Trust Board Meeting

Date and Time: **Thursday 27th September: 10:00 – 13:30**

Venue: **Hyde Park Room, 1st Floor, Lanesborough Wing**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the Tooting site**	**Board Members**	-	Oral
OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Gillian Norton** Chairman	-	Oral
	1.2	**Declarations of interest**	All	-	Oral
	1.3	**Minutes of meeting on 30 August 2018**	**Gillian Norton** Chairman	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
	1.5	**CEO's update**	**Jacqueline Totterdell** Chief Executive	Inform	Report
QUALITY & PERFORMANCE					
11:00	**2.1**	**Quality and Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
	2.2	**Integrated Quality & Performance report**	**James Friend** Director of Delivery, Efficiency & Transformation	Inform	Report
	2.3	**Cardiac Surgery report**	**Andrew Rhodes** Medical Director	Update	Report
	2.4	**Infection Prevention & Control Annual report**	**Avey Bhatia** Chief Nurse & Director of Infection Prevention & Control	Assure	Report
	2.5	**Elective Care Recovery Programme**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
	2.6	**Quality Improvement Academy Update**	**James Friend** Director of Delivery, Efficiency & Transformation	Inform	Report
	2.7	**Children's Safeguarding Annual report**	**Avey Bhatia** Chief Nurse & Director of Infection Prevention & Control	Assure	Report
FINANCE					
12:30	**3.1**	**Finance and Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
	3.2	**Month 5 Finance Report**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
HUMAN RESOURCES					
12:50	**4.1**	**Medical Revalidation report**	**Andrew Rhodes** Medical Director	Assure	Report
	4.2	**Fit and Proper Person Update**	**Harbhajan Brar** Director of HR & OD	Assure	Report
	4.3	**Staff Survey Report**	**Harbhajan Brar**	Assure	Report

Time	Item	Subject	Lead	Action	Format
			Director of HR & OD		
CLOSING ADMINISTRATION					
13:00	**5.1**	**Questions from the public**	-	-	Oral
	5.2	**Any new risks or issues identified**	**All**	-	-
	5.3	**Any Other Business**	**All**	-	-
	5.4	**Reflection on meeting**	**All**	-	Oral
13:10	**STAFF STORY - Aviation Safety Team**				
13:30	**CLOSE**				

Resolution to move to closed session
In accordance with Section 1 (2) Public Bodies (Admissions to Meeting) Act 1960, the Board is invited to approve the following resolution: "That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".

Date of next meeting: Thursday 25 October 2018, 10.00 – 13.00 Hyde Park Room, St George's Hospital

Trust Board
Purpose, Meetings and Membership

Trust Board Purpose:	The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Meetings in 2018-19 (Thursdays)									
25.01.18	22.02.18	29.03.18	26.04.18	31.05.18	28.06.18	26.07.18	30.08.18	27.09.18	25.10.18
29.11.18	20.11.18	20.12.18	31.01.19	28.02.19	28.03.19				

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Sir Norman Williams	Non-Executive Director/Senior Independent Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse & Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
In Attendance	**Designation**	**Abbreviation**
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Kevin Howell	Director of Estates & Facilities	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Mike Murphy	Quality Improvement Director – NHS Improvement	QID
Ellis Pullinger	Chief Operating Officer	COO
Secretariat	**Designation**	**Abbreviation**
Terri Burns	Interim Assistant Trust Secretary	ATS

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting

Thursday 30 August 2018, 10:00 – 13:30, Hyde Park Room, St George's Hospital

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Andrew Grimshaw	Chief Finance Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
IN ATTENDANCE		
Robert Bleasdale	Deputy Chief Nurse	DCN
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Kevin Howell	Director of Estates & Facilities	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Ellis Pullinger	Chief Operating Officer	COO
APOLOGIES		
Avey Bhatia	Chief Nurse and Director of Infection, Prevention & Control	CN
SECRETARIAT		
Terri Burns	Interim Assistant Trust Secretary	ATS

Feedback from Walkabout

Members of the Board gave feedback on the departments they had visited ahead of the meeting. These included: the Security Office, Acute Medicine Unit (AMU), Gray Ward, Transport Lounge, Foetal Medicine Unit, Phlebotomy Outpatients, Benjamin Weir Ward, Coronary Care Unit (CCU), Pre-Operative Assessment, Max Fax Unit, Cavell, and Medical Records.

The DEF reported that the security team had recently had a new CCTV system installed. Board members had been shown the processes in place for its use. New body cameras were also being introduced. Staff reported that around 70% of incidents that have been dealt with were related to parking. Team members also reported experiencing abusive behaviour when asking people not to smoke on the hospital site. Staff changing facilities were also in need of upgrade. The group also visited the Acute Medicine Unit (AMU) and were able to see the full patient journey. They spoke to a patient who attended regularly who, in turn, spoke very highly of all of the staff there. The team reported that staff turnover had settled down and the unit was generally working well. Some concerns

were raised in relation to other wards being more developed technologically.

Tim Wright reported that the group were greeted on Gray Ward by a nurse who was very proud to have worked there for 15 years. Staff were able to give full responses when asked what good care meant to them. Hand hygiene and infection control were very good and communication was a priority for the team. There were some details that needed more focus, such as addressing some clutter on the ward. The team in the Transport and Departure areas were very aware of the importance of getting patients in the right place early in the day to ensure transfers were as efficient as possible.

The COO reported that the Foetal Medicine Unit was calm, well organised and staff were motivated. There was a great deal of research being undertaken, as well as investment in technology. There had been some good utilisation of space, however the administrative area could have been better organised. The group had also visited the Carmen Suite, where the birthing pools were now running. Staff were expecting the Suite to be busy in September. Whilst visiting the Phlebotomy service, the group had seen how patient flow worked. The COO was disappointed that the budget had not been shared with the team, as promised, and agreed to ensure this happened.

Stephen Collier reported that the group had been told that a typical stay on Benjamin Weir Ward was usually five to six days. The Ward was calm and well organised, with a well-motivated team which was keen to improve on their ward accreditation. The challenges faced were mainly related to recruitment and retention, which plans were in place to try to address. Key rings were used as a reminder about the type of behaviours and processes that should be embedded by staff. It was noted that there was a new senior nurse, who due to Agenda for Change, had taken on more responsibility but not received an uplift in pay. The Coronary Care Unit (CCU) was staffed by a very experienced team, which was reviewing how to improve the flow of patient information. There was a flexible approach to the service, due to its nature, with a clear awareness of budgets and how small things could make a difference to visitors.

The DHROD reported that previous issues related to moving patients to the Pre-Operative Assessment area had now been resolved. Signage had improved, but staff had been concerned that, on one occasion, an arrest call was made but the staff responsible for responding had not known where the unit was located. There were plans in place to review income generation, which may have an impact upon the use of space in the unit. It was noted that HR support staff were located in an office in the middle of the clinical areas, which was not appropriate and this needed to be reviewed. In the Max Fax Unit, there was only one lift, which could be problematic if it was out of order. The reception area needed better signage, and a self-check in was being considered. The group noted that there were concerns about privacy in the dental treatment areas, particularly for children. Sir Norman Williams stated that the staff were concerned about the heating and air conditioning in the area, which had been raised several times before but was not yet resolved.

The MD reported that the Cavell Ward had a high turnover of patients due to the nature of the service. The main concerns were related to general estates issues. Staff were keen to improve upon their last ward accreditation rating. The Medical Records department showed a very good turnaround compared with a year ago. There was much greater organisation and the manager had had a significant impact. Some concern was expressed by staff in relation to the consultation which was about to take place. Management would need to ensure that there was sufficient support in place for them. It was noted that there was empty space in the records library due to moving to electronic records. Thought would need to be given to how to use this additional space.

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed members of the public and a number of the Trust's Governors. Apologies had been received from Avey Bhatia, Chief Nurse and Director of Infection, Prevention & Control; Robert Bleasdale was deputising for her.
Declarations of Interest	
1.2	Ann Beasley declared that she would be taking up the role of Trust Chair at South West London & St George's Mental Health Trust, starting on 1st October 2018.
Minutes of previous meetings	
1.3	The minutes of the meeting held on 26 July 2018 were agreed as a true and accurate record, subject to a minor amendment.
Action log and matters arising	
1.4	The Board noted the action log, agreed the actions proposed for closure, and noted the following updates: • TB. 29.03.18/ 77 – The Staff Survey action plan had been discussed by the Workforce & Education Committee and a report on this will be brought to the next Board meeting • TB. 28.06.18/ 85 and TB. 26.07.18/ 94 – Dates for Board Seminars were in the process of being arranged • TB. 26.07.18/ 87 – The Quality and Safety Committee would be reviewing external audit information • TB. 26.07.18/ 92 – To be closed
1.5	**CEO's update**
	The CEO reported that the Trust had taken a number of immediate actions to begin implementing the recommendations of the Bewick review on the cardiac surgery service. The report had been published on the Trust's website earlier in the month. There had been significant media coverage of issues affecting the service. The Trust was taking action to address these issues and the principal focus of the Board was ensuring patients were safe and staff were supported. Significant change was required to introduce the improvements necessary, and the Board was committed to taking the actions necessary to ensure a safe and high quality service over the long term. The 10 year NHS Plan was being developed jointly by NHS England and NHS Improvement and would be published in the autumn. This would identify priority areas nationally and would have implications for allocation of funding and investment. The Trust wanted to ensure it was at the forefront of using new models of care. The Quality Improvement Academy had also been launched, with good levels of staff engagement being seen. The CEO also congratulated Dr Shai Betteridge, Professor Sanjay Sharma and Dr Aneil Malhotra for having their work recognised externally. The Board also noted that the Annual

	Members Meeting was planned for 27 September 2018.
STRATEGY	
2.1	**St George's Hospital Charity Report**
	Anna Walker, Charity Chair, and Paul Sarfaty, interim Charity Chief Executive, attended to present to the Board. They reported that, over the last seven years, the Charity had contributed around £20m to the Trust. Other major hospitals had received significantly greater assets over a longer period of time. The charity would be setting their ambitions significantly higher for the future in relation to income. The majority of the funds had been spent on staff development and welfare, as well as patient experience. More work was needed to create well defined appeals for a popular purpose, in order to increase income. A new Chief Executive had been appointed and would be starting in post on 1st October. It was expected that the Charity would benefit from the new Chief Executive's significant experience. The Charity had made a great deal of progress developing relationships with the Trust. Tim Wright's appointment as a trustee had been invaluable, as well as the close working that the DS had been undertaking. This would be built on further to ensure more progress was made. The Charity recognised the challenges faced by the Trust, but noted the need to engage more with consultants in relation to use of Special Purpose Funds, which were significantly under-spent. A clear definition of what the Trust needed from the Charity was also needed. Paul Sarfaty observed that he had seen a significant improvement in engagement in the last six months. The CEO stated that the programme of work would become more defined as the Trust strategy developed. There was a strong interest in multi-disciplinary research, which would likely be one of the areas considered. The Trust was keen to ensure projects led to direct patient benefit and were carried out by a variety of staff groups. Tim Wright stated that the challenges were clear. He had been concerned about potential conflicts of interest when becoming a trustee, however this had not been an issue. He felt that improvements could be made to processes, as well as communicating how funds were spent to donors. The DHROD informed the Board that the staff awards, which had been funded by the charity, had been very well received by staff. Follow up was needed in relation to staff development and welfare however, in order to better demonstrate outcomes. Paul Sarfaty noted that the next staff awards would be taking place on 16 May 2019. The DS stated that she had been attending trustee meetings where appropriate and was reviewing how to improve processes. She would also be reviewing how best to improve estates project capacity to ensure funds could be used in a timely manner. Katherine Harrison, Lead Governor, noted that governors would be keen to get involved with helping the Charity in any way possible. The Board noted the report.
QUALITY & PERFORMANCE	

3.1	**Quality & Safety Committee Report**
	The Committee Chair reported that the Committee had been pleased with the outcome of the CQC visit, although there was still work to be done for the Trust to come out of special measures. The Committee were assured that an increase in C. difficile was not due to any failures in care and was being closely monitored. The Trust was below the national average in relation to the mortality review, which was positive. However there were a few areas of note. In relation to an alert relating to hip replacements, only complex cases were carried out at St George's Hospital with elective cases being done externally. The Committee were informed that same day cancellations were mostly due to lack of beds and operating lists running over. Around 40% were due to emergency trauma. ECRP was on target for return to reporting. An early stage GIRFT report was also reviewed. The Committee were also updated on cardiac surgery, with importance being placed on implementing the recommendations of the Bewick review. The CQC had also carried out a review of cardiac surgery earlier in the month, but the Trust had not yet received the report. The Committee were assured of water safety and noted significant improvements in relation to learning from deaths. Ann Beasley asked whether the hip mortality alert had been expected and if the system used already made allowance for complex cases. The Committee Chair stated that the alert process was less mature than, for example, NICOR in relation to cardiac surgery, and would therefore not allow for complexities in the same way. The MD noted that the alert was expected and that every death was reviewed. Both the Trust and the CQC agreed that the hip replacement service was safe. The Board noted the report.
3.2	**Integrated Quality & Performance Report**
	The DDET reported that development of the balanced scorecard was continuing. The Trust was on track for Outpatient delivery overall, though further improvements were still needed. Improvements in theatre productivity were not as good as expected. Staff had been challenged to ensure the booking process was used efficiently to improve productivity. Cancer performance was much improved for August. The DHROD reported that agency use was above the cap for two months, however was still below target overall. Appraisal rates were improved, as were vacancy rates. The biggest concern was turnover, which was a key area of focus to address. Sarah Wilton noted that weekend emergency mortality had increased, as well as the number of complaints for July having gone up, and would welcome more detail. The MD stated that the reasons for mortality figures were not yet fully understood and were being investigated, although the Trust remained in a better position than the national figures. The DCN stated that complaints were triaged to establish their complexity. Overall performance was on track to meet the targets set. Additional resource had also been put in place to streamline processes. The COO apologised to patients who had had to wait longer than expected for cancer

	appointments, acknowledging that it was not acceptable. The Board noted the report.
3.3	**Elective Care Recovery Programme**
	The COO reported that only 19 patients were referred following the phase one work in relation to the Clinical Harm Review. He also noted the report appended, from RM Partners, which showed progress against recommendations. Ann Beasley noted that the Patient Tracking List was discussed in detail at the Finance & Investment Committee and noted as remaining a significant challenge. The Board noted the report.
3.4	**Emergency Care Performance**
	The COO reported that the August position for Emergency Department performance was below trajectory. Performance had deteriorated in August across admitted and non-admitted pathways, and the Trust was currently delivering 90.32% against a trajectory of 94% for August. Performance against the agreed trajectory by quarter was linked to eligibility for PSF funding from NHSI, so performance had significant financial implications. Key areas of focus were highlighted and the priority would be shift leadership. Stephen Collier noted that junior doctor vacancies were high in July. The DDET stated that this was due to some junior doctors having resigned earlier than expected and planned for. Actions were in place to address the shortfall. The Board agreed the recommendations and noted the report.
3.5	**Learning from Deaths Quarter 1 Report**
	The MD reported that the report had been reviewed by the Quality and Safety Committee. Reporting to the Board was a national requirement. The number of reviews carried out was above the level required. The main areas of concern would be reviewed by the Mortality Monitoring Committee and reported via the Quality and Safety Committee. The Board agreed the recommendations and noted the report.
3.6	**CQC Report**
	The MD reported that the Trust rating had moved from 'inadequate' to 'requires improvement', but that the Trust remained in quality special measures. Further improvements were therefore needed. The main areas of focus were; leadership in the Emergency Department and Outpatients, mental health provision, the ability to track and monitor patients and processes. An action plan was in place to progress these and other areas which had been submitted to the CQC earlier in the month. This included steps to respond to the "requirement actions" set out in the CQC's inspection report, and the additional actions identified. The CEO stated that the Outpatient consultation would need to ensure that staff were included in the process, as well as improvement being sought for the benefit of patients. The Board noted the report, and that it was committed to taking the actions necessary to exit quality special measures as soon as possible.

FINANCE	
4.1	**Finance & Investment Committee Report**
	The Committee Chair reported that the Committee had expressed concerns in relation to theatre utilisation, as it affected planning and income. The variability of Emergency Department leadership quality was also discussed, which needed to be addressed. Return to reporting was discussed, as well as the need for much broader training and the associated investment necessary. The Committee Chair noted that the Trust had already been aware that quarter two would likely be difficult, with the rest of the year becoming even more so. Because of this, a tight grip would be needed on delivery and accountability ensured where control targets were not being met. CIPs were slightly behind plan. The plans in place came from staff, so they would need to be held accountable for delivery. The Board noted the report.
4.2	**Month 4 Finance Report**
	The CFO reported that quarter one risks were now materialising. Actions were being taken to address the CIPs shortfall and he was confident that they would still be delivered. Clear divisional responsibilities for delivery were in place. Some areas were overspending on staff and more prescriptive direction would be implemented if this was not addressed adequately. Access to capital funds was being controlled tightly. The Board noted the report.
GOVERNANCE	
5.1	**Workforce and Education Committee Report**
	The Committee Chair reported that the Committee had reviewed the Staff Survey results. They were not as good as those of other London trusts. Actions were in place to address those areas with the lowest scores. A lead was in place for diversity and inclusion, with a 12 month plan for delivery agreed. The workforce plan had not yet been reviewed by the Committee, which would have an effect on CIPs. Work on establishment reviews was continuing. There was also a constructive report received in relation to safe working. The GMC had audited the Responsible Officer process that was in place and found there had been progress made. The Committee had noted that pan London locum rates were due to change the following week. This would be difficult to deliver as demand for locums remained strong. Sarah Wilton stated that the staff survey result was disappointing and that it would be helpful for the Board to see the action plan. The CEO noted that the HIS had highlighted the Trust response rate as being the most improved in the country. Although there was still progress to be made, this was a positive step and cultural progress was a slow process. **TB. 30.08.18/ 96: Staff Survey action plan to be reported to the Board.** The Board noted the report.

5.2	**Guardian of Safe Working Report**
	The MD informed the Board that the report was intended to assure them of the welfare of junior doctors. The issues identified correlated to general areas of concern within the Trust. The DS asked whether the reduction in number of junior doctors would have an impact on the results. The MD stated that there tended to be more exception reporting when there were rota gaps, as these gaps needed to be filled. The new junior doctor contract had created political tensions and had in turn led to greater reporting. Sir Norman Williams noted that the NHS as a whole had historically relied heavily on junior doctors. He was keen to ensure that the Trust had consultant led care and that junior doctors were well supported. The MD agreed and noted that when junior doctors were well looked after, improvements were also seen in other metrics. The DHROD stated that the report was a tool to facilitate discussions and allow the Trust to encourage reporting from junior doctors, as this would enable better understanding of the issues that needed to be addressed. The Board agreed the recommendations and noted the report.
CLOSING ADMINISTRATION	
6.1	**Questions from the public**
	Hazel Ingram, Patient Representative, asked whether the issues raised in relation to cardiac surgery were the same as those that raised some years earlier. The CEO stated that issues noted in the Wallwork report were not dissimilar to those raised previously in the Bewick report.
6.2	**Any new risks identified**
	No new risks were identified.
6.3	**Any Other Business**
	No other items of business were raised.
6.4	**Reflection on the meeting**
	Tim Wright queried whether a log was kept of who had visited which areas during the Board Walkabout sessions. The DCA stated that there was a log and that every effort would be made to ensure all areas of the Trust were visited. An action log was also reported from the visits, to the July Board meeting, and would be presented quarterly. The DCN noted that there was a particular focus on including non-clinical and support areas. It was noted that preparatory notes would be helpful ahead of the visits, with any relevant information that may come up during discussions with staff.
	PATIENT STORY
	Liz Aram gave a video account of her experiences as a patient. She had accessed inpatient,

	outpatient, surgical and diagnostic care since she was diagnosed with cervical cancer. She spoke very highly of her care at the Trust and was grateful to all of the staff who took care of her. She became involved in the Macmillan Improving Cancer Care Project and is Co-Chair of the Trust's new Patient Partnership and Experience Group. Liz did, however, have a number of reflections about each stage of her treatment and made some suggestions about what the Trust might do to improve the patient experience, particularly around improved communication. Janice Minter, Macmillan Lead Cancer Nurse, also attended the Board to answer any questions and share more about the patient experience in Cancer Services. Janice stated that the Trust had a very good relationship with Macmillan and strong patient representation. The care in place was good and the relationship was being used to improve processes. Patient pathway issues had been identified and work was taking place to address these. A great deal of communication was taking place to ensure patients knew what to expect and were empowered to ask questions. A new role of Macmillan support workers was also being developed to address the shortage of qualified nurses. The CEO stated that dealing with a cancer diagnosis was obviously a difficult time for patients, so the Trust needed to ensure the experience was as positive as possible and all staff were engaged with the improvements being made. Janice informed the Board that communication training was being given, as well as having a nurse present at appointments and follow up calls being made, so that patients had more opportunity to ask questions. An app was also in development as another communication tool. The Chairman stated that she was very pleased to see the improvements that were being made, although there remained work to be done. She thanked those involved, including Liz for her contribution and constructive suggestions.

Date and time of next meeting: Thursday 27 September 2018, 10:30 – 13:30
Hyde Park Room, St George's Hospital

Trust Board Action Log - August 2018

Action Ref	Theme	Action	Due	Lead	Commentary	Status
TB. 29.03.18/ 77	**NHS Staff Survey 2017**	Staff Survey action plan to be considered by the Board after the discussion at next meeting of the Workforce and Education Committee	28.06.2018	DHROD	Workforce and Educaton Committee considered a report on 9 August. A paper on the staff survey is on the agenda.	PROPOSE FOR CLOSURE
TB. 28.06.18/ 81	**Corporate Objectives 2018-19**	Objectives to be recirculated to Board members following further update, within two weeks	13.07.18	DS	Board noted final version of objectives and considered Q1 report at July Board meeting.	PROPOSE FOR CLOSURE
TB. 28.06.18/ 85	**Workforce & Education Committee Report**	Diversity and inclusion Board seminar to be arranged	26.07.18	DHROD & DCA	Board workshop dates for remainder of 2018/19 are confirmed. An additional slot is being sought for this item.	OPEN
TB. 26.07.18/ 87	**Corporate Objectives 2018-19**	Information from both formal and informal clinical audits to be used as a learning tool to prevent recurrence of SIs and NEs	27.09.18	CN	Six monthly review of SIs presented to QSC in September 2018	OPEN
TB. 26.07.18/ 88	**Corporate Objectives 2018-19**	RAG rating methodology to be reviewed by executive team	31.10.18	DS	To be reported to October 2018 Board meeting.	OPEN
TB. 26.07.18/ 94	**Board Assurance Framework**	Board workshop on BAF to be arranged	30.08.18	CN/DCA	Board workshop dates for remainder of 2018/19 are confirmed. Provisional additional slot in Nov 2018 for BAF has been arranged.	OPEN
TB. 30.08.18/ 96	**Workforce and Education Committee Report**	Staff Survey action plan to be reported to the Board	25.10.18	DHROD	On agenda as part of item 5.1	PROPOSE FOR CLOSURE

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 September 2018	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

Chief Executive's report to the Trust Board – September 2018

Cardiac surgery:

In August, I began my monthly report to the Trust Board with an update on cardiac surgery.

It would be remiss of me not to do so again in September, given the extensive media coverage of the issue in recent weeks; as well as a number of actions we have taken to improve the service since August.

There have been two major developments, which are the result of proactive steps we've taken to stabilise the service, and protect its long-term future.

Since 10 September, we have transferred the operations of a small number of patients requiring the most complex cardiac surgery to other London hospitals. Last week, we also agreed jointly with Health Education England that it would be in the best interests of our trainees for them to complete their rotations elsewhere.

Both decisions were taken in the best interests of our cardiac surgery staff, patients, and the organisation as a whole. However, I also know this represents huge amount in a short space of time – and we are working hard to support staff directly and indirectly affected by the situation.

The changes have been enabled us to improve governance arrangements within the service, and multi-disciplinary working – both of which were highlighted in the Bewick report as requiring strengthening.

We remain focussed on implementing all the recommendations of the Bewick report, and the independent panel convened by NHS Improvement will oversee the improvements we are determined to deliver.

I have said from the outset that independent, external scrutiny of the work we are doing is essential – and I remain confident that the steps we are taking are the right ones.

Of course, the past few weeks have been challenging, but maintaining the status quo – and not tackling the issues identified by Bewick – would have been the wrong thing to do; for both our patients and staff.

Finance:

Last year, we reduced our financial deficit to £53.1 million, and our target end of year deficit for 2018/19 is £29 million.

I am confident we have a robust plan in place to deliver the required savings, whilst also maintaining high quality services for patients.

However, it's clear from our financial performance so far this year that we are not hitting the plan currently - and a step-change is required if we are ensure we don't go further adrift.

