workforce planning has been based on the principle that each care group will need to organise itself based on 24/7 consultant delivered services, to safely release the medical capacity needed to support our COVID 19 response.
- New rota's have had to be agreed and implemented with all specialities to safely release and repurpose our junior doctors.
- Nurses, AHPs, pharmacists and admin & clerical staff (to name a few) have also supported the Trusts COVID 19 response, through new ways of working, new rota patterns and doing the job that patients need us to do – not always the job we have been trained for.
- All staff redeployed to COVID 19 wards (ITU and medical) have been through the COVID 19 'training boot camp' – with a total 1416 staff trained to date, plus 1590 nurse refresher teaching episodes, and an additional 260 HCA trained.
- In the first phase our response was reactive. As we move into the second phase we are consolidating and strengthening the current arrangements and developing our workforce modelling capability.
- The aim being to provide an agile and flexible response through our existing staff, whilst being clear about any extra staff needed to sustainably resource the range of COVID 19 and non COVID clinical services that form part of our, SW London and NHS London's pandemic strategy.

COVID 19



COVID 19
Staff Absences

- Our staff absences have significantly reduced, with our Covid19 absences peaking at 12.9% in late March, to now under 6%.



COVID 19



COVID 19 Stock Update



Note: Graphs showing daily stock levels of key PPE items

- FFP3 and surgical mask stock remains significantly above daily usage.
- Alternative supplies of surgical gowns and coveralls have been received, with stock levels healthy, and direct supply to the Trust looking positive. Gown usage has significantly reduced over the last week.
- The priority going forwards will be to assure sufficient stock operationally on a daily and weekly basis, whilst building the stock levels needed to better manage demand should there be future increases in COVID 19 related activity.



Meeting Title:	Trust Board		
Date:	Thursday, 30 April 2020	Agenda No	3.1
Report Title:	Quality and Safety Committee Report		
Lead Director/ Manager:	Prof. Dame Parveen Kumar, Chairman of the Quality and Safety Committee		
Report Author:	Prof. 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 April 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		



Quality and Safety Committee Report

3.1

Matters for the Board's attention

The Quality and Safety Committee met on 23 April 2020 and in line with the discussions at the March Board focused on only some key matters of business.

The Committee agreed to bring the following matters to the Board's attention:

1. Novel Coronavirus (Covid-19)

The Committee received a comprehensive report on Covid-19. The report included updates on capacity and demand, measures to safely stand down other activities, workforce and staff testing updates, ethical decision making and the revised Complaints and Patient Advisory Liaison processes and related clinical risk assessments and risk management. The Committee was assured by the robustness of the governance systems to manage the Trust during the Covid-19 pandemic and measures in place to manage communication into and from the organisation and internal staff communication. The Trust had responded to the crisis effectively and adapted its systems and practice in the first peak phase of the Covid-19 pandemic. Work was underway to ensure that these revised working arrangements were embedded over the next 12-18 months, although recognising that this would be subject to regular review. Staff have been flexible and stepped up to the challenge with many redeployed to care for the Covid-19 patients. The Trust had scaled up its critical care provision from 66 to 123 fully equipped intensive care beds. The Trust had identified capacity up to 150 intensive care beds with the potential to increase further to 500 beds with additional support from the wider-NHS system. There were dedicated wards for non-Covid-19 patients, patients tested positive for Covid-19 and those that present with Covid-19 related symptoms. The Trust had also refined the patient pathway through the Trust to ensure patients are cared for safely, for example patients coming in for diagnostics. The Committee were also assured by the provisions in place to ensure that there were rigorous risk assessment processes for any change to business as usual services including impact on patients and staff. The Trust stock of personal protective equipment (PPE) was comparatively sufficient given wider supply challenges. The Trust continues to rely on central stocks of Covid-19 related equipment and supplies. The Trust continued to provide maternity, neonatal, emergency endoscopy, heart attack, urgent diagnostic, emergency services, continuing therapies (dialysis, chemotherapy etc.) and other core services to non-Covid-19 patients. The Trust staff testing provisions had been increased with around a third of staff tested and testing available to all symptomatic staff and members of their household. The Committee welcomed the provisions in place to support staff including health and wellbeing hubs, clinical psychological support and counselling services and noted that staff sickness had reduced to 6% from a peak of 12%. The Committee heard about the impact of the Covid-19 lock down with many people choosing to stay away from the hospital and shared the executive concerns about the challenges with managing the waiting lists for non-Covid-19 patients. The Trust was conducting clinical assessments of patients on the waiting lists and whilst it was conducting urgent, emergency lifesaving treatments and operations the Trust was not carrying out elective activity in line with the national guidance. The Trust had also developed ethical protocols (aligned with national guidance) in the event that demand for critical care provision outstripped capacity but fortunately this scenario did not materialise and the Trust continues to be able to support its patients. The Trust was also supporting families and friends in the best way it could in relation to end of life care but recognised the difficulties and distress social distancing causes to people who have family members in



hospital. The Committee also noted that whilst the Government had agreed that the Trust could 'pause' its normal complaints process the Trust continues to respond to complaints within the compliance framework and timelines.

The Committee recognised the scale of the challenge, applauded the Trust robust response but asked that focus be given to the clinical impact of harm for non-covid-19 patients waiting too long for treatment and further work be done to reassess and increase the risk score.

2. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality performance at month 12. At month 12 the Trust had 51 clostridium difficile cases against a year-end threshold of below 48. All cases were subject to root cause analysis validated by local commissioners to ascertain if there were any lapses in care. As of month 10 only eight of the 42 cases were attributable to lapses in care provided by the Trust. The Committee also noted that the Trust continued to comply with the venous thromboembolism (VTE) target and the electronic treatment escalation plan (TEP) was being fully utilised across the Trust and helping to support care for patients in light of Covid-19.

3. Serious Incident Reporting

The Committee noted that four serious incidents had been declared in March 2020 and six investigations closed. The learning and actions from the closed serious incidents, including the two never events related to the insulin overdose and the retained foreign object in the eye of a paediatric patient, was also noted. The Committee asked the executive team to revisit the clinical pathway for managing patients that attend the emergence department with a headache given that the Committee had awareness of at least one previous serious incident related to care of a patient who presented with headache .

4. Care Quality Commission Action Plan

The Committee welcomed the news that the NHS Improvement/England had approved the Care Quality Commission's (CQC) recommendation to take the Trust out of '*quality special measures*' in March 2020. The Committee and the Board had approved the action plan and Trust response to the two must do actions in January 2020 following the 2019 inspection. The Committee considered and endorsed the comprehensive action plan that responded to the 44 'should do' actions from that inspection. The Committee noted that the implementation of the action plan would be monitored on a monthly basis by the Patient Safety and Quality Group and a report would come to the Committee quarterly with any significant exceptions reported as and when required. The Committee also noted that whilst the CQC had suspended its inspection regime and some actions could not be progressed during the Covid-19 pandemic progress was being made on others. The governance systems, which included local care group and divisional scrutiny, would continue with executive leads signing off completion of assigned actions following review of relevant evidence that these actions had been completed.

5. Patient Safety & Quality Group (PSQG) Report

The Committee received and noted the report from the March 2020 meeting of the Patient Safety and Quality Group. The Trust had provided its response to the Regulation 28 Prevention of Death Order. The Trust had implemented additional protocols to ensure staff providing '*specialling*' care to patients were clearly identified and not utilised in any other ways on the wards. Following completion of the paediatric diabetes national audit the Trust



was no longer an outlier and the evidence from external review of the Trust action plan was submitted to the Care Quality Commission in March 2020. The Committee also noted the progress being made on developing the draft 2020/21 Clinical Audit Plan. The Trust continues to make good progress on completing the assessment on NICE guidelines having closed most of the 2018/19 backlog and recognised the plan to ensure on-going monitoring of the Trust position

6. Cardiac Surgery Report

The Board would consider the cardiac surgery report later on the agenda but the Committee noted that following the publication of the independent mortality review in March 2020 the Trust continued to engage with family members. The Trust cardiac surgery service performed only one operation in March 2020 as a result of Covid-19.

7. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register which focussed on the four strategic risks (SR) which fall within its remit. The Committee noted that more work was required to have the quality improvement methodology embedded in the organisation despite the responsive work with quality improvement in relation to Covid-19. The Committee also noted that the Covid-19 pandemic was impacting on all risks on the Board Assurance Framework and reiterated the need to clearly codify the Board's assessment of the Covid-19 risk on the BAF.

8. Committee Forward Plan

The Committee received and approved its business as usual 2020/21 annual workplan noting the interim measures to give due focus on key quality, safety and experience issues during the Covid-19 pandemic. The Committee would present the workplan, updated terms of reference and annual report to the Board in May 2020.

Dame Parveen Kumar
Committee Chair
April 2020



Meeting Title:	Trust Board		
Date:	30 April 2020	Agenda No	3.2
Report Title:	Integrated Quality and Performance Report		
Lead Director/ Manager:	James Friend, Chief Transformation Officer		
Report Author:	Emma Hedges, Mable Wu, Kaye Glover		
Presented for:	Information and assurance about Quality and Performance for Month 12		
Executive Summary:	<p>This report consolidates the latest management information and improvement actions across our productivity, quality, patient access and performance.</p> <p>Our Finance & Productivity</p> <p>COVID-19 has impacted the activity levels at the Trust. Elective and Outpatient activity has been reduced in order to ensure the Trust can manage patients in a safe environment. Theatre capacity has been retained for essential services only and outpatient activity has been reduced in line with social distancing guidance. Where possible patients are being seen virtually.</p> <p>Activity across all PODS has been significantly reduced with 21% less outpatient attendances in March 2020 compared to March 2019. Elective and daycase activity has reduced by 32% compared to the same period; ED attendances have also fallen by 34% compared to the same period.</p> <p>Our Patient Perspective</p> <p>The Trust has finished 2019/20 with a total 51 Cdiff infections; this is above the threshold of 48 Cdiff infections.</p> <p>Carmen Birth Centre was closed to women in labour on over a quarter of the shifts in month due to consolidation of staffing across the unit. However, the team are working hard to keep the Birth Centre open wherever possible during the COVID-19 outbreak, balanced with the need to retain safe staffing across the whole maternity unit.</p> <p>Complaints are still meeting their response targets across all complaint types.</p> <p>Our Process Perspective</p> <p>National reporting has been suspended for all targets except for Cancer, 4 hour Operating Standard and six week diagnostic performance. However, the Trust is continuing to validate and monitor its performance.</p> <p>The Trust met three of the seven cancer standards for the month of February. February 2020's RTT performance was 82.3% against the Trust trajectory of 87.7%.</p> <p>As highlighted in Finance & Productivity, the reduction in Trust activity levels due to COVID-19 has had adverse impacts on the Trust's six week diagnostic performance.</p> <p>The Trust's four hour operating standard performance in March was 79.1% though attendances have dropped by 34% compared to March last year. The Trust's six week diagnostic performance deteriorated to 18.5% against a National Target of 1%.</p> <p>Our Workforce Perspective</p>		



	The Trust sickness rate has spiked in March to 5.1% against a long term average of 3.5%.		
Recommendation:	The Board is requested to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact.		
Legal/Regulatory:	No direct implications.		
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance.		
Previously Considered by:	Trust Executive Finance & Investment Committee Quality & Safety Committee	Date	21/4/2020 23/4/2020 23/4/2020
Equality Impact Assessment:	No direct implications.		
Appendices:	N/A		



Integrated Quality and Performance Report

3.2

For Trust Board
Meeting Date – 30 April 2020

James Friend
Chief Transformation Officer



Our Outcomes

How Are We Doing?

March 2020

Daycase and Elective
Surgery operations

Actual: 3,534
Target: 5,571



AMU bed occupancy at 12 Noon

Actual: 87% Target: 85%



Four Hour
Emergency Standard

Actual: 82.6%
Plan: 95%



February
2020

Referral to
Treatment
Standard -
Incomplete
pathways

Actual:
82.3%

Target:
92%

Whole Trust
Inpatient Friends
and Family Test

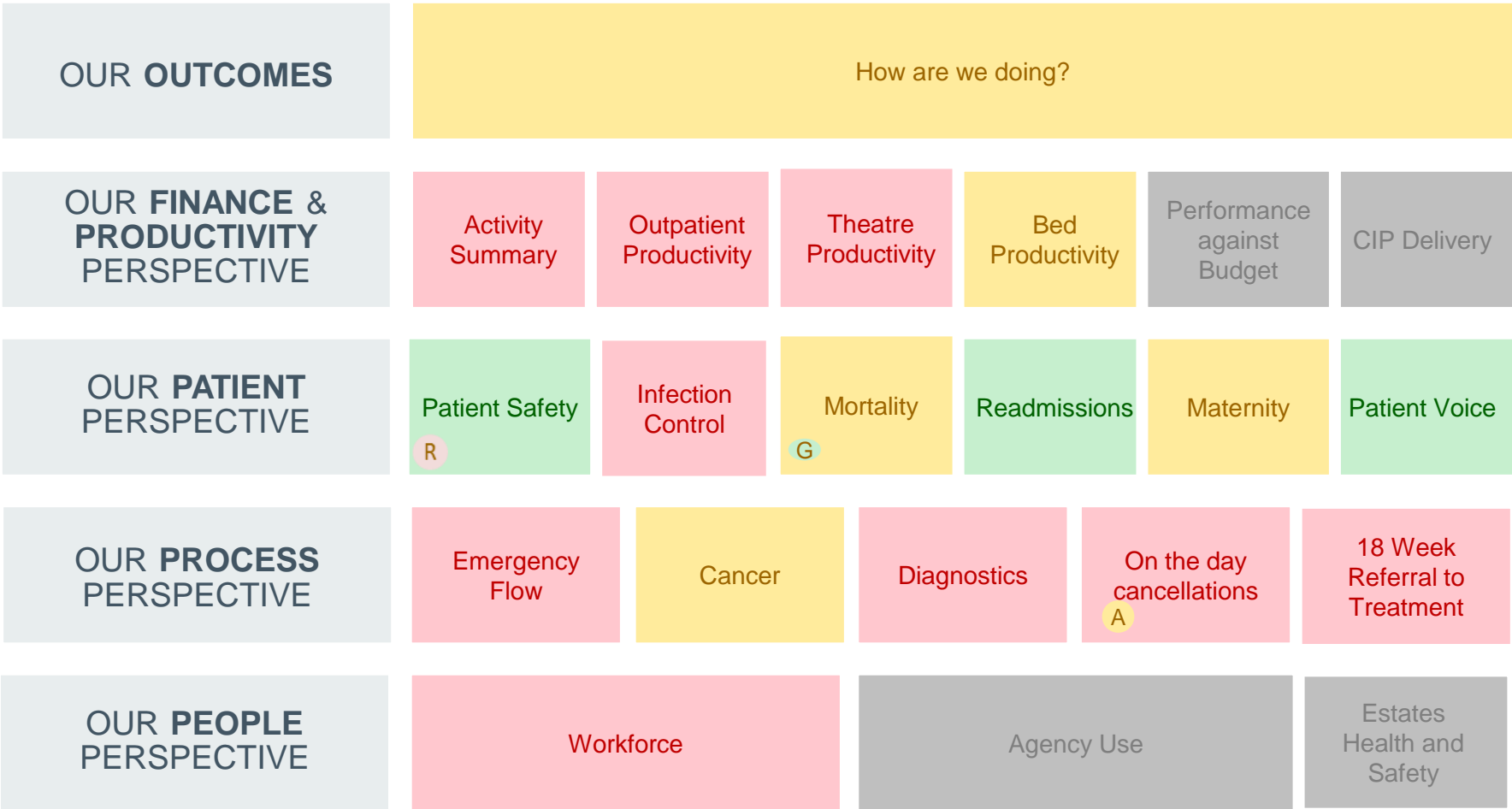
Actual 97.2%
Target 95%



Outpatient First
Attendance

Actual 12,324
Plan 18,502

Balanced Scorecard Approach



Key

Current Month

A Previous Month

Executive Summary – March 2020

Our Finance and Productivity Perspective

- COVID-19 has had a significant impact in activity in March with Elective and Outpatient activity 37% and 31% respectively below plan
- Similarly, Emergency Department attendances and Non-elective admissions are also 31% and 9% below plan for March.
- The Trust has retained enough theatre capacity to maintain essential service whilst closing all other theatres to support COVID-19 Surge plans
- The Trust is also continuing to see outpatients in virtual or safe environments.

Our Patient Perspective

- The Trust has finished the 2019/20 with 51 Cdiff. Infections against a threshold of 48.
- Complaints are continuing to meet their targets against all complaint types
- The percentage of positive responses for Friends and Family Test have increased across all services

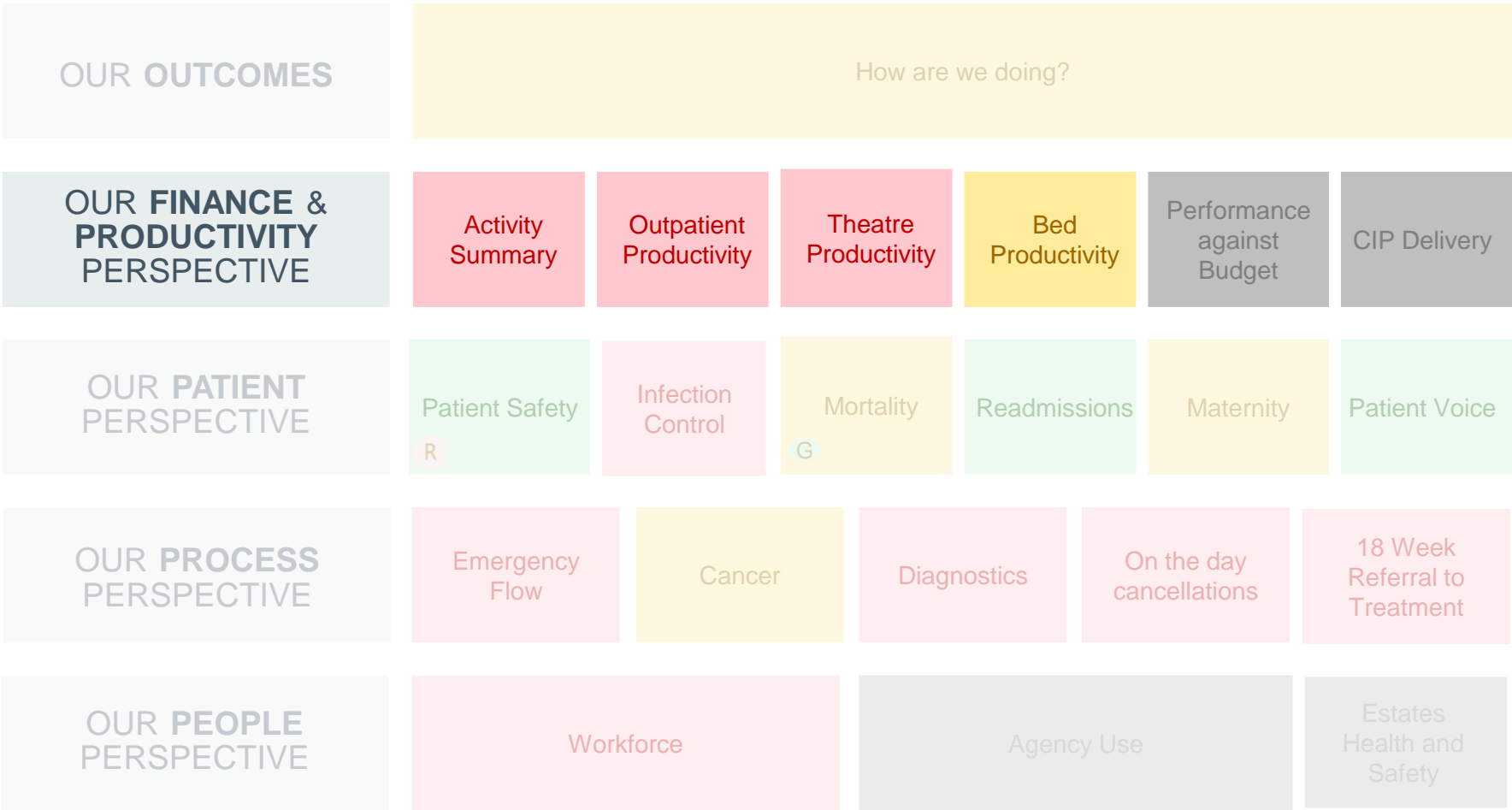
Our Process Perspective

- Four hour operating standard was 79.1% for March though attendances have dropped by 34% compared to the same period last year
- The Trust met three of the seven cancer standards for the month of February, both 14 day standard and 62 day standard performance was under target.
- In March, COVID-19 adversely impacted the Trust's six week diagnostic standard performance with an adverse position of 18.5% against a National Threshold of 1%
- COVID-19 also impacted the number of on the day cancellations, the Trust had 104 cancellations in March. 77 of these patients have not been rebooked as theatre capacity is currently reserved for essential services
- February 2020 incomplete Referral To Treatment (RTT) performance was 82.3% against the Trust trajectory of 87.7% Revised internal trajectory for the month of February was set at 83.5%. The performance is expected to deteriorate as a result of COVID-19 lockdown though patients are being seen where possible.

Our People Perspective

- The Trust level sickness rate spiked in March to 5.1% against a long term average of 3.5%

Balanced Scorecard Approach



Key

Current Month

A Previous Month

Activity against our Plan

3.2

Our Finance & Productivity Perspective

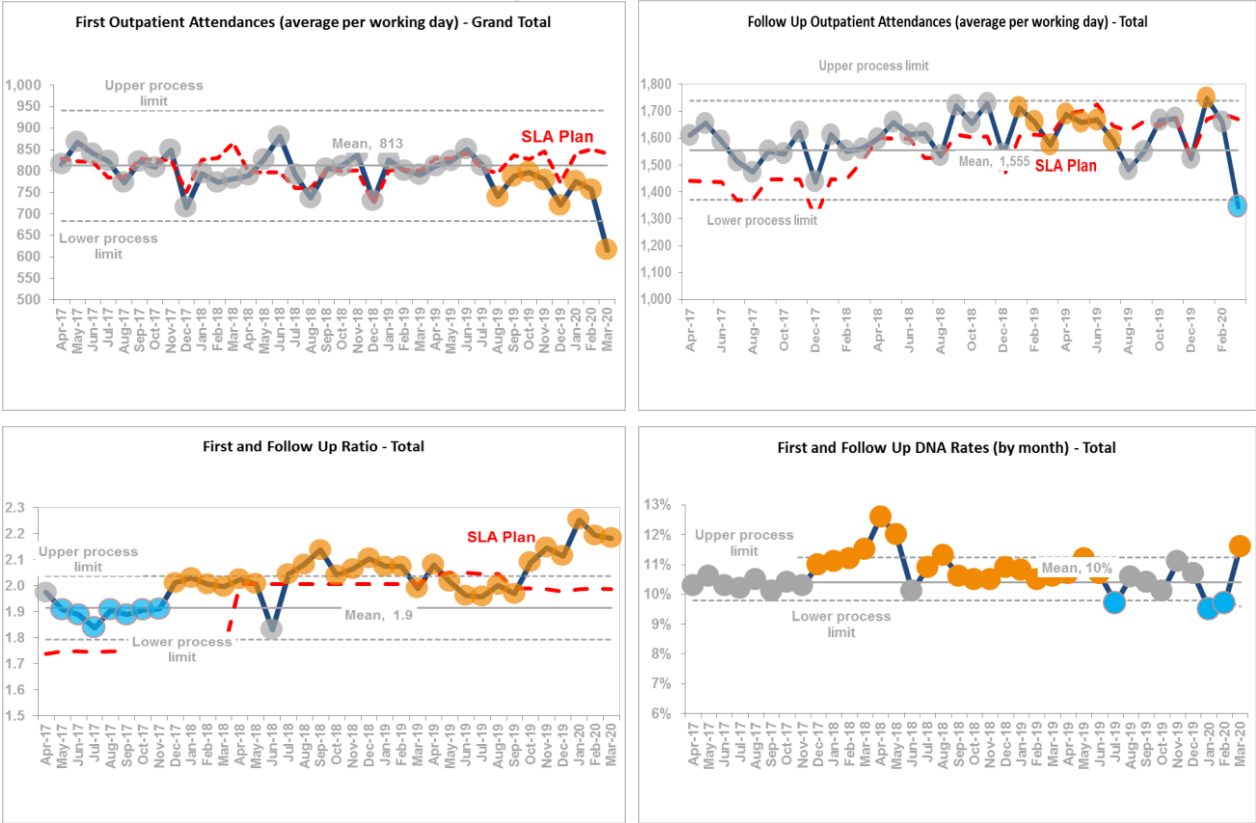
		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Mar-19	Mar-20	Variance	Plan Mar-20	Variance	YTD 18/19	YTD 19/20	Variance	Plan YTD	Variance
ED	ED Attendances	15,040	9,927	-34.00%	14,374	-30.94%	169,331	164,778	-2.69%	169,712	-2.91%
Inpatient	Non Elective	4,415	3,721	-15.72%	4,070	-8.57%	47,738	48,042	0.64%	47,941	0.21%
	Elective & Daycase	5,209	3,534	-32.16%	5,571	-36.56%	58,368	60,320	3.34%	62,489	-3.47%
Outpatient	OP Attendances	53,765	42,327	-21.27%	61,142	-30.77%	668,520	654,449	-2.10%	694,006	-5.70%

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

>= 5% (+ or -)

Note: Figures quoted are as at 09/04/2020, and do not include an estimate for activity not yet recorded (eg. un-cashed clinics).