As stated above, we need to see a sustained increase in elective activity, as well as delivery of our cost improvement plans.

We are putting mitigating actions in place to ensure the position is recovered, but this does mean the coming weeks and months are likely to be challenging as a result.

Quality:

Our quality improvement agenda remains a priority.

The CQC's report in June saw our overall rating improve from Inadequate to Requires Improvement, and we have been working hard since then to address the 'must dos' and 'should dos' in their report.

We also had an unannounced inspection from the CQC in our cardiac surgery unit in late August – and we await their report.

We have talked a lot about delivering the fundamentals of patient, and **treat the patient, treat the person** is one of our organisational objectives.

We continue to see progress in a number of areas in this regard. For example, our MRSA and Clostridium difficile infection rates are below trajectory, and better than the national average for a Trust of our size and the range of specialties we provide.

Our mortality indicators (SHMI and HSMR) continue to be lower than expected, which is another positive, although it is important not to over-interpret the significance of these signals.

The work of our Quality Improvement Academy will be crucial over the coming months, as we continue to try and embed a quality improvement culture within the organisation. There are positive signs in this regard, but this requires a cultural shift, so will take time.

Key Trust-wide developments:

There have been a number of important developments since the last meeting in August.

Last week, I was delighted to announce the appointment of Dr Richard Jennings as our new Chief Medical Officer. Richard's will join us from the Whittington, where he has been Executive Medical Director since June 2014.

A start date for Richard has yet to be agreed, but Professor Andrew Rhodes continues in his role as Acting Medical Director at the Trust. Andy has made an enormous contribution in the role, and I am extremely grateful for the job he has done, and will continue to do.

It was also announced that Ann Beasley, Vice Chair and Non-Executive Director, has taken on the role of Chair at South West London and St George's Mental Health NHS Trust. However, Ann will continue in her role as NED here at St George's, which is great news for the Trust.

We launched two separate Trust-wide campaigns this month, aimed at encouraging staff to get vaccinated against influenza, and to complete the annual staff survey. We saw

improvements in response rates to both campaigns last year – and are aiming for a similar uplift this time around.

We are also continuing to engage with our stakeholders and healthcare partners. In recent weeks, we have held an executive to executive meeting with Ashford and St Peter's, plus Board to Board meetings with Wandsworth and Merton CCGs. This has been helpful in terms of understanding the different demands on our respective organisations, and how we can work in a way that best supports our staff, and the communities we serve.

I am also delighted that we will begin the official roll-out of iClip to the remaining inpatient wards at St George's next month. This is a significant step forward for the organisation, and whilst improving our clinical systems remains a long-term project, this is positive news for staff. I am also pleased that we have appointed Jenny Muir as our first Chief Nurse Informatics Officer – she will provide support to Dr Matt Laundy, who is doing sterling work as our Chief Clinical Information Officer.

Annual Members' Meeting – Thursday 27 September:

On Thursday, 27 September, we are holding our Annual Members' Meeting in the Monckton Lecture Theatre at St George's. The event starts at 6.30pm.

I am delighted to say that Libby Keating, one of our patients, has agreed to speak at the event, having been looked after by our teams after suffering serious facial injuries after a fall from her horse last year.

As always, patients, staff and members of the public are welcome to attend – and, as well as hearing from Libby, there will also be an opportunity to ask questions of the Trust Board, and hear about the progress we have made over the past 12 months.

Use of the Trust seal:

I can confirm that there have been no uses of the Trust seal this month.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 September 2018	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee report**		
Lead Director/ Manager:	Sir Norman Williams, Chairman of the Quality and Safety Committee		
Report Author:	Sir Norman Williams, Chairman of the Quality and Safety Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 20 September 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	N/A		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Quality and Safety Committee Report – September 2018

Matters for the Board's attention

The Quality and Safety Committee met on Thursday 20 September 2018 and agreed to bring the following matters to the Board's attention:

1. **Quality Improvement Plan**

The Committee heard from the Quality Improvement Director that there had been a decline in performance in two metrics relating to Duty of Candour in the Children and Women's' Directorates and that plans were in place and the position had recovered. The percentage of Fire warden trained staff on each shift had deteriorated slightly and increased divisional focus had been agreed at the Trust Executive Committee. Finally the percentage of patients with red flag sepsis receiving antibiotics within one hour in ED had deteriorated, this was thought largely due to changeover of junior doctors and there was a clear expectation that the position would improve going forward.

The Chief Nurse advised that in addition to the QIP dashboard, a progress update against the Trust's response action plan to the CQC inspection would be submitted to the next Committee and regularly going forward.

2. Integrated Quality & Performance Report

The Committee received the report and noted that no new Never Events had been reported and the number of Serious Incidents (SIs) declared had decreased. In relation to C *difficile* the Chief Nurse advised the Committee that the same number of cases had now been reported in 2018/19 as at year end in 2017/18. However, no lapses in care had been identified through root cause analysis of each case. The Committee heard that the Trust was working with the NHSI collaborative around E coli in order to ensure best practice. The Committee also heard that there had been no MRSA bacteraemia now for 13 months.

The Committee was informed that reporting on Pressure Ulcers requirements were changing nationally which will impact on Trust reporting and a more detailed report will be provided to the October Committee.

3. **Deep Dive – Clinical Records**

The Programme Manager for the Clinical Records QiP work stream presented an update report and advised that storage of clinical records overall was improving due to increased staff awareness and better storage facilities. However, loose filing remained a significant problem. The Committee discussed the long term solution as electronic records but challenges remained in the intervening period around ensuring appropriate filing and storage.

4. Elective Care Recovery Programme

The Committee heard from the COO that a meeting had now taken place with commissioners and regulators to agree a schedule for return to reporting. An important stage was for an external assurance review to take place, the scope of which was currently being drafted by the CCG. The Committee heard that commissioners had indicated a desire to

close down the GP validation work as less than 1% of patients seen by GPs to date had required further intervention at the Trust. An updated report would be submitted to the Trust Board in September 2018.

5. Patient Safety and Quality Group

The Committee heard that the implementation of a new Early warning score (NEWS2) had been discussed as problematic at the PSQG due to incompatibility of the Cerner system with the new tool. Use of the new NEWS2 was also a CQUIN requirement and a solution was actively being sought with Cerner. The risk of implementing NEWS2 without Cerner capability had been formally risk assessed.

The PSQG had also discussed the most recent mortality signal for Quarter 3 2017/18 relating to Cardiothoracic ITU. A review of the data had been undertaken to understand the possible reasons for this and the Medical Director emphasised that mortality rate had returned to a normal range the following quarter.

6. Safeguarding Children's Annual Report

The Committee received the annual report for 2017/18 and noted that further detailed data around referrals would be helpful. The Committee heard that this had been difficult to obtain but that since the start of 2018/19 the Head of Safeguarding and Named Nurse Safeguarding Children who were both new in post had instituted a much more robust system for collating and analysing this data. It was agreed that further data would be included before the report is submitted for the September 2018 Trust Board to consider.

7. Cardiac Surgery

The Medical Director advised the Committee that the formal action plan was in place and progressing. Health Education England had now arranged alternate replacement of cardiac trainees and sufficient mitigation was in place to cover rota gaps.

Complex surgery had been paused at St George's currently with other units providing cover and support for our patients. Consideration was now being given to the requirements of returning the activity safely and the longer term potential impact of our surgeons becoming de skilled. The Medical Director assured the Committee that full support was being provided to the wider cardiac team in the face of continuing media coverage. A separate report will be provided to the September Trust Board.

8. Serious Incident (SI) Thematic Analysis

The Committee received the second six monthly report and the Associate Medical Director reported that the number of SIs declared was reducing but that processes for declaration had not changed. In particular the number of falls related SIs had reduced. Actions highlighted from the thematic reviews continued and were a longer term piece of work, especially around intractable issues such as communication, but these would nonetheless need to be tackled.

9. Maternity SI thematic review

The Committee heard that the maternity service had declared six SIs year to date with one of these having been de-escalated, compared with eight in the same period the previous year. One identified theme was the interpretation of CTG monitoring with a significant amount of work on-going in relation to this. Further to this the lead Midwife for Governance advised that

the issues raised in each case were very different and no underlying themes had been identified.

10. Infection Prevention and Control Annual Report

The lead Consultant for Infection Prevention and Control presented the report and the committee was reassured that the trend was largely positive. The full report will be presented to the Trust Board in September 2018.

11. 12 Hour Trolley wait – summary report

The COO updated the committee around the root cause analysis of 12 hour trolley waits and of the six breaches since April 2018, four related to the care of patients attending the ED with acute mental health needs and delays in an appropriate mental health beds being made available. The Chief Nurse advised that she was meeting with the Chief Nurse for SLAM the following week to discuss patient safety and quality issues and what more could be done to safely manage patients.

12. Health and safety Report

The Health and Safety Manager presented the six-monthly report and the Committee heard that of the 1000 health and safety related reported incidents during the period, 2% had caused moderate or above harm, however violence and aggression towards staff continued to be an issue and the number of needle stick incidents had plateaued. More work is being done to deliver the required further reduction in these types of incidents.

13. Board Assurance Framework

The Chief Nurse updated the committee that there had been no material changes to the four risks allocated to the Committee in the intervening period but that there are new risks in relation to cardiac surgery to be fully worked through and aligned appropriately to the BAF in time for the October quarterly BAF update.

14. NHS Social Care Dashboard

The Committee welcomed the positive news from Healthwatch that the NHS Social Care Interface Dashboard for 2017/18 had been published. This dashboard brings together a range of metrics on the performance of local areas in relation to the interface between the NHS and Adult Social Care and Wandsworth was seen to be the second best performing area (out of 150) for joined up working in the country.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 27 September 2018
Reporting period – August 2018

Outstanding care, every time

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

August 2018

Daycase and Elective Surgery operations

Actual
4,476

Target 5,085

Discharges before 11am

Actual 17.70%

Target 30%

Four Hour Emergency Standard

Actual
91.09%

Target 95%

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
90%

Target
88%

Whole Trust Inpatient Friends and Family Test

Actual
97%

Target
95%

Outpatient First Appointment

Actual 15,615

Target 16,732

Activity Summary

St George's University Hospitals NHS
NHS Foundation Trust

The table below compares activity to previous months and quarters and against plan for the reporting period

		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Aug-17	Aug-18	Variance	Plan Aug-18	Variance	YTD 17/18	YTD 18/19	Variance	Plan YTD	Variance
ED	ED Attendances	13,328	13,270	-0.44%	14,398	-7.83%	69,661	69,975	0.45%	71,060	-1.53%
Inpatient	Elective & Daycase	4,618	4,476	-3.07%	5,082	-11.92%	22,885	23,692	3.53%	24,886	-4.80%
	Non Elective	3,733	4,027	7.88%	4,073	-1.14%	19,483	19,868	1.98%	20,393	-2.58%
Outpatient	OP Attendances	51,970	52,198	0.44%	56,012	-6.81%	259,874	272,890	5.01%	273,991	-0.40%

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

Source: SLAM

Balanced Scorecard Approach

OUTSTANDING CARE, EVERY TIME

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE & PRODUCTIVITY** PERSPECTIVE	Activity Summary	Bed productivity (length of stay)	Outpatient productivity (Attendances per day)	Theatre productivity (cases per session)		
OUR **PATIENT** PERSPECTIVE	Patient safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations		
OUR **PEOPLE** PERSPECTIVE	Workforce	Agency use				

Executive Summary – August 2018

St George's University Hospitals NHS
NHS Foundation Trust

Our Outcomes

- The area of greatest delivery challenge to the trust is around Elective activity through Theatres, Workforce planning, including annual leave planning, and operational processes bottlenecks, including booking capacity, combine to mean that the Trust is under utilising main theatre capacity. An activity Recovery Plan, initially focused on Urology and ENT, has been created to provide assurance over the aspects of the delivery control framework and to set out eleven key improvements required.

Finance and Productivity

- Elective and Daycase activity is currently below plan. Cases per session are below previous highs in Cardiothoracic, General Surgery and Trauma and Orthopaedics, and as a Trust below the same period last year. Recent improvements have been seen within Urology. Overall theatre touchtime utilisation is tracked weekly and continue to perform at 79% against the 85% threshold targeted. Recent increase seen within ENT and Neurosurgery. The number of daycase procedures per working day have seen a reduction in the month of August, however Elective treatment has seen an increase

Our Patients

- The Trust reported two patients with attributable Clostridium Difficile infection in August, against an annual target set at 30 cases in 2018/19. The Trust is reporting fifteen cases year to date and is above the threshold trajectory for the period between April and August.
- Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns.

Process

- The Trust has delivered the aggregate position for Quarter 1 against the Four Hour Operating Standard however August's reportable position at 91.1%, below the monthly trajectory of 94%. The improvement trajectory requires the delivery of 95% performance in September 2018 and relies upon continued improvement in the experience for patients not requiring admission.
- The Trust achieved five of the seven national mandated cancer standards in the month of July, continuing to achieve 62 day compliance, however both the 14 day breast symptomatic standard and the 62 Day Screening were not met reporting 55.2% and 73.8%. This primarily due the performance within the Breast pathway.
- The target for the number of elective patients cancelled for non-clinical reasons continues. Focus remains on reducing this further and on ensuring that all patients are always rebooked within 28 days which has seen a significant improvement in August the Trust re-booked 84.1% of patients within 28 days.

Our People

- Staff sickness remains above the trust target of 3% for the month of August.
- Non-medical appraisal rates have seen a 2.1% improvement. Performance in August was 69.7% against a 90% target.
- For August, the Trust's total pay was £0.39m adverse to the plan with the biggest area of overspend within interim posts.

Length of Stay

Non Elective Length of Stay (General and Acute Beds)

															Average length of Stay			
Directorate	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Discharges in the last month	2017-18	2018-19	Variance	Trend
Acute Medicine	3.1	2.8	2.9	3.0	3.2	3.4	3.5	2.8	2.9	2.7	2.6	2.7	2.8	2,558	3.0	2.7	-0.25	
Cardiothoracic	8.6	8.5	8.2	9.2	8.8	9.4	8.3	9.0	9.0	8.7	7.8	8.3	8.5	276	8.8	8.5	-0.31	
Childrens & Women	3.9	3.1	3.7	3.4	3.4	3.9	3.3	3.2	4.4	3.5	2.9	3.8	3.5	386	3.3	3.6	0.31	
Neurosciences	8.0	10.7	10.1	9.5	10.6	9.4	8.7	10.6	8.9	10.6	11.6	9.2	9.0	307	9.4	9.9	0.44	
Senior Health	13.6	19.3	19.2	8.9	9.5	9.9	9.3	8.4	11.3	10.2	11.8	7.6	11.8	100	12.9	10.5	-2.42	
Specialist Medicine	6.2	8.4	7.0	6.8	9.7	7.7	9.7	7.6	6.1	9.2	7.3	6.0	8.6	239	7.8	7.4	-0.33	
Surgery & Trauma	4.3	4.4	5.0	4.6	4.4	4.8	5.0	4.3	4.6	4.0	4.4	3.2	5.1	846	4.5	4.3	-0.22	
Theraputics	12.8	18.0	20.7	7.8	17.2	6.1	7.5	13.2	9.4	9.8	3.6	18.8	9.9	17	11.9	10.3	-1.58	
Grand Total	**4.4**	**4.5**	**4.7**	**4.4**	**4.8**	**4.8**	**4.9**	**4.5**	**4.5**	**4.4**	**4.3**	**4.0**	**4.4**	**4,831**	**4.4**	**4.3**	-0.08	

Briefing

- Over the last twelve months patients admitted to the hospital via an emergency pathway spend on average 4.5 days in a hospital bed, this includes patients with a zero length of stay. At Trust level this is in line with National Model Hospital data.
- This has decreased in recent months within Acute medicine, this has been due to the implementation of a fully embedded ambulatory care unit operating in line with the best practice model, enabling rapid access to same day assessment, diagnostics and treatment and increased usage of the discharge lounge.
- Patients waiting in the Emergency Department for a bed to become available has decreased significantly due to improved workflow and from optimising discharge planning.

Actions
The Unplanned and Admitted Patient Care Programme is working to roll-out the SAFER and Red 2 Green initiatives to ensure that patients do not stay in hospital longer then necessary and that every patient moves towards discharge everyday

Length of Stay

Elective Length of Stay (Excluding Daycase)

														Average length of Stay			
Directorate	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Discharges in the last month	2017-18	2018-19	Variance	Trend
Cardiothoracic	4.2	4.3	4.8	4.4	4.4	4.5	4.2	4.8	4.1	4.0	4.4	4.2	4.4	205	4.4	4.2	-0.21	
Childrens & Women	2.2	2.6	2.4	2.1	3.6	2.8	2.0	2.1	2.3	3.2	2.7	2.2	2.1	112	2.7	2.5	-0.20	
Neurosciences	9.3	12.0	7.5	9.8	11.3	11.9	7.8	12.7	8.7	7.3	12.8	7.1	8.5	139	10.0	8.9	-1.12	
Surgery & Trauma	4.9	3.7	4.4	4.5	4.0	4.4	3.1	3.2	3.8	4.1	3.7	3.4	4.5	376	3.9	3.9	-0.02	
Grand Total	3.9	3.8	3.6	3.9	3.9	4.1	3.2	4.2	3.4	3.4	4.1	4.2	5.0	**947**	**4.0**	**4.0**	-0.01	

Briefing

- Patients who are admitted to a hospital bed for a planned elective procedure on average spend four days in hospital, however an increase was seen in the month of August in all areas with the exception of Children and Womens Division.
- The Trust has observed significant improvement within Neurosciences compared to last year reducing the length of stay of our planned patients by over one day.

St George's University Hospitals NHS
NHS Foundation Trust

Outpatient Productivity

First Outpatient Attendances (average per working day)

Directorate	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	First Outpatient Attendances 2017-18	2018-19	Variance	Variance	Trend
Other	74	67	31	35	31	33	35	33	37	38	43	37	30	54	37	-17	-32.1%	
Cardiothoracic & Vascular Services	63	70	62	72	53	65	59	63	59	62	66	57	51	66	59	-7	-10.9%	
Childrens Services	40	54	49	51	44	50	47	42	41	50	49	42	41	47	45	-2	-4.6%	
Neuro	65	78	89	98	81	91	85	90	87	83	83	73	65	83	78	-4	-5.4%	
Renal & Oncology	23	22	26	25	21	23	24	23	25	27	30	23	23	23	26	2	9.9%	
Specialist Medicine	134	141	142	156	129	151	152	155	139	153	157	141	127	145	143	-1	-0.9%	
Surgery	250	259	283	279	240	249	248	257	265	271	300	264	250	257	270	13	4.9%	
Womens Services	80	79	82	79	76	81	74	73	82	85	92	87	71	80	83	3	4.4%	
T&O	44	51	44	54	40	51	47	57	55	56	60	62	51	50	57	6	12.5%	
Total	**773**	**821**	**808**	**849**	**715**	**794**	**771**	**794**	**790**	**827**	**880**	**797**	**710**	**806**	**801**	**-5**	**-0.6%**	

Follow Up Outpatient Attendances (average per working day)

Directorate	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	FollowUp Outpatient Attendances 2017-18	2018-19	Variance	Variance	Trend
Other	91	91	89	84	76	89	88	81	99	98	94	89	84	89	88	-1	-1.2%	
Cardiothoracic & Vascular Services	103	110	113	119	96	119	107	103	121	116	113	107	92	111	114	3	2.7%	
Childrens Services	72	87	82	88	73	82	81	73	72	81	73	77	72	79	73	-6	-7.0%	
Neuro	82	102	96	116	98	112	104	112	114	113	113	109	96	102	101	-2	-1.6%	
Renal & Oncology	218	218	209	204	193	206	197	200	205	217	228	228	213	210	215	6	2.7%	
Specialist Medicine	456	467	461	494	442	500	489	524	500	520	501	508	471	484	494	10	2.1%	
Surgery	334	350	361	367	327	361	346	349	354	374	357	349	328	353	362	10	2.7%	
Womens Services	45	46	50	64	55	65	61	49	50	58	52	56	44	53	50	-3	-5.2%	
T&O	71	80	83	87	75	79	73	80	86	82	84	87	76	80	84	4	4.7%	
Total	**1,473**	**1,551**	**1,541**	**1,623**	**1,437**	**1,612**	**1,545**	**1,571**	**1,598**	**1,659**	**1,613**	**1,608**	**1,475**	**1,560**	**1,581**	**21**	**1.4%**	

Briefing

- Across the Directorates, First Outpatient attendances averaged 710 per working day, this is a decrease compared to previous months and below the same month the previous year. The RAG rating applied compares to the SLA plan per working day.
- Follow-up attendances on average also saw a reduction compared to previous months, however in line with the same period last year, with the decreases seen across all three divisions.

Actions

- Switch off for paper referrals from Primary Care took place from July 2nd 2018 with eRS (electronic Referral Services) being the only commissioned access method.

Outpatient Productivity

First and Follow Up Ratio

														First to FollowUp Ratio				
Directorate	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**2017-18**	**2018-19**	**Variance**	**Variance**	**Trend**
Other	1.24	1.35	2.87	2.37	2.51	2.68	2.49	2.44	2.68	2.58	2.19	2.41	2.80	1.90	2.53	0.63	33.0%	
Cardiothoracic & Vascular Services	1.63	1.58	1.81	1.66	1.80	1.84	1.80	1.63	2.05	1.87	1.71	1.88	1.80	1.68	1.86	0.18	11.0%	
Childrens Services	1.78	1.61	1.68	1.74	1.68	1.65	1.74	1.76	1.76	1.62	1.49	1.83	1.76	1.69	1.69	0.00	0.2%	
Neuro	1.27	1.31	1.07	1.19	1.20	1.24	1.23	1.24	1.31	1.36	1.36	1.49	1.48	1.24	1.40	0.16	12.8%	
Renal & Oncology	9.53	9.79	7.94	8.28	9.39	8.77	8.07	8.67	8.20	8.04	7.60	9.91	9.26	9.04	8.60	-0.44	-4.8%	
Specialist Medicine	3.40	3.32	3.25	3.17	3.44	3.30	3.22	3.38	3.60	3.40	3.19	3.60	3.71	3.35	3.50	0.15	4.6%	
Surgery	1.34	1.35	1.27	1.31	1.36	1.45	1.40	1.35	1.34	1.38	1.19	1.32	1.31	1.37	1.31	-0.06	-4.6%	
Womens Services	0.56	0.58	0.61	0.81	0.73	0.80	0.82	0.67	0.61	0.68	0.57	0.64	0.62	0.67	0.62	-0.04	-6.2%	
T&O	1.61	1.56	1.86	1.59	1.86	1.56	1.56	1.40	1.56	1.46	1.40	1.40	1.49	1.60	1.46	-0.14	-8.7%	
Total	**1.91**	**1.89**	**1.91**	**1.91**	**2.01**	**2.03**	**2.01**	**1.98**	**2.02**	**2.01**	**1.83**	**2.02**	**2.08**	**1.94**	**1.99**	**0.05**	2.8%	

First and Follow Up DNA Rates (by month)

															Patients not attending rate			
Directorate	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**DNA's in the last month**	**2017-18**	**2018-19**	**Variance**	**Trend**
Cardiothoracic & Vascular Services	8.8%	8.7%	9.4%	9.6%	9.6%	9.9%	9.3%	10.3%	10.8%	10.2%	9.4%	12.2%	10.2%	248	8.8%	10.5%	1.7%	
Childrens Services	13.0%	10.9%	11.5%	12.1%	13.3%	11.5%	12.4%	13.3%	16.0%	14.1%	12.9%	14.2%	13.1%	346	10.4%	14.1%	3.7%	
Neuro	7.1%	8.0%	8.3%	7.3%	8.0%	9.3%	9.7%	9.2%	10.8%	10.9%	8.5%	9.5%	9.4%	313	8.4%	9.8%	1.4%	
Other	10.5%	11.5%	10.6%	12.7%	12.0%	10.6%	11.5%	14.0%	10.0%	9.5%	11.6%	12.9%	13.8%	1,297	10.8%	11.6%	0.8%	
Renal & Oncology	10.0%	9.2%	10.4%	10.1%	10.9%	11.8%	11.2%	10.6%	10.6%	11.0%	8.1%	11.1%	11.0%	312	13.0%	10.4%	-2.6%	
Specialist Medicine	11.0%	11.4%	11.9%	10.5%	12.2%	12.3%	12.7%	11.7%	14.3%	13.1%	11.3%	11.4%	11.8%	1,326	10.9%	12.4%	1.5%	
Surgery	10.1%	9.8%	9.6%	10.0%	10.1%	10.3%	10.1%	10.7%	12.1%	11.7%	9.0%	10.9%	10.9%	1,277	9.9%	10.9%	1.0%	
Womens Services	9.6%	8.0%	7.5%	7.4%	9.6%	7.9%	7.2%	8.4%	8.6%	8.7%	7.3%	8.4%	9.8%	651	9.3%	8.6%	-0.7%	
T&O	11.2%	10.8%	10.7%	11.0%	11.4%	12.0%	12.6%	12.0%	11.8%	13.7%	8.4%	9.2%	11.0%	334	10.0%	10.8%	0.8%	
Grand Total	10.5%	10.1%	10.4%	10.3%	11.0%	11.1%	11.2%	11.5%	12.6%	12.0%	10.1%	10.9%	11.3%	6,104	10.2%	11.3%	1.1%	