Outpatient Productivity



Actions and Quality Improvement Projects

A Safely Standing Down workstream was set up on 24 March 2020. The workstream centres on review and reprioritisation of activity in light of the current COVID-19 pandemic. The aim of the workstream is to minimise the number of patients on site within a risk assessed approach to prioritisation.

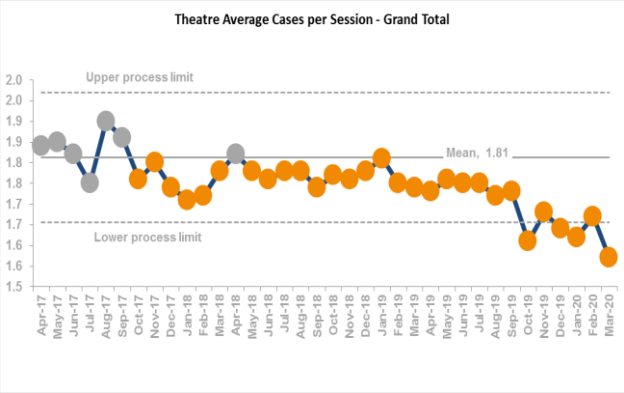
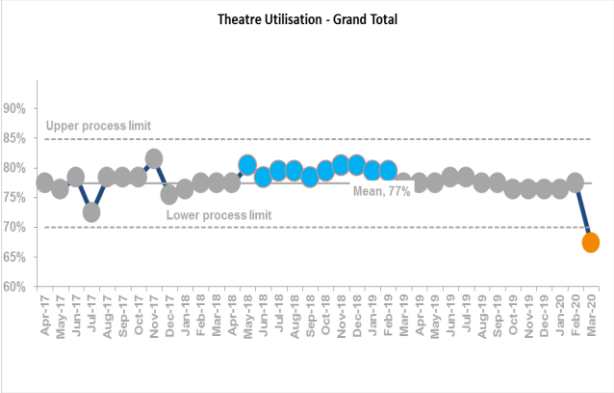
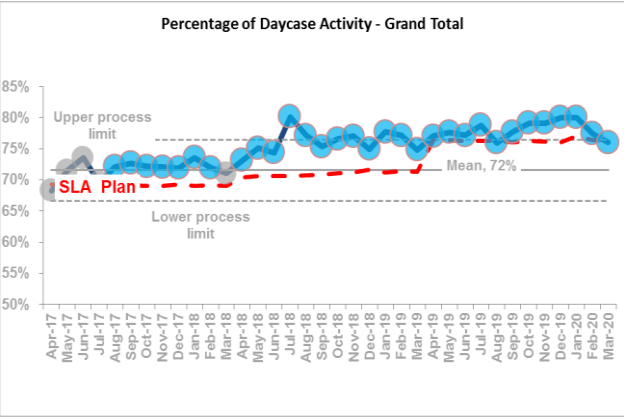
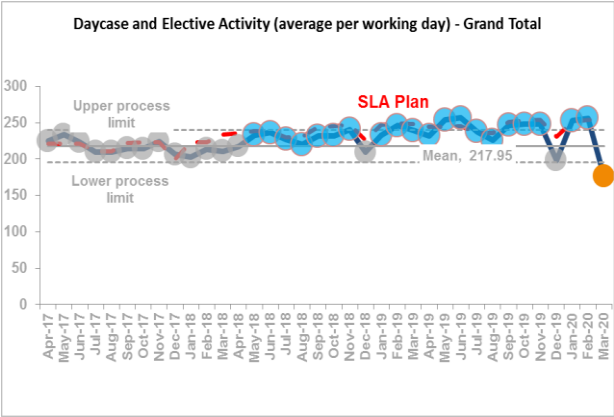
The workstream has successfully migrated outpatient activity to virtual settings across the Trust to reduce footfall on the Tooting site.

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

What the information tells us

- Outpatient first activity has fallen in the month of March. A number of specialties have fallen below the lower control limit; Cardiology, Cardiac & Vascular services, Endoscopy, Ear Nose & Throat, General Surgery, Maxillo Facial, Trauma & Orthopaedics and Urology. Other areas although have seen a decrease in activity remain within the upper and lower control limits.
- At Trust level, follow-up activity has significantly fallen and performed below the lower control limits in March. Surgical specialties observed the largest drop in activity.
- The Trust DNA rate increased to 11.6% in March with particular higher increases within Renal 7 Oncology and Women's Services.

Theatre Productivity



Actions and Quality Improvement Projects

From the Surge & Sustain workstream, theatres in operation have been reduced in order to maximise Level 3 capacity to meet demand for COVID-19 patients whilst maintaining Trust essential services.

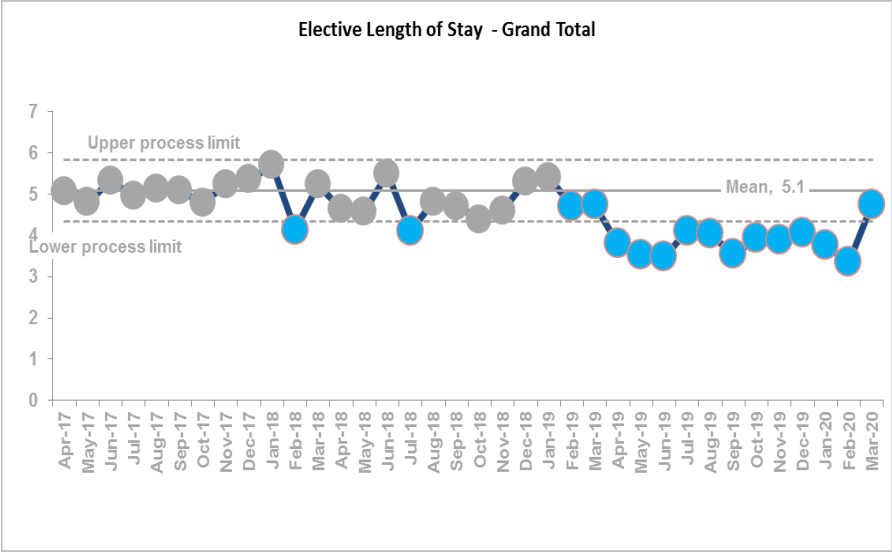
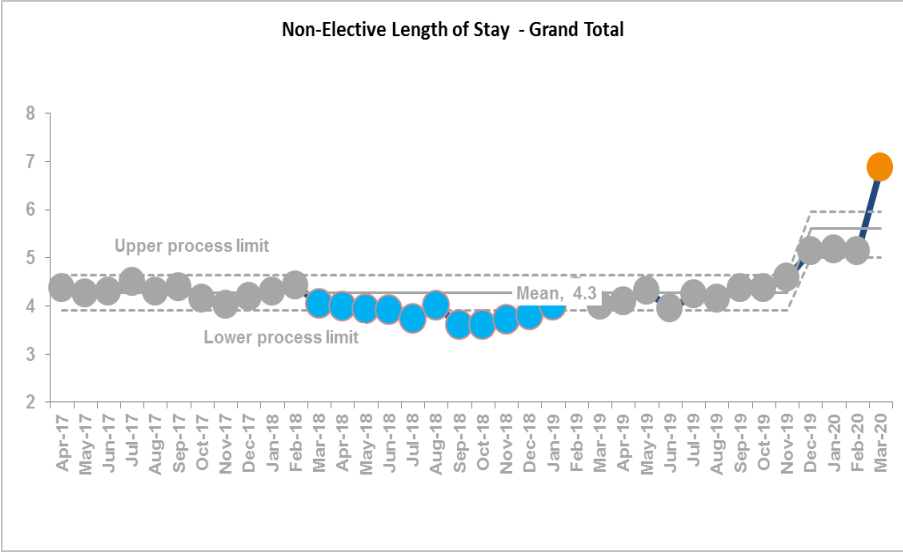
The Executive meet three times a week to review theatre capacity ensuring that the Trust can maintain essential services in a safe environment.

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

What the information tells us

- Activity data for elective treatments for March fell below the lower control limits with a significant number of elective activity cancelled.
- Cardiology & Cardiac Surgery, Endoscopy, Ear Nose & Throat, General Surgery, Neuro Surgery, Trauma & Orthopaedics, Urology and Vascular services all observed a fall in activity below the lower confidence limit. Although some areas also saw a decrease in activity all other areas remained within the control limits.
- Trust level theatre utilisation and theatre cases per session has fallen as expected with the number of theatres reduced to manage current challenges.

Length of Stay



3.2

Our Finance & Productivity Perspective

What the information tells us

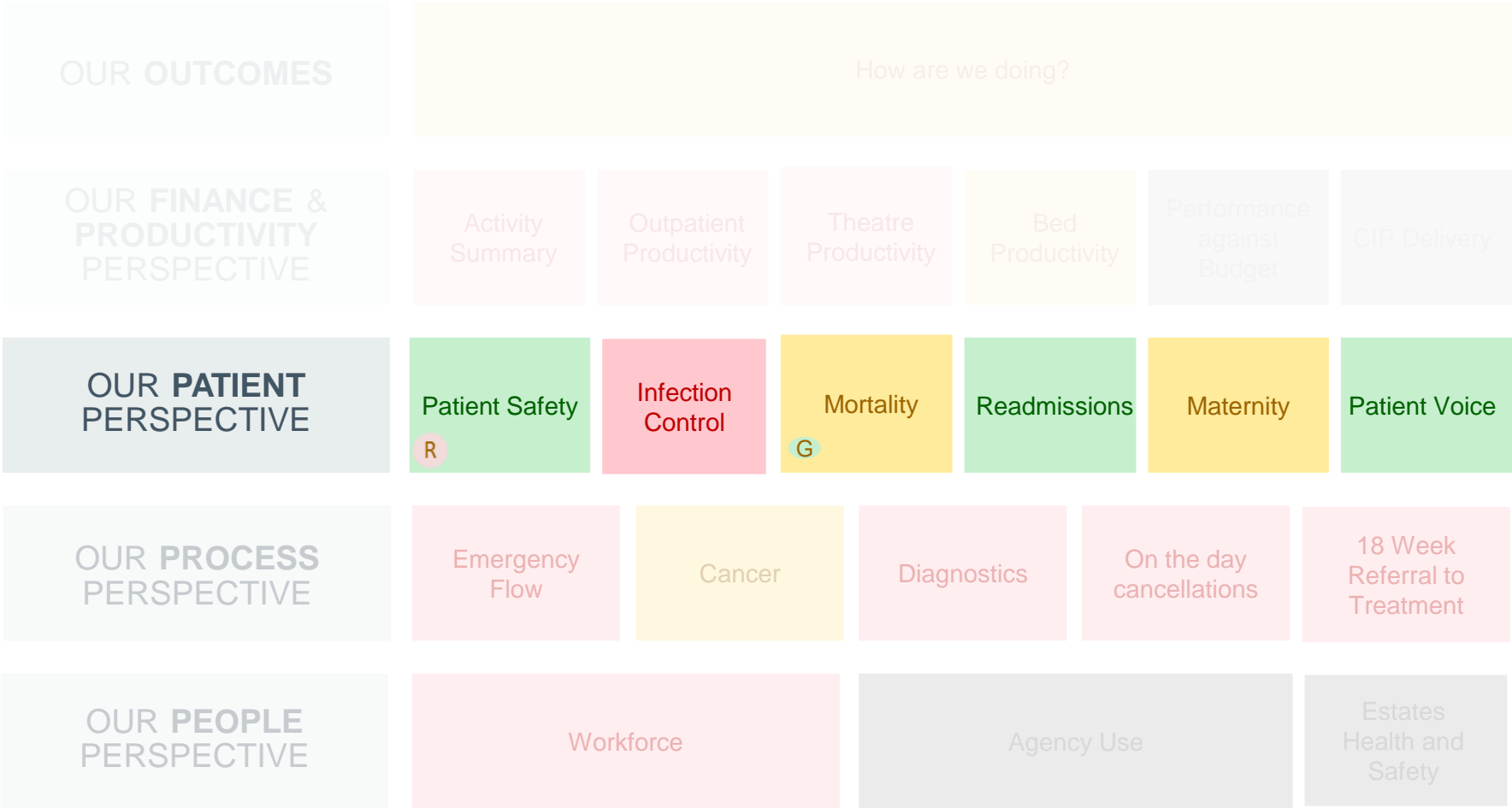
- The number of non-elective admissions have reduced in March by 6% following a decrease in demand impacting the profile of non-elective length of stay which has seen an increase at Trust level . Acute Medicine and Trauma & Orthopaedics have both seen increases above the upper control limits.
- Elective length of stay remains within the upper and lower control limits, although length of stay has increased the number of elective procedures and admissions have reduced.

Actions and Quality Improvement Projects

The accelerating discharge project has been working with its system partners to reduce the number delayed discharges and to expedite repatriation of patients.



Balanced Scorecard Approach

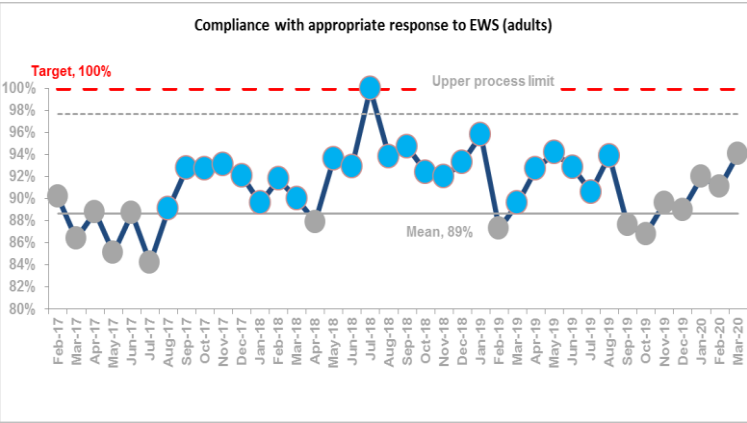
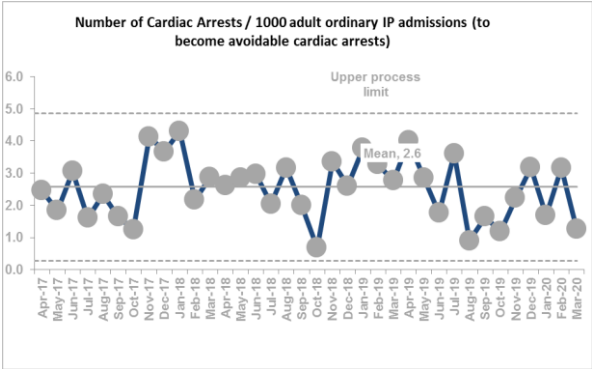
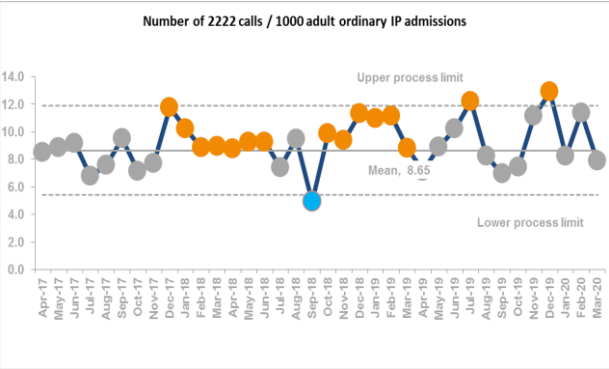


Key

Current Month

A Previous Month

Quality Priorities – Treatment Escalation Plan



What the information tells us

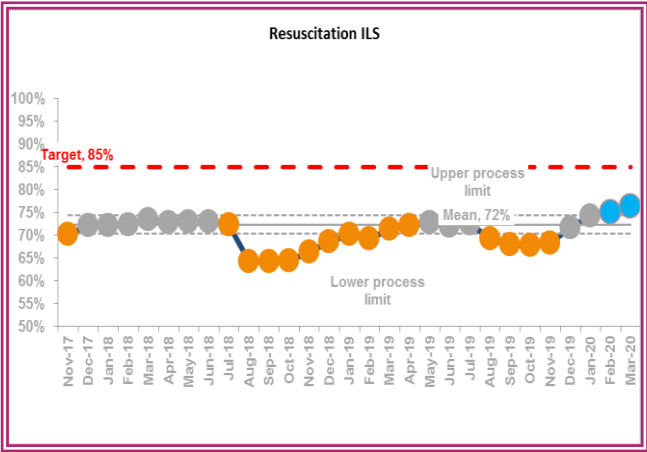
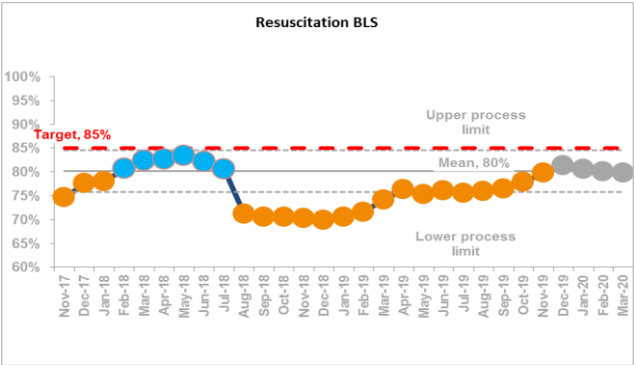
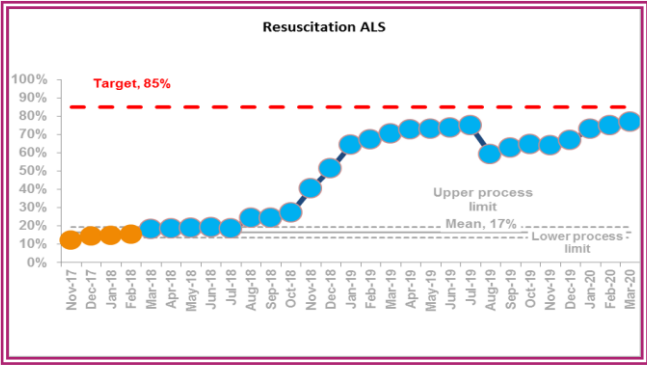
- The number of 2222 continues to show common cause variation.
- Compliance with appropriate response to Early Warning Score (EWS) increased to 94% in March compared to 91% last month and continues to show common cause variation

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

Actions and Quality Improvement Projects

- Treatment Escalation Plans are now live in iClip.

Quality Priorities – Deteriorating Patients



- ALS (Advanced Life Support) training performance shows continued improved performance but has not met the 85% performance target.
- BLS (Basic Life Support) training performance is within the process control limits. ILS (Intermediate Life Support) has increased and is now above the mean and showing special cause variation, both continue to underperform against the 85% target.

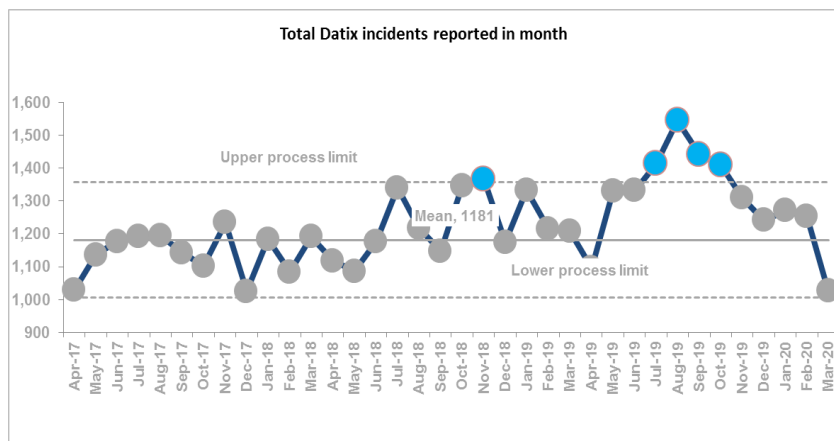
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

Actions and Quality Improvement Projects

- From mid-March 2020 the focussed provision of ALS and ILS training has been scaled back due to the need for the resuscitation training team members to return to practice in critical care. BLS continues to be targeted at staff where training is not up to date and in addition for practitioners returning to practice in response to Covid-19.

Quality Priorities – Learning from Incidents

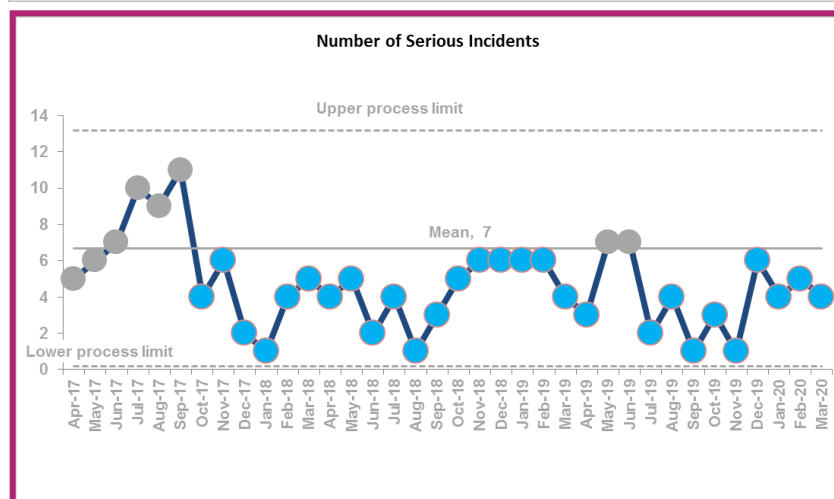
Indicator Description	Threshold/Target	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Total Datix incidents reported in month		1,208	1,096	1,329	1,332	1,413	1,544	1,442	1,410	1,309	1,241	1,271	1,252	1,026
Monthly percentage of Incidents of Low and No Harm			97.0%	97.0%	99.0%	97.0%	98.0%	97.0%	97.0%	96.0%	96.0%	96.0%	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	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%	98.0%	86.0%	84.0%	data two months in arrears	



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 March 2020 resulting in no / low harm.
- There were no reported Never Events in March 2020.

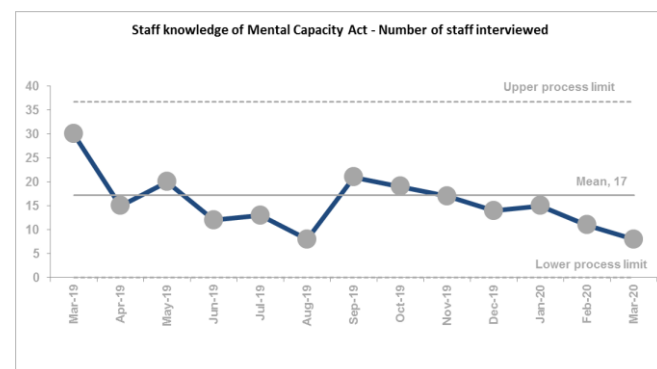
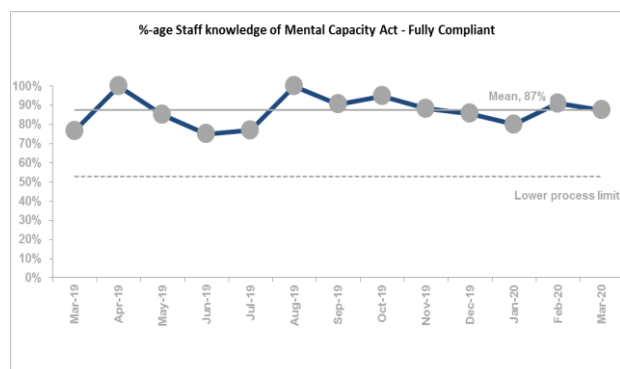
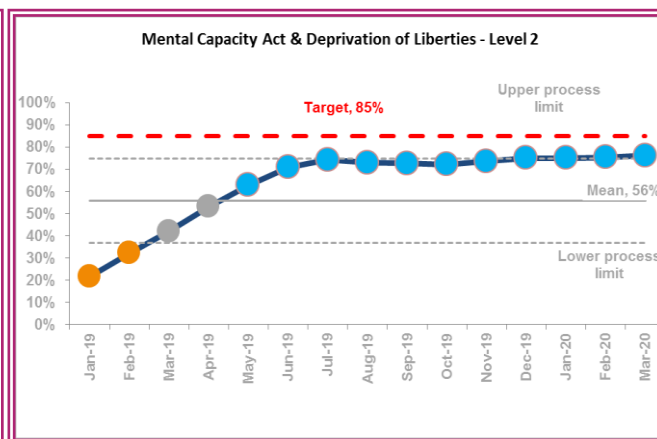
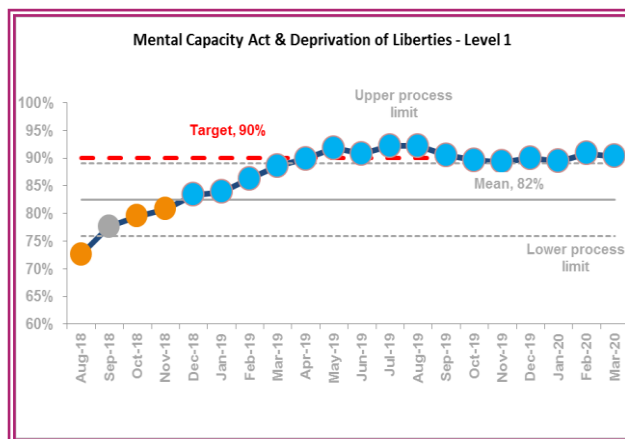
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



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.

Quality Priorities – Mental Capacity Act & Deprivation of Liberties



What the information tells us

- Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Level 1 remains within target
- Level 2 training performance has plateaued. Overall level 2 compliance currently stands at 76.4%
- Metrics taken from the ward accreditation system shows the number of staff interviewed and their level of knowledge. Of the 8 staff interviewed in March, 87.5% could fully answer the question on MCA/DoLs.

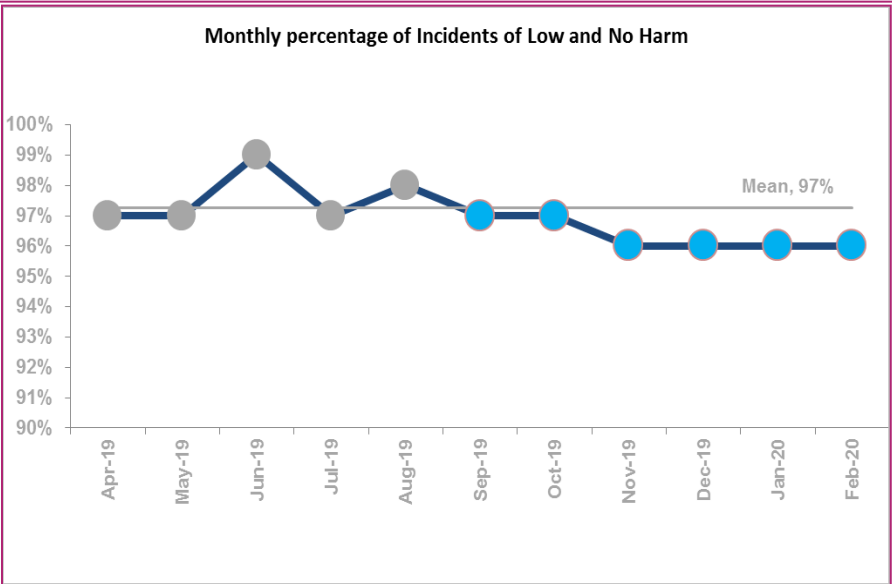
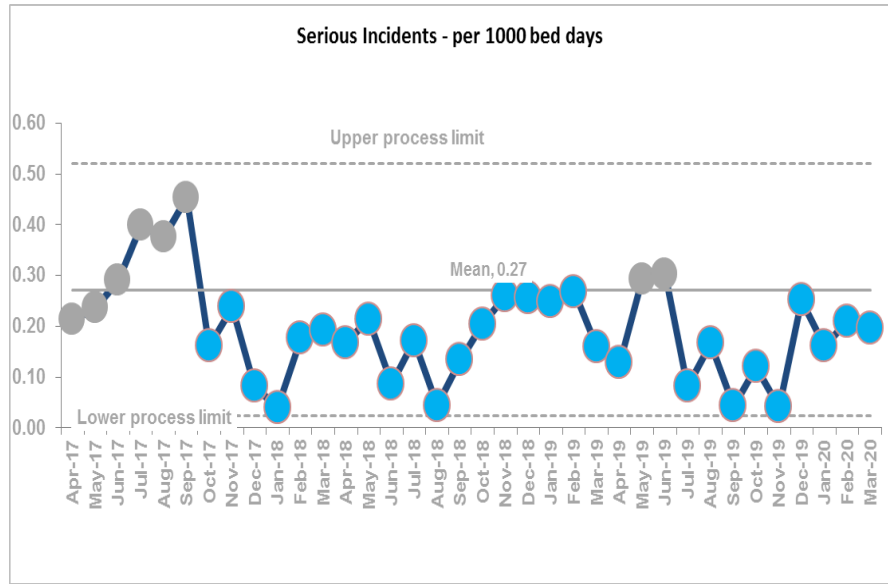
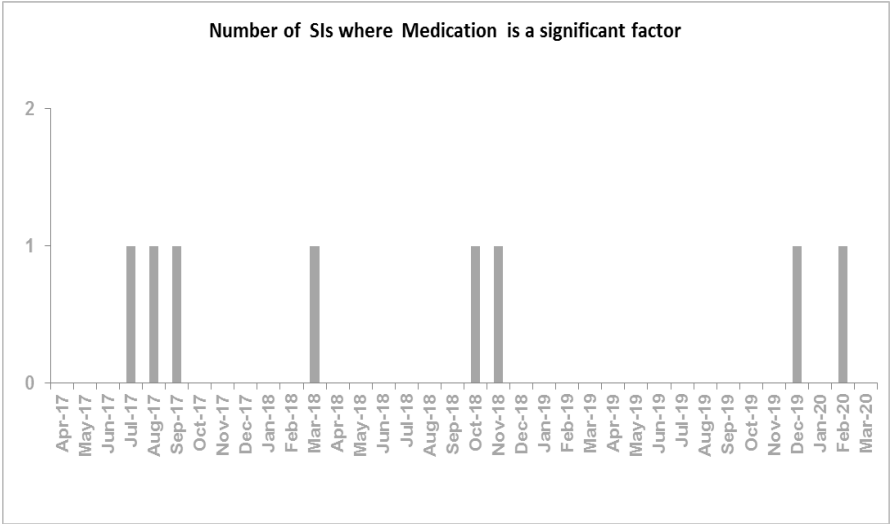
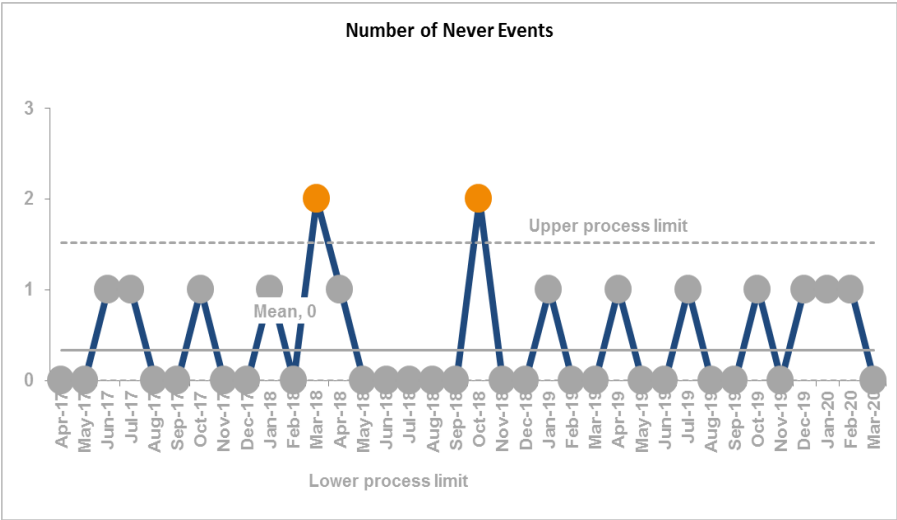
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

Actions and Quality Improvement Projects

- Mental Capacity Act & Deprivation of Liberties lead commenced in post on 17 February 2020. Interviews for vacant B7 MCA Practitioner post scheduled for 22 April.
- The team awaiting IT revisions and implementation of required forms to standardise recording and enable efficient audit processes.
- Quarterly staff knowledge audit delayed / currently suspended due to current COVID 19 outbreak. The aim of this audit, developed in partnership with South West London partners, is to enable the Trust to benchmark and review level of staff knowledge against an expert agreed pass mark and in relation to other local healthcare organisations.

Quality Priorities – Learning from Incidents

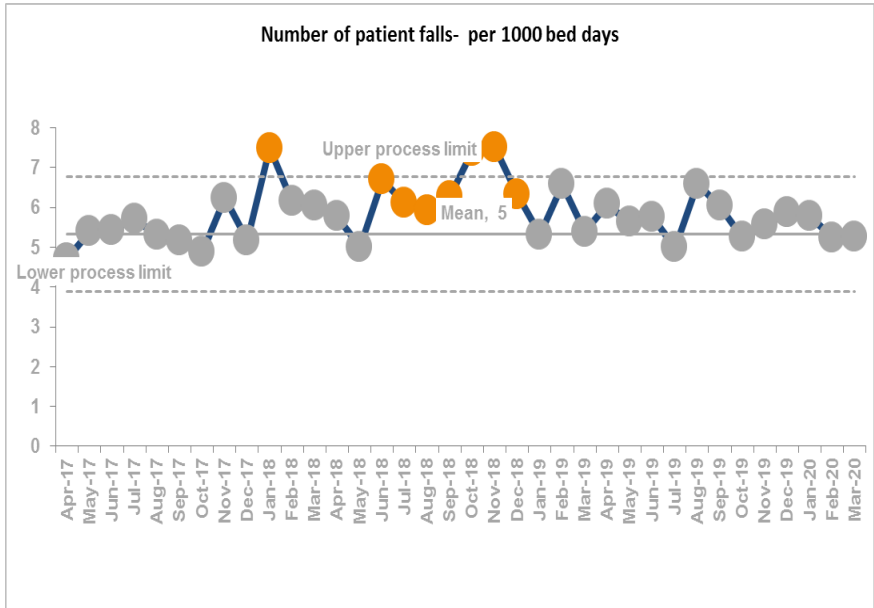
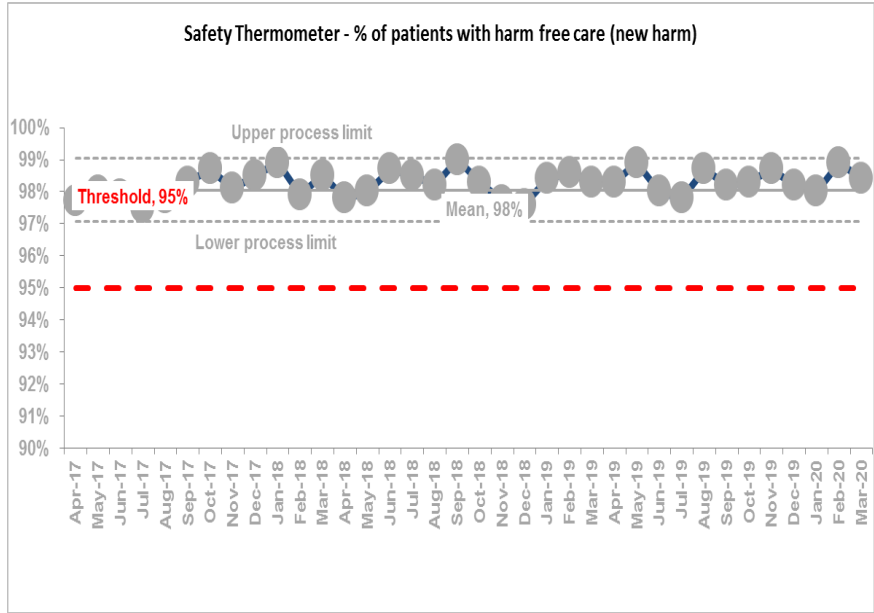
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



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

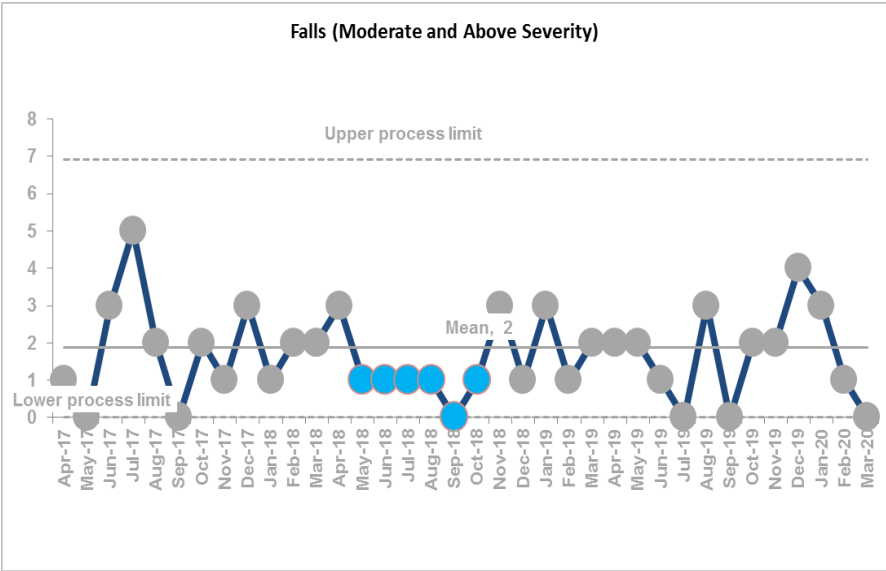
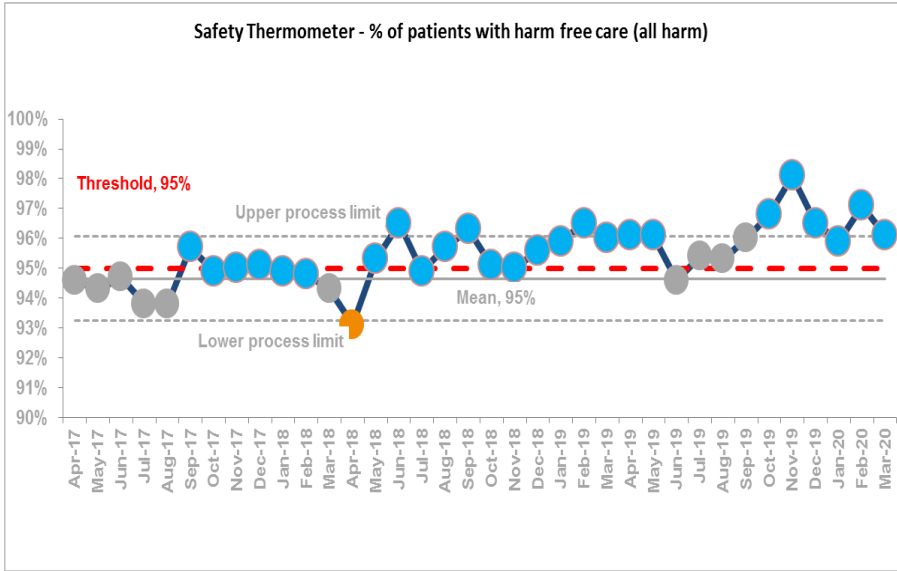
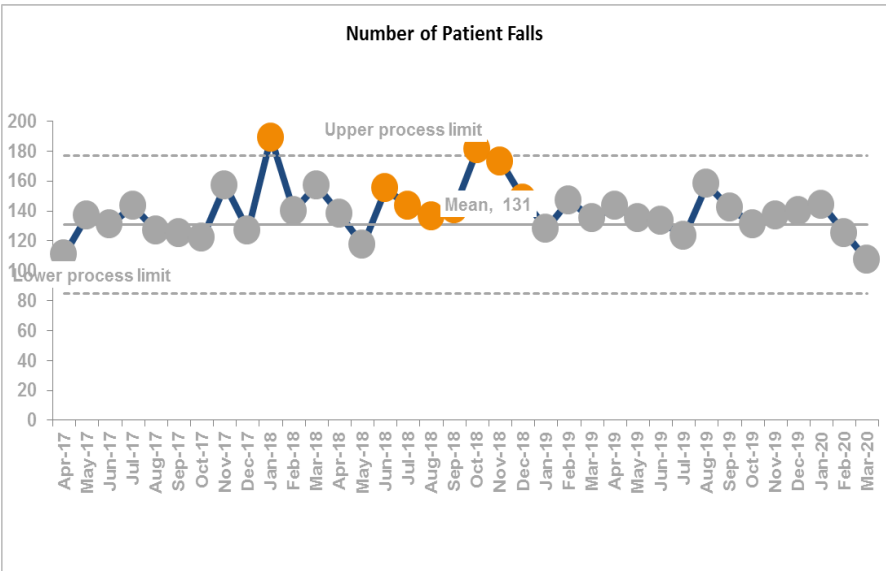
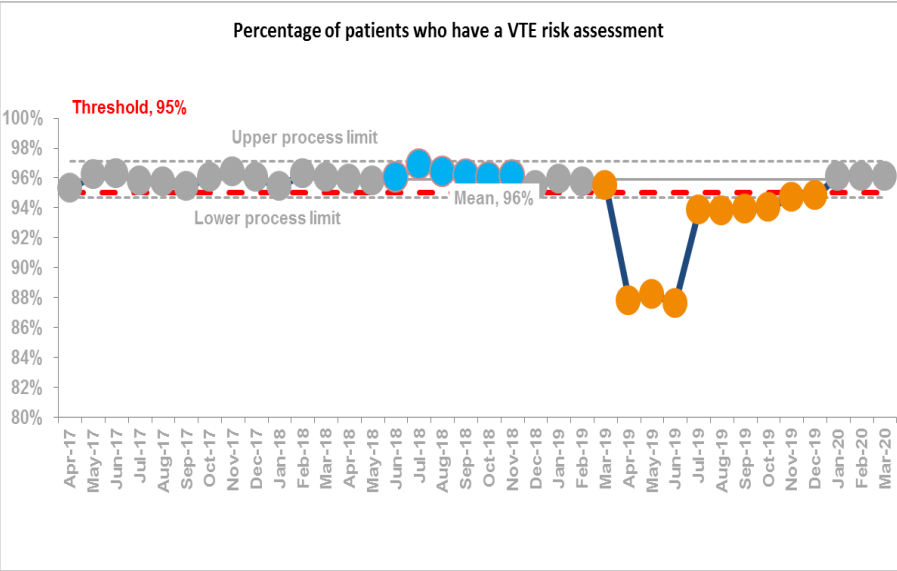
- The Trust is meeting its VTE standards and is above the upper process control limit. As outlined in the actions below, the patient cohort has been updated in line with NICE guidance.
- Safety thermometer – percentage of patients with harm free care remains above the average; all other metrics show common cause variation.

Actions and Quality Improvement Projects

- All patients who have a length of stay less than 14 hours and all non-inpatient areas are now excluded from the VTE risk assessment compliance figures as per NICE guidelines. Trust VTE performance continued to be monitored by the Hospital Thrombosis Group.
- The Trust is working to deliver the Falls CQUIN, specifically focussing on lying and standing blood pressure for patients over 65 in line with NICE guidance.
- Category 3 and above pressure ulcers have undergone Root Cause Analysis (RCA) to identify any key learning. RCA discussed in a cross divisional meeting for shared learning.

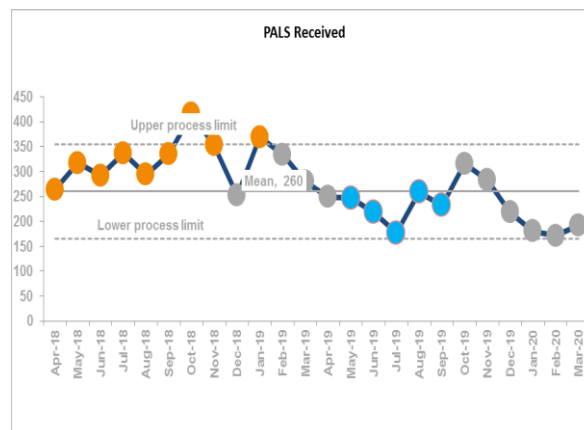
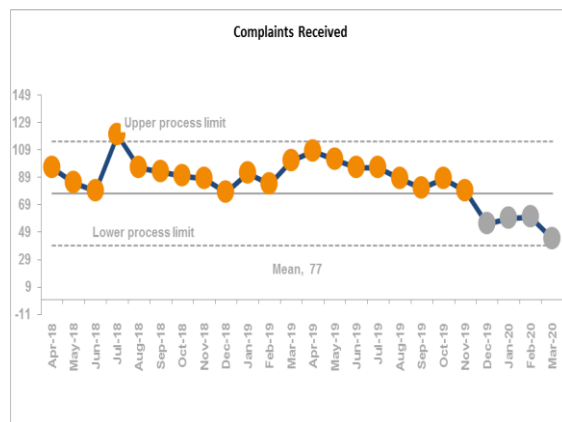
Patient Safety

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



Complaints

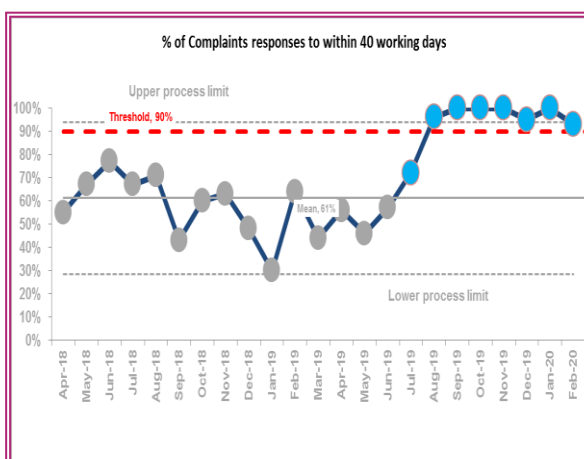
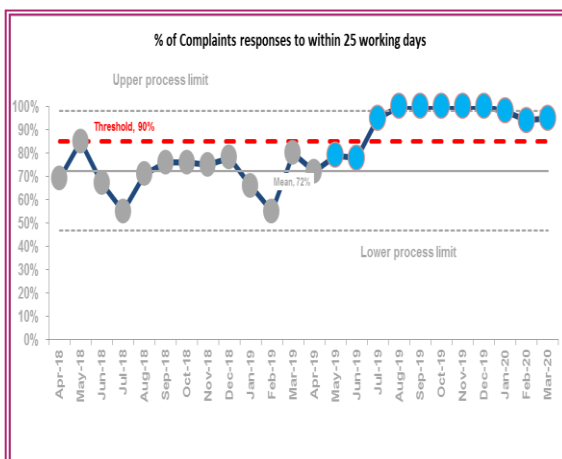
Indicator Description	Target	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Complaints Received		101	108	102	96	96	88	81	88	79	55	59	60	44
% of Complaints responses to within 25 working days	85%	80%	72%	79%	78%	95%	100%	100%	100%	100%	100%	98%	94%	95%
% of Complaints responses to within 40 working days	90%	44%	56%	46%	57%	72%	96%	100%	100%	100%	95%	100%	93%	
% of Complaints responses to within 60 working days	100%	100%	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		280	249	247	218	177	259	232	316	283	218	180	171	192



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

What the information tells us

- Response compliance is above performance targets for all response categories
- The number of PALS enquiries has increased slightly. However, this change is common cause variation and within upper and lower process limits



Actions and Quality Improvement Projects

The daily complaints CommCell continues.