Briefing

- The Netcall text reminder service has been bedded in during June and a reduction in DNA rate was seen, however August observed an increase in the number of patients not attending their appointment with all areas seeing a negative decrease compared to last year with the exception of Renal, Oncology and Children and Womens

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Actions

- Continue to roll out Netcall and develop two way text interaction to enable patients to rebook
- The migration to electronic Referral Services should enable patients to select the appointment date and time best suited to them

Theatre – Touch Time Utilisation

Main List Specialty	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Number of Patients in the last month
Cardiothoracic	90%	76%	89%	81%	76%	69%	74%	64%	79%	81%	75%	74%	69%	72
ENT	75%	74%	79%	74%	71%	70%	75%	77%	75%	81%	77%	80%	84%	119
General Surgery	77%	83%	80%	83%	78%	79%	78%	77%	79%	78%	80%	82%	79%	161
Gynaecology	77%	79%	79%	76%	77%	84%	77%	78%	73%	76%	74%	81%	78%	173
Neurosurgery	78%	76%	83%	86%	76%	81%	77%	83%	76%	87%	80%	74%	84%	156
Oral and Maxillo Facial Surgery	73%	58%	72%	81%	50%	82%	76%	62%	58%	71%	73%	89%	75%	33
Paediatric Dentistry	56%	38%	56%	61%	61%	51%	46%	57%	62%	53%	50%	53%	58%	30
Paediatric Surgery	82%	82%	79%	74%	83%	79%	78%	74%	78%	82%	80%	81%	78%	98
Plastic Surgery	74%	76%	79%	75%	71%	68%	68%	69%	73%	74%	73%	77%	75%	159
Renal Medicine & Surgery	55%	78%	75%	68%	74%	77%	74%	79%	67%	76%	71%	72%	78%	26
Trauma & Orthopaedics	87%	82%	87%	96%	80%	82%	86%	80%	87%	76%	85%	84%	79%	136
Urology	76%	83%	80%	82%	74%	75%	79%	79%	77%	84%	78%	88%	84%	198
Vascular Surgery	70%	76%	78%	73%	66%	65%	75%	77%	77%	77%	76%	72%	68%	61
Grand Total	**78%**	**78%**	**81%**	**81%**	**75%**	**75%**	**76%**	**77%**	**77%**	**79%**	**78%**	**79%**	**79%**	**1,421**

Theatre Average Cases per Session

Main List Specialty	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Cardiothoracic	1.7	1.6	1.5	1.5	1.3	1.6	1.5	1.5	1.6	1.6	1.8	1.8	1.5
ENT	2.0	1.9	1.8	1.6	1.5	1.7	1.4	1.6	1.8	1.9	1.8	1.7	1.8
General Surgery	2.1	2.0	2.0	1.9	2.0	1.7	1.8	1.9	1.9	1.9	1.8	1.8	1.7
Gynaecology	2.7	2.7	2.6	2.8	2.5	2.6	2.0	2.9	2.6	2.6	2.6	2.9	2.7
Neurosurgery	1.2	1.1	1.3	1.3	1.1	1.2	1.2	1.2	1.2	1.2	1.1	1.1	1.1
Oral and Maxillo Facial Surgery	2.9	2.9	3.2	3.2	1.9	3.9	3.6	3.3	3.0	3.6	3.0	4.0	3.7
Paediatric Dentistry	4.4	4.1	3.7	4.7	3.8	3.6	4.0	4.3	4.3	3.7	4.2	4.0	3.8
Paediatric Surgery	2.6	2.3	2.5	2.6	2.5	2.5	2.6	2.7	2.4	2.6	2.4	2.6	2.6
Plastic Surgery	2.1	2.1	2.3	2.1	1.9	2.0	1.9	2.2	2.2	2.0	2.0	2.0	2.2
Renal Medicine & Surgery	2.1	1.5	1.5	1.4	1.7	1.5	1.8	1.3	1.8	1.5	1.7	1.4	1.4
Trauma & Orthopaedics	1.8	1.9	1.8	1.8	2.0	1.7	1.8	1.5	1.6	1.4	1.6	1.6	1.5
Urology	1.8	1.7	1.8	1.8	2.1	1.8	1.8	2.0	2.1	2.1	2.1	2.0	2.1
Vascular Surgery	1.0	1.1	1.2	1.1	1.0	1.0	1.2	1.2	1.2	1.3	1.0	1.1	1.2
Grand Total	**1.9**	**1.9**	**1.9**	**1.8**	**1.8**	**1.7**	**1.7**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**	**1.8**

Briefing

Touchtime Utilisation on average for the past 12 months is at 78% against a targeted threshold of 85%. Work is on-going across all specialties to support an increase in utilisation and increase in theatre case bookings

Actions

- Focused actions and additional support to the centralised Patient Pathway Coordinators (PPC) team from operational management across theatres and anaesthetics and speciality services.
- Clinicians are reviewing their lists to verify patient order and appropriate case mix, this is linked to theatre team review identifying theatre equipment requirements, skill mix and specialist equipment to be ordered as required.
- Theatre Schedules are locked down after review
- Actions form the weekly list planning are reviewed and discussed which is further reviewed and supported by General Managers and services. All actions are reviewed in list planning the following week.
- There is a specific action plan to support utilisation in Paediatric dentistry
- Increase to baseline PPC numbers has been agreed for financial year 18/19 to provide additional bank support to the teams to streamline processes particularly around the pre-assessment pathway and build a pool of pre assessed patients.
- The booking teams (PPC) will commence using the Four Eyes Insight scheduling tool this will provide accurate activity planning information along with the ability to schedule lists at 95-105 %.

St George's University Hospitals NHS
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Number of Elective Patients treated per Working Day

														Average No. of Patients per month		
Months	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**2017-18**	**2018-19**	**Variance**
Cardiology	5	6	5	6	5	5	6	6	5	6	6	4	6	5	5	-3%
Clinical Haematology	0	1	0	1	1	1	0	1	1	1	1	0	1	1	1	4%
Endoscopy	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	-13%
ENT	6	5	7	6	5	5	5	6	4	5	5	4	5	6	5	-22%
General Surgery	5	5	5	7	6	5	6	7	5	5	5	4	5	6	5	-14%
Gynaecology	3	3	3	3	3	2	3	4	3	3	3	2	3	3	3	-13%
Maxillofacial & Dental	3	2	2	3	3	4	3	3	3	3	3	2	3	3	3	0%
Neuro Surgery	5	6	5	6	5	5	6	7	6	6	6	6	5	6	6	2%
Neurology	1	1	2	2	2	1	2	1	2	2	2	2	2	2	2	17%
Oncology	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	-21%
Other	7	6	6	7	6	6	6	7	6	6	8	6	5	6	6	-2%
Paediatric Medicine	1	1	1	1	1	1	1	0	2	1	1	0	2	1	1	38%
Paediatric Surgery	2	2	2	2	2	2	2	2	2	2	2	2	1	2	2	-11%
Plastic Surgery	5	7	6	7	7	5	6	6	5	6	5	2	4	6	4	-30%
Renal Medicine	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	-2%
Trauma & Orthopaedics	3	2	3	3	3	3	2	4	3	2	2	2	2	3	2	-26%
Urology	7	6	6	6	5	5	6	7	8	6	6	5	6	7	6	-13%
Vascular Surgery	2	3	3	2	3	3	4	4	3	3	3	3	3	3	3	5%
Grand Total	59	58	59	62	58	53	60	66	59	58	61	45	54	61	55	-10%

Briefing

Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions this is linked to a weekly task and finish group, highlighting and unblocking issues for long term sustainability and change; the work from the task and finish group will be shared across all theatre services.

Actions

- Bespoke scheduling manuals for Day Surgery Unit services to support activity will be rolled out to inpatient services as phase 2
- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases and utilisation.
- Identified data quality issues with informatics team which will identify increased theatre utilisation
- SNCT Division finance has completed service specific one pagers in conjunction with the FEI to identify actions required to support SLA achievement
- Additional admin support commencing on 20th August for the centralised PPC team.

St George's University Hospitals NHS
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Number of Patient Daycases per Working Day

														Average No. of Patients per month		
Months	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**2017-18**	**2018-19**	**Variance**
Cardiology	10	9	9	8	7	8	9	7	7	8	8	9	8	8	8	-4%
Clinical Haematology	1	1	2	2	1	2	2	2	1	2	2	1	0	2	1	-27%
Diabetes/Endocrinology	2	2	2	2	1	1	2	1	2	2	1	2	1	2	2	2%
Endoscopy and General Medicine	54	53	52	49	53	46	51	50	54	60	60	55	52	53	56	6%
ENT	3	4	3	3	3	2	3	2	2	4	3	5	2	3	3	9%
General Surgery	4	5	4	5	4	4	4	4	4	5	5	5	3	4	4	9%
Maxillofacial & Dental	4	3	3	4	3	3	3	3	3	4	3	5	3	3	4	15%
Neuro Surgery	3	3	4	3	3	3	3	3	3	2	3	3	3	3	3	4%
Neurology	20	21	21	27	21	24	21	21	29	29	31	29	25	22	28	27%
Obstetrics and Gynaecology	7	7	8	8	6	7	7	7	7	7	7	9	8	7	8	7%
Oncology	1	1	1	2	1	2	1	1	1	1	1	1	1	2	1	-42%
Other	6	9	8	9	7	8	9	9	4	6	6	7	2	8	5	-40%
Paediatric Medicine	8	7	8	8	8	9	8	7	9	9	7	10	7	8	8	2%
Paediatric Surgery	8	7	8	8	5	6	7	7	7	6	7	7	7	7	7	-4%
Plastic Surgery	8	8	7	9	7	8	9	8	11	13	13	15	15	8	13	71%
Renal Medicine	4	3	3	3	4	4	3	3	4	4	4	3	4	3	4	24%
Trauma & Orthopaedics	4	4	4	5	5	4	4	4	4	5	5	6	3	4	5	13%
Urology	4	5	6	6	7	6	5	4	4	5	7	8	4	5	6	19%
Vascular Surgery	2	3	3	3	2	2	2	2	2	3	2	2	2	2	2	-8%
Grand Total	151	156	155	162	148	149	153	145	159	175	176	182	149	154	168	9%

Daycase as a percentage of all Activity	72%	73%	72%	72%	72%	74%	72%	69%	73%	75%	74%	80%	73%

Patient Safety

Indicator Description	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend (12 months)
Number of Never Events in Month	0	0	0	1	0	0	1	0	2	1	0	0	0	0	
Number of SIs where Medication is a significant factor	0	1	1	0	0	0	0	0	1	0	0	0	0	0	
Number of Serious Incidents	8 / mth	9	11	4	6	2	1	4	5	4	6	3	4	2	
Serious Incidents - per 1000 bed days	N/A	0.38	0.45	0.16	0.24	0.08	0.04	0.18	0.19	0.17	0.26	0.13	0.17	0.09	
Safety Thermometer - % of patients with harm free care (all harm)	95%	93.8%	95.7%	94.9%	95.0%	95.1%	94.9%	94.8%	94.3%	93.1%	95.3%	96.5%	94.9%	95.7%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	97.8%	98.3%	98.7%	98.1%	98.5%	98.9%	97.9%	98.5%	97.8%	98.0%	98.7%	98.5%	98.2%	
Percentage of patients who have a VTE risk assessment	95%	95.7%	95.4%	96.1%	96.4%	96.0%	95.4%	96.3%	96.0%	95.9%	95.8%	96.0%	96.9%		
Number of Patient Falls	N/A	127	125	122	157	127	189	140	157	138	117	155	143	136	
Falls (Moderate and Above Severity)	N/A	2	0	2	1	3	1	2	2	3	1	1	1	1	
Number of patient falls- per 1000 bed days	N/A	5.29	5.15	4.89	6.23	5.17	7.49	6.15	6.05	5.77	5.01	6.70	6.11	5.92	
Number of Grade 2 Pressure Ulcers	N/A	15	18	7	16	13	16	13	12	2	6	10	20	15	
Acquired Grade 2 Pressure Ulcers per 1000 bed days	N/A	0.63	0.74	0.28	0.64	0.53	0.63	0.57	0.46	0.08	0.26	0.43	0.85	0.65	
Avoidable Grade 3 & 4 Pressure Ulcers	0	1	2	0	0	0	0	0	0	5	0	2	2	3	
Avoidable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0	0.04	0.08	0.00	0.00	0.00	0.00	0.00	0.00	0.21	0.00	0.09	0.09	0.13	
Acquired Grade 3 Pressure Ulcers					15	6	9	6	6	11	4	6	5	3	
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Briefing

- No Never Events were reported in August
- The Trust declared two Serious Incidents in August, with a total of nineteen year to date.
- The number of falls reported in August decreased from 143 in July to 136. Of the falls reported, 135 resulted in Low or No Harm.
- All grade 3 and 4 pressure ulcers that are acquired at the Trust have had an Rapid Response Report completed. These are now reviewed by a panel chaired by the Chief Nurse to establish their avoidability. From April 2018 all grade 3 and 4 pressure ulcers are reported to the Board that have been acquired at St Georges. Historically only grade 3 or 4 pressure ulcers that met the threshold for Serious Incident declaration were reported. In August three avoidable Grade 3 and 4 Pressure Ulcers were recorded and three patients with Acquired Grade 3 Pressure Ulcers.

Actions: The Falls co-ordinator is working with divisions, wards and falls champions to improve falls practice, promote best practice for falls prevention and is continuing to carry out bespoke falls education and training.

The Trust is participating in NHSI Pressure Ulcer Collaborative and focusing work on the 4 wards with the highest instance of pressure ulcers

St George's University Hospitals NHS
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Infection Control

Indicator Description	Threshold	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD Actual	YTD Theshold	Trend (12 months)
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Cdiff Incidences (in month)	30	3	1	4	0	0	0	1	2	6	1	3	3	2	15	12.5	
MSSA	25	4	1	1	2	3	0	3	1	2	2	1	1	2	8	10	
E-Coli	60	6	8	6	2	5	5	5	5	1	9	6	4	3	23	25	

Briefing

- The C Diff annual threshold for 2018/19 is 30 cases. For 2019-2020 the time limit for apportioning healthcare onset versus community onset is 48 hours rather than 72 hours. The data collected in 2018-19 for each Trust will be used to set the new targets for these categories. In the month of July the Trust reported three cases, totalling thirteen cases year to date.
- The Trust annual threshold for E coli is 60.3 for 2018-19 and year to date the Trust has reported twenty three cases, three of which occurred in July.
- There are no National thresholds for MSSA bacteraemia at present however the Trust has set itself an internal target of a 10% reduction on last years position setting the threshold at 25 incidents for 2018/19 . The Trust is reporting eight cases since April 2018.
- There were no reported MRSA Bacteraemia in August.

Actions

All Cdiff cases have undergone a Root Cause Analysis (RCA) the ward has been placed on a period of increased surveillance and audit. No immediate learning has been identified

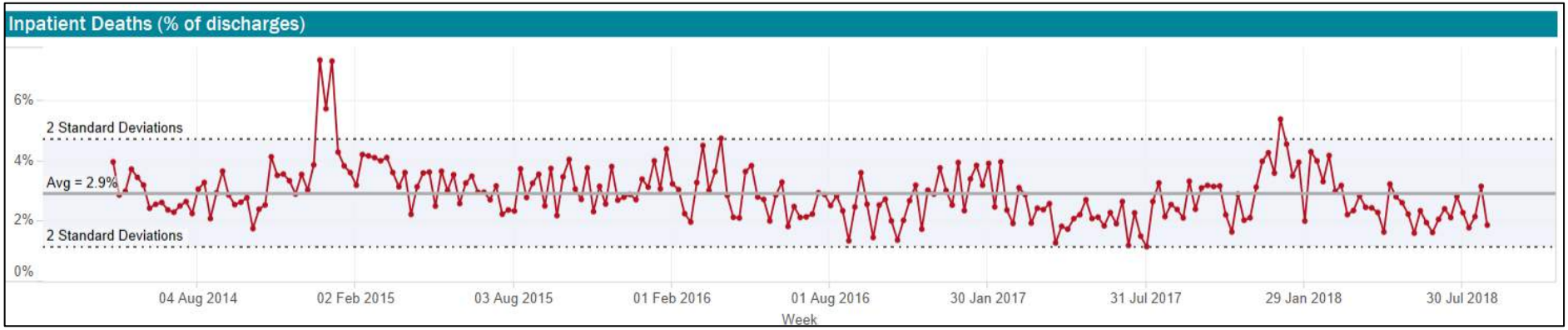
Mortality and Readmissions

Indicator Description	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	79.7	81.1	80.6	81.3	81.4	82.2	80.8	81.1	81.9	83.4	85.6	86.2	86.3	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	76.4	77.4	77.2	77.5	76.6	77	77.1	76.8	77.8	78.5	79.7	79.8	80.9	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	81.3	81.8	81.2	82	83.8	84.1	83.7	86.7	89.7	91.8	94.4	95.9	96.4	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.83	0.83	0.83	0.83	0.82	0.82	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	TBC	9.0%	9.7%	10.2%	9.2%	9.4%	8.9%	9.0%	9.2%	8.7%	8.8%	8.3%	8.90%		

Please note SHMI data is reflective of the period January to December 2017 based on a rolling 12 month period (published 19th July).
HSMR data reflective of period June 2017 – May 18 based on a rolling 12 month period (published 19th July).

Briefing

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



Maternity

- Maternity indicators continue to be monitored and reviewed by the Divisional Governance process. A number of metrics are being reviewed and a monthly dashboard to be produced and included in the report going forward.

Indicator Description	Threshold	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend
C Section Rate - Emergency and Non Elective	28%	24.9%	30.2%	29.7%	31.9%	25.4%	23.6%	23.1%	26.9%	25.4%	29.2%	26.7%	26.4%	22.1%	
Admission of full term babies to neo-natal care		20	15	10	16	6	11	7	4	10	13	9	5	9	

Patient Experience

St George's University Hospitals NHS
NHS Foundation Trust

Patient Voice

Indicator Description	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend
Emergency Department FFT - % positive responses	90%	85.9%	83.5%	86.4%	84.1%	86.5%	82.2%	81.0%	81.4%	84.0%	85.0%	85.5%	83.7%	84.6%	
Inpatient FFT - % positive responses	95%	96.8%	96.5%	96.5%	95.7%	95.6%	94.7%	96.0%	96.3%	97.2%	97.3%	97.1%	96.7%	96.6%	
Maternity FFT - Antenatal - % positive responses	90%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	97.2%	100.0%	100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	96.4%	100.0%	92.6%	96.0%	100.0%	99.0%	90.4%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	98%	100%	100%	91.6%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	
Community FFT - % positive responses	90%	98.3%	94.1%	98.9%	95.7%	96.5%	99.2%	93.3%	98.3%	97.1%	98.5%	98.3%	98.0%	98.4%	
Outpatient FFT - % positive responses	90%	96.2%	94.4%	96.3%	94.3%	98.2%	97.6%	96.1%	98.4%	97.3%	97.3%	97.4%	97.4%	97.1%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		97	80	96	77	68	90	80	94	96	85	79	120	96	
PALS Received		244	203	198	305	262	290	236	259	264	317	292	337	294	

Briefing

- ED Friends and Family Test (FFT) – The score has seen a slight increase in August reporting 84.6% in the recommended rate..
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 96.6% in August providing reasonable assurance on the quality of patient experience
- Maternity FFT – The score for maternity care remain above local threshold with work continuing to improve the number of patients responding.
- The number of complaints received in the month of August was 96, this is a reduction compared to July. All complaints are assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days. For 25 day complaints received in July 73% were responded to within 25 working days, this is against a trajectory to achieve 85% by September 2018. For 40 day complaints received in June 68% were responded to within 40 working days, working towards a trajectory of 95% by the end of September.

Actions

FFT action being taken to improve response rates includes: weekly feedback to all areas on their response rate, this is published on the Quality Posters at the entrance to the area; improving the accessibility of the FFT by increasing the number of tablets and using volunteers to assist patients with the survey; scoping other opportunities to improve accessibility for example putting FFT and other patient surveys on our public website.

Complaints and PALS: The weekly CommCell is being used to maintain organisational focus on meeting both timeliness and quality standards for complaint responses. There has been a significant improvement with responding to complaints in the time given in the majority of directorates. The surgery directorate is a significant outlier, at the time of report 38% of all open complaints belong to the surgery directorate and 14 of the 20 overdue complaints. Additional resource to respond to complaints has been made available and the Director of Quality Governance is meeting with the directorate to put a recovery plan in place.

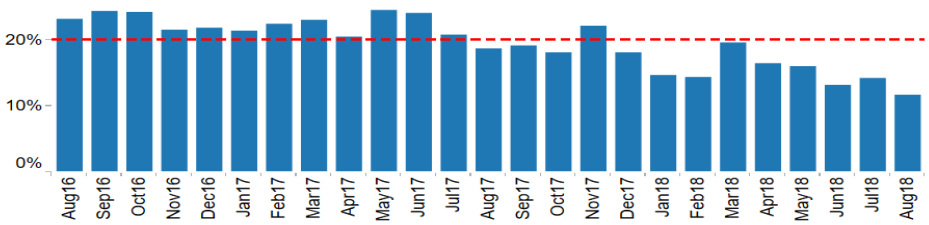
Patient Voice

CARING – Friends and Family Test

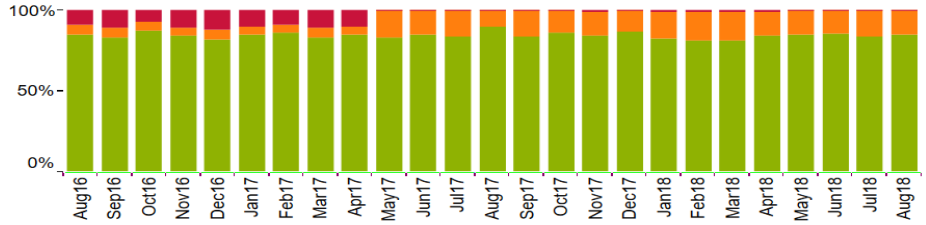
--- Target ¢ MetricMeasure Numerator Neutral Denominator

A&E Friends & Family Response Rate

Target: 20% Jul 18: 14.11% Aug 18: 11.62% Movement: ▼-2.49%

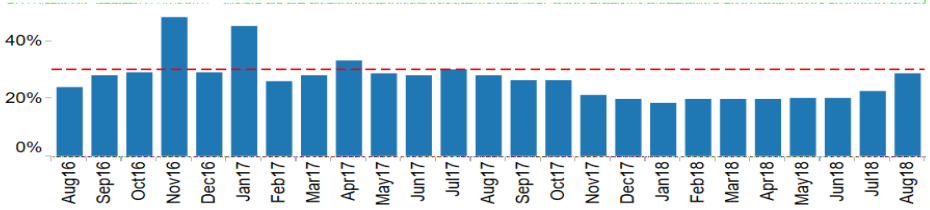


A&E Friends & Family Recommend Rate
The expected target is 90%

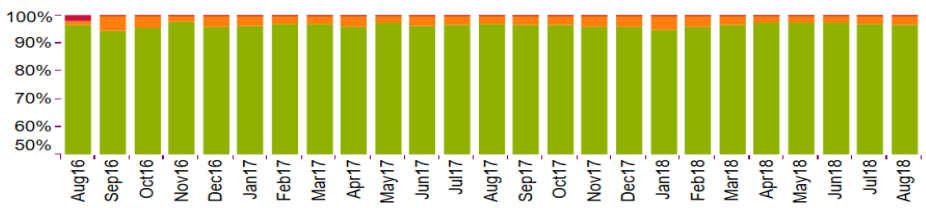


IP Friends & Family Response Rate

Target: 30% Jul 18: 22.41% Aug 18: 28.62% Movement: ▲6.21%

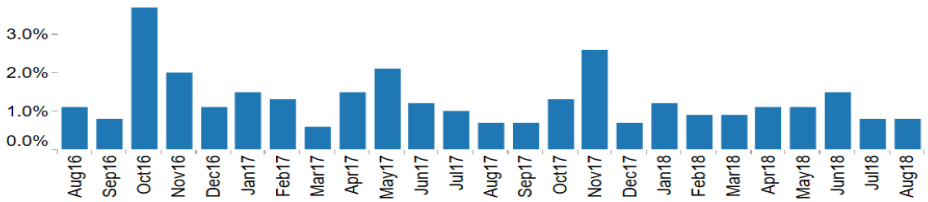


IP Friends & Family Recommend Rate
The expected target is 95%

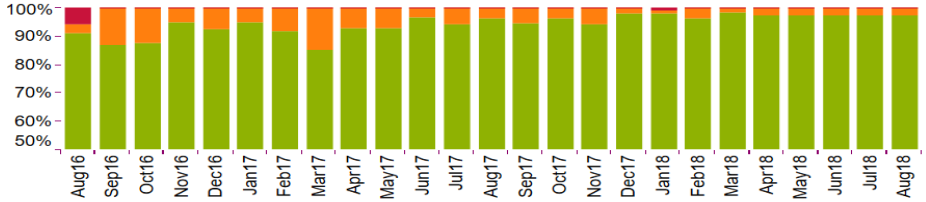


OP Friends & Family Response Rate

Target: 20% Jul 18: 0.80% Aug 18: 0.80% Movement: ▸0.00%



OP Friends & Family Recommend Rate
The expected target is 90%



St George's University Hospitals NHS
NHS Foundation Trust

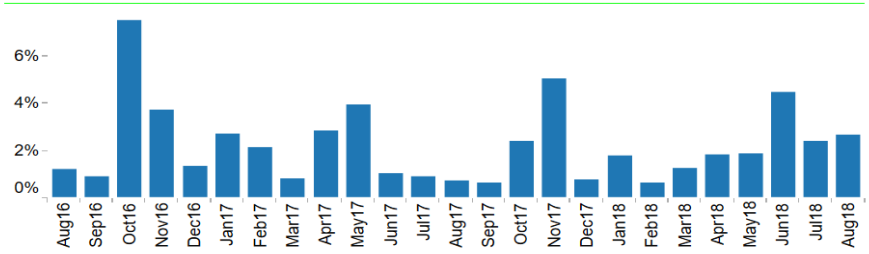
Patient Voice

CARING – Friends and Family Test

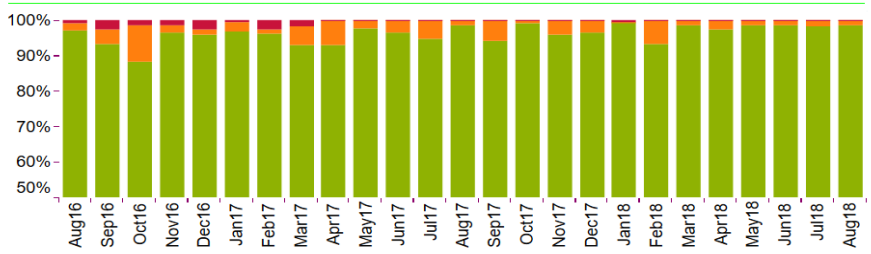
--- Target ¢ MetricMeasure Numerator Neutral Denominator

Community Friends & Family Response Rate

Target: 20% Jul 18: 2.36% Aug 18: 2.63% Movement: ▲0.27%

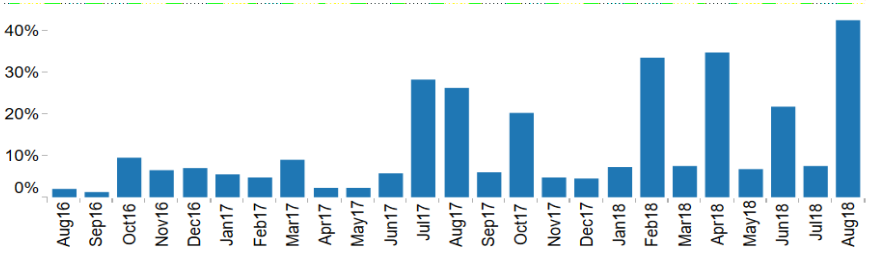


Community Friends & Family Recommend Rate
The expected target is 90%

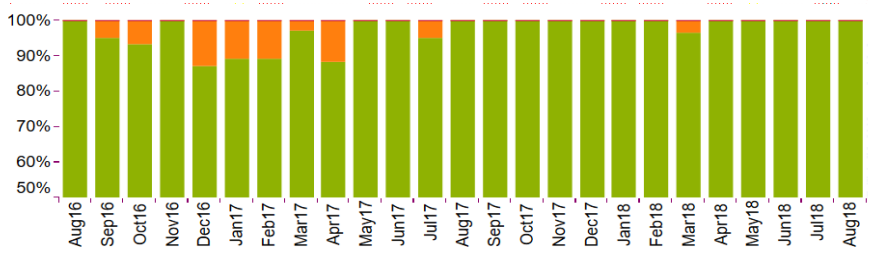


Maternity (Birth) Friends & Family Response Rate

Target: 20% Jul 18: 7.37% Aug 18: 42.50% Movement: ▲35.13%



Maternity (Birth) Friends & Family Recommend Rate
The expected target is 90%



Emergency Flow

Indicator Description	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend
4 Hour Operating Standard	95%	90.1%	90.0%	88.0%	87.2%	85.0%	83.0%	83.5%	81.6%	88.4%	93.3%	93.6%	93.3%	91.1%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	0	1	0	0	0	2	1	1	0	1	0	
Time to Treatment (number of patients seen within 60 minutes)	60%	56.2%	54.1%	54.2%	54.2%	54.1%	51.7%	52.2%	52.6%	61.5%	63.5%	65.5%	63.7%	70.3%	
Admitted patients with a length of stay 7 Days or Greater		336	349	348	362	376	373	337	343	356	301	313	304	309	
Ambulance Turnaround - % under 15 minutes	100%	51.8%	50.9%	49.9%	49.0%	44.3%	41.0%	42.2%	41.0%	45.0%	45.7%	43.6%	42.0%	42.3%	
Ambulance Turnaround - % under 15 minutes (London Average)	100%	47.0%	46.5%	45.1%	46.1%	42.1%	41.4%	42.2%	41.1%	45.2%	45.7%	47.4%	46.7%	47.7%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	84	71	57	82	112	180	135	105	92	65	72	75	85	
Ambulance Turnaround - % under 30 minutes	100%	96.0%	96.6%	97.4%	96.2%	94.8%	91.3%	93.2%	94.5%	95.3%	96.8%	96.3%	98.5%	95.5%	
Ambulance Turnaround - % under 30 minutes (London Average)	100%	93.1%	92.2%	91.9%	91.7%	91.6%	86.7%	87.4%	87.5%	88.8%	91.9%	93.7%	93.1%	91.3%	
Ambulance Turnaround - number over 60 minutes	0	1	0	0	0	2	3	3	10	1	0	0	0	2	

Briefing

- The Trust has delivered the aggregate position for Quarter 1 against the Four Hour Operating Standard however August's reportable position at 91.1%, below the monthly trajectory of 94%.
- Urgent and Emergency Care Attendances in August were 2% higher than in the same month in 2017. There is an emerging trend of a reduction in Urgent Care patients, with the increases coming in the more complex patients that require access to the full Majors Emergency facility. Four Hour Operating Standard performance for Majors patients not requiring admission was 1% better than in 2017 and for those patients requiring admission the year on year improvement was 6%.
- Through the concerted effort of the operational and ward teams, the number of patients who have stayed more than 21 days in hospital fell from 136 at the start of August to 87 at the end of the month.
- Key issues included delays in the Emergency Department assessment process, treatment to decision waiting times and four hour operating standard for patients referred to specialties, which fell from 82% in July to 79% in August. Four Hour Operating Standard for patients requiring Mental Health assessment fell in month from 64% to 58%, but remains above the 49% seen in April 2018.

Actions

- Non-Admitted Pathway: The introduction of Ed Paperlight in November will shorten the processing and administrative time required of clinicians accelerating flow for all patients. Other actions include revisiting the consistency of shift leadership, extending the role of the Patient Flow Co-ordinators, ensuring clinical capacity is aligned to pathway demand particularly around lunchtime to ensure that the department does not become congested and extending the opening hours of the co-located Pathology Lab.
- Admitted Pathway: The key objective is to have no more than 80% bed occupancy on the Acute Medical Unit at 10am and at Midday. Ambulatory Care opening hours have been extended and key wards are focusing on earlier morning discharges. Other actions include ring-fencing Discharge Co-ordinator capacity on the wards, basing the site manager in ED, reviewing ward based therapies cover and the opportunity to create a patient transfer team to ensure that patients leave the Emergency Department as soon as a bed is available.
- Mental Health Pathway: - The Trust is starting to work more closely with colleagues in South West London St George's Mental Health NHS Trust to improve the patient experience for our shared patients with an ambition to have the best Four Hour Operating Standard for patients requiring Mental Health Assessment in London

Cancer

Indicator Description	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	80.3%	89.7%	94.0%	96.1%	97.3%	98.5%	94.8%	96.7%	96.8%	93.1%	93.3%	83.2%	93.1%	1,306	
Cancer 14 Day Standard Breast Symptomatic	93%	86.9%	90.3%	98.2%	99.6%	98.0%	97.3%	95.9%	96.5%	96.8%	94.4%	79.4%	22.2%	55.2%	192	
Cancer 31 Day Diagnosis to Treatment	96%	96.9%	96.2%	96.2%	98.1%	96.9%	97.4%	98.2%	99.3%	96.5%	98.4%	99.0%	97.0%	98.4%	182	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	90.9%	95.8%	82.4%	94.1%	96.9%	94.3%	94.6%	100.0%	95.5%	100.0%	95.7%	94.1%	95.0%	40	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	108	
Cancer 62 Day Referral to Treatment Standard	85%	77.8%	75.6%	76.7%	85.5%	80.8%	86.8%	77.8%	80.8%	88.1%	92.3%	85.9%	90.0%	85.7%	59.5	
Cancer 62 Day Referral to Treatment Screening	90%	86.1%	92.5%	93.0%	78.4%	92.7%	93.9%	86.1%	89.1%	95.2%	80.8%	92.7%	84.6%	73.8%	21	

Briefing

- The Trust met five of the seven Cancer standards in the month of July, continuing to achieve 62 day standard reporting 85.7% and internally reporting 89.4%.
- Performance against the 14 day Standard's was compliant in the month of July reporting 93.1% and below the 93% target in four tumour groups
- Two week wait Breast Symptomatic performance is below the national requirement and has seen a significant improvement from June reporting 22% with a total of 147 patients breaching, to 55.2% in July with 86 breaches. This is in line with the recovery plan.

62 Day wait for First Treatment- GP referral to treatment (actual and internal performance)

Month	Target	Actual Performance	Internal Performance
Dec-17	85%	86.8%	97.0%
Jan-18	85%	77.8%	79.0%
Feb-18	85%	80.8%	84.6%
Mar-18	85%	88.1%	87.5%
Apr-18	85%	92.3%	96.7%
May-18	85%	85.9%	87.1%
Jun-18	85%	89.2%	93.1%
Jul-18	85%	85.7%	89.4%

Actions

- There is a continued focus on improving internal processes as well as working with local providers to improve 38 day performance. Improvement trajectories have been agreed with other SWL providers to improve waiting times and quicker access to diagnostics and treatment for shared patients
- Capacity within the Breast pathway has been created within diagnostics through the addition of a new ultrasound machine at St Georges Rose Centre site increasing the minimum weekly capacity by 60 slots weekly. On-going recruitment of vacant consultant posts, the creation of a new consultant post, and the introduction of a trainee position will further increase capacity by 60 slots and provide a more flexible and responsive service in the current year and a further 50 slots in year 2 once training is completed. Further capacity sourced from another brings the demand and capacity into balance. This will enable the backlog to be eliminated by the first week of August and a return to compliance against 2 Week Rule breast symptomatic from the WC 06th August 2018

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	No of Patients
Brain	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	4
Breast	93%	76.4%	93.4%	94.1%	97.4%	98.4%	98.2%	96.0%	96.5%	93.9%	94.8%	91.9%	61.2%	87.4%	175
Children's	93%	80.0%	100.0%	100.0%	100.0%	71.4%	100.0%	87.5%	100.0%	100.0%	80.0%	100.0%	100.0%	90.9%	11
Gynaecology	93%	93.4%	90.4%	91.1%	90.8%	95.0%	97.6%	98.0%	96.8%	94.3%	94.9%	91.9%	86.1%	91.7%	132
Haematology	93%	95.7%	100.0%	100.0%	96.8%	100.0%	94.7%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	20
Head & Neck	93%	88.0%	82.4%	90.6%	99.1%	99.4%	98.4%	100.0%	97.6%	100.0%	100.0%	97.5%	92.3%	93.0%	129
Lower Gastrointestinal	93%	60.0%	73.9%	94.6%	97.4%	97.7%	99.3%	95.2%	100.0%	97.8%	94.1%	90.3%	67.5%	94.7%	247
Lung	93%	95.6%	100.0%	94.1%	97.7%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	96.3%	90.9%	97.6%	41
Skin	93%	74.3%	96.6%	93.4%	95.0%	95.5%	97.9%	92.7%	94.8%	95.9%	94.1%	93.8%	92.7%	93.3%	403
Upper Gastrointestinal	93%	97.6%	98.8%	98.8%	98.5%	99.0%	100.0%	89.0%	97.3%	95.3%	85.2%	88.1%	89.9%	96.6%	59
Urology	93%	93.8%	97.0%	96.4%	93.3%	97.1%	98.9%	95.0%	95.1%	98.2%	81.3%	92.9%	96.5%	95.2%	85

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	No of Patients
Brain	85%	100.0%	0.0%	100.0%	-	100.0%	-	-	-	-	-	-	-	-	0
Breast	85%	87.5%	100.0%	91.7%	100.0%	95.2%	100.0%	71.4%	100.0%	88.9%	94.1%	84.6%	91.7%	90.9%	11
Children's	85%	-	0.0%	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	61.5%	100.0%	50.0%	83.3%	75.0%	67.0%	80.0%	77.8%	0.0%	100.0%	80.0%	100.0%	75.0%	4
Haematology	85%	100.0%	100.0%	88.9%	100.0%	-	100.0%	88.9%	83.3%	81.8%	100.0%	63.6%	100.0%	100.0%	5
Head & Neck	85%	66.7%	71.4%	87.5%	78.6%	81.8%	71.0%	100.0%	83.3%	80.0%	100.0%	90.0%	75.0%	72.7%	5.5
Lower Gastrointestinal	85%	60.0%	100.0%	66.7%	100.0%	80.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	71.4%	3.5
Lung	85%	41.7%	47.4%	72.2%	72.7%	41.2%	33.0%	90.9%	57.1%	100.0%	100.0%	87.5%	83.3%	71.4%	7
Skin	85%	100.0%	76.5%	93.8%	90.9%	91.7%	93.0%	86.7%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	7.5
Upper Gastrointestinal	85%	100.0%	77.8%	0.0%	100.0%	84.0%	100.0%	33.3%	57.1%	66.7%	87.5%	33.3%	80.0%	100.0%	2
Urology	85%	63.0%	64.3%	77.4%	100.0%	72.7%	91.0%	60.7%	70.0%	96.7%	80.5%	84.6%	84.9%	85.7%	14

Diagnostics

Indicator Description	Threshold	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend
6 Week Diagnostic Performance	1%	2.0%	1.4%	0.3%	1.9%	0.1%	0.1%	0.0%	0.2%	0.2%	0.2%	0.3%	0.3%	0.2%	
6 Week Diagnostic Breaches	N/A	154	98	22	143	6	10	3	17	15	14	25	24	15	
6 Week Diagnostic Waiting List Size	N/A	7,751	7,184	7,072	7,534	6,440	6,884	7,232	7,075	7,956	7,735	7,809	7,236	6,946	

Indicator Description	Threshold	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend
MRI	1%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.4%	0.0%	0.3%	
CT	1%	0.3%	1.2%	0.3%	0.1%	0.0%	0.1%	0.0%	0.3%	0.1%	0.0%	0.3%	0.0%	0.0%	
Non Obstetric Ultrasound	1%	0.9%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.1%	
Barium Enema	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Dexa Scan	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	
Audiology Assessments	1%	5.7%	4.5%	0.0%	17.4%	0.0%	0.0%	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	
Echocardiography	1%	0.3%	0.3%	0.3%	0.8%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	
Electrophysiology	1%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.0%	0.0%	0.0%	0.0%	0.3%	0.9%	0.0%	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	
Sleep Studies	1%				26.8%	0.0%	0.0%	0.4%	0.6%	0.0%	0.0%	0.0%	1.1%	1.5%	
Urodynamics	1%	50.6%	37.0%	16.7%	6.7%	0.0%	0.0%	0.0%	9.1%	5.0%	23.9%	6.3%	26.5%	0.0%	
Colonoscopy	1%	0.0%	0.4%	1.1%	0.0%	0.0%	0.0%	0.6%	0.7%	0.6%	0.4%	0.0%	0.0%	0.0%	
Flexi Sigmoidoscopy	1%	0.7%	1.5%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	
Cystoscopy	1%	12.3%	14.7%	4.0%	1.8%	1.5%	2.8%	0.7%	0.0%	1.0%	0.8%	3.0%	1.8%	4.4%	
Gastroscopy	1%	6.7%	0.8%	0.0%	0.8%	0.4%	0.0%	0.0%	1.8%	1.0%	0.0%	0.0%	1.8%	0.0%	

Briefing

- The Trust has continued to achieve performance in August reporting a total of fifteen patients waiting longer than 6 weeks, 0.2% of the total waiting list.
- Compliance has been achieved in all modalities with the exception of Sleep studies and Cystoscopy.
- The Trust expects to remain compliant in the month of September and performance continues to be monitored through the weekly performance meetings.

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend
Number of on the Day Cancellations		54	49	52	86	100	94	55	86	64	87	42	54	44	
Number of on the Day cancellations re-booked within 28 Days		43	43	34	76	67	76	48	76	60	80	33	51	37	
% of Patients re-booked within 28 Days	100%	79.6%	87.8%	65.4%	88.4%	67.0%	80.9%	87.3%	88.4%	93.8%	92.0%	78.6%	94.4%	84.1%	

Briefing

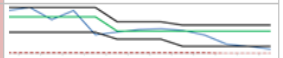
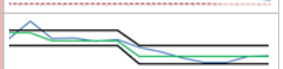
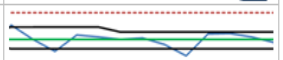
- In August 84.1% of our on the day cancelled patients were-rebooked within 28 days.
- The number of patients cancelled on the day for non clinical reasons have remained lower compared to the previous months and is 13% lower than the same period last year, reporting 43 cancellations.
- Of the 30 cancellations reported, 40% were due to emergency cases taking priority.

Actions

- Continue to improve the Pre Operative Assessment (POA) Process and the availability of more high risk capacity for POA
- Text reminder service to be implemented within pre-assessment.
- Introduce a call to every patient before surgery to check that they are Ready, Fit and Able to attend 72 hours prior.
- At times of high non-elective activity, ensure that elective patients are reviewed, including their bed requirements, in advance of the day of surgery
- Standard operating procedures have been signed off and implemented.

St George's University Hospitals NHS
NHS Foundation Trust

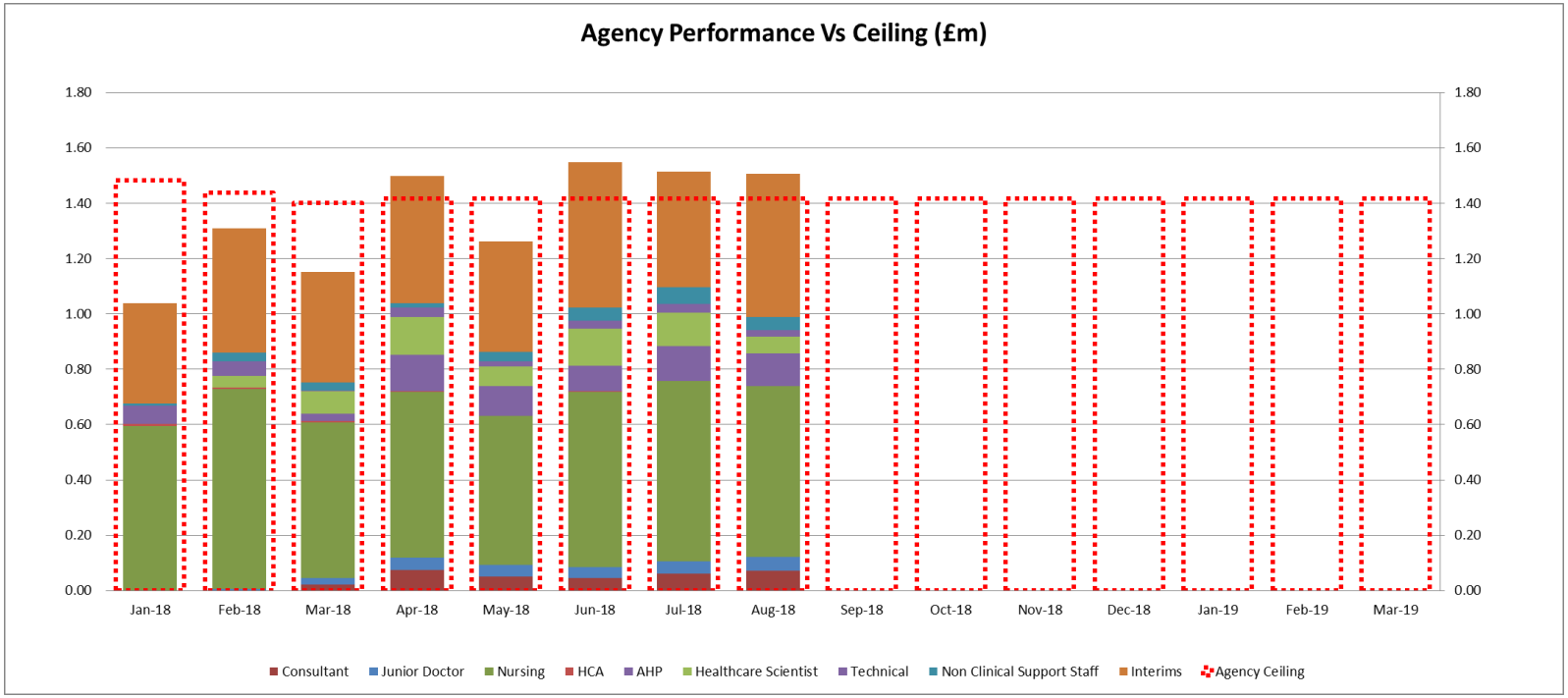
Workforce

Indicator Description	Target	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Trend
Trust Level Sickness Rate	3%	3.6%	3.7%	3.6%	3.4%	3.8%	3.6%	4.1%	4.0%	3.6%	3.2%	3.2%	3.6%	3.5%	3.5%	
Trust Vacancy Rate	10%	16.1%	16.5%	14.8%	16.1%	12.7%	13.0%	13.4%	13.5%	13.3%	12.6%	11.3%	11.0%	10.6%	10.2%	
Trust Turnover Rate* Excludes Junior Doctors	13%	18.4%	19.6%	18.5%	18.5%	18.3%	18.4%	17.9%	17.6%	17.2%	16.9%	17.0%	17.3%	17.4%	17.1%	
Total Funded Establishment		9,879	9,855	9,794	9,808	9,470	9,474	9,515	9,540	9,497	9,469	9,318	9,242	9,239	9,160	
IPR Appraisal Rate - Medical Staff	90%	84.8%	79.0%	74.0%	80.7%	80.0%	78.9%	79.6%	76.9%	72.2%	81.1%	81.3%	79.9%	77.7%		
IPR Appraisal Rate - Non Medical Staff	90%	76.1%	75.1%	79.4%	73.5%	70.2%	70.2%	67.2%	65.9%	61.6%	61.2%	63.4%	64.6%	67.6%	69.7%	
% of Staff who have completed MAST training (in the last 12 months)		86%	86%	85%	86%	87%	86%	87%	87%	87%	87%	87%	87%	89%	88%	
Ward Staffing Unfilled Duty Hours	10%	5.9%	6.5%	5.9%	6.1%	6.6%	7.8%	7.7%	7.9%	8.9%	6.5%	5.1%	4.9%	5.8%		
Safe Staffing Alerts	0	2	1	0	1	2	2	4	1	1	1	0	2	0	0	

Briefing

- Funded Establishment has continued to fall compared to the previous month reporting 9,160 WTE in August, a reduction of 7% reduction from 2017 as a result of the changes to the Community Division.
- The Trust Vacancy Rate continues to decrease in August reporting 10.2% in month.
- The Trust sickness level has remained above target of 3% reporting 3.5% in the month of August
- Mandatory and Statutory Training figures for August were recorded at 88%
- Medical Appraisals rates are being reviewed and will not be reported this month.
- Non-medical appraisal rates have seen a 2.1% improvement. Performance in August was 69.7% against a 90% target.