The change in process continues to have a positive impact on complaints performance showing sustained improvement for the last 8 months

Infection Control

Indicator Description	Threshold	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	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	1	0	1	0	1	0	3
Cdiff Hospital acquired infections	48	3	4	4	5	4	4	6	3	2	2	5	3	1	51
Cdiff Community Associated infections		0	0	0	1	1	1	0	1	2	0	0	0	2	
MSSA	25	2	4	6	1	0	3	2	2	3	5	6	3	2	37
E-Coli	60	6	5	7	5	7	7	8	6	4	9	5	7	4	74

What the information tells us

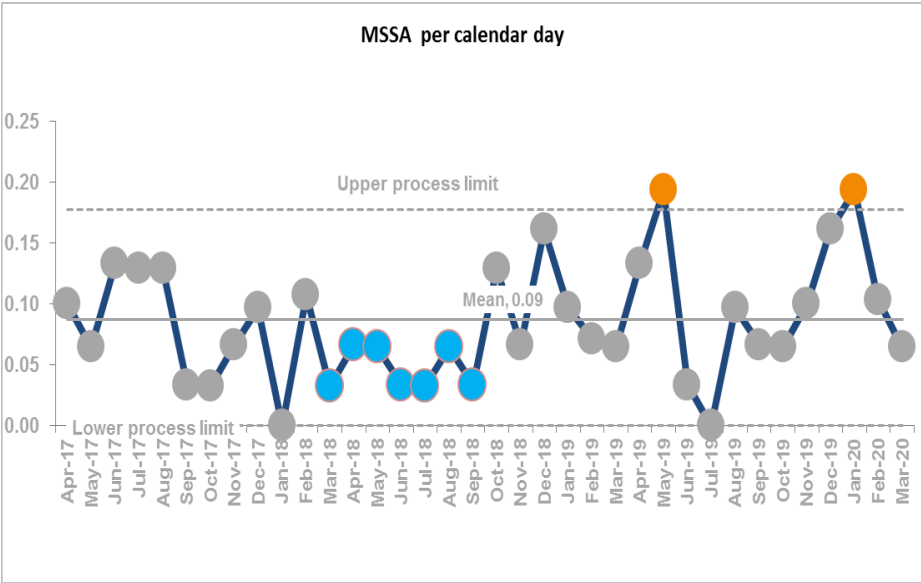
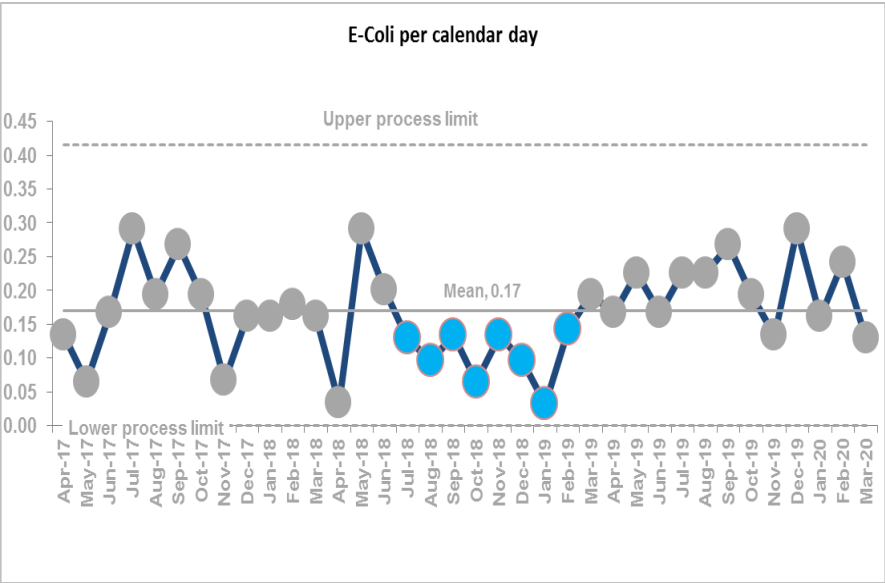
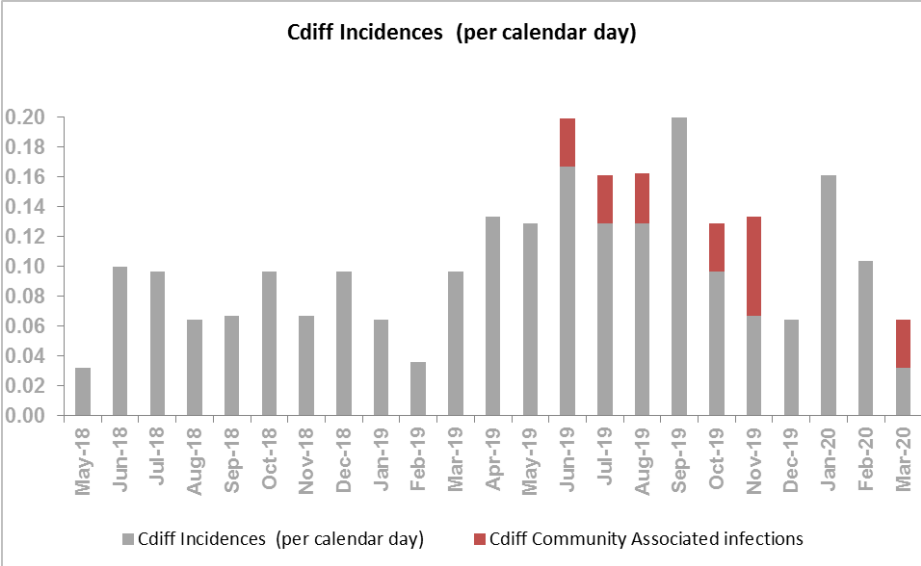
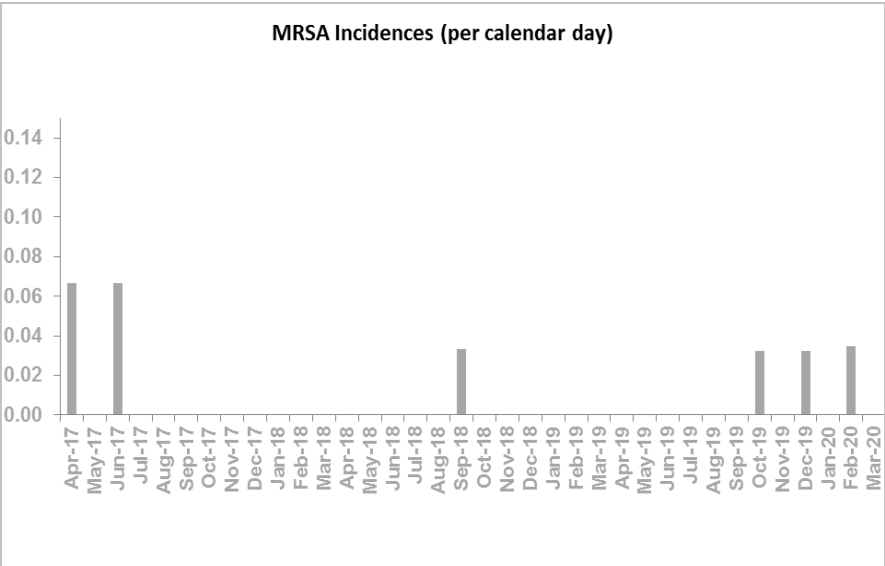
- The Trust reported no MRSA incidents this month, three year to date.
- This month there was three Cdiff incidents, one of which was Hospital Acquired. The Cdiff YTD position is 51 with 43 Hospital Acquired Infections and eight Community Associated infections. The Trust exceeded its annual target of 48.
- The number of Ecoli and MSSA cases reported remains within control limits. The Trust has now exceeded the yearly threshold for both Ecoli and MSSA incidents.

Actions and Quality Improvement Projects

- The Trust continues with infection control measures with more emphasis on care of invasive lines and Aseptic Non Touch Technique
- Back to the floor by the Matrons and lead nurses focusing on line management and documentation on visual inspection of phlebitis (VIP) score
- Infection control and cleaning standards measured through the ward accreditation process.
- Areas where Hospital Acquired Infections have occurred are placed under a higher frequency surveillance and audit programme.
- A data quality exercise has resulted in an increase in the number of Ecoli and Cdiff incidents. A review is being conducted.

Infection Control

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



Our Patient Perspective

Mortality and Readmissions

3.2

Our Patient Perspective

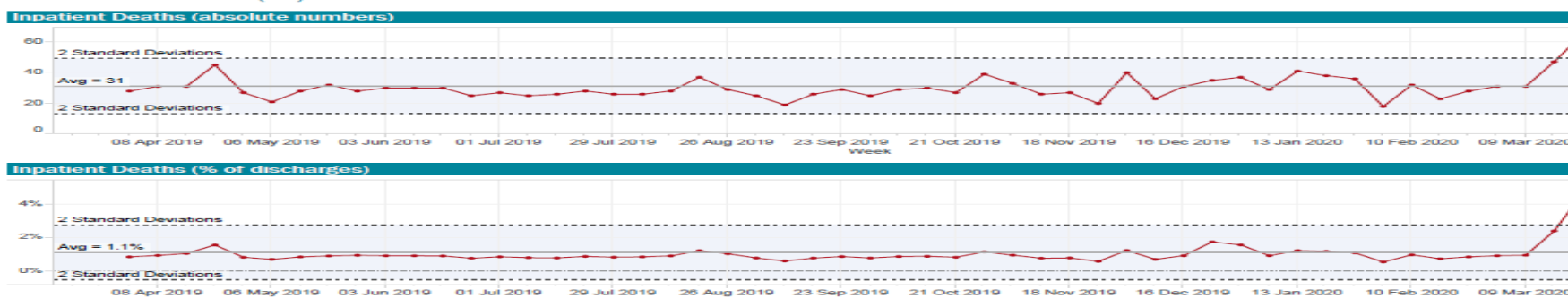
Indicator Description	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan 2019 to Dec 2019
Hospital Standardised Mortality Ratio (HSMR)	79.4	91.9	89.5	105.5	87.9	92.1	88.5	95	101.6	91.4	92.7
Hospital Standardised Mortality Ratio Weekend Emergency	82.9	91.3	73.5	113	77.2	93.8	107.3	80.6	100.1	87.6	92.6
Hospital Standardised Mortality Ratio Weekday Emergency	76.3	91.5	92.5	100.4	90.8	96.2	80.4	102.9	102.9	90.8	92.3

Indicator Description	Apr18-Mar19	May18-Apr19	Jun18-May19	Jul18-June19	Aug18 to Jul19	Sep18-Aug19	Oct18-Sep19	Nov18-Oct19
Summary Hospital Mortality Indicator (SHMI)	0.82	0.82	0.81	0.83	0.83	0.83	0.85	0.85

Indicator Description	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	8.9%	10.0%	9.5%	9.8%	9.6%	9.3%	10.6%	5.3%

Inpatient Deaths - Weekly Trend

Admission Method: (All)..



Note: HSMR data reflective of period Jan 2019 – Dec 2019 based on a monthly published position.

SHMI data is based on a rolling 12 month period and reflective of period November 2018 to October 2019 published (March 2020). Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways.

What the information tells us

Both of the Trust-level mortality indicators (SHMI and HSMR) remain lower than 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.

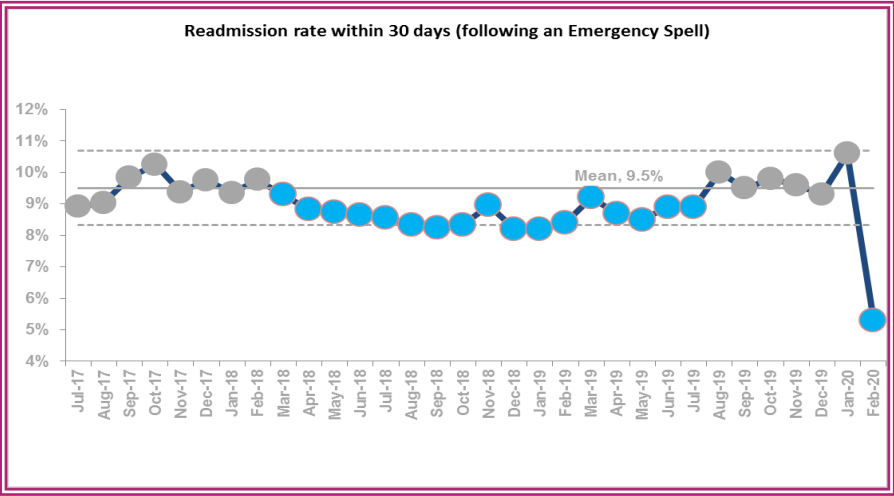
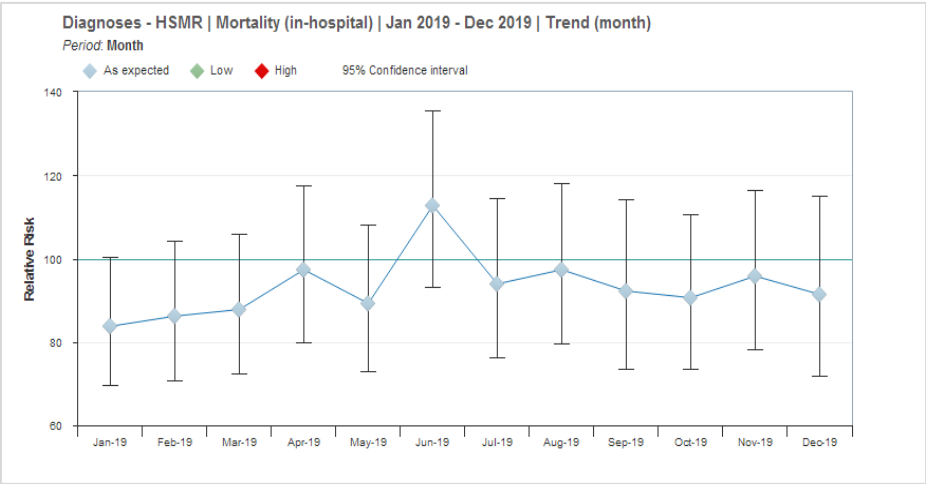
Actions and Quality Improvement Projects

We continue to monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Committee (MMC). In March the outcome of investigations in relation to two signals, Acute Myocardial Infarction (AMI) and Coronary Angioplasty (PCI) were presented to the committee by the Head of Audit & Governance. Comprehensive review showed that the vast majority of deaths were not avoidable. Examination of more recent data for AMI and local data for PCI were used to provide assurance that there are no current concerns. A summary of the investigation, learning and actions will be provided in the next quarterly report to the Board. We are currently carrying out investigations of two outlier alerts that have been raised to us from external organisations: procedure group 'Reduction of fracture of bone (upper/lower limb)' and diagnosis group 'Intracranial injury'.

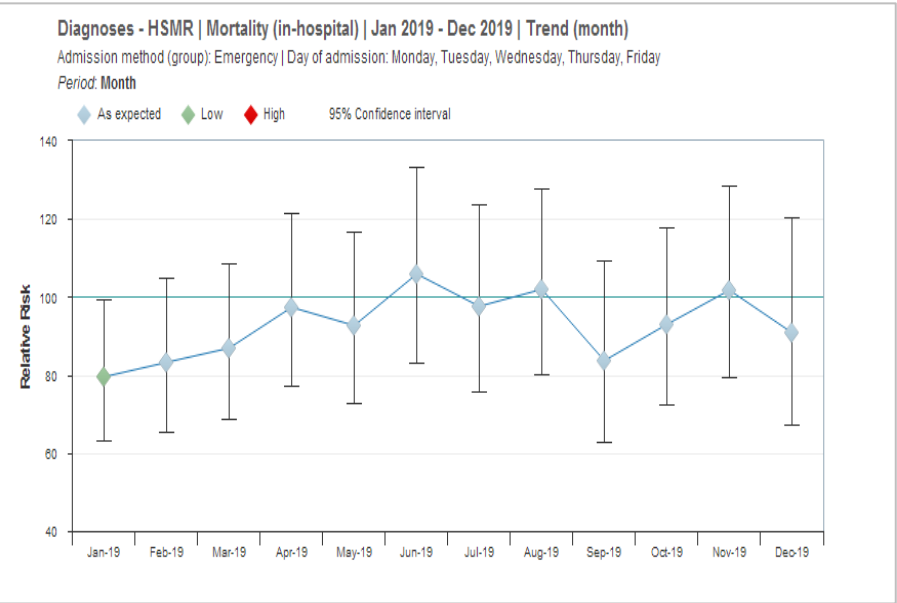
Mortality and Readmissions (Hospital Standardized Mortality Rate)

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

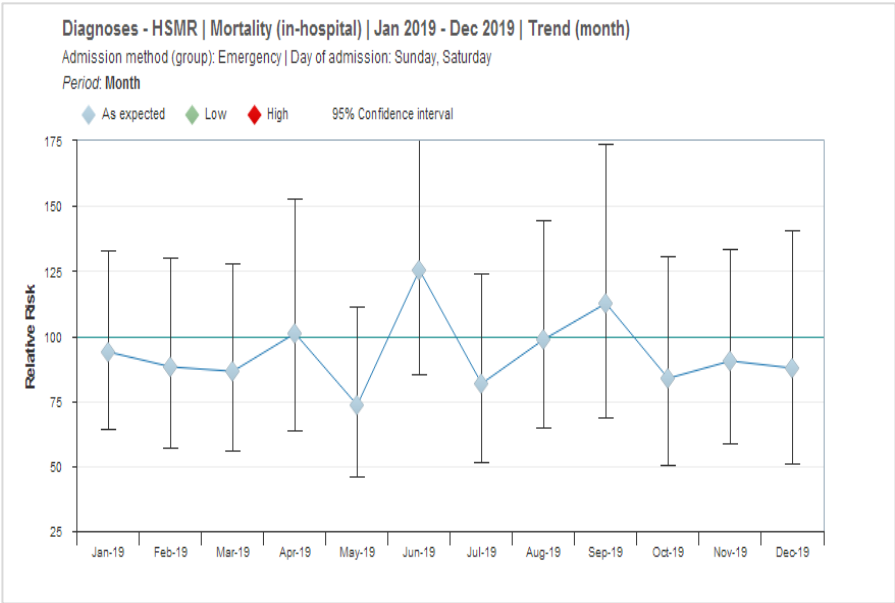
HSMR



HSMR Weekday



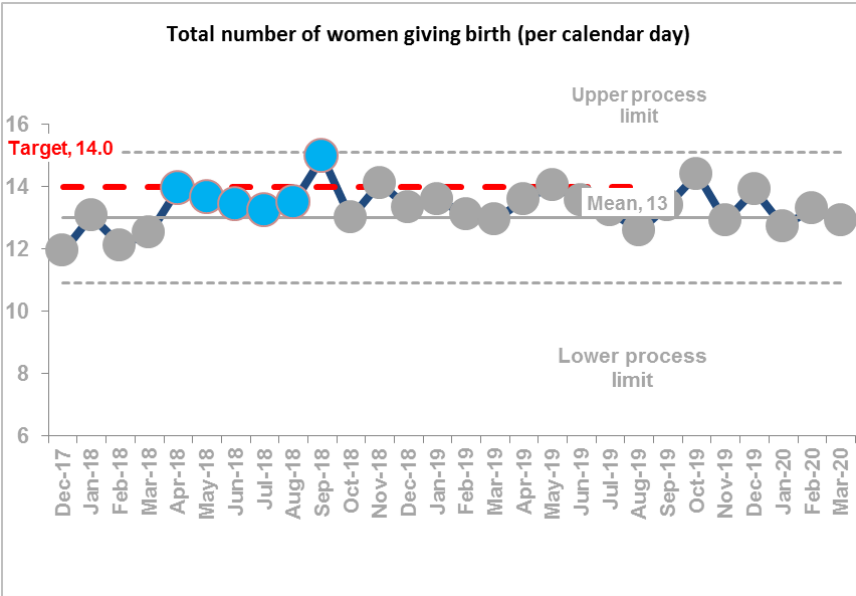
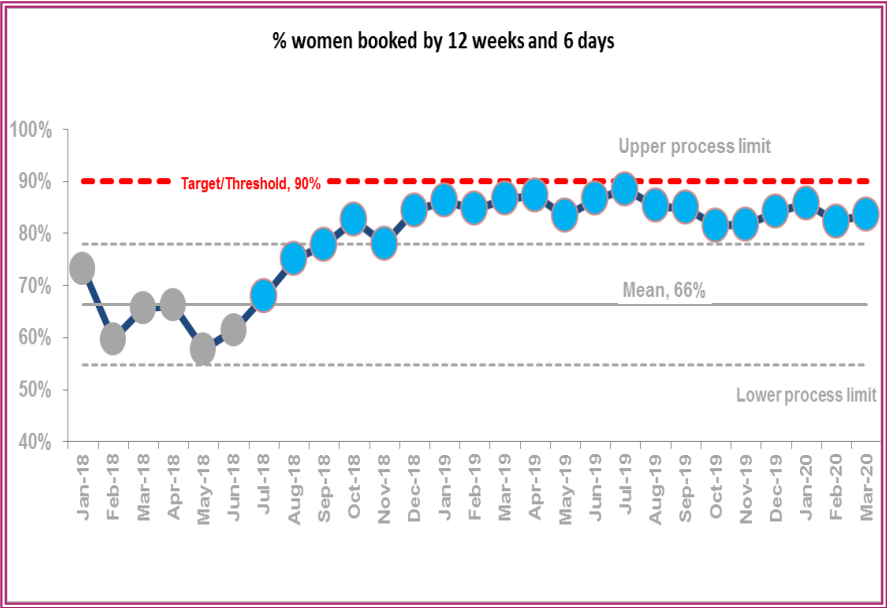
HSMR Weekend



Our Patient Perspective

3.2

Maternity



What the information tells us

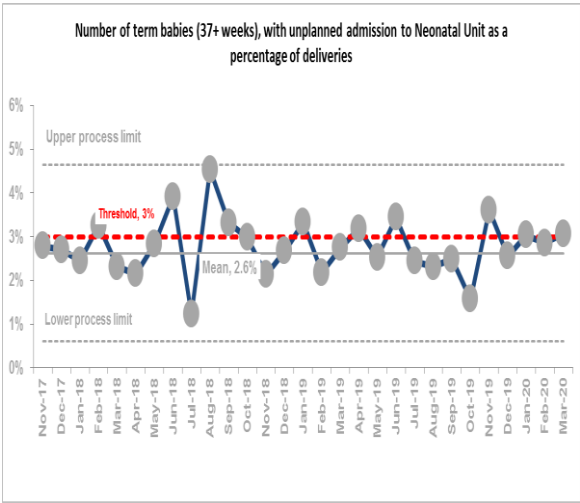
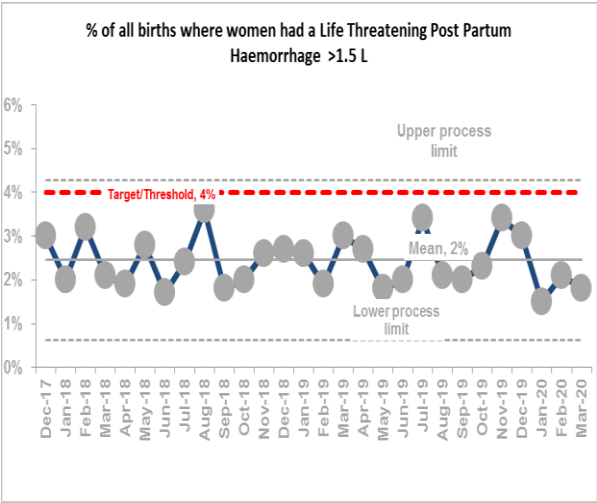
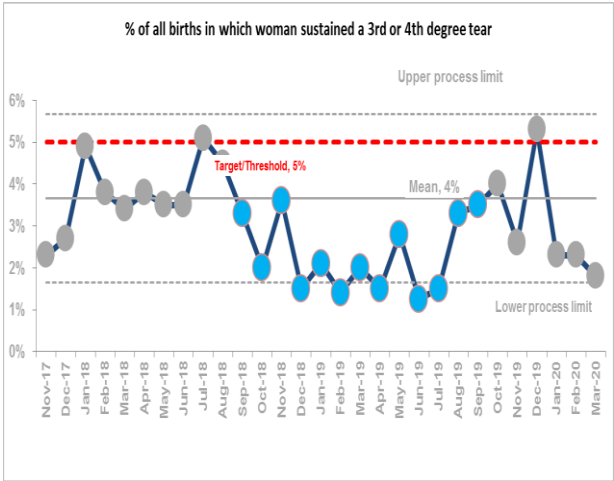
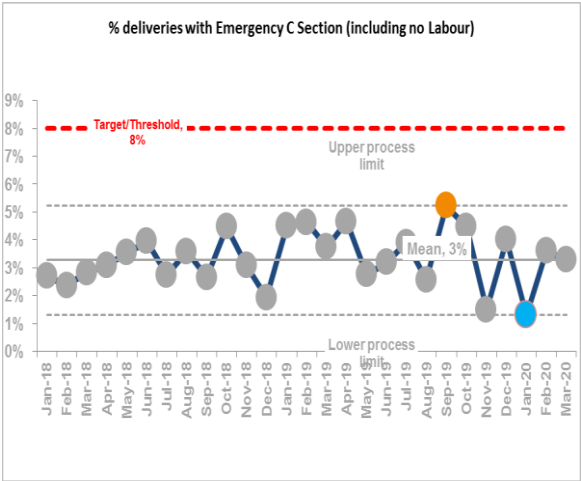
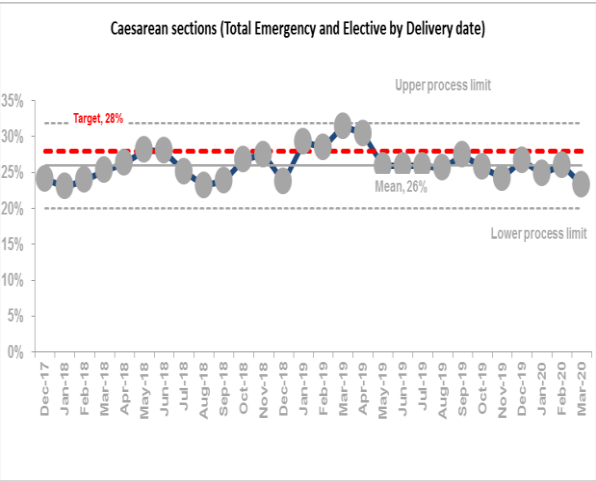
- The overall birth rate decreased slightly in March and continues to remain within common cause variation.
- The percentage booked within 12 weeks plus 6 days of pregnancy was at 82.4%, and above the upper control limits. The number of women booked by 9 weeks plus 6 days also increased. (62.8% in March compared to 58.6% February and 46.8% January).
- The percentage of births by caesarean section, including emergency caesareans, remained stable.
- The number of women sustained a 3rd or 4th degree tear remains under 3%.