Agency Use



Please note that the figures in the table have been restated to reflect the underlying agency spend.

- The Trust's total pay for August was £43.25m. This is £0.39m adverse to a plan of £42.86m.
- The Trust's 2018/19 annual agency spend target set by NHSI is £21.30m. There is an internal annual agency target of £17.00m.
- Total agency cost in August was £1.51m or 3.5% of the total pay costs. For 2017/18, the average agency cost was 4.2% of total pay costs.
- For August, the monthly target set was £1.42m. The total agency cost is worse than the target by £0.09m.
- Agency cost remained the same compared to July. There has been increases across Interims (£0.10m) and Consultant (£0.01m). This is offset by decreases in Healthcare Scientist (£0.06m), Nursing (£0.03m), Non Clinical Support Staff (£0.01m) and AHP (£0.01m).
- The biggest area of overspend was in Interims, which breached the target by £0.22m.

Meeting Title:	Trust Board (Part 1)		
Date:	27th September 2018	**Agenda No.**	**2.3**
Report Title:	Cardiac Surgery Update		
Lead Director/ Manager:	Professor Andrew Rhodes, Medical Director		
Report Author:	• Lisa Pickering, Divisional Chair, • Peter Holt Clinical Director		
Presented for:	Discussion Update		
Executive Summary:	The Trust Board has previously considered the on going challenges within the cardiac surgery service. The Trust received the independent external review of cardiac surgery by Professor Mike Bewick in July 2018 ("the Bewick report"). The Trust accepted the recommendations in full and is now implementing these at pace. This paper provides an update to the Board on the Trust's progress in implementing the recommendations of the Bewick report. It also provides an update on developments regarding the service since the Board's last meeting on 30 August 2018. This includes the measures put in place to temporarily transfer the operations of a small number of patients requiring the most complex cardiac surgery to other London hospitals, and the withdrawal of doctors in training from the cardiac surgery service. The paper also provides an update on the establishment of the independent external panel appointed by NHS Improvement to oversee the actions the Trust is taking to improve the service.		
Recommendation:	The Board is asked to note the progress made to date in implementing the recommendations of the Bewick report and the update on the operation of the service.		
Supports			
Trust Strategic Objective:	Right care, right place, right time. Champion Team St George's		
CQC Theme:	Safe, Well Led		
Single Oversight Framework Theme:	Quality of Care (safe, effective, caring, responsive) Operational Performance Leadership and improvement capability		
Implications			
Risk:			
Legal/Regulatory:			
Resources:			
Previously Considered by:	Trust Executive Committee Quality & Safety Committee	**Date:**	19 September 2018 20 September 2018
Appendices:	Update on progress in implementing the recommendations of the Bewick report.		

CARDIAC SURGERY SERVICE: UPDATE
TRUST BOARD, 27 SEPTEMBER 2018

1.0 PURPOSE

1.1 This report updates the Trust Board on progress in implementing the recommendations of the Bewick report and developments in the cardiac surgery service since the August meeting.

2.0 BACKGROUND

2.1 In April 2018 the Trust was informed of a second NICOR alert covering the period 2014-17 which highlighted an increased mortality rate for patients receiving cardiac surgery at the Trust when compared to the rest of the country. This followed a previous NICOR alert in 2017 covering the period 2013-16.

2.2 In response to this alert, the Trust commissioned an independent review of its cardiac surgery service. This was led by Professor Mike Bewick, former Deputy National Medical Director at NHS England, who had experience of conducting similar independent reviews elsewhere. The review was carried out over a three week period in June and July 2018. The Trust received the report on 11 July 2018.

3.0 IMPLEMENTATION OF THE RECOMMENDATIONS OF THE BEWICK REPORT

3.1 The Bewick report contained a number of recommendations to improve and strengthen the service and build on the improvements in safety that had been delivered since the first NICOR alert in 2017. The Trust Board accepted all of Professor Bewick's recommendations and is committed to implementing these at pace.

3.2 Since receipt of the report on 11 July, the Trust has taken a series of actions to stabilise and improve the service:

- The one consultant with a split cardiac and thoracic practice has been moved into full time cardiac surgery.
- Two new fixed term consultant cardiac surgeons have been appointed.
- One cardiac surgical consultant has been seconded to another Trust on a temporary basis for additional support and development.
- Decision-making and oversight of all cardiac surgical patients has been strengthened by the appointment of a full time programme lead (Clinical lead for Cardiology) and also additional support for the governance aspects of the service.
- A consultant of the week model has been initiated.
- There are daily MDTs in place to review all patients
- There is a daily performance and quality dashboard that is scrutinized to provide assurance as to the safety of the service.
- All adverse incidents are reviewed on a daily basis 3.3 Appendix 1 sets out in detail the Trust's progress to date in implementing the recommendations.

4.0 DEVELOPMENTS IN THE CARDIAC SURGERY SERVICE

4.1 Since the last Board meeting on 30th August, there have been a number of significant developments with the cardiac surgery service:

- Training of junior doctors and undergraduates in cardiac surgery has been temporarily paused following discussions with HEE and the GMC.
- Cardiac surgical practice has been reduced in cooperation with our system partners so that high-risk cases are temporarily transferred to partner organizations.
- Additional advice and support is being provided to the staff members impacted by these changes.

4.2 The CQC had previously conducted an unannounced inspection of the cardiac surgery service at the Trust on 23 August. Their formal report into what they found is awaited.

4.3 Cardiac surgery at the Trust remains safe and the steps we have taken, in discussion with our regulator and other external stakeholders, have ensured greater space for the Trust to make changes (including those set out above) to strengthen the service going forward.

5.0 INDEPENDENT SCRUTINY PANEL

5.1 A series of reviews and correspondence from experts have identified that there are longstanding issues with the cardiac surgical services at the Trust. The Trust has asked, and NHS Improvement has agreed, to set up an independent panel to advise, challenge and support the Trust's actions in addressing those issues and related work force challenges in a comprehensive and appropriate manner, with a view to ensuring the quality and safety of those services.

5.2 The purpose of the panel is to scrutinize the Trust's response to the reviews undertaken in respect of the cardiac surgical services at St George's NHS Foundation Trust, to advise the Trust to ensure that the actions taken are appropriate and that implementation of recommendations is effective.

5.3 The panel membership consists of:

- Sir Andrew cash (Chair)
- Dr Chris Welsh (Medical Director)
- Dr Richard Grocott-Mason (Cardiologist)
- Mr David Richens (Cardiac surgeon)
- Ms Ann Stringer (Human Resources Director)
- Ms Janice Barber (NHS Employment matters / legal)

6.0 RECOMMENDATIONS

6.1 The Board is asked to note the progress made to date in implementing the recommendations of the Bewick report and the update on the operation of the service

Appendix 1. Update against the Recommendations from the Bewick Report.

	Recommendation	Update (24/9/18)
1	**The current consultant cardiac surgical team** membership is incompatible and requires **restructuring** with some urgency.	Further consideration is being given to this recommendation and an independent focused review was commissioned to help inform this.
2	To facilitate the required changes in practice to sustain and develop the service an expansion to 8 full time surgeons is required. This would allow for a surgeon of the week, expansion of sub-specialisation roles and increased research and ambassadorial roles.	During the Bewick review we had 5.5 WTE in the cardiac surgical consultant workforce. One consultant with a split (cardiac and thoracic) practice has been asked to move solely into cardiac and one consultant has been temporarily seconded to another Trust for additional training. Two new appointments have been made on a fixed term basis. This leaves us with 7 WTE.
3	**There is a need for an immediate appointment of 2 consultants** which will be challenging in the current climate. One should be straightforward as there is a suitable post CCT surgeon working in the unit who could be interviewed for initially a long term locum role.	The first of these appointments started on the 17th September and the second is due to start in the first week in October.
4	**Seek out a proficient and credible cardiac surgeon to lead the unit**. One of the issues that was raised by many of the interviewees was to widen the recruitment process to seek a competent experienced surgeon with an interest in mitral valve repair. The pursuance of such a person, who would ideally be placed to offer a leadership role, should not be limited to the UK	This is a longer-term recommendation and needs to follow on from the re-structuring described in recommendation 1. We are currently discussions the possibility of on site leadership support with our partners but this is not yet agreed.
5	**Succession plan to be produced within 2 months**. To plan for the probable retirement of at least one surgeon succession planning should commence now to seek a 3rd surgeon. Again, this could be from a sub-speciality offering more innovative surgical procedures such as robotics or less invasive surgery. International candidates could be approached	Implementing this recommendation is subject to the re-structuring described in recommendation 1. Individual one to one conversations have been had with all surgeons. Succession plans are being developed.
6	**Skills development of junior surgeon(s).** To assist the unit in further expansion of its services (either at SGH or as part of a wider South London network) one of the less experienced surgeons to be offered a sabbatical at a specialist unit where specific new skills can be developed.	One surgeon started at another Trust on the 10th September for additional training. Initially for a one month period but with a view of reviewing progress and expectations at the end of the month to agree longer-term plan. We will need to develop a longer OD strategy for the team that takes skills development as well as training into account.
7	**Pathway leadership role**. To complement the role of CGL which concentrates on the operational and governance issues of the unit a new role supporting development of a 'total pathway of care' model, encouraging multi-speciality team working across pre-, peri-and post-operative care. We see this as an essential step in promoting more critical analysis and safer care for all patients, but particularly those in	We have implemented many changes to the pathway of these patients. A consultant of the week model was initiated on the 10th September and the leadership of the pathway with daily MDT and enhanced collaborative decision-making has been taken assisted by Cardiology. SOPs are being drafted and will be signed off at TEC. A consultant surgeon has been seconded to GSTT to examine and

	a 'high risk' category. This role, while open to anyone, would be suitable for a relatively new consultant who wishes to develop new managerial as well as leadership skills	report back on pathways, and how these might be implemented at SGUH.
8	**Move to a single speciality surgical practice only**. The unit should develop a policy of only employing single speciality surgeons. There is an increasing evidence base for splitting the role of cardiac and thoracic surgery and our recommendation is that this should be adopted by the Trust enhancing safe practice	This was implemented with immediate effect on the receipt of the Bewick report (July 2018).
9	**Sustainability of the unit. Develop senior ambassadorial roles**. The cardiac surgery service is under considerable scrutiny and there has been extensive media coverage about challenges within the service. The most senior clinicians (and new leaders as they come on stream) need to take responsibility for rebuilding trust in the unit. This will involve significant work with colleagues in 'feeder' units, academic and service links with other cardiac surgery centres in S London. SGH has a significant experience in sub-speciality working, examples being HOCM, Aortic Arch disease, Marfans and complex mitral valve repair. Only by demonstrating a single vision for the service as a revitalised and innovative one, will organisations be convinced of SGH's intent to build a better service. To achieve this senior surgeon's may have to temporarily reduce clinical commitments.	Since the Bewick review, the service has continued to be the subject of media coverage which has had reputational implications for the service and Trust as a whole. We have also seen referrals from partner organizations reduce. . In addition since 10th September, we have implemented temporary measures to refer patients requiring the most complex cardiac surgery to other London hospitals in order to allow the space for the Trust to make the changes required to improve the service. The Trust has proactively communicated with referring hospitals and GPs, as well as a wider group of key external stakeholders, to set out the current position of the service and will continue to do so. We have also communicated with all patients on the waiting list.
10	**Unit project manager**, to support the expansion of consultant numbers and to develop a unit strategy the Trust should employ suitable project support.	A project manager is in place, back fill for General manager time has been provided so that the GM of the service can concentrate on this full time. Clinical backfill has been provided for Dr Raj Sharma (Clinical lead for Cardiology) so that he can take a FT leadership role in the pathway development and Dr Lisa Anderson has had time freed up to support the governance changes.
11	**Cardiac institute.** There is already cooperation between cardiologists and vascular surgeons across South London. There has been some reluctance to include cardiac surgery into the process. This should be revisited and, supported by lead clinicians and an executive director sponsor, lines of communication opened up with GST to commence meaningful negotiations	Whilst short to medium term changes have been implemented, it is imperative that the longer term strategic position of cardiac surgery at SGUH is considered together with our partner organizations. These discussions have commenced (facilitated by NHS E) but remain on going. As of this week, a 'complex' MDT has been commenced jointly with KCH to review elective cases prior to transfer. On going support from GSTT and KCH is now in place to facilitate patient care when meeting high-risk criteria and not being performed at SGUH.
12	Technical advice to improve patient safety. The following we hope are practical steps to assist surgical and associated specialities in improving clinical outcomes. These are summarised in Appendix 5**.**	This recommendation involves the wider parts of the pathway, such as re-structuring the job plans and care provision in cardiac intensive care and cardiac anaesthesia. The Quality Improvement Academy is

		now focussing and supporting the care provision aspects of this recommendation. Job plan changes are still in discussion and have not progressed at the pace we would hope for.
13	**Improved data entry** Unsatisfactory at present.	
a	There needs to be clinical sign-off of each case accompanied by data validation / audit etc. This can be arranged internally – e.g. every month each surgeon checks at random the entries for one patient operated on by colleague. We note the trust is moving to surgeons entering their own data via the dendrite system and a definite start date would be helpful.	Data is now shared with each individual surgeon prior to it being submitted externally. This will be helped when the Dendrite database system is installed. This has now gone through procurement processes and a start date is being reviewed together with the governance processes that dictate how the system is used. The software company ran a demo internally last week.
b	The current data manager is the sole authority on data quality in the unit and responsible for data extraction, entry and coding. We believe this to be unsafe for the unit as there are no checks and balances, leaves the Trust vulnerable if he departs and is professionally isolating for him. Even with adoption of the Dendrite system this will not change and the Trust is advised to manage this situation *so that further analytical support* is available	Line management has been moved to the GM, but clinical management in terms of data production under the CGL and therefore CD/Div Chair
14	**Outcome monitoring.**	
a	We have found little evidence of ongoing outcome monitoring of VLAD plots, until a surgeon feels under threat, nor significant engagement by surgeons in morbidity review – e.g. unexpected long ITU stay, unexpected long cross clamp time. Needs to be standing agenda item at M&M.	Data are now presented at the M&M meetings. An external (to cardiac surgery) governance lead has been identified who is working with the surgeons to develop reporting models.
b	We suggest that only the unit plot is shown to the meeting. CD or med director should review individual surgeons' plots quarterly and take appropriate action as needed. This we believe would allow good professional discourse and interaction.	Unit level VLAD plots have been shared with the team. Consultant level plots have been scrutinized by the leadership group and each individual consultant has been asked to reflect on their own data.
15	**Pooling patients** with decision on appropriate allocation at the MDT, led by 'surgeon of the week'. This is dependent on recruitment but is a clear need in the next few months (3-6).	Pooling of patients has been agreed and specific details of how this will work in practice are being drafted into a SOP that will get TEC sign off. This has not yet occurred. There remains limited assurance that this is now in place.

Meeting Title:	Trust Board		
Date:	27 September 2018	**Agenda No**	**2.4**
Report Title:	**Annual Report of the Infection Prevention and Control Team 2017/18**		
Lead Director	Avey Bhatia- Chief Nurse & DIPC		
Report Author:	Peter Riley, Consultant Medical Microbiologist and Infection Prevention and Control Doctor		
Presented for:	Review		
Executive Summary:	To provide the Trust Board with the Annual Report on Infection Prevention & Control 2017/18 in order to: • Provide assurance of the Trust's compliance with the Health and Social Care Act 2008 (DH, 2015) during 2017/18. • Highlight aspects of good performance in the previous year with regards to infection control, areas for further improvement and key areas of focus for 2018/19. Main highlights are as follows: • The number of hospital-acquired episodes of Clostridium difficile was the lowest on record with a total of 16 compared to a target of 31. This is the lowest rate for any London or English teaching hospital trust. For 2018-19 the target has been reset at 30 episodes. • The IPC team continues to receive support from the antimicrobial stewardship team and the vascular access team whose work over the year has helped keep the low levels of bacteraemia in the Trust. The Trust-assigned MRSA bacteraemia numbers showed an increase compared to the previous year with 4 Trust-assigned episodes in 2017-18. This compares to two episodes in 2016-17. • Two categories of surgical-site infection surveillance modules were completed and the rates of infection matched the national means. • Influenza activity was higher in 2017-18 compared to any year since the pandemic of 2009-10. A cohort ward for patients with influenza was successfully deployed and combined with early diagnosis in A&E using a rapid point of care test, helped to control and the number of episodes of hospital-acquired infection. The uptake of influenza vaccine was the highest recorded for St George's being the 2nd highest in London and 4th highest in England.		
Recommendation:	The Board is asked to review and discuss the Annual Report of the Infection Prevention and Control Team 2017 – 2018		
Supports			
Trust Strategic Objective:	Treat the patient, Treat the person Build a better St George's		
CQC Theme:	Safe, Well-led, Responsive, Caring, Effective		
Single Oversight Framework Theme:	Quality of Care Strategic Change		
Previously Considered by:	Quality and Safety Committee	**Date**	20/09/18
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Annual Report of the Infection Prevention and Control Team

2017 – 2018

Contents

Summary

This report summarises the activities of the Infection Prevention and Control Team at St George's University Hospitals NHS Foundation Trust during the financial year 2017-18.

The Trust-assigned MRSA bacteraemia numbers showed an increase compared to the previous year with 4 Trust-assigned episodes in 2017-18. This compares to two episodes in 2016-17. This is still a relatively low number compared to other similar trusts in London and the rest of the country. The number of acquisitions of MRSA colonisation fell again compared to the previous year. Two clusters of MRSA colonisation were investigated on two wards during the year. The IPC team continues to receive support from the antimicrobial stewardship team and the vascular access team whose work over the year has helped keep the low levels of bacteraemia in the Trust.

Rates of meticillin-susceptible *Staphylococcus aureus* (MSSA) were the same as in the previous two years representing the median rate for acute teaching trusts in London.

The number of hospital-acquired episodes of *Clostridium difficile* was the lowest on record with a total of 16 compared to a target of 31. This is the lowest rate for any London or English teaching hospital trust. For 2018-19 the target has been reset at 30 episodes.

Numbers of bacteraemias with glycopeptide-resistant enterococci remained low in comparison with similar trusts in London.

Two categories of surgical-site infection surveillance modules were completed and the rates of infection matched the national means.

Influenza activity was higher in 2017-18 compared to any year since the pandemic of 2009-10. The work generated from this took up much of the time of the Infection Prevention and Control Team. A cohort ward for patients with influenza was successfully deployed and combined with early diagnosis in A&E using a rapid point of care test, helped to control and the number of episodes of hospital-acquired infection. The uptake of influenza vaccine was the highest recorded for St George's being the 2nd highest in London and 4th highest in England.

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

There continue to be low levels of colonisation and infection with multi-drug resistant bacteria although the trend is for a small increase. The strong antimicrobial stewardship programme at St George's continues to support the prevention of resistance.

Further actions to reduce the risk of infections in cardiothoracic surgery associated with heater-cooler units were implemented.

There was one episode of likely hospital-acquired legionella infection in an inpatient who despite treatment sadly died. A Serious Incident investigation took place.

The IPC team continues to receive support from the antimicrobial stewardship team and the vascular access team whose work over the year has helped keep the low levels of bacteraemia in the Trust.

Richard Lloyd Booth joined the Trust as Deputy Chief Nurse and Deputy DIPC in early 2018

I would like to thank all the members of the infection prevention and control team, the pharmacy team, the link nurses and all others in the Trust involved in infection control for their hard work during the year.

Finally with great sadness I need to record the death in January 2018 of Selma Mehdi, an esteemed member of our Infection Prevention and Control team at St George's. Selma trained as a nurse at St George's in the 1970s before embarking on a career as an infection control nurse at several hospitals in London before returning to St George's in 2009 to take up the role as Lead Infection Control Nurse which she shared with Ruth Law. Selma's experience, knowledge, hard work and diligence are a great part of the success that we have seen in the prevention and control of infections at St George's in recent years and she will be greatly missed.

Peter Riley
Consultant Medical Microbiologist and Infection Prevention and Control Doctor

July 2018

Organisation & Management of Infection Prevention and Control in the Trust

Infection Prevention and Control within the Trust

A key part of the Trust's strategy is to emphasise that Infection Prevention and Control is the responsibility of all Trust staff, not just the Infection Prevention and Control Team. Thus, all staff are accountable for their actions with regard to infection prevention and control through their medical, nursing, therapy and managerial lines of responsibility. Infection Prevention and Control remains a standing agenda item for divisional clinical governance meetings.

The Trust as a whole is committed to participation in the DH Saving Lives Initiative and, like other Trusts, participates in the DH mandatory reporting schemes for MRSA, MSSA and *Escherichia coli* bacteraemia, *Clostridium difficile* infection, Glycopeptide-resistant enterococcal bacteraemia and Surgical Site Infection Surveillance (orthopaedics).

The Team:

It is the responsibility of the Infection Prevention and Control Team (IPCT) to provide the Trust with relevant specialist guidance and advice at every level, from senior management down to individual staff members. The team sits within the Infection Care Group which is part of the Medicine and Cardiac Division. The IPCT have direct access to the Chief Nurse who is also the Director of Infection Prevention and Control, via regular scheduled meeting and ad-hoc discussions as required. Its specific activities include:

On-going support and advice for clinical staff – regular clinical site visits, dealing with problems, outbreaks & incidents
Education of all staff groups
Drawing up policies and guidance documents (The Infection Prevention and Control Manual)
Clinical and environmental audit
Surveillance of healthcare associated infection, including participation in mandatory DH surveillance schemes
Antibiotic Stewardship ward rounds conducted by the Consultant Medical Microbiologists and antimicrobial pharmacists.

During the year 2017/18 the team consisted of:

- Avey Bhatia — Director of Infection Prevention & Control, & Chairman of the Infection Prevention and Control Committee
- Richard Lloyd Booth — Deputy Director of Infection Prevention and Control
- Dr Peter Riley — Trust Infection Control Doctor
- Ruth Law — Lead Infection Prevention and Control Nurse

- Selma Mehdi — Lead Infection Prevention and Control Nurse
- Jane Callaway — Senior Infection Prevention and Control Nurse
- Kristina Hager — Infection Prevention and Control Nurse
- Melissa Farragher — Infection Prevention and Control Nurse
- Jane Goldman — Infection Prevention and Control Nurse
- Umara Adamu — Infection Prevention and Control Nurse
- Belinda Awadzi — Infection Prevention and Control Nurse
- Pam Bridle — Staff nurse for Infection Prevention and Control
- Hasan Al-Ghusein — Information Analyst
- Helen Graham — PA/Office manager

Infection Prevention and Control Link Staff

There are currently 98 Infection Prevention and Control Link Staff in the Trust. A 3 day IPC Link programme was delivered on two occasions during 2017/18. There was good attendance, engagement and participation at these meetings.

Governance of the Infection Prevention and Control Team 2017-18

The work of the Infection Control Team is overseen by the Infection Prevention and Control Committee (ICC), chaired by the Director of Infection Prevention and Control (DIPC), with a membership representing the whole Trust, as well as representation from the South London Health Protection Unit (HPU). The IPCC meets every two months. The IPCC defines the infection control strategy for the Trust

The Healthcare Associated Infections Task Force met every two weeks and is also chaired by the DIPC or Infection Control Doctor. This is an operational group, which is attended by representatives from all clinical divisions, focuses on bringing about rapid interventions aimed at control of health care associated infections. It is also attended by the infection control lead for the South London Commissioning Support Unit.

Infection Control Team Partners

Lead Consultant for Antibiotic Stewardship

Dr Matthew Laundy

Antibiotics and Infection Management Pharmacist

Laura Whitney	Consultant Pharmacist

Venous Access Team

Jackie Nicholson	Consultant Nurse

The Antibiotic Stewardship and Venous Access Teams while separately managed to the IPCT, are both involved in areas that are key to achieving better infection control, and both also attend the Infection Control Committee and work closely with the IPCT as appropriate.

Estates and Environmental Hygiene

Jenni Doman	Assistant Director, Facilities

Diagnostic Microbiology

Dr Tim Planche	Microbiology Lead - South West London Pathology (SWLP)

Infection Care Group

Dr Meaghan Cotter	Joint Care Group Lead until October 2017
Dr Aodhan Breathnach	Joint Care Group Lead from October 2017
Prof Derek Macallan	Care Group Lead

Other organisations

Dr Yvonne Young	South London Health Protection Team
Anne Lusmore	South London Health Protection Team
Sheila Loveridge	Commissioning Support Unit

Organisation and Management Community Services Division

In 2017-18 there was a single, integrated infection control team within the Trust. Currently there is one programme activity for a community infection control doctor and 1 WTE infection prevention and control nurse.

Mandatory Surveillance of Healthcare-Associated Infection:

Trusts are required to participate in six mandatory reporting schemes;

1. MRSA bacteraemia
2. MSSA bacteraemia
3. *Clostridium difficile* infection
4. Glycopeptide-resistant enterococcal bacteraemia
5. *Escherichia coli*, Klebsiella and *Pseudomonas aeruginosa* bacteraemia
6. Surgical Site Infection Surveillance

MRSA Bacteraemia

Since April 1st 2001 all NHS trusts have been required to report the number of episodes of bacteraemia (bloodstream infection) with MRSA. Bacteraemias are categorised into community-acquired episodes (positive within 48 hours of admission or hospital-acquired episodes (positive after 48 hours following admission). This system is relatively crude and does not always accurately classify the bacteraemia; however it is systematic and reproducible.

All MRSA bacteraemias are initially apportioned to the organisation based on the timing of the positive blood culture The MRSA bacteraemia then undergoes a post infection review (PIR) process, the results of which are submitted to Public Health England. The bacteraemia is then assigned to the organisation deemed to be responsible. Disagreements are dealt with by an appeals process. Despite the threshold being zero avoidable there is no official process to label an episode avoidable or not unless the episode is classified as "third party". This process can occur when the trust and the CCG do not agree on assignment and an independent panel agree that neither organisation could have prevented the bacteraemia.

In line with the government thresholds St George's has reduced the number of MRSA hospital assigned bacteraemias significantly since 2002-03. See figure 1. More recently the number of assigned episodes were as follows; 2011-12 one episode, 2012-13 nine episodes, 2013-14 six episodes, 2014-15 six episodes, 2015-16 three episodes and 2016-17 two episodes

In 2017-18 there were 4 episodes assigned to the Trust; two episodes were in April 2017 and two were in June 2017. There were two episodes of "third party" assigned epsiodes in November 2017. The number of assigned episodes is equal to a rate of 1.31 per 100,000 bed days.

Although there were twice the number of episodes in 2017-18 compared to 2016-17 comparison with other similar trusts in London shows that this is not a poor performance. The numbers of episodes and rates in these 7 other similar trusts ranged from 1 to 10 and 0.36 to 3.68 respectively.

Figure 1

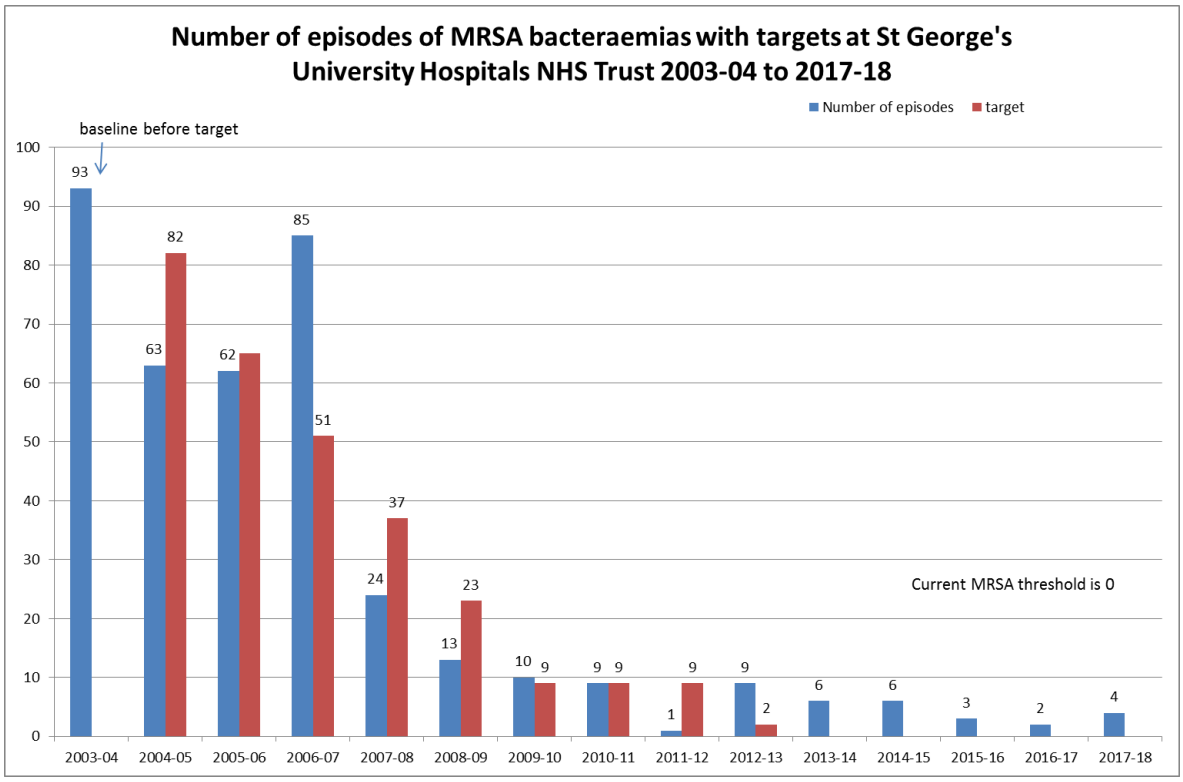


Table 1: Summary of Hospital Acquired MRSA Bacteraemia RCA Findings (four episodes) for 2017-18

Episode	date	Focus of infection	Location
547864	4th April 2018	Nephrostomy	Vernon ward
550019	13th April 2017	peripheral venous catheter site infection	Amyand ward
562885	12th June 2017	Hospital-acquired pneumonia	CTICU
562893	16th June 2017	Central venous catheter infection	Ben Weir ward

Lessons learned from these episodes

Episode 547864 occurred in a patient who had undergone surgery for removal of a renal stone. The patient was not known to be colonised with MRSA before this episode. Screening for MRSA had followed the Trust guidelines. During the time period in which initial MRSA colonisation took place, the patient had numerous interactions in many different areas of the hospital including outpatients, St James' Theatres, surgical ward (Vernon ward), radiology, A&E and Nye Bevan Unit. Prior to this the patient had also attended Kingston Hospital. The patient had been at home with a nephrostomy tube in place (not an unusual practice) and had been admitted via A&E because of bleeding. It is likely that the nephrostomy site became colonised with MRSA resulting in infection of the urinary tract and subsequent bacteraemia. The Post Infection Review process could not determine the exact timing or location of when initial colonisation with MRSA took place, nor when actual infection occurred. There were not demonstrable lapses in care that could

be shown to be causative, however examination of audit data for basic infection prevention and control practices (hand hygiene, scrubbing up, cleaning and decontamination) showed deficiencies in several of the areas that had provided care for this patient.

Episode 550019 occurred in a patient who attended A&E with a possible stroke. This was subsequently ruled out and the patient was admitted under the general medical team for investigation of fitting. The focus of infection was a peripheral venous catheter that had been inserted as an emergency when the patient attended A&E. The patient was not known to be colonised with MRSA before this episode. Screening for MRSA had followed the Trust guidelines. The patient had a complex medical and surgical history prior to this episode including multiple interactions with different locations at St George's and other providers. These included other trusts (Croydon, Royal Marsden and East Grinstead), plastics outpatients, surgical wards (Vernon and Gray), St James' Theatres, GICU and NICU, plastics dressing clinic, district nursing (provided by a different trust), ENT outpatients, A&E, stroke team and general medicine (Richmond ward and Amyand ward). It is likely that the peripheral venous catheter became infected soon after it was inserted. The Post Infection Review process could not determine the exact timing or location of when initial colonisation with MRSA took place but did show that at that time the patient developed the peripheral venous catheter infection, there already was MRSA colonisation of a surgical wound that had been acquired sometime earlier in the patient journey. Although there were some shared locations with episode **547864,** whole genome sequencing of the isolates from these two episodes showed the MRSA isolates to be different. There were not demonstrable lapses in care that could be shown to be causative, however examination of audit data for basic infection prevention and control practices (hand hygiene, scrubbing up, cleaning and decontamination) again showed deficiencies in several of the areas that had provided care for this patient. A subsequent audit of peripheral line care revealed deficiencies on the acute admissions ward.

562885 and 562893.

Both patients came from the same ward in a hospital in Kent and travelled to the same ward at St George's on the same day (but at different times) where they were admitted to the same bay on Ben Weir ward. They had been located on different parts of the same ward at the previous hospital in Kent. Investigations there have shown that they had been appropriately screened for MRSA and had been negative and were known to have been negative in the past. They had no close contact with patient known to have MRSA during their time there. On Ben Weir ward they were in the same bay and looked after by many of the same nursing staff and medical staff and had a similar range of pre-op investigations. The pre-op investigations were conducted at different times by different staff. Timing of the patients' admissions and swab results indicate that colonization with MRSA is likely to have taken place sometime between 23/05/17 and 01/06/17 at St George's. However, given the limitations of MRSA screening and the natural history of colonization, it is possible that colonization of one or both of the patients might have taken place earlier. There is no evidence to support that hypothesis, though typing results have shown the two MRSA strains to be identical and furthermore not of a type detected at St George's over the last two years or subsequent to the two episodes of bacteraemia. Examination of audit data and subsequent audits performed by the Infection Prevention and Control Team demonstrated some deficiencies in hand hygiene and cleaning and decontamination on the wards where the patients received their care. It also became apparent that the frequency of face to face Infection Prevention and Control teaching across the cardiac division was lower than required. As in the previous episodes no demonstrable causative lapses in care can be demonstrated. Episode 562893 was the

result of a central line infection and the removal of that line was delayed for other patient safety reasons.

The thresholds for 2018-19 remain at zero avoidable MRSA bacteraemias permissible, but there will be changes to the reporting procedures. Only the worst 15% of performing trusts will be required to have formal local procedures for post infection review. St George's is not one of the worst performing trusts but will maintain the current processes for investigation episodes as it is important to understand how infections are acquired in order to prevent further infections. Third party assignment will cease and all episodes will be apportioned strictly on the basis of the timing of the blood culture in relation to hospital admission. This may result in an apparent rise in the number of bacteraemias.

MSSA Bacteraemia

From 1st January 2011, the Trust has been required to report all cases of meticillin susceptible *Staphylococcus aureus* (MSSA) bacteraemia using similar criteria and mechanisms as employed for MRSA.

There were 65 episodes in 2017-18 of which 28 were apportioned to the Trust. Previous numbers are shown in the table 2.

Table 2. MSSA bacteraemias

Year	Total	Hospital-acquired
2013-14	80	31
2014-15	82	29
2015-16	80	36
2016-17	79	31
2017-18	65	28

There are no national thresholds for MSSA bacteraemia at present. The rate of trust-apportioned episodes for St George's for 2017-18 was 9.15 per 100,000 bed days. Numbers and rates at other London teaching trusts ranged from 14 to 72 and 7.41 to 11.06 respectively with St George's having the second lowest rate. In the past it has been theorised that MRSA bacteraemias were additional to MSSA bacteraemias meaning measures to prevent MRSA bacteraemias would not necessarily reduce healthcare-acquired MSSA bacteraemia, though others have argued that the routes of transmission and infection are similar. Given that only 1-2% of patients are colonised with MRSA, whereas 30% of patients are colonised with MSSA, it is not surprising that the rates of MSSA bacteraemia are proportionally higher especially since MSSA colonised patients are not given decolonisation treatment.

Clostridium difficile

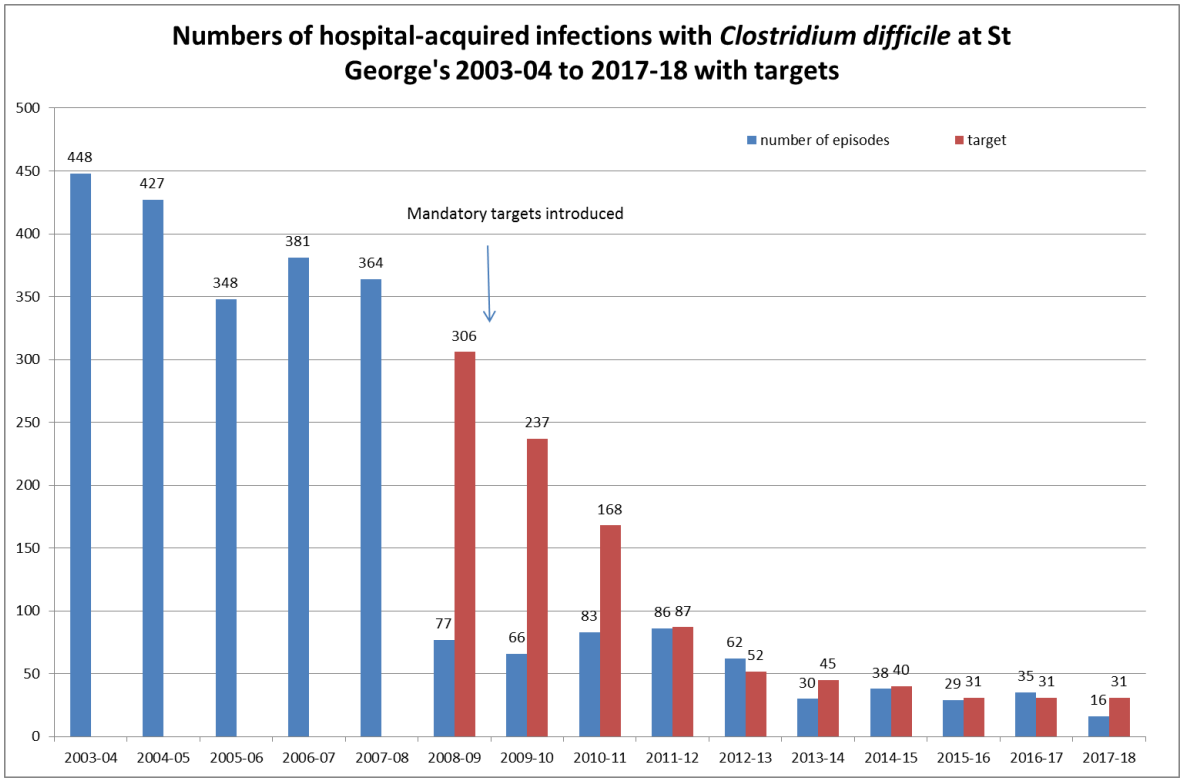
Clostridium difficile infection is a major cause of antibiotic-associated diarrhoea, and became widespread in UK hospitals in the late 1990s with significant increases in numbers of patients being infected. In response to this the Government announced in October 2007 a plan to reduce the number of *C difficile* infections nationally by 30% by the

end of the calendar year 2010-11. The baseline that this reduction was applied to was the number of "attributable" cases in the financial year 2007-08.

The 30% reduction was for the total number of cases nationally. Some trusts already had low levels before the start of the programme in 2008-09; thus the reductions were applied differentially. That is, historically good performing trusts only needed to make a 10% improvement, whereas others with higher baselines needed to make improvements of greater than 30%. St George's was one of the latter.

St George's significantly improved its *C. difficile* rate since then. The reduction in *C. difficile* episodes was in response to a bundle of measures introduced which has been described in detail in previous annual reports. Figure 2 indicates the reduction in numbers of episodes since 2002-03.

Figure 2



Each year the Trust has a target (threshold) for trust-apportioned episodes. The targets are individualised for each trust with a very wide range. The target for St George's in 2016-17 was again 31 episodes, equating to a rate of 10.2 per 100,000 bed day as it was in 2016-17. Other London Teaching hospital trusts had targets up to 4 times higher.

In 2017-18 St George's had only 16 episodes of Trust-apportioned infection corresponding to a rate of 5.56 episodes per 100,000 bed days. This is the lowest rate on record and was the lowest rate for any London teaching trust, the lowest rate for any English teaching trust and the 19th lowest rate in the country overall compared to the other 149 trusts.

Episodes that are trust-apportioned undergo RCA and all isolates of *C difficile* also undergo ribotyping to look for any evidence of cross-infection. Together, the RCA findings and ribotyping can be used to ascertain if there have been any lapses in care.

For 2017-18 analysis showed the following:

Ribotyping do not reveal any evidence of transmission of infection within the hospital from one patient to another.

One episode was clearly a community-acquired infection but justifiable delays in obtaining a specimen meant that the timing of the diagnosis resulted in the episode being categorised as trust-apportioned.

One patient experienced three positive results. Clinical details indicated that this patient probably did not have *Clostridium difficile* infection and the results are likely to reflect colonisation.

In 2018-19 the target has been reduced to 30 episodes. New targets will be introduced in 2019-20 based on European definitions of infection with new categories such as healthcare-onset healthcare-associated and community-onset healthcare associated. These categories will be determined by the date of the specimen in relation to current or recent hospital inpatient care.

Glycopeptide resistant enterococcal bacteraemia

This reporting scheme started on 1st October 2003 and data have been published annually for all hospitals for a year running from October to September. St George's figures are illustrated in table 3 below with figures up to end of September 2017. There are no national thresholds. St George's has always had very low levels (up to six times lower than some trusts) and this trend continued.

Table 3: Annual numbers of GRE bacteraemias at St George's Hospital

Year	Number of patients
October 09 to September 2010	3
October 10 to September 2011	4
October 11 to September 2012	13
October 12 to September 2013	11
October 13 to September 2014	12
October 14 to September 2015	11
October 15 to September 2016	8
October 16 to September 2017	8

Gram-negative bacteraemia including *E. coli, Klebsiella and Pseudomonas aeruginosa*

All Trusts have been required to report cases of *E. coli* bacteraemia using similar mechanisms as for MRSA and MSSA bacteraemia. Surveillance began in June 2011 and in 2017-18 the requirement to include risk-factors for each episode was made mandatory. This was instigated to help enable the 50% reduction target over the next 5 years.

Additionally this was extended to include Klebsiella and Pseudomonas aeruginosa in 2017-18.

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

Table 4 shows the past numbers of *E coli* bacteraemias

Table 4

Year	All	Trust apportioned
2013-14	233	72
2014-15	267	71
2015-16	250	66
2016-17	262	71
2017-18	256	72

The rate for 2017-18 is 22.2 per 100,000 bed days. Comparative data haver only recently become available but comparison with other London teaching trusts shows numbers and rates of hospital-acquired episodes ranging from 20.04 to 39 and 53 to 138 respectively.

An analysis of the first 47 episodes of hospital-acquired infection (April to November 2017) showed the following foci of infection

Table 5. Foci of infection in 47 episodes of healthcare-acquired *E coli* bacteraemia

Focus	number	Risks
Bone	3	2 diabetic foot infections ?preventable
Bone with prosthesis	1	Post surgery preventable
GI	4	2 post surgery preventable
genital	1	
hepatobiliary	5	1 post ERCP and 1 post surgery ?preventable
CVC	3	Preventable
Respiratory	3	2 intubated i.e, VAP preventable
neutropenic sepsis	5	? preventable
lower UTI	12	6 with catheters preventable
upper UTI	4	1 post surgery preventable
No focus	6	
Total	47	

From these 47 infections a total of 18 may be preventable where the focus of infection is known.

There need to be actions instituted for those types of infections that are potentially preventable. The major sources of infection are urinary tract including catheter-related infections, hepatobiliary (some related to endoscopic procedures, GI tract (some related to surgery)**,** neutropenic sepsis**,** bone and joint infections including diabetic foot infections.

Potential actions include:

1. Previous audits have shown that although patients with urinary catheters have good reason for initial catheterization, many still have catheters when no longer required. A new audit should be conducted.

2. Review of diagnosis and treatment of urinary tract infections. Are patients getting the correct antibiotics for the correct duration?

3. Review of prophylaxis for biliary procedures

4. Review of prophylaxis for surgical procedures

5. Review of prophylaxis for neutropenic patients

6. Prevention and management of diabetic foot infections: the Trust established a diabetic foot team 10 years ago.

As an initial starting point the Trust has agreed a 10% reduction target for hospital-acquired episodes in 2018-19. This is no more than 64 episodes.

Surgical Site Infection Surveillance

It is mandatory for any hospital that performs orthopaedic surgery to complete one module of the nationally organised surgical site infection surveillance service per year. The Surgical Site Infection Surveillance Service (SSISS) is organised by the Public Health England. Hospitals record data using a set of standard criteria. Infection rates are calculated on the basis of data collected during the patient's admission and include a post-discharge surveillance period that can be up to a year from the procedure date if the patient has received a prosthetic implant. This means trusts can monitor their performance against previous results and other hospitals.

Post discharge questionnaire forms were not used at St George's; a larger surveillance team would be needed for this. At present there is one cardiac nurse practitioner undertaking surveillance for patients who have had Coronary Artery bypass grafts along with other duties and one Infection Prevention and Control nurse, band 5, who is also designated to undertake SSI surveillance. With an anticipated expansion of staff numbers, post discharge surveillance for the orthopaedic module is expected to start in the late summer of 2018.

Fractured Neck of Femur

It is mandatory for hospitals to undertake surveillance on an orthopaedic module for one quarter of each year.

Surveillance on patients with fractured neck of femur was performed for all 4 quarters of 2017. The results are shown in the table below. The rate overall for 2017 was 0.9%.This represents an improvement compared to 2016 when the rate was 1.3%. The national mean over the five year period from 2012-2017 was 1.3%.

Table 6 Fractured Neck of Femur

Trends in rates of SSI by surveillance period at your hospital							
Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	52	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
2017 Q2	63	**1**	**1.6%**	**0**	**0.0%**	**1**	**1.6%**
2017 Q3	54	**1**	**1.9%**	**0**	**0.0%**	**1**	**1.9%**
2017 Q4	56	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported							

Since January 2018 surveillance has now moved to patients who have had reduction of long bones. Commencing in July 2018, patients will be given post discharge questionnaires.

Coronary Artery Bypass Grafts (CABG)

The cardio-thoracic surgery team in conjunction with the infection prevention and control team undertook SSI surveillance of all CABG surgery. The results are shown in the table below.

Table 7 CABG

Trends in rates of SSI by surveillance period at your hospital							
Year and Period	No. operations	Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2017 Q1	182	**3**	**1.6%**	**0**	**0.0%**	**3**	**1.6%**
2017 Q2	180	**5**	**2.8%**	**0**	**0.0%**	**5**	**2.8%**
2017 Q3	164	**3**	**1.8%**	**1**	**0.6%**	**4**	**2.4%**
2017 Q4	158	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported							

After the introduction of multiple measures following the high rates reported in the 2013-14 annual report the infection rate reduced significantly. The overall rate dropped from 9% in 2013-14 to 6% in 2014-15 and 3.6% in 2015-2016. The rate for 2017 is 1.8%. In the last quarter there were no SSIS. The national mean over the five year period from 2012-2017 was 3.7%.
.

Previous measures included and continue to include:

- Analysis of the cases. This did not reveal any obvious common cause such as surgeon, surgical assistants, theatres or pre-existing conditions. There was some trend towards the relation being with longer surgery although this is not unexpected.
- Establishment of a cardiothoracic infection committee consisting of cardiothoracic surgeons, cardiothoracic nurses, theatre staff, infection prevention and control team, the audit and surveillance nurse and consultant microbiologist.
- Renewing nursing competencies for aseptic non-touch technique for all wound & dressings care. Dressings are not touched for the first 2 days after surgery. Transparent dressing introduced to allow inspection of the wound.
- Introduction of “Sternal Support Vests” to prevent wound mechanical dehiscence.
- Introduction of measures to reduce inappropriate traffic through theatres.
- Weekly surgical site infections ward round with nursing, microbiology and cardiothoracic surgery consultants.
- Increased use of Endoscopic Vein Harvesting for CABG surgery has helped to further reduce the risk of SSIs

Expansion of Surgical Site Surveillance

The results of this surveillance of post-operative infections only represent a fraction of all surgical procedures conducted in the Trust. Thirteen further modules covering other surgical procedures are available and an interest in SSI Surveillance has been shown by other surgical teams. Plans to increase participation are being developed.

Alert Organism Surveillance

MRSA acquisitions

The Infection Prevention and Control (IPC) team record all new MRSA acquisitions in the Trust i.e. MRSA grown from clinical samples other than blood cultures, including screening swabs. The following criteria are used to decide whether MRSA was acquired in the trust.

Acquired in the trust

- Newly positive specimen in an inpatient known to be MRSA negative on admission.
- Newly positive specimen on admission from a patient known to have been a patient in the trust in the preceding year (for greater than 48 hours) and not having been inpatient elsewhere or resident at nursing or care home.
- Newly positive specimen in a patient who has been admitted for greater than 48 hours.

Not acquired in the trust

- Newly MRSA positive in a swab taken less than 48 hours after admission and no admission to the trust in the preceding year.

The acquisitions are shown below since 2005-06 in figure 3 and table 7. It will be seen that numbers of acquisitions have steadily fallen since records began.

Currently all patients admitted to St George's Hospital are screened for MRSA in accordance with previous NHS requirements mandated in 2010. In 2014 new advice was published indicating that MRSA screening could be reduced to "high-risk" patients only i.e. the practice up to 2010. This new advice was reviewed at St George's and a decision was made to continue with universal screening.