Actions and Quality Improvement Projects

- Carmen Birth Centre was closed to women in labour on over a quarter of the shifts in month due to consolidation of staffing across the unit. The team are working hard to keep the Birth Centre open wherever possible during the COVID-19 outbreak, balanced with the need to retain safe staffing across the whole maternity unit.
- Booking appointments for newly pregnant women are now being undertaken by phone and it is hoped that this will lead to further increases in the percentage of women booked within 9 weeks and 6 days.

Maternity

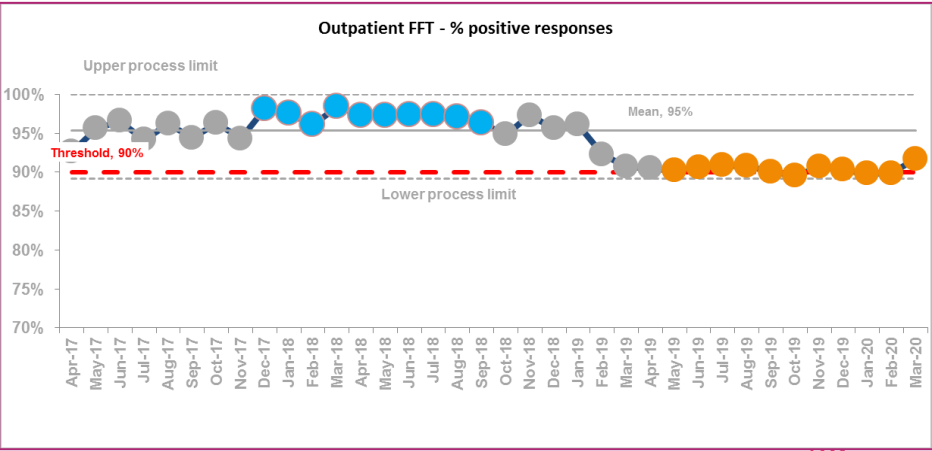
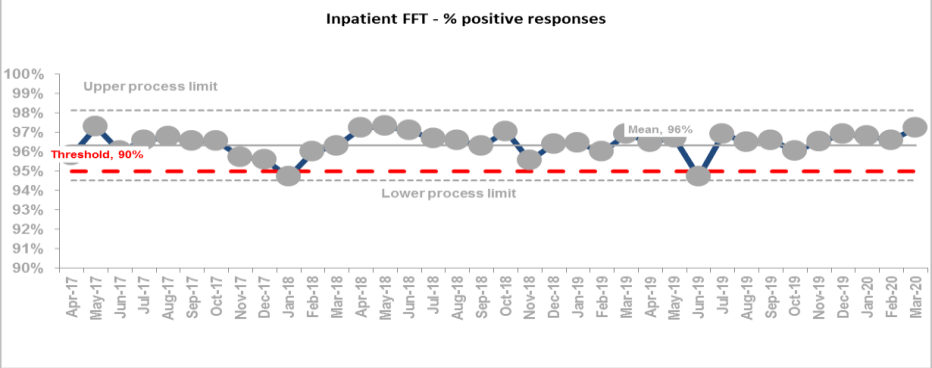
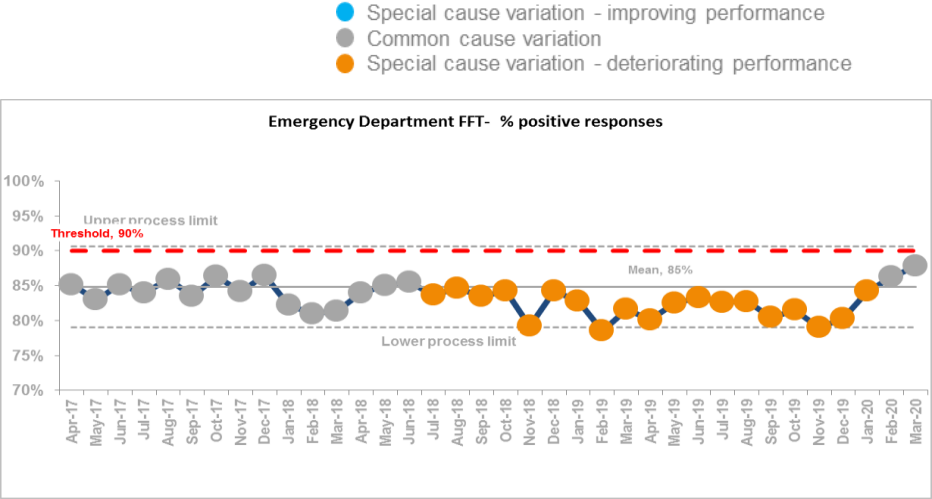
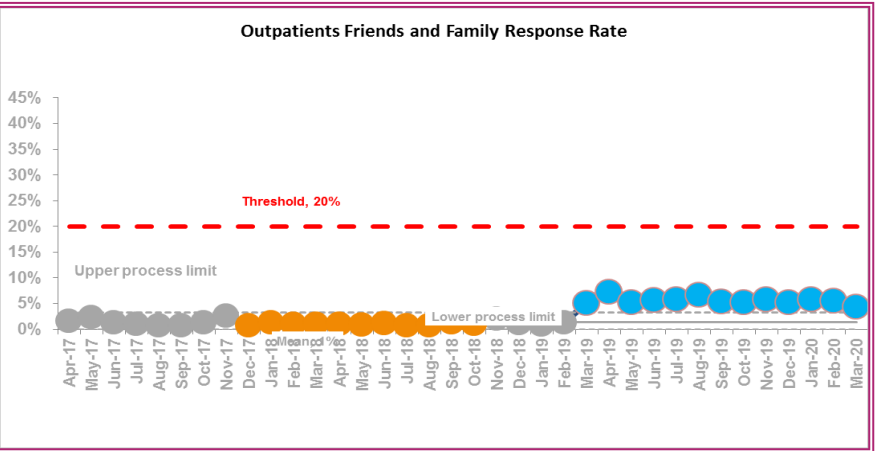
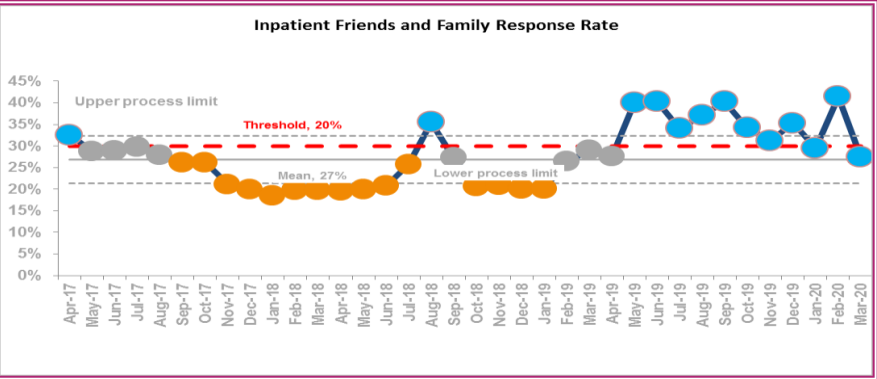
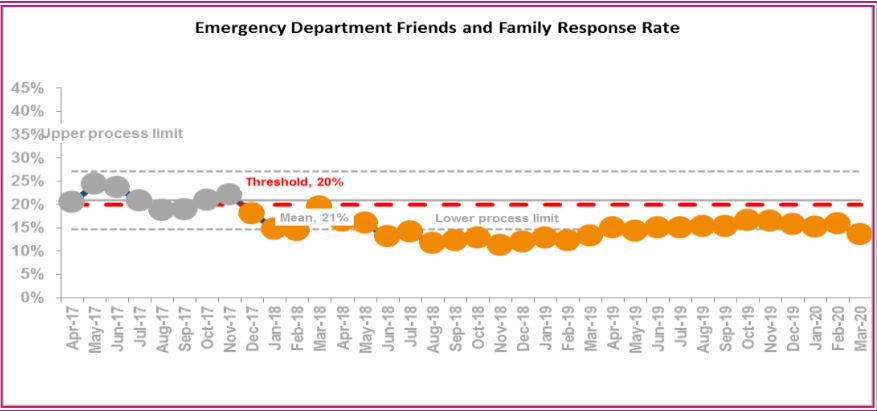
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance



3.2



Friends and Family Test



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

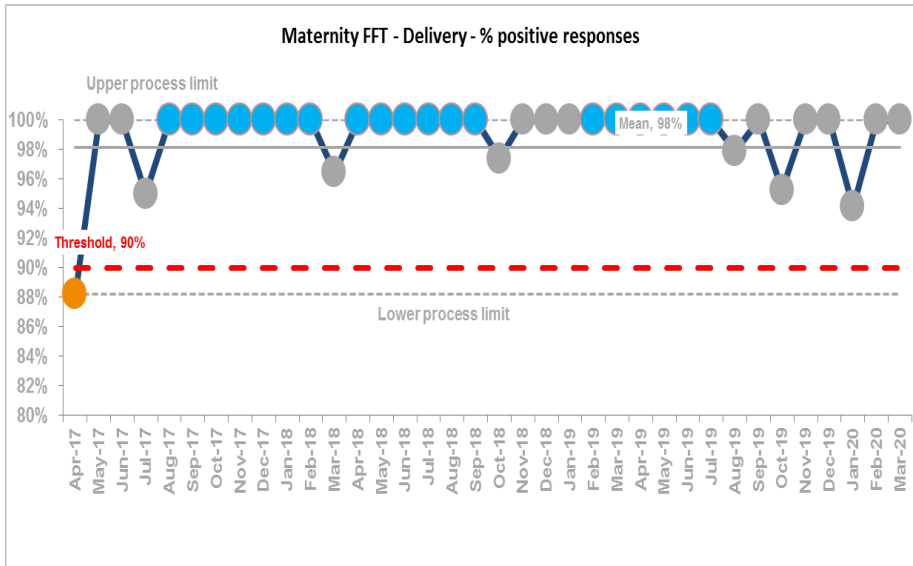
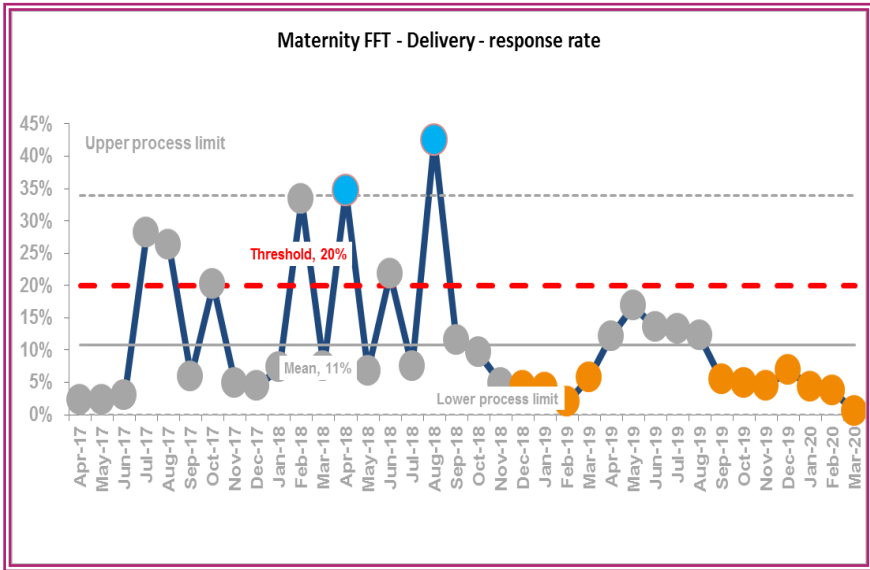
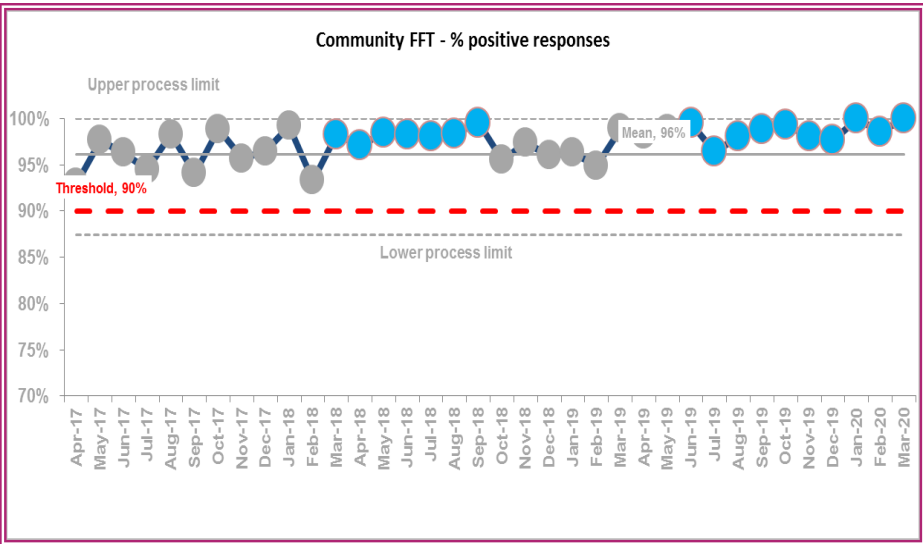
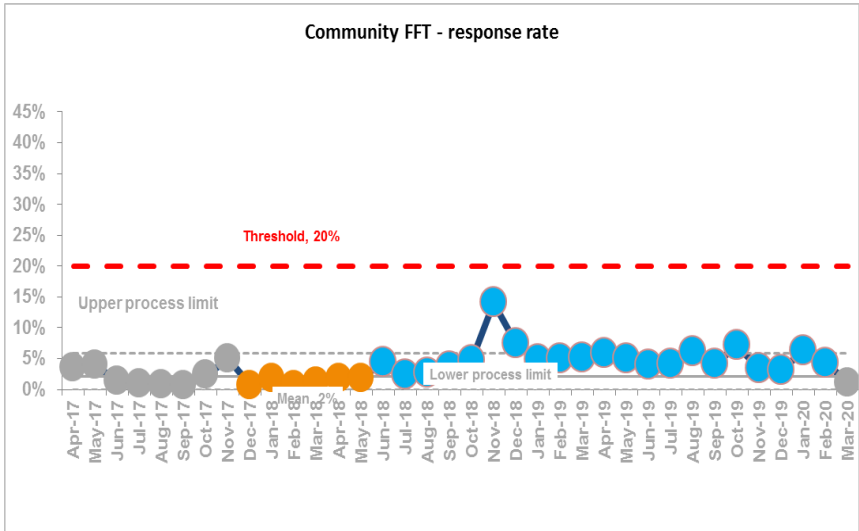
3.2

Our Patient Perspective



Friends and Family Test

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



Friends & Family Survey

Indicator Description	Target	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
Emergency Department FFT - % positive responses	90%	81.6%	80.1%	82.5%	83.3%	82.6%	82.7%	80.5%	81.5%	79.0%	80.3%	84.2%	86.2%	87.8%
Inpatient FFT - % positive responses	95%	96.9%	96.5%	96.7%	94.7%	96.9%	96.5%	96.6%	96.0%	96.5%	96.9%	96.8%	96.6%	97.2%
Maternity FFT - Antenatal - % positive responses	90%		100.0%	90.0%	85.7%	100.0%		100.0%			100.0%	100.0%		100.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	95.2%	100.0%	100.0%	94.1%	100.0%	100.0%
Maternity FFT - Postnatal Ward - % positive responses	90%	91.7%	96.4%	94.6%	98.0%	100.0%	98.3%	95.2%	100.0%	97.3%	88.0%	90.7%	96.9%	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	90.0%	100.0%
Community FFT - % positive responses	90%	98.9%	98.3%	98.8%	99.5%	96.4%	98.1%	98.8%	99.3%	98.1%	97.7%	100.0%	98.6%	100.0%
Outpatient FFT - % positive responses	90%	90.7%	90.5%	90.2%	90.6%	90.9%	90.8%	90.1%	89.6%	90.7%	90.3%	89.9%	89.9%	91.7%

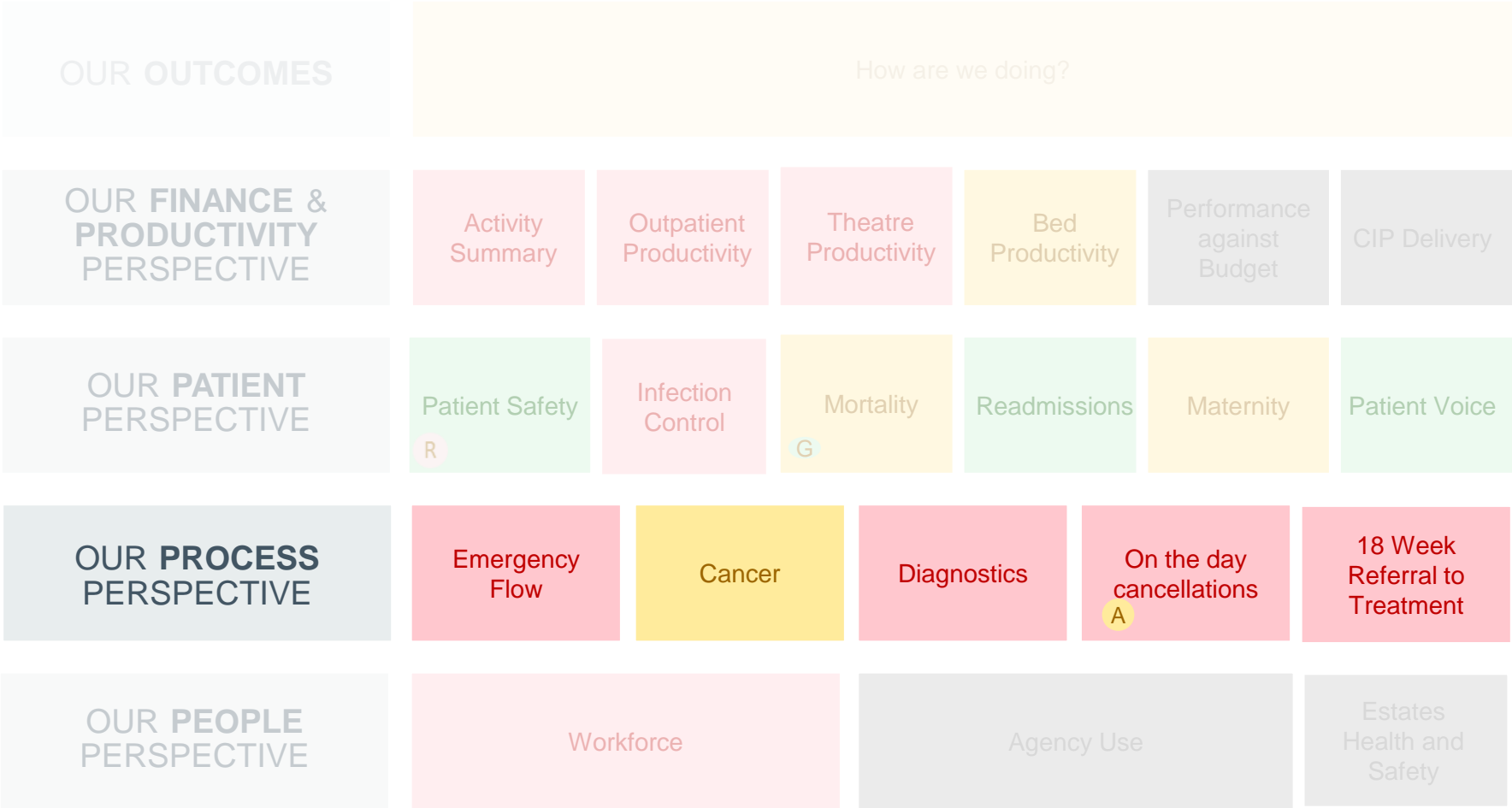
What the information tells us

- The Emergency Department Friends and Family Test (FFT) – In the month of March, 87.8% of patients attending the emergency department would recommend the service to family and friends. This remains above the mean and is the highest performance for over two years.
- Maternity and Community FFT are above local thresholds in March 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 recommended rate in March was 91.7% against a target of 90%. The response rate remains below target at 4.22%.
- The percentage of positive responses across all services has improved this month with a lower cohort of patients being surveyed.

Actions and Quality Improvement Projects

- Changes in Friends and Family (FFT) guidance will be implemented in April 2020. The guidance encourages patients to provide feedback throughout their care episode. In preparation for this and in line with guidance, the wording of the questions and changes to the Trust systems are being developed for launch in April 2020

Balanced Scorecard Approach

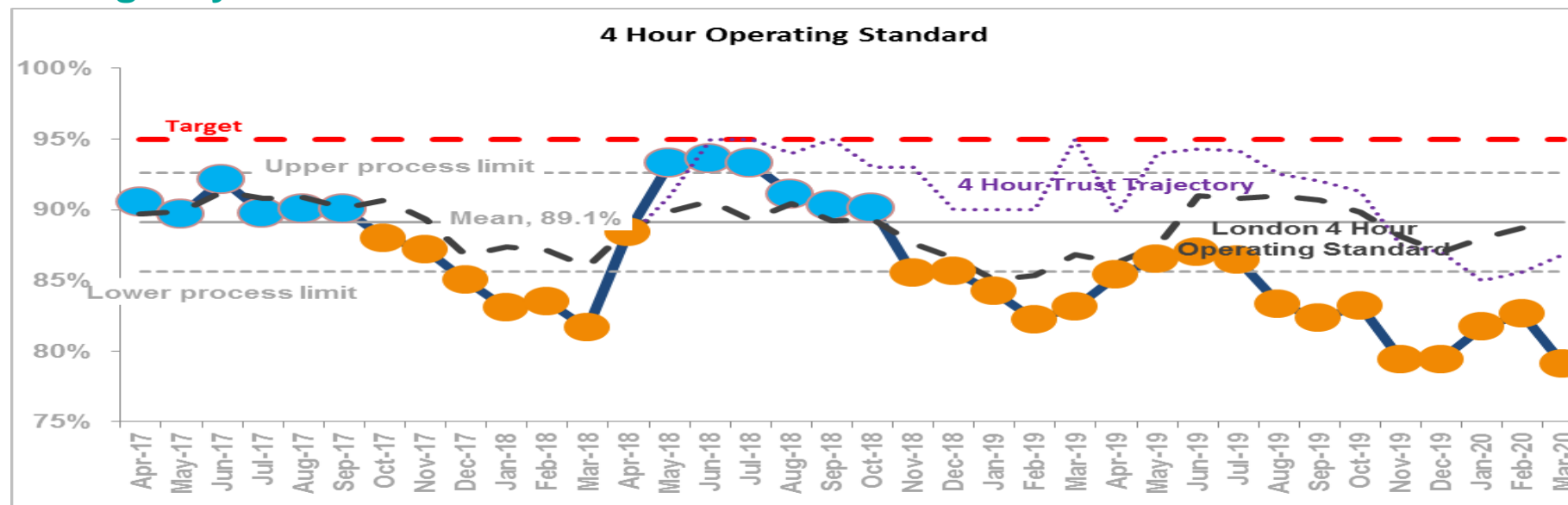


Key

Current Month

A Previous Month

Emergency Flow



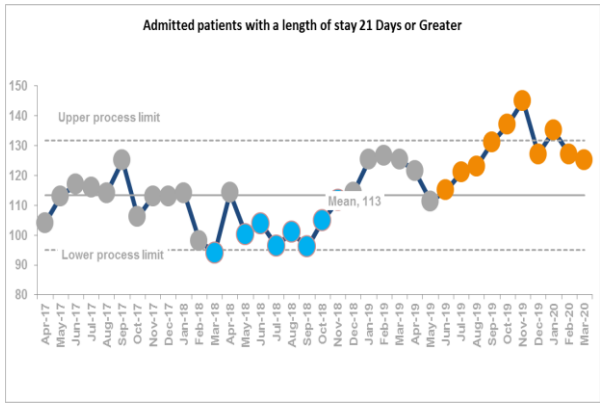
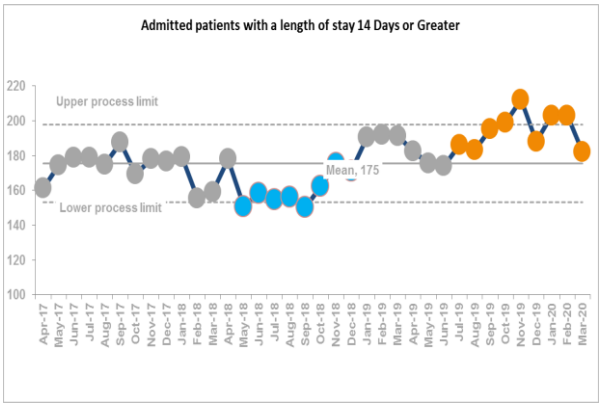
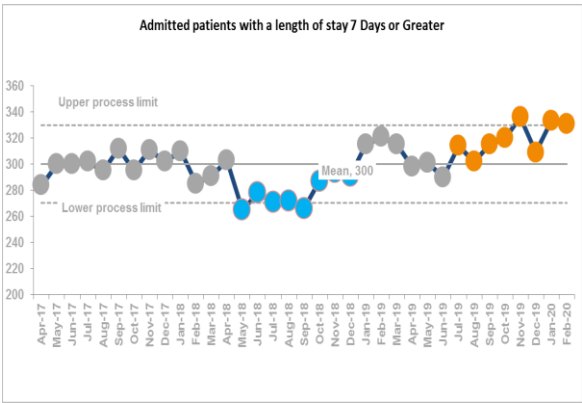
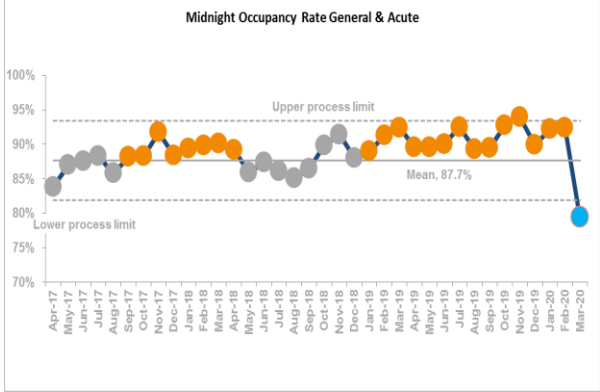
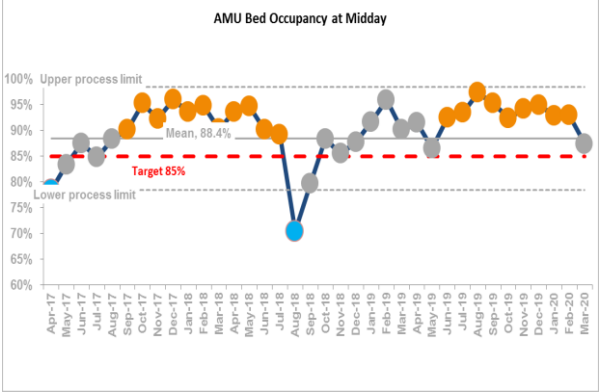
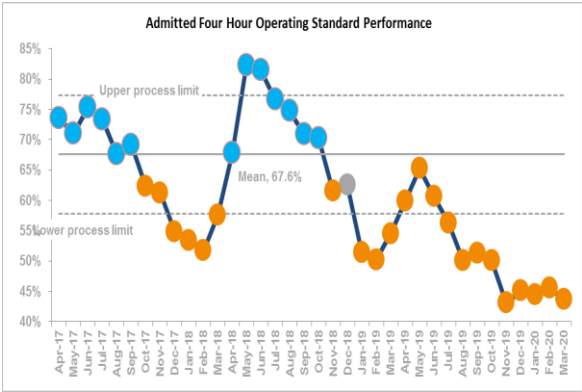
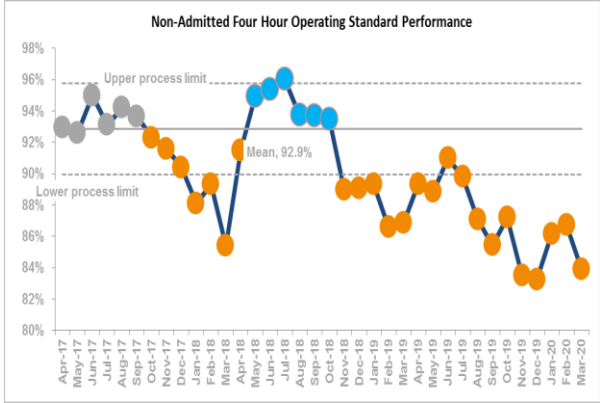
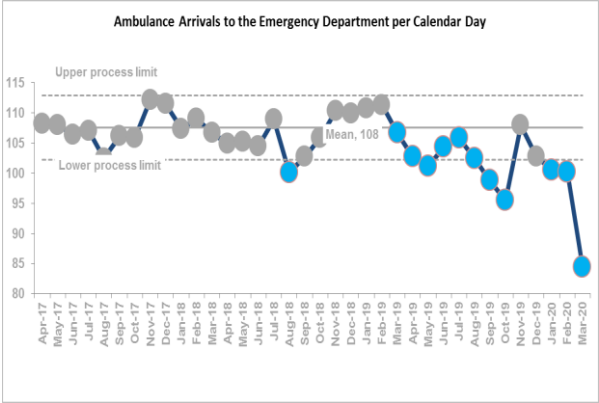
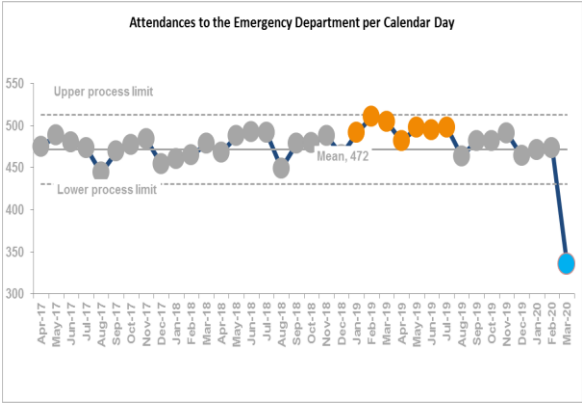
What the information tells us:

- The number of patients either discharged, admitted or transferred within four hours of arrival in the month of March was 79.1%, performance has deteriorated compared to February and remains below the lower control limit.
- The daily attendances numbers have fallen significantly below the lower control limits and the emergency department has also seen a reduction in ambulance arrivals throughout March. Compared to the same period last year the Trust has seen a 34% drop in the number of attendances.
- In March, the Trust reported three patients waiting in the Emergency Department over twelve hours following a decision to admit.
- Bed occupancy for both Trust (general and acute beds) and AMU has reduced, this is in line with Trust actions plans in relation to creating bed capacity in response to an expected COVID-19 surge.
- The number of patients who have been in a hospital bed longer than 7, 14 and 21 days, has seen a continuous daily decrease throughout March with internal and external teams supporting our inpatients to return home. The average number of patients with a length of stay over 14 days in March was 182, and as at the end of March this number further reduced to 136, this is a reduction of 33% compared to February.

Actions and Quality Improvement Projects

- Emergency Care Processes:** Emergency Care attendances have reduced significantly as a result of patients supporting social distancing and using healthcare services differently. Whilst the attendances have reduced the acuity is higher than normal due to COVID-19. ED have been split into Red/Green areas to protect patients. Speciality pathways have been redesigned and implemented at pace to support the National Pandemic and challenge in acuity.
- Urgent Care Centre Waits and Direct Access:** UCC direct pathways have been implemented at pace to ensure timely turnaround of non-COVID patients, this has been cross Divisional joint working. All pathways risk assessed and standard operating procedures agreed.
- Mental Health:** Alternative mental health pathways put in place to support this patient cohort and again attendances are reduced and redirected where appropriate, following action taken by South West London & St. George's Mental Health Trust and London Ambulance Service.
- Inter Professional Standards (IPS):** IPS launch paused –launch date 16 March 2020
- Flow:** The Emergency Care Intensive Support Team work is currently paused however some support is being received remotely as and when required.

Emergency Flow



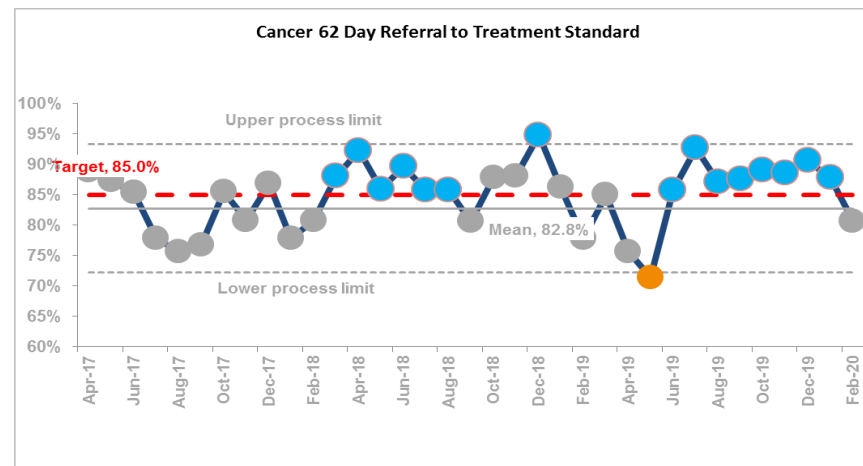
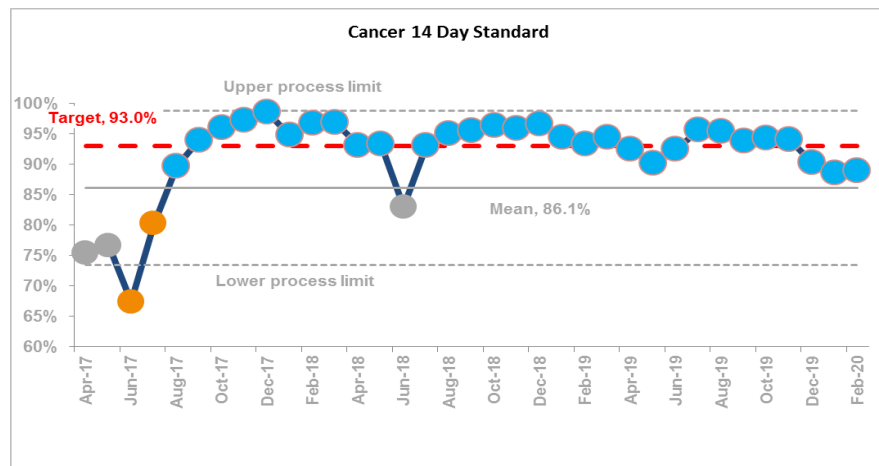
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

3.2

Our Process Perspective



Cancer



What the information tells us

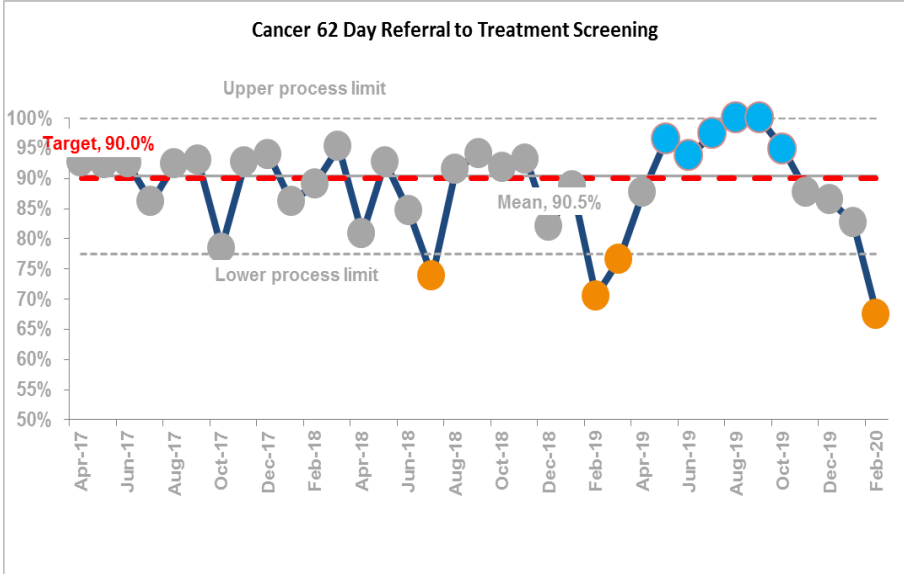
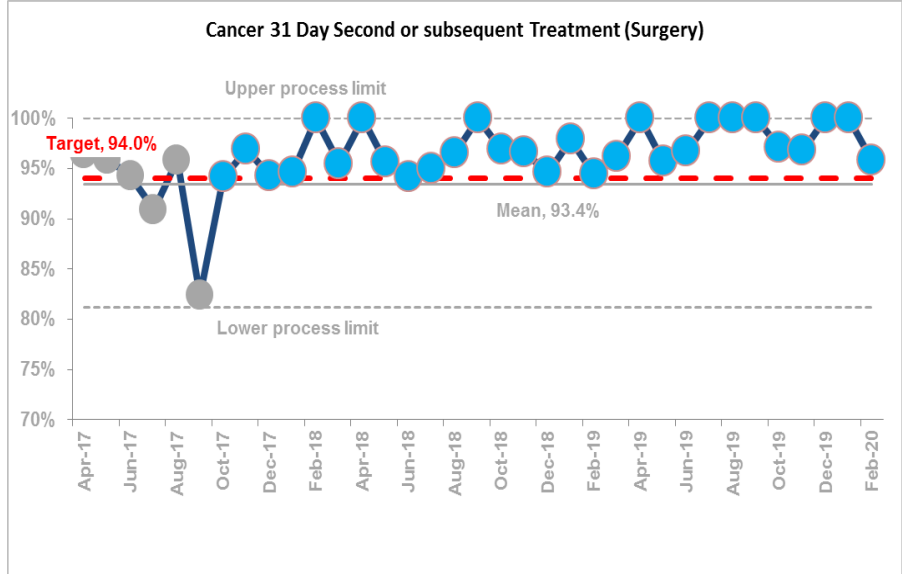
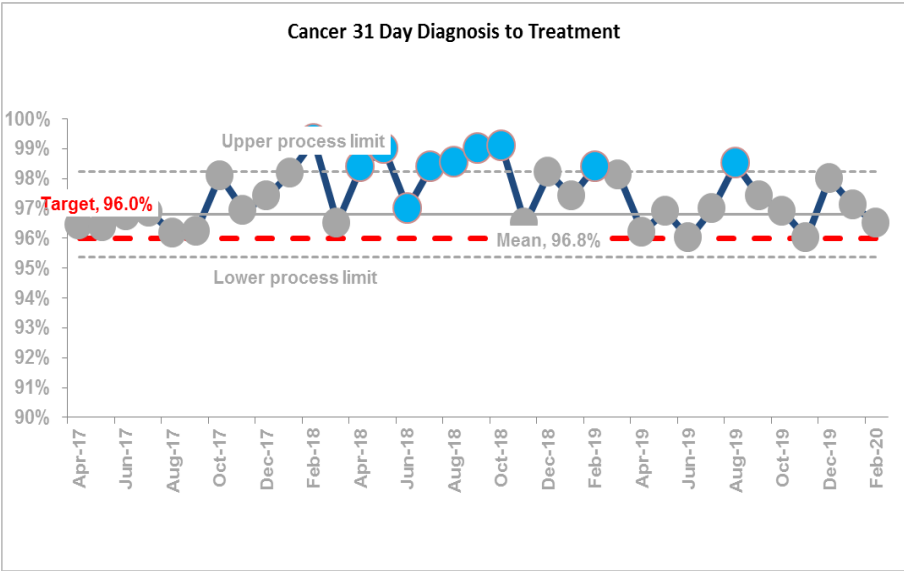
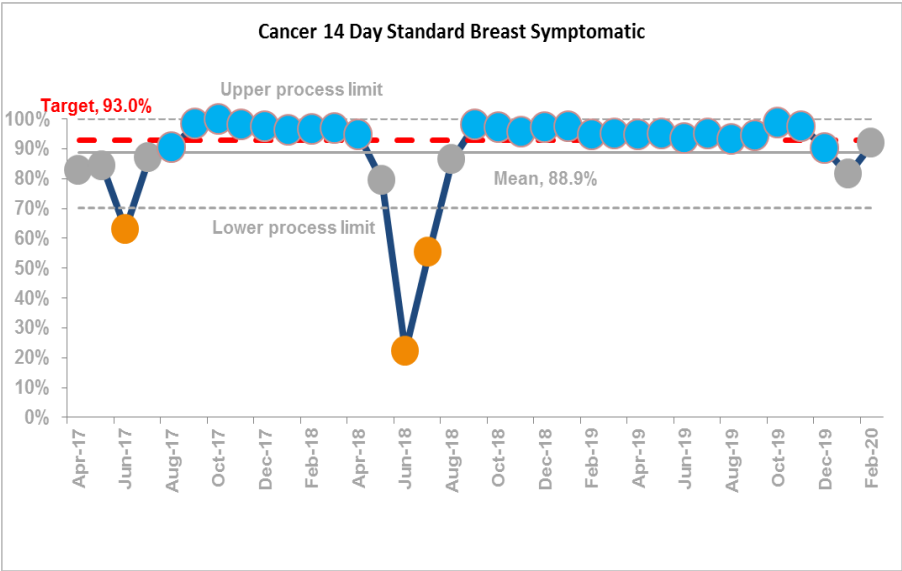
- The Trust met three of the seven cancer standards for the month of February, both 14 day standard and 62 day standard performance was under target.
- Within the 14 Day Standard performance for the month of February was at 88.9%, three tumour groups were non-compliant against the 93% national target, these were Lower Gastrointestinal, Lung, and Upper Gastrointestinal. Overall Trust performance remains within the upper and lower control limits.
- Performance against 62 days fell below the mean reporting a performance of 80.7% and below the national target of 85% - seven tumour groups reported non-compliant with Breast and Haematology reported a performance below the lower control limit.
- In the month of February, the Trust remained non-complaints against the Cancer 62 Day Referral to Treatment Screening target of 90% reporting 67.5%. This is the fifth consecutive drop with performance now below the lower control limit signifying special cause variation.

Actions and Quality Improvement Projects

- All TWR referrals are being triaged by consultants and where necessary face to face appointments and diagnostics are continuing. Low risk patients are being returned to GPs with management advice.
- Patients on TWR, subsequent and screening pathways have been prioritised as per NHSE guidance. All patients who require surgery within four weeks (Cat 1A/1B and 2) are being tracked on a separate PTL with patients being worked up for surgery here at the Trust or referred for surgery via the RMP Hub. Priority 3 (can be treated within 10/12 weeks) patients are being tracked on a separate PTL with review dates being agreed by consultants/MDTs to ensure there is adequate safety netting in place
- Chemotherapy is continuing as per recommendations and has been relocated to the Day Surgery Unit area
- Where possible follow up appointments are taking place virtually
- MDTs continue to provide oversight of clinical decision making and are being hosted with reduced numbers on site and supported with secure video conferencing via MS Teams
- All cancer patients continue to be tracked with the focus being on working up and treating the patients identified by the MDT as requiring treatment within four weeks and safety netting of the less urgent patients.

Cancer

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



Our Process Perspective

Cancer

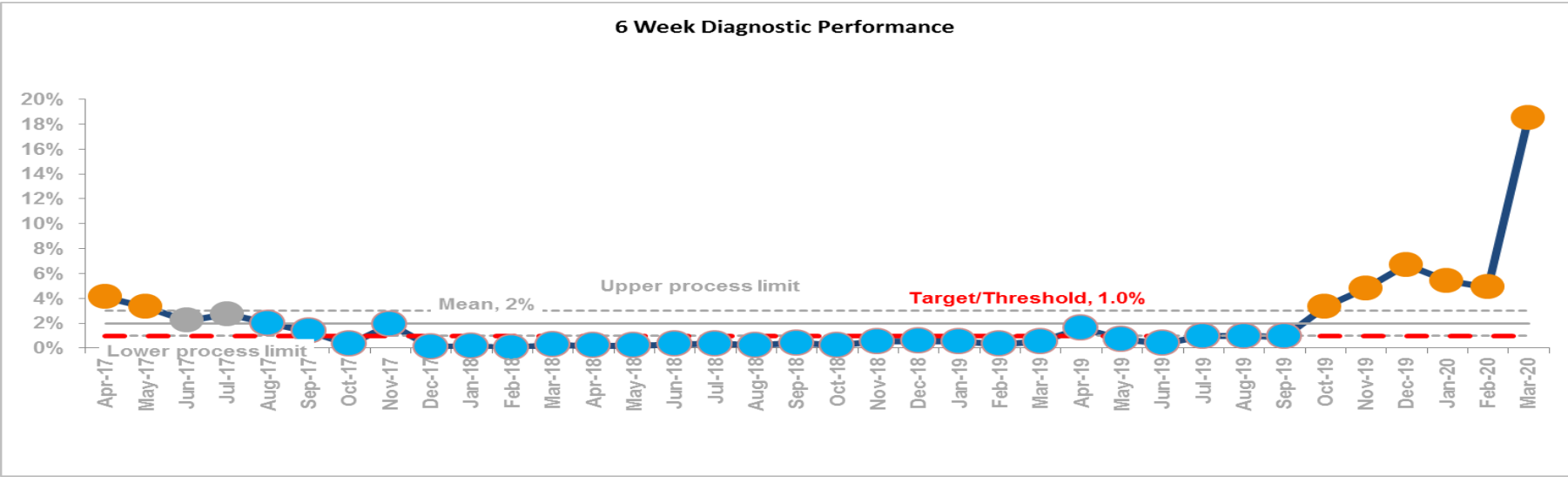
14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	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	No of Patients
Brain	93%	100.0%	-	100.0%	-	100.0%	-	100.0%	100.0%	-	-	-	100.0%	-	0
Breast	93%	98.6%	97.9%	99.5%	96.3%	96.9%	95.4%	94.9%	95.9%	100.0%	97.0%	95.6%	84.7%	95.6%	136
Children's	93%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	85.7%	100.0%	5
Gynaecology	93%	65.3%	80.0%	75.0%	59.3%	78.0%	95.5%	97.2%	95.4%	97.6%	99.2%	99.0%	94.4%	95.9%	122
Haematology	93%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	86.7%	95.2%	100.0%	100.0%	100.0%	100.0%	19
Head & Neck	93%	100.0%	99.3%	98.0%	97.8%	100.0%	98.9%	96.4%	96.6%	99.0%	96.6%	89.4%	95.2%	95.5%	157
Lower Gastrointestinal	93%	92.1%	94.5%	85.6%	91.1%	87.9%	93.7%	93.1%	92.8%	89.7%	91.5%	80.3%	81.8%	69.9%	246
Lung	93%	100.0%	96.9%	100.0%	95.6%	96.8%	95.7%	100.0%	97.1%	97.7%	100.0%	84.1%	80.6%	90.9%	44
Skin	93%	95.9%	97.6%	96.9%	95.5%	94.8%	96.0%	98.0%	91.8%	95.9%	91.0%	94.8%	94.7%	93.3%	298
Upper Gastrointestinal	93%	90.9%	83.5%	87.9%	70.2%	90.9%	95.1%	88.9%	87.2%	82.5%	88.1%	82.7%	75.3%	84.4%	77
Urology	93%	94.2%	92.2%	90.1%	95.4%	92.1%	93.8%	93.0%	97.0%	88.4%	95.6%	92.9%	93.6%	93.6%	126

62 Day Standard Performance by Tumour Site - Target 85%

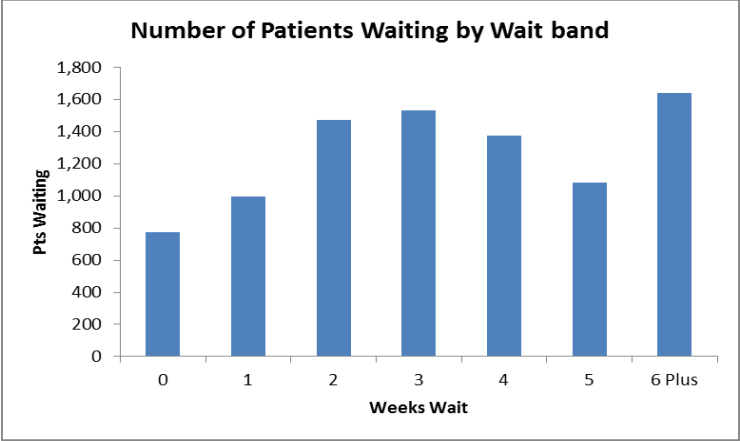
Tumour Site	Target	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	No of Treatments
Brain	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Breast	85%	82.4%	90.9%	83.3%	80.0%	87.5%	73.3%	88.6%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	9
Children's	85%	-	-	-	-	-	-	100.0%	-	-	-	-	100.0%	100.0%	0.5
Gynaecology	85%	50.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%	60.0%	100.0%	80.0%	66.7%	100.0%	5.5
Haematology	85%	100.0%	100.0%	30.0%	33.3%	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	85.7%	66.7%	3
Head & Neck	85%	85.7%	80.0%	77.8%	40.0%	28.6%	80.0%	80.0%	75.0%	76.5%	76.9%	68.2%	89.5%	73.7%	9.5
Lower Gastrointestinal	85%	81.8%	66.7%	41.7%	100.0%	69.2%	83.3%	63.6%	90.0%	100.0%	87.5%	83.3%	60.0%	71.4%	7
Lung	85%	75.0%	70.0%	71.4%	100.0%	100.0%	91.7%	89.5%	60.0%	100.0%	66.7%	100.0%	100.0%	100.0%	6
Skin	85%	100.0%	89.7%	100.0%	75.8%	95.7%	100.0%	100.0%	78.9%	100.0%	89.5%	100.0%	91.7%	100.0%	11
Upper Gastrointestinal	85%	50.0%	60.0%	100.0%	20.0%	75.0%	100.0%	53.8%	66.7%	80.0%	50.0%	100.0%	0.0%	40.0%	2.5
Urology	85%	71.1%	88.9%	83.0%	75.8%	93.9%	100.0%	94.4%	100.0%	83.8%	87.8%	100.0%	85.0%	84.0%	12.5
Other	85%	-	100.0%	-	-	100.0%	-	-	-	100.0%	-	100.0%	100.0%	0.0%	1

Diagnostics



What the information tells us

- In March, the Trust did not achieve the six week diagnostic standard with an adverse performance of 18.5%. The total number of patients waiting greater than six weeks was 1,638, a 72% increase compared to February.
- Of the total of breaches reported, 97% were related to COVID-19 and or capacity constraints.
- Echocardiography, Computed Tomography, Magnetic Resonance Imaging and Ultrasound have seen the biggest rise in patients waiting greater than six weeks.