Figure 3. MRSA acquisitions 2005-06 to 2017-18

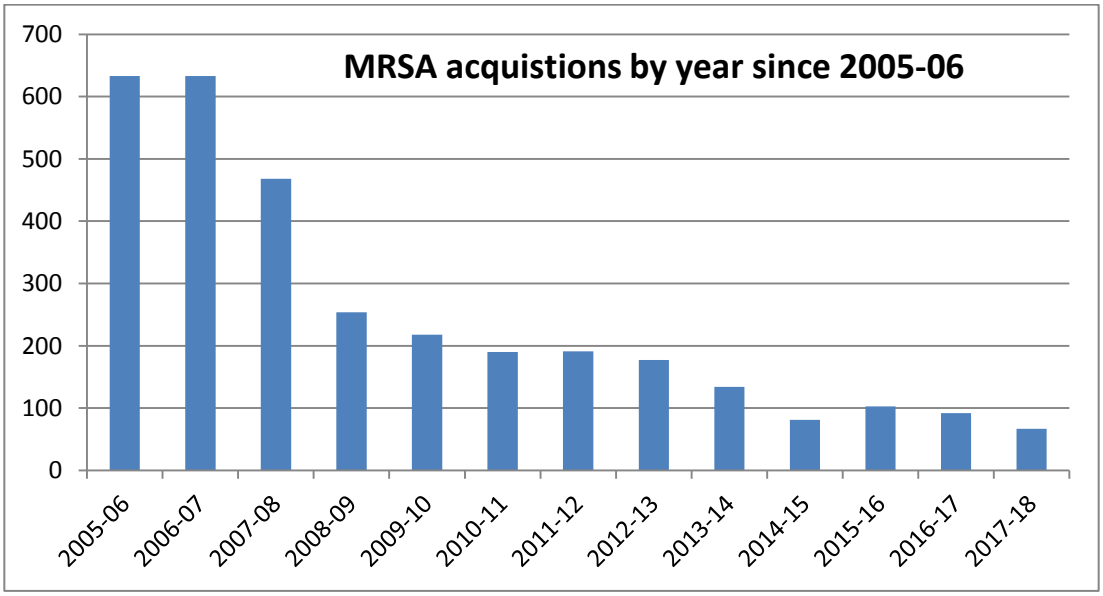


Table 7: Total number of acquisitions and percentage fall for successive years from 2005-06.

Year	Total acquisitions
2005-06	633
2006-07	633
2007-08	468
2008-09	254
2009-10	218
2010-11	190
2011-12	191
2012-13	177
2013-14	134
2014-15	81
2015-16	103
2016-17	92
2017-18	69

The majority of patients who acquire MRSA are colonised only. However it is possible that infection may develop. This can be prevented by early use of decolonisation treatment which can remove MRSA colonisation or, if given before surgery, prevent surgical site infection by reducing the MRSA bio-burden.

Decontaminating hands at the point of care and adherence to the WHO five moments for hand hygiene are essential factors to preventing the transmission of MRSA to patients. The IPC team along with the Hand Hygiene Champion (an additional post this year) promote the importance of hand hygiene through teaching sessions, monthly hand hygiene audits, assessment of healthcare workers hand hygiene technique and promotion of hand hygiene day across the trust.

Wards with clusters of MRSA acquisitions

Two wards had clusters of apparent acquisitions of MRSA in 2017-18.

In the previous report for the year 2016-17 a cluster of acquisitions of MRSA was described on the NNU. Further investigations including a review of archived results demonstrated that there had been on-going sporadic acquisitions with a strain of MRSA with spa type t121 since at least the summer of 2015. In June of 2017 a further 4 babies were found to be colonised with this stain of MRSA. No babies had infection i.e. they had no symptoms and required no antibiotic treatment. Investigations did not reveal an obvious source leading to the consideration that this may have been due to an unknown staff source. Staff screening was considered as was a plan for universal decolonisation. However before either of these plans were put in place, surveillance demonstrated that there had been no other occurrences of acquisition with the t121 strain since June 2017. Surveillance continues.

An investigation of a possible cluster of MRSA acquisitions on Rodney Smith ward took place in October 2017. Eight patients with MRSA had been identified. However several of these patients had histories of previous MRSA colonisation and it is likely that only one additional patient possibly acquired MRSA during this time. Following recognition of this cluster and implementation of the PISA process (see section XXXX), there were no new episodes detected.

The two patients who had been on Ben Weir ward and who developed MRSA bacteraemias have been discussed earlier in this report.

Other Outbreaks and Incidents

Infections associated with heater-cooler units in cardiothoracic surgery.

Heater-cooler units (HCUs) are used during cardiothoracic surgery to keep blood at the correct temperature and to cool cardioplegia solution In 2015 PHE and the MHRA alerted all trusts in England to the risk of infections associated with these units. The machines contain water which is at risk of becoming contaminated with environmental mycobacteria, in particular the species *Mycobacterium chimaera*. Some HCUs can also cause aerosols of this contaminated water to be released into the operating environment thus contaminating open wounds, surgical instruments and equipment. There is now strong evidence to show that these HCUs became contaminated at the manufacturers resulting in a world-wide problem. In the UK over 39 patients have been identified with this infection, mostly with endocarditis and worldwide there are over 100 cases reported so far, and likely to be many more. Overall the risk is still considered to be very low – in the order of 1 in 5000.

The implicated HCUs were used at St George's since 2007. Following the alert in 2015, new cleaning and decontaminating schedules were introduced and in July 2016 the suspect HCUs were replaced with an alternative model made by a different manufacturer. Although these new HCUs contain water that can also become contaminated with bacteria, they have been shown not to produce aerosols, a property that has also been verified in tests commissioned at St George's as well as by PHE. Thus the risk to patients since July 2016 is negligible. National guidance was updated in late 2016 and St George's is following this guidance which includes enhanced cleaning and decontamination, regular water testing and relocation of the HCUs from the operating environment. This was actioned in early 2018.

Five patients have been diagnosed with *Mycobacterium chimaera* infection at St George's Hospital. Four of these patients acquired the infection at St George's. The 5th patient acquired the infection at another hospital. Four of these patients were diagnosed with endocarditis and one with a sternal wound infection. All of the infections at St George's were acquired following cardiac surgery before the summer of 2015 when the Trust was first warned about the risks of infection associated with the Sorin 3T Heater Cooler Unit.

Due to the potential exposure of thousands of patients nationwide, NHS England and PHE mandated a patient notification exercise that took place in March 2017. All patients who had surgery since the start of January 2013 in hospitals where the implicated HCUs were used have been alerted to the small risk of infection, given information regarding symptoms and advice on what to do if they are concerned. Their GPs have also been informed. As a result of alert, patients who contacted the hospital have been reviewed and investigated. None of these patients were found to have infection.

Influenza infections and outbreaks

Although the influenza season started later than 2016-17 the number of diagnoses of influenza was significantly higher than all previous years with the exception of the pandemic year of 2009-10. In 2016-17 just over 300 patients were diagnosed in the trust of which 154 were admitted. In 2017-18 there were 1198 diagnosed with influenza of which 654 were admitted. 293 patients had influenza A H1N1 and 505 had influenza A non H1N1, most likely H3N2. There were 399 patients diagnosed with influenza B. Unusually influenza B infections were seen in higher numbers at the beginning of the

season. The high numbers of influenza B were probably as a result of the poor match with the trivalent vaccine that had been extensively used. Also the vaccine was not a good match for all the circulating H3N2 strains of influenza A.

The higher number of diagnoses was also probably as a result of the installation of a point of care test in A&E which was used for diagnosis in all patients who needed admission and had 'flu-like symptoms. 1027 tests were performed in A7E and 308 patients were diagnosed with influenza using this method. Knowing the diagnosis at that point of the patient's journey allowed for more efficient used of single rooms and earlier treatment and prophylaxis. Also it probably helped reduce transmission of infection to other patients. However because of the very large number of patients diagnosed, for the first time, the Trust took the decision to open a designated influenza cohort ward and used Caesar Hawkins for this very successfully. The ward utilised 4 separate bays to nurse patients with influenza segregating patients by gender and type of infection i.e. influenza A or B. As a result of the success of this ward, the option to pen a cohort ward will be part of the Trust's winter plans for 2018-19.

Despite the rapid diagnosis and use of the cohort ward hospital-acquired infections were still seen with a total of 143 representing 21% of all inpatient diagnoses. This is a lower percentage compared to last year. Not all hospital-acquired infections are preventable. Patients with influenza can have very mild symptoms so that diagnosis is not immediately obvious and furthermore patients can be infections before symptoms start. Also vaccination does not prevent all episodes of infection. 17 wards had cluster of infection i.e. more than one hospital-acquired infection with larger numbers seen on Heberden Rodney Smith and Amyand wards.

Due to the excellent work of the Occupational Health Department, influenza vaccine uptake increased further with overall uptake by patient-facing staff reaching 90.3.%. Previously the uptake had been 53.7% and 72.7% in 2015-16 and 2016-17 respectively. This was the 2nd highest rate in London and 4th highest rate in the country.

Uptake amongst various staff groups showed improvements compared to previous years as illustrated in the table below. Uptake by nurses, midwives and heath visitors was still lower than desired by had increased from 62.2% in 2016-17.

Table 8

Immform report	**Overall total**	**Number vaccinated**	**Percentage**
All Doctors	1026	1026	100
Qualified Nurses + Midwifes/health Visitors	2397	1822	76
Clinical Staff	1269	1244	98
Support to clinical + Admin	1484	1484	100
Denominator	**6176**	**5575**	**90.3**

A trivalent vaccine was used but unfortunately, as mentioned earlier, cover against the commonest circulating strain of influenza B was poor. The vaccine was still provided protection but there were a number of immunised staff who still developed influenza. An innovative scheme was previously set up whereby staff who have influenza-like symptoms can obtain a swab from the laboratory reception and take a sample from themselves for rapid diagnosis. A positive result indicating that they should not be at work. This is a further mechanism to reduce influenza transmission to patients and other staff.

The number of staff tested and results are shown below.

Table 9

		immunised	Not immunised
Staff swabbed for influenza	385		
Positive Flu A	53	27	26
Positive Flu B	50	20	30
Negative swabs	282		
Unlabelled specimens	31		

Knowing that 5575 staff had been immunised versus 601 who were not immunised the rates of influenza in the two groups are as follows;

Immunised group: 8.4 per 1000 staff

Non-immunised group: 93 per 1000 staff

These figures show that staff who were not immunised were 10 times more likely to have been diagnosed with influenza.

For the next winter, a quadrivalent vaccine will be used for staff, thereby increasing the protection against all the predicted circulating strains of flu.

Norovirus Infections and Outbreaks

As in all years since 2007-08, enhanced testing for Norovirus was available for the winter months. Any patient admitted with diarrhoea or vomiting, or who developed these symptoms within 48 hours of admission is tested for Norovirus infection as are any patients where there are suspected clusters or outbreaks. In total the laboratory tested 438 patient samples from the trust either from A&E or inpatients (both stool and rectal swabs).This was less than last year (558). Of these, a total of 72 patients were confirmed Norovirus genogroup II positive and 2 patients were Norovirus genogroup I positive. This is an increase from 50 patients confirmed positive last year.

There were 7 outbreaks within the trust an increase from 3 outbreaks last year.

Rodney Smith (October 2017)
Closed for 6 days, 6 symptomatic patients- 4 confirmed patients and 8 staff with symptoms no samples received from staff.

Amyand Ward (November 2017)
Closed for 11 days, 14 patients confirmed and 9 staff with symptom.

Belgrave Ward (November 2017)
Closed for 2 days, 6 patients with symptoms 1 confirmed, 2 staff with symptoms. As all patients were in side rooms when the outbreak started, the ward was able to contain the spread and re-open after 48hrs.

NICU (November 2017)
Closed for 3 days, 14 patients affected and 10 staff with symptoms.

Amyand ward (December 2017)
Closed for 4 days, 5 patients symptomatic- none confirmed. 5 staff with symptoms.

Gray Ward (December 2017)
Closed for 2 days, 2 confirmed patients and 2 staff with symptoms. As patients were isolated in side rooms promptly the ward was able to contain the spread and re-open after 48hrs.

Amyand Ward (January 2018)- closed for 10 days, 11 confirmed patients and no staff with symptoms. The decision was made to use hydrogen peroxide vapour to decontaminate the ward after the final outbreak.

During the outbreaks the combined number of staff cases reporting symptoms of Norovirus was 36 which is an increase from 17 staff cases reported last year.

A large outbreak of norovirus infection occurred in December 2017 at HMCP Wandsworth. Four to five cases tested positive but there were over 50 symptomatic cases. The outbreak was very well controlled by the staff with help from the South London HPU.

Multi-drug resistant Gram-negative bacteria

Antibiotic-resistant *Enterobacter cloacae* on the Neonatal Unit

Since 2006 there have been intermittent episodes of colonisation and infection due to a virulent and multiply-antibiotic resistant *Enterobacter cloacae* on NNU. No episodes of either colonisation or infection with this organism were detected in 2017-18.

Multi–drug resistant *Pseudomonas aeruginosa*

Patients may be sporadically identified with colonisation and in some cases infected with a multiply-antibiotic resistant strain of *Pseudomonas aeruginosa* that has been periodically isolated from environmental sources within the trust since 2006. The investigations surrounding this organism have been reported in detail in previous annual reports. In 2017-18 one patient was identified with colonisation with this multiply-antibiotic resistant *Pseudomonas aeruginosa,* designated as ST111. This patient was known to have been identified with previous colonisation in 2008. No new patients were identified with infection. A set of control measures and actions were designed so that whenever an episode of infection or colonisation is identified a thorough investigation takes place in order to determine if other patients have been affected. No evidence of colonisation or

infection of other patients was found in this episode in 2017-18. Regular environmental and patient screening is conducted in other wards where previous infections have occurred; currently this is Ruth Myles ward and GICU. In September 2017 this organism was detected from a swab of the plughole of a clinical hand wash basin on GICU. This hand basin has subsequently been removed and replaced and since then environmental swabs have been negative.

Carbapenamase Producing *Enterobacteriales* and other carbapenem-resistant organisms

These are multiply-resistant Gram-negative bacteria. Nine patients with CPEs were treated in the hospital. Many of these patients acquired their infections elsewhere before admission to the Trust, specifically overseas in the case of four patients who had NDM producing organisms. Five patients were identified with OXA-48 producing organisms. Acquisition while an inpatient cannot be proven as they were not specifically screened for these organisms on admission. Currently this Trust does not screen all patients for CPEs but operates a programme of enhanced surveillance. All bacteria with an antibiotic resistance pattern indicative of possible carbapenamase production are investigated further. Patients at high risk are screened, for example on admission to Augmented care units. Ward contacts are screened if there has been possible contact with another patient who is colonised or infected.

The Trusts reports episodes to the voluntary PHE operated CPE database as well as submitting antibiotic resistance data to the PHE. Compared to other trusts the rates of carbapenem-resistance and CPE numbers are low. The strong antimicrobial stewardship programme at St George's continues to support the prevention of resistance. This does not provide total re-assurance however as other trusts have different screening and laboratory investigation protocols, so a direct comparison cannot be made. The policies and procedures at St George's are under constant review and the gradual increase given the gradual increase in the detection of these organisms from clinical specimens, it is likely that a recommendation for more widespread screening will be made.

Measles

Sporadic diagnoses of measles were made in patients attending the Trust, but the numbers were lower than in 2016-17.

Candida auris

This is a multiply-antifungal resistant yeast that has caused outbreaks worldwide including several hospitals in London. Not all laboratories can easily identify this fungus, but the SW London Microbiology laboratory is able to screen as well as identify this organism accurately. So far no patients have been identified at St George's with colonisation or infection but this is likely to occur at some time in the future.

Healthcare-associated Legionella infection

In October 2017 a patient was admitted to the hospital with pneumonia that was diagnosed as legionella infection. Despite treatment the patient sadly died. Investigations demonstrated that it was most likely that the infection was acquired during a previous inpatient stay at St George's Hospital on the Clinical Decision Unit (CDU). This episode was reported as a serious incident and a detailed investigation took place. Water testing demonstrated the presence of legionella bacteria in a bathroom that the patient probably used. Specifically the bacteria were identified in water supplying a shower and a handwash basin. Legionella can be prevented by ensuring that hot water temperatures are sufficiently high and cold water temperatures are sufficiently low and that opportunities for biofilm formation by the bacteria in areas of low flow are prevented by flushing of underused outlets and removal of deadlegs. An incorrectly positioned thermostatic mixer valve (TMV) was found in the pipework supplying the bathroom leading to inadequate hot water temperatures in the water, Legionella bacteria were grown in the pipework where the TMV was located. Examination of records demonstrated that this TMV had been incorrectly installed when CDU was built in 2012. Taps had been replaced at a later date and an opportunity to have spotted this incorrectly positioned TMV was missed than as well. The SI report has made recommendations to prevent recurrence of such a situation and the Estates team are developing a plan to review all aspects of water safety in the Trust which will be regularly reviewed at the Trust Water Safety Committee.

Community Incidents and Outbreaks

The outbreak of norovirus at HMW Wandsworth has been described in the norovirus section of this report. There were no other incidents or outbreaks in the Community Services Wandsworth division.

Saving Lives audits

The Saving Lives Programme is a set of 'Care Bundles' or High Impact Interventions (HII) for Acute Trusts that was first issued by the Department of Health in 2005. Originally a collection of five audit tools, this was expanded to eight in 2007.

In order to streamline the number of internal audits, the Trust previously combined the Saving Lives Programme with two other mandatory Trust audits (hand hygiene and PPE) to produce a programme of ten audits that are completed as a rolling programme twice per calendar year (with the exception of hand hygiene and cleaning and decontamination which are carried out monthly.)

The current programme is shown below in table 10:

Table 10

Audit	Month	Month
1. Central venous catheter	January	July
2. Peripheral intravenous catheter	January	July
3. Renal dialysis catheter care	February	August
4. Prevention of surgical site infection	February	August
5. Ventilation associated care bundle	March	September
6. Urinary catheter care	March	September
7. Reducing the risk of *C. difficile*	April	October
8. Cleaning and decontamination of clinical equipment	Monthly	-
9. Hand hygiene observation of practice	Monthly	-
10. Isolation and PPE	May	November

Clinical areas were required to submit a minimum number of audits for each of the tools. Audits are completed on a web based system (RaTE) by the last day of the allocated month. Reports in pie chart format show a breakdown for each question allowing services to examine the audit results in more detail. These can also be downloaded for display. An example is below in figure 4.

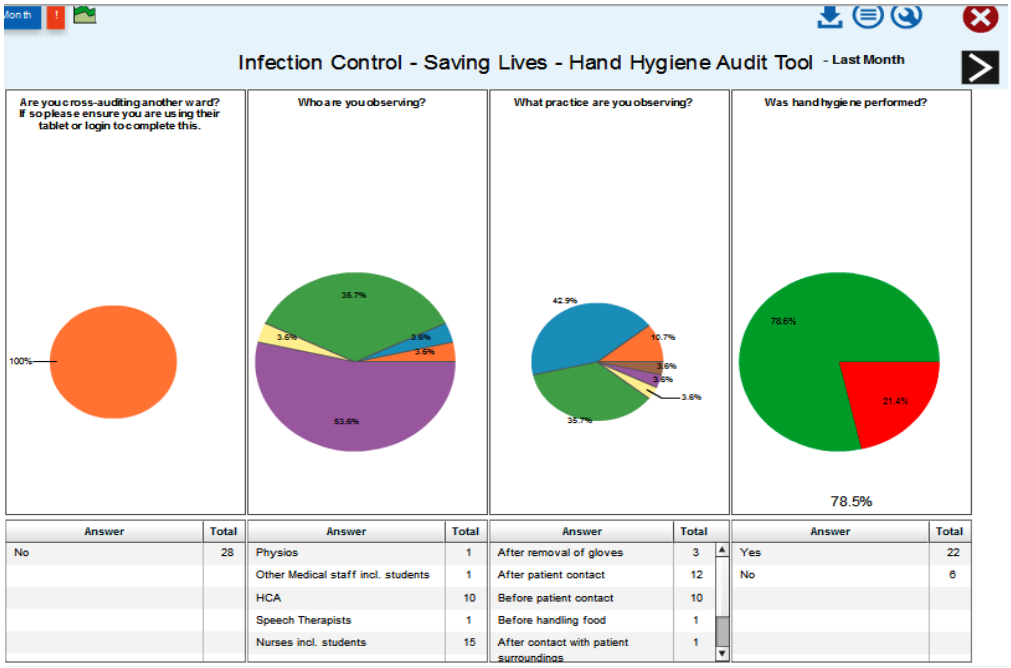
The data are linked to a table report on RaTE called the Saving Lives Scorecard which is updated in real time as audits are completed. This scorecard can be filtered by Division and month/year so services can check at any time to see how they are doing. Audits that have been previously agreed as not locally applicable within a ward/department are not visible on the electronic system. Please see 'Composite Scorecard' section for more detail.

Monthly audit results are displayed on the Infection Prevention and Control notice board or Corporate notice board for hand hygiene and cleaning and decontamination, for departments participating in the programme. If the required level of compliance (95% for Hand Hygiene and 100% for the other audits) is not achieved, a local action plan is displayed on the notice board to raise awareness and to enhance compliance.

Results for clinical areas within the Trust directorates are presented by the divisional representative at the bi-monthly HAI taskforce meetings. Clinical areas that perform poorly are required to produce an action plan to address any failings within a stipulated timeframe.

NHSI and the Infection Prevention Society revised the High Impact Interventions in 2017; work has been commenced by the IPC team to review the audits on RaTE to ensure that they reflect these revised tools.

Figure 4. Example of audit results



Answer	Total
No	28

Answer	Total
Physios	1
Other Medical staff incl. students	1
HCA	10
Speech Therapists	1
Nurses incl. students	15

Answer	Total
After removal of gloves	3
After patient contact	12
Before patient contact	10
Before handling food	1
After contact with patient surroundings	1

Answer	Total
Yes	22
No	6

Composite Scorecard

A scorecard that combines several infection prevention and control indices was first published quarterly from Apr-June 2013. Since then the scorecard is published monthly on RaTE in order to give real-time feedback to the clinical areas. These data are also now included in a trust "Quality Dashboard" also available on RaTE.

The scorecard includes data on Saving Lives audits and hospital MRSA and *Clostridium difficile* acquisitions. Data on antibiotic stop dates is not included; this data is incorporated in antibiotic audit reports disseminated by the Pharmacy department.

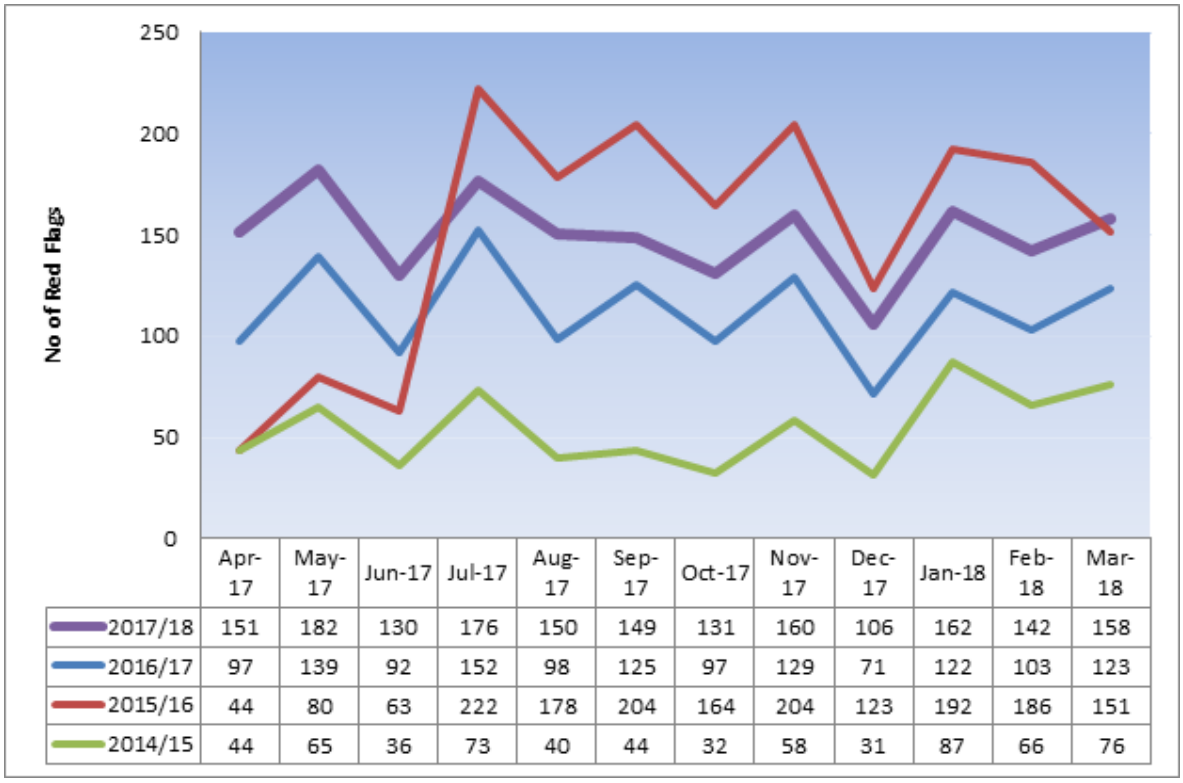
Wards and departments are allocated a red flag depending on the number of acquired infections or results achieved in the Saving Lives audit programme. The criteria for ward/ departments being allocated red flags is as follows:
-Acquisition of an MRSA bacteraemia that occurs greater than forty-eight hours after admission and the Root Cause Analysis (RCA) demonstrates that the infection is preventable.
-Acquisition of two or more MRSA colonisations
-Acquisition of one or more *C. difficile* infections.
-Hand hygiene audit results below the required level of compliance (95%) or insufficient number of audits carried out.
-Saving Lives audit results below the required level of compliance (100%) or insufficient number of audits are carried out.