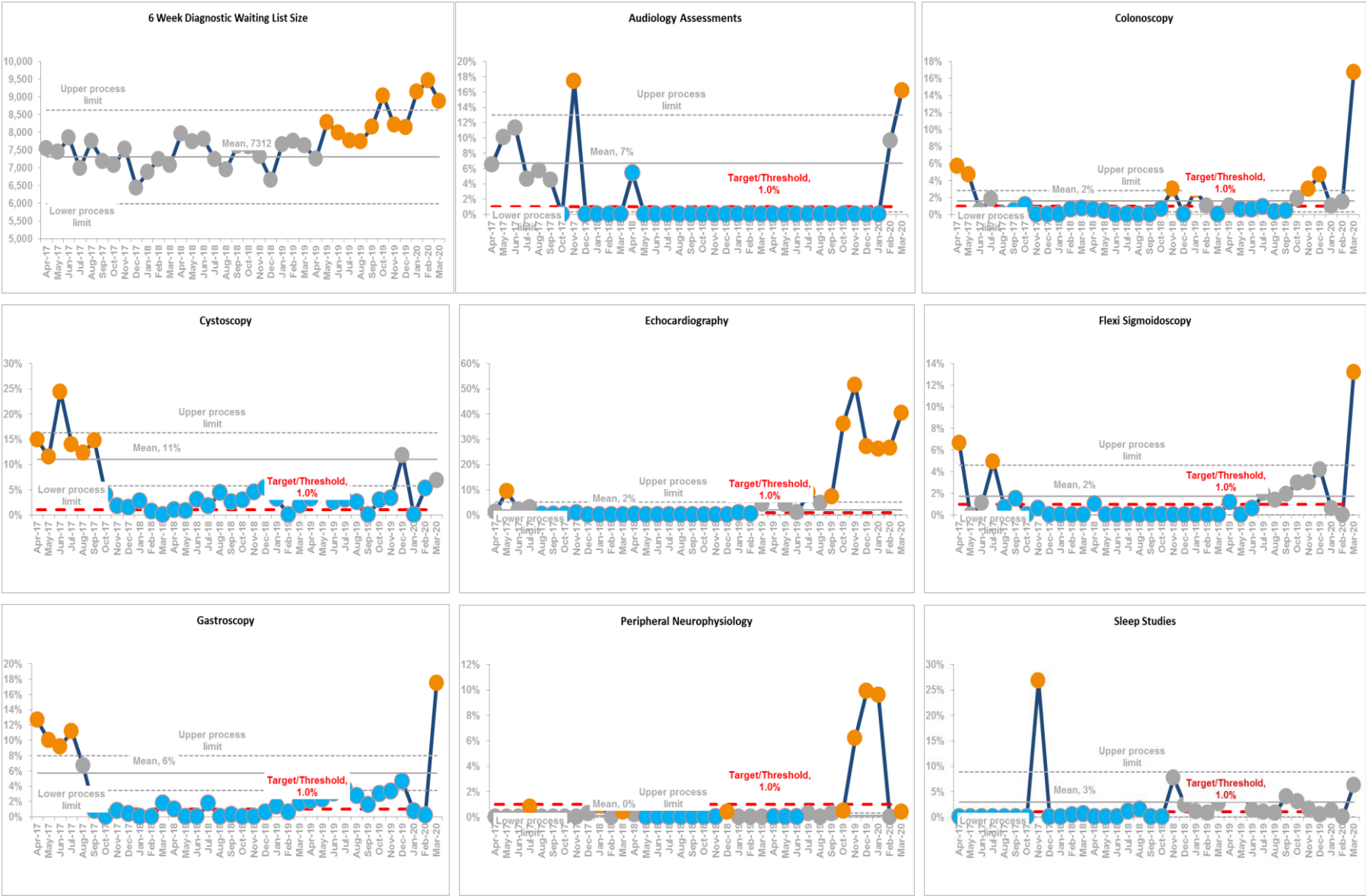


Actions and Quality Improvement Projects

- As part of the Safely Standing Down workstream, provision of services by private providers is being explored.
- Services are being asked to review patients referred to diagnostics to determine which patients can be safely sent for diagnostics offsite or brought in to the Tooting site

Diagnostics

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

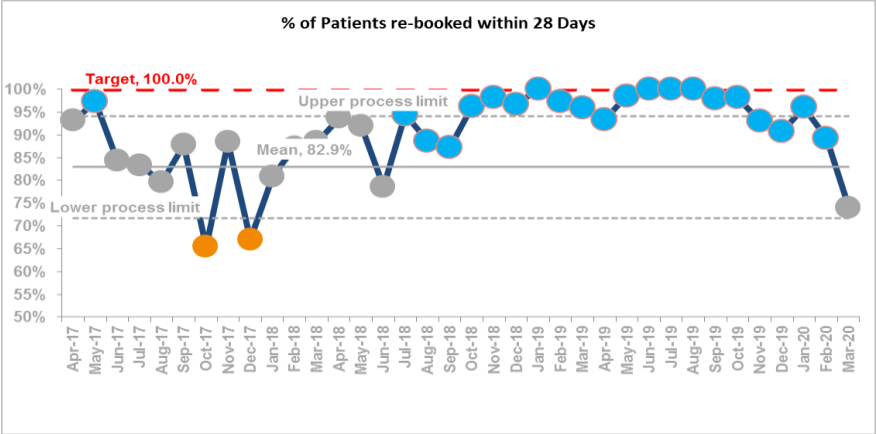
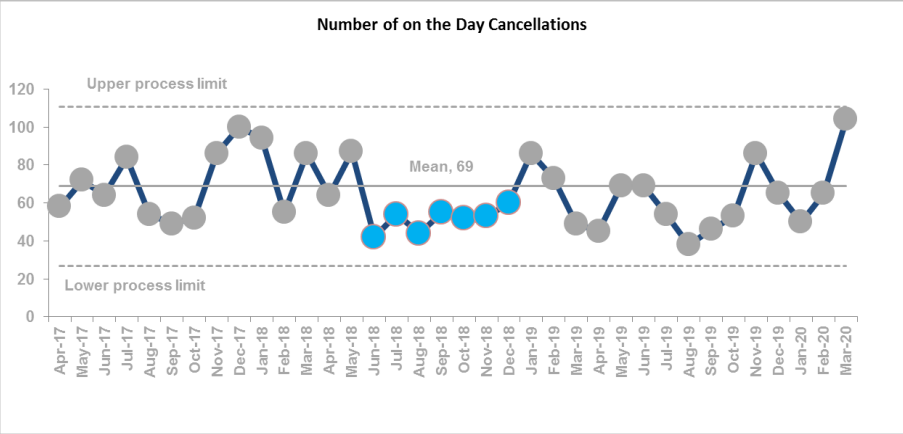


3.2

Our Process Perspective



On the Day Cancellations for Non Clinical Reasons

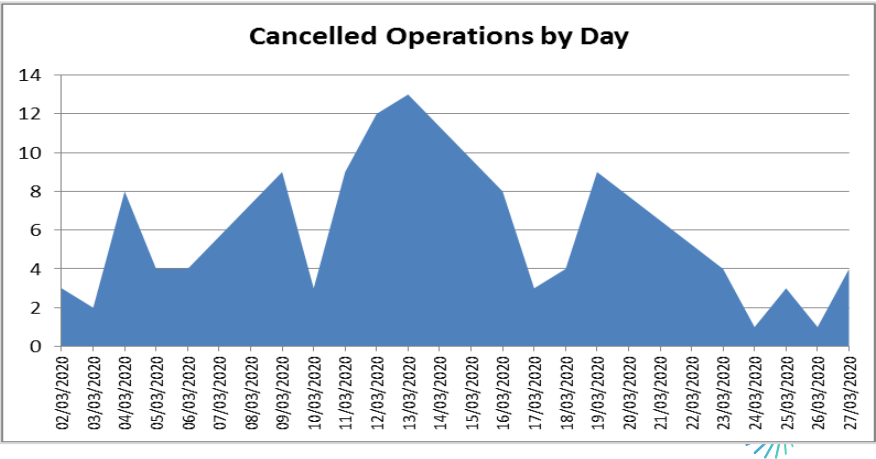
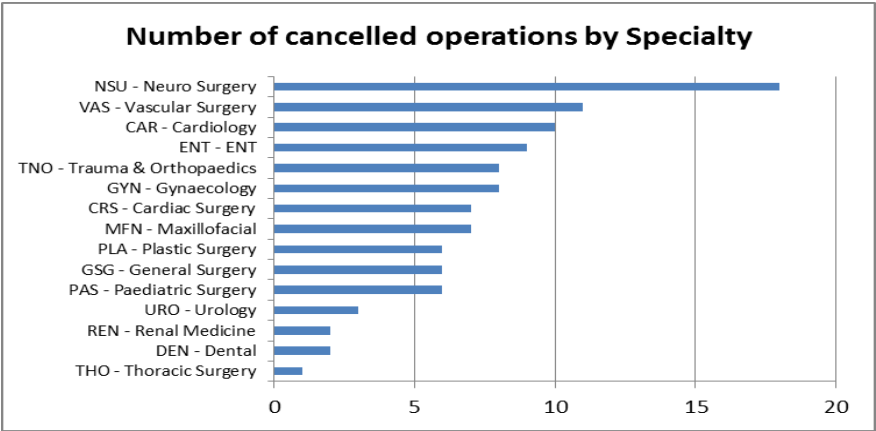


What the information tells us

- In the month of March where the Trust cancelled all routine elective activity, the number of on the day cancellations increased reporting 104 patients, of which at present 77 patients have not been re-booked within 28 days reporting a performance of 74%. The majority of patients were cancelled due to COVID-19 and bed availability.
- Neurosurgery patients along with Vascular Surgery and Cardiology patients were most affected by on the day cancellations.

Actions and Quality Improvement Projects

- Theatre capacity is reviewed weekly to ensure there is enough capacity for essential services.
- Patients are reviewed by services and are scheduled for urgent elective based on clinical risk assessments.



Referral to Treatment

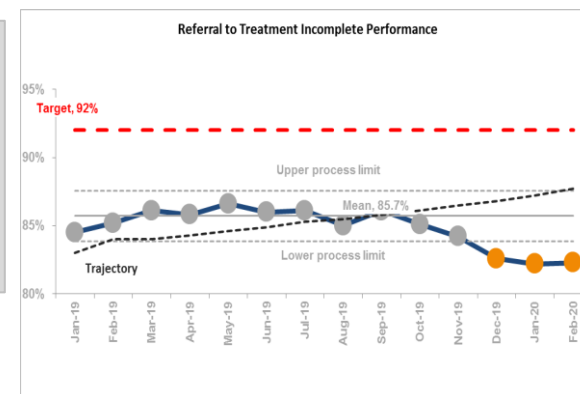
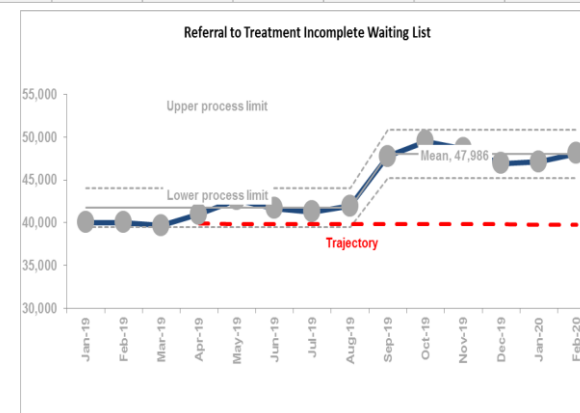
Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
RTT Trust Incomplete Performance	92%	84.5%	85.2%	86.1%	85.8%	86.6%	86.0%	86.1%	85.0%	86.1%	85.1%	84.2%	82.6%	82.2%	82.3%
RTT Trust Incomplete Performance Trajectory for 19/20		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%
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	46,918	47,089	48,061
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
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	8,183	8,382	8,498
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
Total waits greater than 52 weeks	0	118	116	27	22	16	7	5	6	6	1	7	9	10	11
Total waits greater than 52 weeks Trajectory				31	23	16	9	5	5	5	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%	61.40%	60.50%	61.90%
Total waits greater than 18 weeks - Admitted		1563	1,563	1428	1511	1459	1494	1523	1655	1643	1686	1719	1876	1950	1891
Total waits greater than 52 weeks - Admitted	0	62	63	18	7	8	4	1	2	4	0	2	5	2	3
RTT Incomplete Performance -Non Admitted		88%	88%	88%	88.3%	88.8%	88.3%	88.5%	87.6%	88.3%	87.3%	86.4%	85.0%	84.7%	84.7%
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	6,107	6,432	6,607
Total waits greater than 52 weeks - Non Admitted	0	56	53	9	15	8	3	4	4	2	1	5	4	8	8

What the information tells us

- The Trust remains behind the Trust trajectory for incomplete Referral To Treatment (RTT) with a submitted performance of 82.3% in February 2020 against the Trust trajectory of 87.7%. Revised internal trajectory for the month of February was set at 83.5%.
- The Total Patient Tracking List (PTL) size reported in February 2020 was 48,061 (inclusive of Queen Mary Hospital pathways) against a Trust trajectory of 39,790. A revised internal trajectory was set at 45,990. The Trust 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 February reporting eleven patients waiting greater than 52 weeks

Actions and Quality Improvement Projects

- The Trust continues to monitor and validate the PTL position to ensure an accuracy of the list
- The Trust is launching an electronic outcome form to enable clinicians to easily record outcome of appointments
- Virtual appointments have been launched across a variety of services which enables patients to still be seen during the current lockdown.



Referral to Treatment

Specialty	Admitted		Non Admitted	
	Total	% within 18 weeks	Total	% within 18 weeks
General Surgery	302	42.4%	903	79.4%
Urology	276	55.1%	1,583	93.0%
Trauma & Orthopaedics	113	42.5%	1,948	87.1%
Ear, Nose & Throat (ENT)	531	30.5%	2,632	86.3%
Ophthalmology	-	-	505	89.7%
Oral Surgery	5	60.0%	330	71.8%
Neurosurgery	213	67.1%	2,448	79.0%
Plastic Surgery	486	41.4%	896	87.3%
Cardiothoracic Surgery	-	-	17	100.0%
General Medicine	-	-	35	91.4%
Gastroenterology	836	86.7%	2,401	83.4%
Cardiology	887	69.9%	2,929	81.9%
Dermatology	5	80.0%	3,139	85.6%
Respiratory Medicine	14	100.0%	1,635	89.4%
Neurology	25	88.0%	2,628	86.8%
Rheumatology	2	100.0%	1,088	83.5%
Geriatric Medicine	2	50.0%	98	95.9%
Gynaecology	211	45.5%	2,395	88.7%
Other (Next Slide)	1,050	71.0%	15,493	83.4%
Total	4,958	61.9%	43,103	84.7%

Incomplete Pathway					
Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
845	360	1,205	70.1%	44	4
1,624	235	1,859	87.4%	17	0
1,745	316	2,061	84.7%	8	0
2,434	729	3,163	77.0%	57	0
453	52	505	89.7%	1	0
240	95	335	71.6%	2	0
2,076	585	2,661	78.0%	32	0
983	399	1,382	71.1%	53	0
17	0	17	100.0%	0	0
32	3	35	91.4%	0	0
2,728	509	3,237	84.3%	23	0
3,019	797	3,816	79.1%	33	1
2,692	452	3,144	85.6%	7	0
1,476	173	1,649	89.5%	3	0
2,303	350	2,653	86.8%	7	0
910	180	1,090	83.5%	2	0
95	5	100	95.0%	0	0
2,220	386	2,606	85.2%	5	0
13,671	2,872	16,543	82.6%	124	6
39,563	8,498	48,061	82.3%	418	11

- 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.

Balanced Scorecard Approach



Key

Current Month

A

Previous Month

3.2

Our People Perspective



Workforce

Indicator Description	Target	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
Trust Level Sickness Rate	3.2%	3.4%	3.1%	3.5%	3.8%	3.8%	3.5%	3.4%	3.7%	3.8%	4.0%	3.9%	4.0%	5.1%
Trust Vacancy Rate	10%	9.6%	9.1%	10.3%	10.5%	11.9%	12.8%	12.8%	9.3%	9.9%	11.2%	10.8%	10.7%	10.6%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.5%	17.1%	17.4%	17.4%	17.5%	17.7%	17.7%	17.8%	17.6%	17.6%	17.4%	17.3%	16.9%
Total Funded Establishment		9,248	9,112	9,241	9,251	9,365	9,432	9,534	9,280	9,294	9,403	9,383	9,369	9,369
IPR Appraisal Rate - Medical Staff	90%	Data Unavailable		85.4%	84.5%	84.4%	85.7%	81.5%	83.9%	81.5%	83.6%	84.9%	81.7%	80.0%
IPR Appraisal Rate - Non Medical Staff	90%	70.4%	71.6%	72.5%	73.6%	73.3%	71.3%	70.4%	70.9%	72.3%	72.3%	72.0%	72.4%	69.6%
Overall MAST Compliance %	85%	89.4%	89.8%	90.6%	91.1%	91.2%	91.3%	90.6%	89.7%	89.7%	90.0%	89.7%	90.6%	90.7%
Ward Staffing Unfilled Duty Hours	10%	7.2%	5.7%	5.9%	6.1%	6.3%	5.4%	6.5%	6.1%	3.8%	5.3%	5.4%	6.2%	

What the information tells us

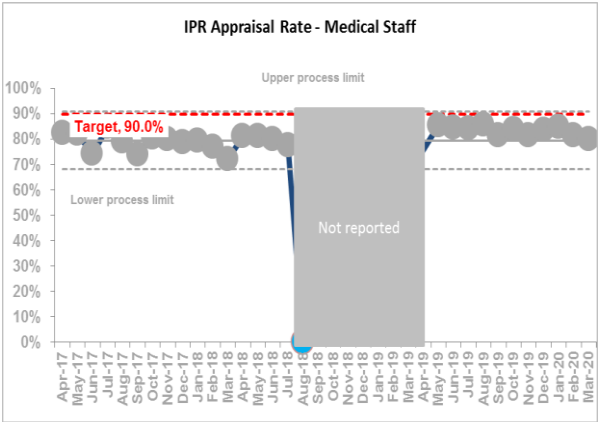
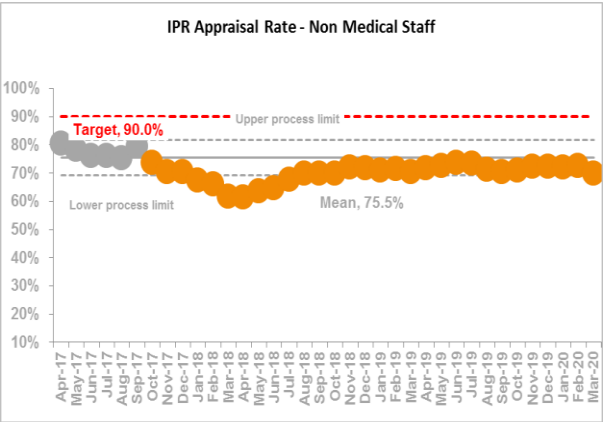
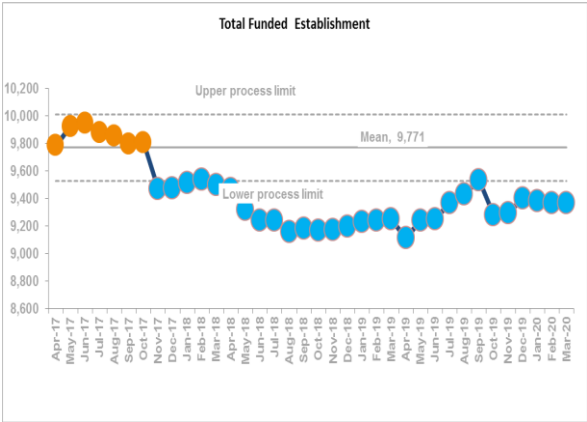
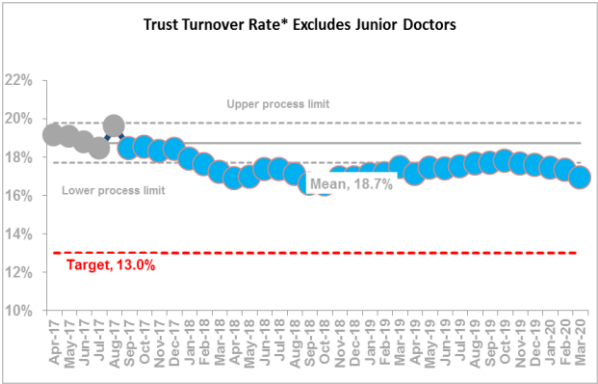
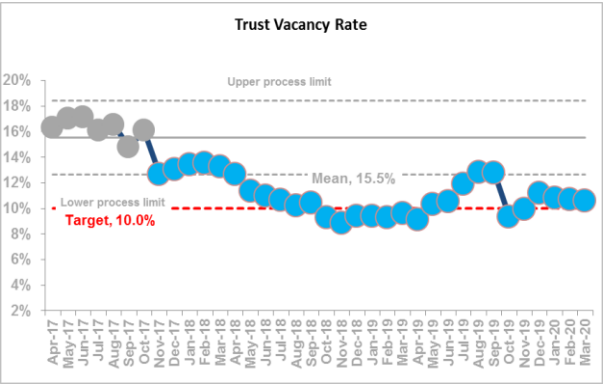
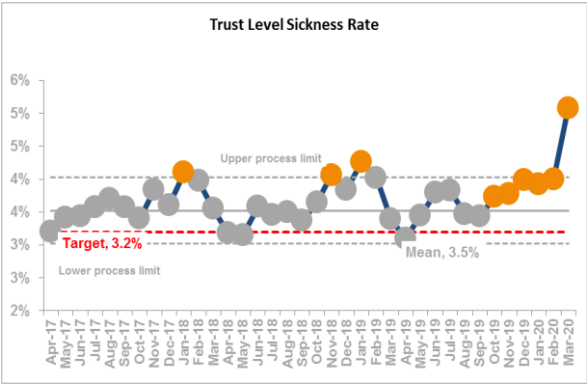
- Sickness rate has increased by 1.1% in the month of March reporting a rate of 5.1%
- Appraisal rates for both Medical and Non Medical staff has fallen.

Actions and Quality Improvement Project

No update.

Workforce

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



3.2

Our People Perspective



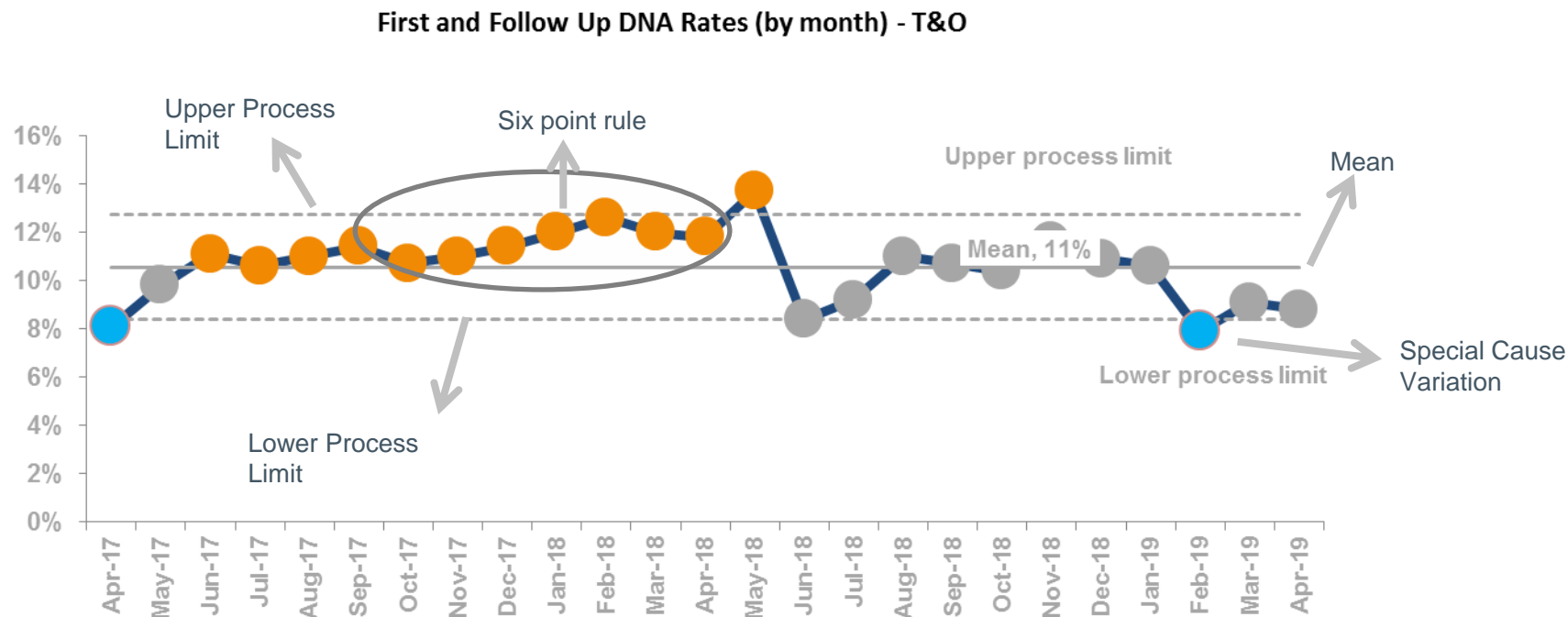
Appendix

Additional Information

3.2



Interpreting SPC (Statistical Process Control) Charts



3.2

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

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

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

Maternity

Definitions	Target	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
Total number of women giving birth (per calendar day)	14 per day	12.9	13.6	14.0	13.6	13.2	12.6	13.4	14.4	12.9	14	13	13	13
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	31.4%	30.4%	25.9%	25.9%	25.9%	25.6%	27.4%	25.7%	24.2%	26.7%	24.8%	26.0%	23.3%
% deliveries with Emergency C Section (including no Labour)	<8%	3.7%	4.7%	2.8%	3.2%	3.9%	2.6%	5.2%	4.5%	1.5%	4.0%	1.3%	3.6%	3.3%
% Time Carmen Suite closed	0%	0.0%	5.0%	0.0%	6.7%	0.0%	4.8%	1.7%	19.4%	11.7%	8.1%	1.6%	22.5%	27.4%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	2.0%	1.5%	2.8%	1.2%	1.5%	3.3%	3.5%	4.0%	2.6%	5.3%	2.3%	2.3%	1.8%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	3.0%	2.7%	1.8%	2.0%	3.4%	2.1%	2.0%	2.3%	3.4%	3.0%	1.5%	2.1%	1.8%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		11	13	11	14	10	9	10	7	14	11	12	11	13
Supernumerary Midwife in Labour Ward	>95%	95.2%	96.7%	98.4%	98.3%	100.0%	96.8%	96.7%	96.8%	96.7%	96.8%	96.8%	94.8%	93.5%
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	<2	1	0	0	2	0	0	0	0	0	3	0	0	0
% women booked by 12 weeks and 6 days	90%	87.3%	83.3%	86.6%	88.4%	85.3%	84.9%	81.5%	81.7%	84.1%	85.7%	82.3%	83.6%	82.4%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	2.8%	3.2%	2.5%	3.4%	2.4%	2.3%	2.5%	1.6%	3.6%	2.6%	3.0%	2.9%	3.1%



Meeting Title:	Trust Board		
Date:	30 April 2020	Agenda No	3.3
Report Title:	Cardiac Surgery: Update following the publication of the reports of the Independent Mortality Review and Independent Scrutiny Panel and proposal to provide continued assurance on the safety of the cardiac surgery service		
Lead Director	Richard Jennings, Chief Medical Officer		
Report Author(s):	Richard Jennings, Chief Medical Officer		
Presented for:	Review and Assurance		
Executive Summary	<p>This paper provides an update following the publication by NHS Improvement of the two external reports into the Trust’s cardiac surgery service on 26 March 2020 and the Trust Board discussion on the same day.</p> <p>This paper provides the Board with an update on the following:</p> <ol style="list-style-type: none">1 The events following the publication of the external reports and the Board discussion.2 The communication and support being offered to the bereaved families of deceased patients.3 An update on safety and quality in the service since the last Board paper4 An update on the current arrangements for cardiac surgery in the light of the Covid-19 pandemic.5 The arrangements in place for continuing internal and external assurance and oversight of the cardiac surgery service.6 A proposal for the future arrangements for Quality and Safety Committee and the Trust Board to receive assurance and have oversight of cardiac surgery.		
Recommendation:	<p>The Board is asked to:</p> <ol style="list-style-type: none">I. Note the steps that have been taken to communicate with and support the families of deceased patients.II. Consider the recommendation (Section 5) regarding future reports on cardiac surgery to the Quality and Safety Committee and the Trust Board.		
Supports			
CQC Theme:	Safe, Well Led		
Single Oversight Framework:	Quality of Care Leadership and Improvement Capability		



Cardiac Surgery: Update following the publication of the reports of the Independent Mortality Review and Independent Scrutiny Panel and proposal to provide continued assurance on the safety of the cardiac surgery service

3.3

1.0 Update following the publication and Trust Board consideration of the Independent Mortality Review and the Independent Scrutiny Panel

Media interest

- 1.1 NHS Improvement's publication of the findings of the reports into cardiac surgery at St George's was accompanied by a press release. The Trust also issued a press release to the media, and the story was covered by the BBC, the Daily Telegraph, and the Daily Mail, as well as the Health Service Journal, the British Medical Journal and other media outlets. Most media reports quoted from the NHS Improvement and Trust press releases. Briefings were provided for staff and stakeholders prior to the media coverage appearing and information for patients and the public was published on the Trust's website and social media channels.

Staff support

- 1.2 A number of engagement sessions were held with staff groups (the cardiac surgeons, the cardiologists, the wider cardiac surgery multi-disciplinary teams) leading up to the publication of the external reports. The purpose of these sessions was to keep staff informed, to hear and, where possible, address any concerns, and to remind staff of the various sources of pastoral support available to them. If any staff groups or individuals wish to have further engagement with the Trust leadership, these meetings will be arranged.

Support for current patients and their families

- 1.3 In view of the anticipated media interest in the publication of the external reports, a letter was provided to all the Trust's current cardiac surgery inpatients, informing them of the situation, reassuring them that the service is safe and offering to discuss any concerns that they might have.

Communicating with deceased patients' families

- 1.4 Following the commencement of the work of the Independent Mortality Review, in spring 2019 the Trust wrote to the next of kin of the patients whose death was being considered as part of the review. This was to ensure that the families were aware of the work of the review and the fact that their loved ones' deaths were being examined. We committed at that stage to write to them again following the conclusion of the panel's work to set out the panel's findings.
- 1.5 Starting on 16 March 2020, we telephoned the families of patients whose deaths were being considered by the panel to explain that the Trust had received the final Structured Judgement Review regarding the care provided to their deceased relatives and that we would be writing to them to set out what the panel had found. On Friday 20 March, we wrote to each of the families and explained in these letters the conclusions the panel had reached in respect of their relative. As part of this process, we have offered to meet with any family who would like to discuss the findings in more detail and the care provided by the Trust. A number of these meetings have taken place already. Since 16 March 2020, over 40 families have made contact with the Trust and most have accepted the offer of a meeting. Family meetings have to be virtual in the context of the current COVID-19 pandemic, and more than half the families who would like a meeting have expressed a preference to wait until after the social distancing measures have been relaxed, so that the meeting can be face-to-face. The Trust will facilitate all meetings requested and welcomes the chance to meet any family affected.
- 1.6 The Trust has also been liaising with NHS Resolution to identify an approach to be appropriately



supportive towards families who may wish to bring a legal claim against the Trust, in such a way as to minimise any difficulty or distress that they might otherwise experience in trying to navigate the system.

2.0 Safety update since the last Trust Board

Internal safety monitoring

- 2.1 Key patient safety metrics are reported on the cardiac surgery monthly dashboard and reviewed within the department and at the Cardiac Surgery Steering Group, which is chaired by the Chief Medical Officer and meets monthly. The patient safety metrics include hospital acquired infections, pressure ulcers, post-operative stroke, post-operative renal failure, deep wound infection, repeat surgery for bleeding and post-operative deaths. All post-operative deaths are reviewed by the Trust's Serious Incident Decision Making Group (SIDM), and the decisions made by this group are independently reviewed by an external cardiac surgery expert from outside the Trust. It is worth noting that the CQC's inspection report of 18 December 2019 finds concludes that the cardiac surgery weekly dashboard "*provided a comprehensive view of quality and safety in the specialty*".

Safety of the service following publication of the reports

- 2.2 On 23 April 2020 the Quality and Safety Committee received a report that contained an update on safety.
- 2.3 Since the last Board report there has been one death of a patient who died over 40 days after cardiac surgery. This will be reviewed in accordance with the normal governance processes described above, and the Quality and Safety Committee will be updated appropriately.

3.0 Cardiac surgery service in light of Covid-19 pandemic

- 3.1 Cardiac Surgery in London is being guided by the Pan London Emergency Cardiac Surgery (PLECS) Standard Operating Procedure (SOP). This plan has been agreed by all the cardiac surgical units; the basis of the agreement is that if urgent cardiac surgery cannot be provided locally then the patient will be transferred to Bart's or Harefield. We have not performed a cardiac surgery operation at St George's since 17 March 2020. One patient has been transferred to Bart's under the PLECS system.
- 3.2 Before the onset of the Covid-19 pandemic, as has previously been described to this Committee and the Trust Board, discussions were underway to bring about closer networking of cardiac surgery services in South London in the future, as a way of placing quality and sustainability of cardiac surgery in South London on a more robust footing. It is anticipated that these discussions will resume at an appropriate time when the pandemic in London is past its peak.

4.0 Arrangements for on-going internal and external oversight and scrutiny of cardiac surgery at St George's

- 4.1 The Trust's Cardiac Surgery Service Steering Group, chaired by the Trust's CMO, will continue to meet and provide internal scrutiny and oversight. All post-operative deaths will continue to be reviewed by the Trust's Serious Incident Decision Making Group (SIDM), and the decisions made by this group will continue to be independently reviewed by an external cardiac surgery expert from outside the Trust.
- 4.2 In his press statement on behalf of NHS Improvement, Sir David Sloman confirmed that "*[e]nhanced oversight of the unit is being maintained using the powers available to NHS Improvement in London, and a package of support measures is in place to ensure there is continued progress and*



improvement.” The Trust continues to work closely with NHSE/I regarding the continued quality and safety of the cardiac surgery service.

5.0 **Recommendation for the future Quality and Safety Committee and Trust Board assurance and oversight of the cardiac surgery service**

- 5.1 It is proposed that reports updating on the key areas of safety and quality of the Trust's Cardiac Surgery Service are from now on received by the Quality and Safety Committee and the Board quarterly.



Meeting Title:	Trust Board		
Date:	30 April 2020	Agenda No	4.1
Report Title:	Finance and Investment Committee 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 April 2020.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	Date:	N/A
Appendices:	N/A		



Finance and Investment Committee – April 2020

The Committee met on 23 April, combining the 'Core' and 'Estates' committee meetings that have been held since May 2019. In addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on the 2020/21 Financial Plan and Procurement Contracts.

Committee members discussed the BAF risks on finance and ICT in respect of the COVID-19 virus, although noting no change in overall risk scoring at present. The Committee noted performance in Diagnostics, Cancer, RTT and Emergency Flow as well as outlining recovery processes in each area. The Committee discussed current financial performance, cash management and capital expenditure, as the Trust was in the process of completing its draft accounts for 2019/20. Implications for the annual plan in 2020/21 were also discussed, in view of new funding arrangements. **The Committee wishes to bring the following items to the Board's attention:**

1.1 Finance & ICT Risks – the Acting Chief Financial Officer (ACFO) and the Chief Information Officer (CIO) gave updates on their respective BAF risks. They noted no change in risk scoring although noting the emerging risk on COVID-19 would have financial and ICT implications. Discussions on financial risk focussed on the risk as it stood before COVID-19, in delivering a balanced financial position. ICT discussions included the impact of current arrangements on cyber security.

1.2 Estates Report – the Deputy Chief Executive Officer (DCEO) introduced the paper on Estates. The Committee commended the efforts of the department in responding to COVID-19, and discussed possible scenarios of how the Trust could organise itself to treat elective patients once this is a viable option again.

1.3 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 79.1% in March, which is adverse to the Trust's trajectory in the month. The Chief Operations Officer (COO) noted the challenges of sickness and self-isolation of staff in the month, although the Trust compares well against London peers. The COO also noted the current situation with respect to COVID-19, where attendances have dropped by as much as 57%, and 66% in paediatrics. The Committee discussed the importance of patients using the hospital if they need to clinically and the use of the Orchid facility at South West London & St George's Mental Health Trust which is having a positive impact on the Trust's ED performance.

1.4 Cancer Performance – the COO noted that the Trust met 3 of the 7 Cancer performance targets in February, noting challenges in patient choice and capacity in Diagnostics from previous months that continue to have an impact. She also noted primary care concerns, where referrals are lower than expected despite all referral pathways remaining open. The Committee discussed the different categories of cancer in terms of the urgency of surgical intervention.

1.5 Diagnostics Performance – the COO noted the pause in all non-urgent diagnostics owing to COVID-19. Diagnostics performance was therefore challenged in March, with 18.5% of patients having a Diagnostic wait of over 6 weeks compared with a target of 1%. The Committee discussed the use of Queen Mary's and St Anthony's Hospitals, and patients choosing not to come in owing to COVID-19 (even though they are entitled to).

1.6 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in February of 82.3% was below the incomplete target trajectory of 87.7%, and the number of 52 week waits of 11 was more than the trajectory of 0. The size of the waiting list (including QMH patients) was 48,061 patients. The COO noted performance in March, where 32 52-week waits had been observed (5 owing to patient choice from COVID, 20 through a consultant decision related to COVID, and 7 for non-COVID related reasons). She also noted performance in March against the



incomplete target (revised to 84.5%) of 79.0%, and a waiting list size of 47,100 against a trajectory of 43,750. The Committee discussed the use of the independent sector for elective care as the restrictions begin to be lifted from COVID-19 in the coming months.

1.7 Workforce Performance – the Chief People Officer (CPO) noted that the Trust ended the financial year with agency expenditure of £18.5m against an internal target of £15m, although the external target was £20.6m. He also noted staff sickness of 8.9%, which included 5.8% of COVID-19 related sickness. The committee discussed the use of volunteers, and progress with staff testing. On the latter subject, the Trust is offering a testing service to other trusts in South West London following challenges with their original testing provider.

1.8 Financial Performance – the ACFO noted performance in the draft accounts for 2019/20 (due to be submitted on April 27th) was adverse to plan by £10.3m (which was in line with the £9m adverse forecast- owing to an allowed control total adjustment for untaken COVID annual leave of £1.3m). The Trust is therefore expecting to show a £48.0m Pre-PSF/FRF/MRET deficit, or a £13.3m deficit after PSF/FRF/MRET. He noted that £5.1m of COVID-19 revenue costs were submitted for external funding, including the £1.3m annual leave value and £1.3m of lower SLA income not covered by year end settlements or block contracts. He also noted £1.7m of capital COVID-19 costs, and that all COVID-related costs were expected to be signed off by the regional NHSI/E team. The Committee discussed the different COVID cost submissions of other trusts in South West London.

1.9 2020/21 Planning Update (COVID-19) – the ACFO introduced the Committee to the paper providing an update on the financial plan for 2020/21, which included a paper that was shared with the Chair of FIC, Chair of the Audit Committee, Chair of the Trust, CEO and CFO for formal budget sign off prior to the 1st April. Discussion was had on the gap of £36.2m and the dialogue with the regional NHSI/E team on this subject. Capital funding was also discussed, where the South West London STP would have an overall capital pot that the Trust would need to bid against.

1.10 Procurement Update – the ACFO introduced an update on Procurement which looked at steps taken to maintain the supply of Personal Protective Equipment (PPE) and an update on 3 large contracts due for extension. The Committee noted this update.

2.0 Recommendation

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

Ann Beasley
Finance & Investment Committee Chair,
April 2020



Meeting Title:	TRUST BOARD		
Date:	30 April 2020	Agenda No.	4.2
Report Title:	M12 Finance Report 2019/20		
Lead Director/ Manager:	Tom Shearer, Acting Chief Financial Officer		
Report Author:	Michael Armour, Financial Accountant		
Presented for:	Update		
Executive Summary:	<p>The Trust has reported a Pre-PSF/FRF/MRET deficit in 2019/20 of £48.0m which £10.3m adverse to the Pre-PSF/FRF/MRET plan. This is in line with the forecast variance of £9m from previous months, as the Trust was allowed a control total adjustment for the COVID-19 impact on untaken annual leave of £1.3m.</p> <p>The Trust has recognised the full £34.7m of PSF/FRF/MRET funding available in 2019/20, in line with latest expectations. This means a post PSF deficit of £13.3m is reported.</p> <p>Against the external plan, income is favourable to plan by £12.3m, and expenditure is overspent by £22.6m.</p> <p>COVID-19 costs in March have been experienced of £5.1m, including the £1.3m noted above.</p> <p>The Trust spent £56.7m on capital in 19/20, including £1.7m relating to COVID 19.</p> <p>The Trust exited the year with £3.4m cash, in-line with plan.</p> <p>The Trust also recognised £0.5m of prior year PSF as discussed at the Finance & Investment Committee in June.</p>		
Recommendation:	The Trust Board notes the Trust's financial performance in 2019/20.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Finance & Investment Committee	Date	23/4/20
Appendices:	N/A		



Financial Report Month 12 (March 2020)

4.2



Chief Finance Officer

30th April 2020

Executive Summary

Month 12 financial position

It should be noted that all figures included in this paper are draft.

The Trust's forecast in M11 was a post-PSF/FRF/MRET deficit of £12m (£3m deficit control total + £9m adverse variance).

This has been adjusted by £1.3m to a £13.3m deficit. This is owing to a control total change allowed for the COVID implications on annual leave recognised in the year end financial position.

The Trust has achieved this year end forecast position.

The Trust has also spent capital inline with it's forecast. This is a spend of £55m. On top of this is £1.7m spend relating to COVID 19, which is expected to be funded.

The Trusts cash balance as at 31st of March was £3m. This was inline with forecast.

2019/20 Outturn By Division and Category- draft position

Externally reported position

Reconciliation to internal plan

			M12 Budget (£m)	M12 Actual (£m)	M12 Variance (£m)	M12 Variance %	Annual Budget (£m)	Annual Actual (£m)	Annual Variance (£m)	Annual Variance %	Internal vs External Plan Adjustments (£m)	Annual Variance vs Internal Plan (£m)
Pre-PSF/FRF/MRET	Income	SLA Income	57.8	67.2	9.3	16.1%	675.5	687.2	11.6	1.7%	(13.2)	(1.5)
		Other Income	14.3	11.6	(2.6)	(18.4%)	161.8	162.5	0.7	0.4%	0.0	0.7
	Income Total		72.1	78.8	6.7	9.3%	837.3	849.6	12.3	1.5%	(13.2)	(0.9)
	Expenditure	Pay	(43.0)	(58.2)	(15.1)	(35.1%)	(532.6)	(554.4)	(21.8)	(4.1%)	14.7	(7.1)
		Non Pay	(24.9)	(20.4)	4.6	18.4%	(306.6)	(308.9)	(2.3)	(0.8%)	(1.5)	(3.8)
	Expenditure Total		(68.0)	(78.5)	(10.5)	(15.5%)	(839.2)	(863.3)	(24.1)	(2.9%)	13.2	(10.9)
	Post Ebitda		(3.0)	(2.0)	1.0	33.6%	(35.8)	(34.4)	1.5	4.1%	0.0	1.5
Pre-PSF/FRF/MRET Total			1.2	(1.7)	(2.8)	(242.1%)	(37.7)	(48.0)	(10.3)	(27.3%)	0.0	(10.3)
PSF/FRF/MRET			3.8	10.4	6.6	171.0%	34.7	34.7	0.0	0.0 %	0.0	0.0
Total			5.0	8.7	3.7	74.4%	(3.0)	(13.3)	(10.3)	(343.1%)	0.0	(10.3)
Prior Year PSF			0.0	0.0	0.0	0.0 %	0.0	0.5	0.5	0.0 %	0.0	0.5
Grand Total			5.0	8.7	3.7	74.4%	(3.0)	(12.8)	(9.8)	(326.4%)	0.0	(9.8)

Division	M12 Budget (£m)	M12 Actual (£m)	M12 Variance (£m)	Annual Budget (£m)	Annual Actual (£m)	Annual Variance (£m)
C&W, Diagnostics, Therapies	2.1	(0.2)	(2.4)	14.9	1.0	(13.9)
Medicine and Cardiovascular	8.1	7.1	(1.0)	90.0	81.7	(8.2)
Surgery and Neurosciences	4.7	1.8	(3.0)	43.3	32.6	(10.7)
Overheads	(11.1)	(12.3)	(1.1)	(142.4)	(144.5)	(2.1)
Total Divisions	3.8	(3.6)	(7.4)	5.7	(29.2)	(34.9)
Other & Central	(2.6)	1.9	4.6	(43.4)	(18.9)	24.6
Grand Total	1.2	(1.7)	(2.8)	(37.7)	(48.0)	(10.3)

Month 12 financial position by category

- The Trust is reporting a Pre-PSF/MRET/FRF annual deficit of £48.0m at the end of March, which is £10.3m adverse to plan.
- The External performance of £21.8m adverse on pay expenditure is owing to shortfalls in pay CIPs, which were partially offset by additional Income and Non-Pay CIPs.
- Annual PSF/MRET/FRF income of £34.7m in the plan has been achieved, which is on 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.

Month 12 financial position by division

- Divisional shortfalls in financial performance have mainly been caused by shortfalls in CIP delivery.
- This has been partially offset by additional central CIP schemes.

Financial Report Month 12 (March 2020)
St George's University Hospitals NHS Foundation Trust



COVID costs- March 2020

Description- top 5 COVID items	Total £m
Annual Leave carry forward	1.3
Missing SLA income (outside block and year end settlements)	1.3
Pathology - testing materials	0.3
Repair & Kitting Parts (Estates)	0.2
Ward Nursing (Medcard)	0.2
Other	1.8
Total	5.1

COVID return for March 2020

- NHS Improvement are expected to agree funding of £3.8m and a control total adjustment of £1.3m (for annual leave) for COVID. The top 5 items in this total cost of £5.1m is shown in the adjacent table.
- The biggest items were additional annual leave (£1.3m; Trust Wide), SLA income shortfall on non-block or year end settlement commissioners (£1.3m; split by division), Pathology testing materials (£0.3m; SWLP), Repair & Kitting parts (£0.2m; Estates) and Ward Nursing (£0.2m; Medcard).

4.2

Capital spend DRAFT outturn

The trust achieved its overall capital budget for 2019/20

Application of funds	Original plan	FOT	Comments
Estates (all including P22)	18.977	17.131	Reduction is due to some of the programme on P22 being delayed into 2020/21, and some delays in construction works due to covid.
IT	12.700	17.619	The increase is made up of: £2.2m on capital bid monies + £0.7m through slippage on estates and £1.5m on Cyber security and Local Health record additional funding received
Equipment (purchase - including mammography monies)	1.000	6.483	The increase is a result of the additional £5.4m funding and slippage in other areas. Original plan £1m + Bid monies £3.5m + Buying planned leases £1.8m +Mammography £0.173m + PO for Phillips licenses - £0.150m
Equipment leases	5.500	3.850	Reduction in leased equipment offset by outright purchase noted above
HSLI	0.158	0.158	
Donated assest	0.500	0.500	
SWLP	0.500	0.500	
Cath labs and other contingency	6.100	5.500	Some slippage in cath lab build programme, offset by purchase of equipment
Other/contingency	2.554	3.000	Includes directly attributable costs to programmes incurred - will be allocated to specific categories above
SWL APC		0.280	New in year. Based on SWL APC Business Case
Total (excluding Covid)	47.989	55.021	
Covid related costs	-	1.756	Funded by DH - application for funding made
Total capital for the year	47.989	56.777	

- Overall the trust has a capital envelope of **£55m** to spend in 2019/20 made up as:
- Original plan - £47.989m
- Mammography - £0.168m
- Capital bid - £5.400m
- Cyber security PDC - £0.439m
- Local Health record funding - £1.024m
- In addition, the trust has been advised that any costs relating to Covid-19 response will be funded separately. Up to 31 March 2020, covid-19 response related capital costs were £1.7m. We have advised NHS London and the STP of this and expect to be re-imursed for these costs in April 2020***

- In individual areas, underspends in Estates relate primarily to P22 where delays in the programme meant not all works were completed by 31 March.
- There were further underspends in estates stemming largely from moving resource to the covid response in March, and covid related issues with supply chain; e.g. a generator ordered from a factory in Italy has not yet been delivered. As above, this has given rise to commitments in 2020/21.
- These underspends in some areas were noted due to weekly monitoring of capital spend since January 2020. Accordingly, spend which would have ordinarily been incurred in 2020/21 on IT, medical equipment (including cath labs medical equipment) was brought forward. This offsets the rise in estates commitments in 20/21.

4.2