The ward/ department is required to generate and implement a remedial action plan and present the work to the HAI Taskforce as required.

Figure 5 illustrates an increase in the number of red flags in 2017-18 compared to 2016-17;. Annual peaks and troughs correspond to particular audits that are being carried out in that month; for example in June and December the fall in red flags may be because during these months only 'hand hygiene' and 'cleaning and decontamination of clinical equipment' audits are carried out. By contrast, in July and January when intravenous catheters (CVC and peripheral) are audited the number of red flags increases. The peaks in May and November correspond to the auditing of isolation and PPE.

The reason for annual variation is more difficult to determine; this could reflect more robust auditing practices or equally, a decline in compliance.

Figure 5– Red flags results for 2014/15, 2015/16,2016/17 and 2017/18



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
2017/18	151	182	130	176	150	149	131	160	106	162	142	158
2016/17	97	139	92	152	98	125	97	129	71	122	103	123
2015/16	44	80	63	222	178	204	164	204	123	192	186	151
2014/15	44	65	36	73	40	44	32	58	31	87	66	76

Infection Prevention and Control Audits

The Infection Prevention and Control team undertook a programme of policy audits during the year, as part of the action plan. These included:

1. **Assessment of compliance with aspects of the trust 'Protocol for the Prevention and Management of *Clostridium difficile'*** with the aim of reducing the risk of *Clostridium difficile* (CDI) cross-infection from patient to patient. The objectives of this audit were to :

- Identify areas with high incidences of CDI.
- Establish whether patients with new onset of diarrhoea are appropriately reviewed by medical teams determining whether the likely cause is infectious.
- Review time to isolation.
- Review the infection prevention and control precautions taken when managing a CDI patient.

This audit is carried out quarterly and the results and recommendations were discussed and agreed at the Infection Prevention and Control Committee (ICC).The results and recommendations are fed back to wards and departments via the ICC.

Results indicate an overall decline in standards from Q1 to Q4, although the number of cases of CDI was small . Further work is required to ensure full compliance.

Table 7. Compliance with Performance Parameters

Standard	Apr-Jun 2017 (Q1)	Jul-Sep 2017 (Q2)	Oct-Dec 2017 (Q3)	Jan-Mar 2018 (Q4)
Was a medical review carried out?	80% ↓	77% ↓	91% ↑	100% ↑
Was the patient isolated within 2 hours of medical review?	60% ↓	69% ↑	67% ↓	75% ↑
Was a fluid balance chart completed?	100% ↑	92% ↓	100% ↑	100% –
Was a stool chart completed?	100% ↑	100% –	100% –	100% –
CDI checklist initiated?	100% ↑	31% ↓	80% ↑	50% ↓
Correct signage on isolation room door?	100% –	100% –	100% –	100% –
Isolation room door shut	100% ↑	78% ↓	100% ↑	100% –
PPE available?	100% –	100% –	100% –	100% –
Hand hygiene facilities available?	100% –	92% ↓	100% ↑	100% –
Patient specific commode/ toilet?	100% ↑	92% ↓	100% ↑	33% ↓
Ward commodes clean?	100% ↑	67% ↓	70% ↑	33% ↓
Chlor-clean made up in past 24 hours	100% –	83% ↓	71% ↓	67% ↓

Compliance
<90%
90% - 95%
96% - 100%

2. Sharps Audit

A 2017/18 sharps audit site survey was undertaken by the trust sharps bin provider, Daniels Healthcare Ltd. to review compliance with sharps practices and to identify areas within the trust that required further education, training and support from the company. 14 criteria were assessed

Following the audit, areas of poor practice were identified, wards and departments were scored and additional training was provided by the company. The audit was circulated to the organisation for local managers to review data and to ensure processes are in place to promote and maintain compliance.

A repeat audit will be undertaken in 18/19.
Table 12 below is a summary of the main findings.

Table 12 Audit Results.

Criterion	Number	Comments
Wards/dept. visited	101	
Number of sharps bins assessed.	984	
Sharps containers in use		Mainly Daniels although there were also Rexam and Frontier types seen. These were either old stock or the ward/department had been sent the wrong type.
Protruding sharps	14	These were not necessarily overfilled but had long objects protruding from them
Improperly assembled	48	These were immediately assembled properly and staff informed that sharps containers not assembled properly could lead to lids coming off if dropped or during transportation
Overfilled	1	Staff advised to only fill to the line
Wrong lid on base	9	Staff advised to check the colour of the lid and label.
Sited on the floor or at an unsuitable height or place	5	Staff advised to have them bracketed if possible or remove them from public areas.
Inappropriate non sharp contents	19	Staff advised not to put packaging or non-sharp items in sharps containers.
Temporary closure not used	33	Staff advised this to be in place when container left unattended or during movement.
Wall/trolley brackets		Many areas required wall/trolley brackets, discussed with staff.
Labelling of bins		All staff understood that the label on the sharps bin was to be completed at assembly and closure and this was adhered to.
Small sharps bins and trays.		These were available to take to the bedside

Wards and departments were ragged as follows:

Red < 85%
Amber 85% - 95%
Green > 95%

30 ward/departments scored between < 85-95%, 71 wards/departments scored >95% i.e. Green. Only one department was ragged Red. Table 13 shows wards and departments scoring < 85-95%.

Table 13 Wards/departments with < 85-95%

A and E Children and Paediatrics	94%
Allingham ward	94%
Anticoag Clinic St James OPD	88%
Belgrave Ward and CCU	94%
Blood tests The Nelson	94%
Brodie Ward	95%
Caesar Hawkins	95%
Cardio Cath Labs	94%
Caroline Ward	95%
Cavell Ward	94%
Child Development Centre	88%
Day Case and Endoscopy QMH	95%
Day Unit and Trevor Howard Ward	93%
Delivery Suite HDU	89%
Mary Seacole A	85%
Mary Seacole B	94%
Minor Injuries QMH	93%
OPD The Nelson	94%
Pinckney Ward	88%
Pre op assessment (Willow Annex)	94%
Podiatry QMH	83%
Podiatry St. John's	88%
Rehab Workshops - QMH	85%
Rodney Smith Ward	92%
Radiology – QMH	94%
SCBU	88%
St James OPD (Lung Function)	88%
St James Therapies	93%
Surgical Admission Lounge	91%
Pharmacy	88%

3. Commode and Sluice Room Audit

A commode and sluice room audit was undertaken by Vernacare, the company which supplies many of the commodes in the trust. Using photographic evidence, this audit identified that many commodes need to be replaced as they are cracked, chipped or rusty. The audit

also highlighted non-compliance within the sluice e.g. clean items located in the sluice that should be stored elsewhere and the lack of clinical handwash basins (CHWB) in many of the sluices in St. James' wing. The lack of CHWBs has been escalated by the IPC team to the infection control committee and the trust on a number of occasions.

A project is now in progress, in conjunction with Procurement, to review commodes used within the trust and to make a recommendation to the organisation for replacement commodes.

The audit has been circulated to the divisions for their action.

Hand Hygiene

1. Hand Hygiene Champion

As part of the trust's drive to improve compliance with the Hand Hygiene Policy the IPC team employed a hand hygiene champion from monies awarded by Health Education South London following the CQC visit in June 2016. This was a 6 month post from July 2017 to December 2018. However, the post holder has continued to be employed on the Bank from January 2018 as it was not possible to extend the contract.

This is a clinical post which includes hand hygiene training updates, hand hygiene observational audit and training with the Surewash machines and light boxes. All departments and staff across the organisation have been targeted including medical staff, porters, therapists and other health care professionals.

To-date 55 hand hygiene training drop-in sessions have been undertaken by the hand hygiene champion, with 520 attendees

2. Surewash Machines

Surewash uses gesture recognition technology to automate the training, allowing staff to train at any time of the day or night. The combination of real-time feedback on hand hygiene technique, scoring, different difficulty levels and quizzes promotes compliance with the Hand Hygiene Policy.

The trust has two Surewash machines and The IPC team has secured funding from the trust Charity to purchase a portable Surewash machine. It will now be possible to take this machine to QMH in order to train and assess staff in hand hygiene technique.

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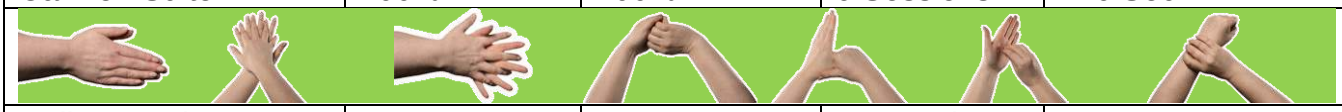
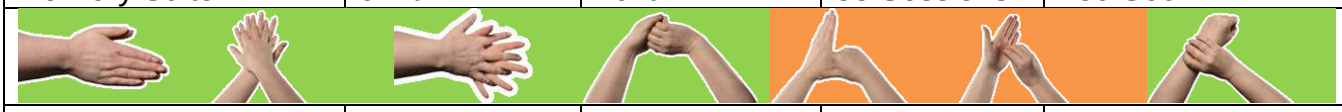
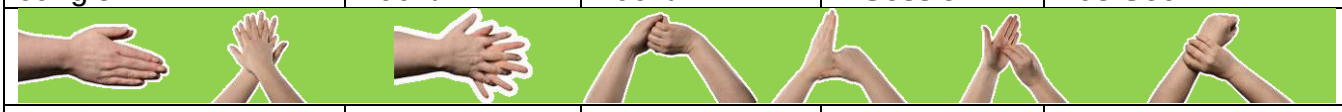
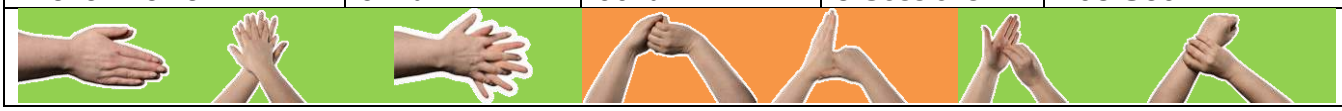
Priority for use of the Surewash machines was to wards that were on a Period of Increased Surveillance and Assessment (PISA) as well as wards which had poor hand hygiene scores as part of the trust hand hygiene quality improvement programme. Using the Surewash machine the hand hygiene champion assessed all staff working on the ward, as well as visiting staff. If possible the machine was left in the clinical area so that staff on subsequent shifts/days could use it. On average, 5 minutes were required to assess each staff member's hand hygiene technique as well as talking through the WHO "Your Five Moments for Hand Hygiene at the Point of Care."

From July 2017 to March 2018 the Surewash machine was used by 1,780 individual staff with a pass rate of 69%. Individual ward/department reports are circulated to clinical areas; an example is shown below in Table 14 below.

In total 183 departments and clinical areas have been visited by the hand hygiene champion with the Surewash machines, although some of these are revisits.

Table 14 Surewash Hand Hygiene Assessment Results August 2017

Ward/Dept.	Average Score	Percentage of Assessments Passed	Sessions	Average time to pass
Carmen Suite	100%	100%	6 Sessions	126 Sec
				
Delivery Suite	94%	79%	33 Sessions	139 Sec
				
Frederick Hewitt	91%	62%	21 Sessions	101 Sec
				
GICU	64%	32%	126 Sessions	106 Sec
				
Gwillim	100%	97%	33 Sessions	111 Sec
				
Heberden	96%	88%	16 Sessions	101 Sec
				
Jungle	100%	100%	1 Session	108 Sec
				
McKissock	86%	25%	4 Sessions	104 Sec
				
Nicholls	86%	67%	12 Sessions	90 Sec
				
Physiotherapy	100%	100%	2 Sessions	79 Sec
				
Pinckney	80%	53%	17 Sessions	89 Sec
				
Specialist Medicine	100%	100%	2 Sessions	56 Sec
				

Trevor Howell	94%	60%	5 Sessions	103 Sec
				

Period of Increased Surveillance and Audit

In May 2017 the Trust instituted a process of focussed audits for wards with episodes of healthcare-associated infections. This process has been used successfully at Maidstone and Tunbridge Wells Trust and St George's adopted and modified the process that was in use there. Since May 2017 all wards that acquire *Clostridium difficile*, MRSA blood stream infection (BSI) or have a suspected MRSA outbreak undergo a period of increased surveillance and audit (PISA). These tools (see appendix) allow observation of the management of patients with the infection and others with suspected infections including documentation of medical reviews, hand hygiene, PPE, screening and isolation. General ward cleaning, hand hygiene, decontamination of patient equipment, management of clean linen and venous access devices (for MRSA) are all audited during the PISA process. The ward must achieve 95% or above to pass and must pass 3 consecutive weeks to successfully complete the PISA process.

C.difficile PISA

Since May 2017 there have been 14 wards on PISA process for hospital acquired *Clostridium difficile*. It took an average of 8 weeks to come off the process with the shortest time of 5 weeks and the longest time of 12 weeks. Recurring themes include;

- Attention to detail for decontamination of patient equipment including commodes
- Missing or out of date "I am clean" labels
- Poor adherence to 5 moments for hand hygiene and incorrect hand hygiene technique by multidisciplinary teams
- Medical reviews not documented

From October 2017, Antimicrobial Stewardship (AMS) component was added to the *C.difficile* PISA. The AMS team review antimicrobial prescriptions for all patients on the ward. The ward must achieve 95% to come off the AMS component of the PISA. Two wards passed on their first audit, two wards took 2 weeks to pass and one ward took 4 weeks to pass.

MRSA BSI/ outbreak PISA

There have been 5 wards on PISA process for MRSA BSI and 2 for MRSA outbreaks. It took an average of 7 weeks to come off the process. The shortest time was 5 weeks and the longest 9 weeks. Recurring themes include;

- Inconsistent documentation of venous access devices
- Delay in prescription of MRSA treatment
- MRSA treatment administered inappropriately
- Attention to detail for decontamination of patient equipment including commodes
- Missing or out of date "I am clean" labels
- Poor adherence to 5 moments for hand hygiene and incorrect hand hygiene technique by multidisciplinary teams

The infection prevention and control team provided training, support and advice to ward areas during the PISA process. From July 2017 the hand hygiene champion supported with hand hygiene on these wards. A total of 21 PISAs were undertaken which equates to 157 cumulative weeks.

Estates and Facilities including Environmental Cleaning 2017-18

The estates and facilities team in conjunction with the nursing and infection control teams help to audit and assure the Trust of its obligation to provide a safe care environment and meet the CQC outcome requirements.

1. Monitoring and Assurance

In 2017-18 the team were part of the audit teams for the annual infection control audits and the corporate inspections which formed part of the assurance and preparations for the formal CQC visits and annual governance programmes.

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

The National Standards of Cleanliness scores across all areas continue to meet the Trust overall percentage with standards are being maintained. Any areas of non-compliance from auditing processes were rectified in the correct rectification times. Cleaning Standards are maintaining at a good level across all sites – over 95% against Trust standards of 89.63%.

2. Main areas of development in 2017-18 through from the Estates and Facilities team were

- Permanent Director in place January 2018, Mr Kevin Howell.

Capital Projects: (now includes all Estates Capital works)

- Capital investment into major infrastructure works on the St. George's site
- Ambulatory Care unit projects delivered – Ambulatory Care Richmond Ward, Blue Sky Unit Children's and Young Peoples Ambulatory Care Unit, Trevor Howell Cancer Ambulatory Unit
- Water Safety improvements in both clinical and non-clinical areas
- Significant estates works including Fire safety works; water safety including new sanitary fittings in ward areas
- Electrical infrastructure works in progress
- Dalby ward closed for refurbishment
- Further work on the bore hole in progress
- Ward environment condition surveys in progress for the St. George's Site.
- Lifecycle plans in place for repainting of areas in AMW
- Theatres 3 and 4 St. James Wing fully refurbished
- SSD project delivered new RO, sterilisers and washers.
- Replacement generator project in progress Lanesborough Wing

Estates:

- New washers installation in Endoscopy on the St. George's Site
- Roll out of new dishwashers actioned for all wards on the St. Georges' site.
- Moorfields 5th Floor area being full refurbished (funded by Moorfields)
- Energy Centre Project has completed
- New reception desk and SJW X-ray
- CT scanner replacement in ED
- Antiligature works completed in ED and Paediatrics
- 57 soil stacks cleaned in LNS wing in March, should reduce blockages

Facilities:

- Caesar Hawkins opened as a Flu cohort ward and then closed in April 18
- Winter pressures have had impact on cleaning teams with over 30% additional calls to the helpdesk for deep cleans – team have managed well.
- New Curtains in place and further additional 500 panels purchased in March 2018
- Offensive waste stream in place – further auditing and monitoring is required
- MITIE team shortlisted as finalist in BiCS training category at Golden Service Awards
- St. George's Commended in the Hospital Cleaning Award category at the Health Business awards.

3. Patient-Led Assessments of the Care Environment (PLACE) Programme 2017-18

The 2014 Patient-Led Assessments of the Care Environment (PLACE) is a new assessment and replaces the previous assessments known as Patient Environment Assessment Team (PEAT).

PLACE builds on the foundations of PEAT the two main differences are as follows:

1. Patients make up at least 50% of the assessment team providing a stronger voice
2. Focus on improvement with hospitals required to report publicly and say how they plan to improve

The definition of patients is:
"anyone whose relationship with the hospital is as a user rather than a provider of the services"

Assessors are recruited from patient representatives via the local Healthwatch, Residents Committees, Patient Reference Group, Patient Issues Committee and Access Committees and training on the assessment was provided by the Trust team.

The Assessment

The assessment period took place in St George's Hospital and Queen Mary's in May 2017 with dates not being shared widely.

The areas of assessment include the following four domains:

1. Cleanliness
2. Food
3. Privacy & dignity

4. General maintenance and decor

A minimum 25% of the site needs to be assessed at the St George's Hospital and 100% of Trust space at Queen Mary's Hospital.

Areas to be assessed

There no single assessment form rather there is a series of nine assessment sheets specific to each area:

1. Organisation/Hospital details
2. Organisation facilities questions
3. Accident & Emergency
4. External Areas
5. Food & Hydration Assessment
6. Organisation food questions
7. Ward assessment acute/community
8. Outpatients Departments
9. Internal Areas

Scores were as follows and a robust action plan was completed with 85% of actions being rectified in the financial year with the remaining areas requiring funding and planned for action in 2018.

Services at St George's Hospital

Results are provided for the following domains:-

(negative = lower than national average; positive = higher that national average)

Table 15

St Georges Hospital	Site Score %	National Average %	Variance %
Cleanliness	94.74	98.38	-3.64
Food	82.97	89.68	-6.71
Organisation Food	74.20	88.80	-14.6
Ward Food	84.62	90.19	-5.57
Privacy, Dignity & Wellbeing	79.02	83.68	-4.66
Condition, Appearance and Maintenance	89.96	94.02	-4.06
Dementia	70.28	76.71	-6.43
Disability	73.47	82.56	-9.09

Table 16 Services at Queen Mary's Hospital

Queen Mary's Hospital	Site Score %	National Average %	Variance %
Cleanliness	100	98.38	1.62
Food	89.18	89.68	-0.5
Organisation Food	84.02	88.80	-4.78
Ward Food	93.39	90.19	3.2
Privacy, Dignity & Wellbeing	92.38	83.68	8.7
Condition, Appearance and Maintenance	98.40	94.02	4.38
Dementia	94.25	76.71	17.54
Disability	95.89	82.56	13.33

Environmental Hygiene

The IC team, with the cooperation of Facilities, Waste Manager, Health and Safety, Patient Partners and Matrons, are responsible for carrying out annual ward and department accreditation audits.

A new tool has been rolled out. Actions from these audits are then fed back and rectifications actioned with the timescales and then fed back to the senior nursing team members and the IC team.

Other audits continued in relation to the National Cleanliness standards audit tools, corporate inspections; and in partnership with the infection control team other environmental audits including the *C. difficile* MDT rounds and actions from the PDSA audits.

Estates maintenance – this has been a challenging year with the priority areas being Fire Safety, Water Safety, buildings beyond use and infrastructure.

Future plans are in place for ward refurbishment works but this will depend on funding and decant space or the closure of beds to enable these works to be actioned effectively.

Disposable curtains have been rolled out to very high and some high risk areas and the remaining wards in St. James Wing will have their tracks lowered at the beginning of 2017-18.

A full roll our programme has been completed in relation to new curtains and lowering of tracks across St James Wing so that there is one length of curtain across all areas.

Further capital project works are planned for expansion of critical care areas in Atkinson Morley Wing; compliance works in outpatient areas; further assessment areas in the emergency department and the demolition of the now vacant buildings.

Further works are required to assist nursing staff with training on cleaning and food safety as a priority in 2018-19.

Divisional training for the Estates and Facilities division was over 90% for infection control.

he site is still operating a BiCS (British Institute of Cleaning Science) accredited site and Mitie have both accredited BiCS trainers and assessors and Food Safety trainers and train their staff accordingly.

In Medical Physics and Capital projects further central capital investment was allocated to the Trust towards the end of the year which led to significant additional clinical equipment being purchased under medical physics.

There was also a full roll out of new beds across the organisation via the bed management team in Medical Physics as part of the planned upgrading of beds in the Trust.

Ward and Department Accreditation Audits

The IPC nurses continue to participate in the Quality Inspection audits, now termed Accreditation audits, led by Corporate Nursing, who are responsible for their reporting.

Venous Access Service

The most recent vascular access device (VAD) audit was presented to the Infection Prevention and Control Committee in February 2018 and showed a drop in performance in 5 out of 6 categories, however it was pleasing to see an improvement in documentation since the last audit. There may be some inter-auditor unreliability in relation to the definition of 'inflammation' or the definition of 'intact and clean' which could explain the perceived drop in performance. There is however, significant room for improvement. It has been increasingly difficult for staff to be released for VAD training and ward based sessions are often cancelled due to low staffing levels on the day.

The Venous Access Team has asked to be involved in mandatory training days and this has worked very well when Practice Educators have been able to allocate sessions. This is only happening in a couple of areas however and could be much more widely utilised across the Trust.

Use of the top up catheter care (TUCC) box has improved compliance with the weekly dressing of long term devices (up from 79% to 92% compliance). The Venous Access Team would now like to focus on developing systems to effectively measure catheter related blood stream infections (CRBSIs) across the Trust as has been done within our Critical Care units for some time.

IPC MAST, Training and Education.

1. IPC MAST Compliance

All wards and departments were encouraged to ensure that their compliance with MAST on-line training was greater than 85%. This proved to be a challenge but significant progress has been made. At present, the compliance rate for IPC clinical on-line MAST is 86% (n=4771) and for non-clinical 94% (n=2568); this is an improvement on last year 16/17 when compliance was 78% and 88% respectively. Medical and Dental clinical staff were the least compliant group with 67%.

2. Link Professional Training

The 3–day link professional course took place in November 2017 and March 2018. The course provided a small group of links with the knowledge and resources to be proactive in their ward or department. This was well received by attendees and the aim is to continue this regularly.

3. IPC Nurse Teaching

The IPC nurses delivered trainings across the organisation throughout the year. These included trust, nurse and HCA induction, annual updates, link staff training, study days, a master class and additional bespoke training.

Hand hygiene training was delivered to all staff attending induction, utilising the Surewash machine; these use a camera, video and graphics to deliver independent hand-hygiene training to healthcare workers, measuring their performance whilst providing real-time feedback.

Face-to-face IPC updates trainings (in addition to on-line MAST):

Monthly IPC update training (1 hour session)

- General Medicine and Senior Health
- General Surgery
- Neurosciences
- Nurse Induction
- Paediatrics
- Renal
- Trauma and Orthopaedics
- ICUs

Other training / frequencies

- HCA Induction – 1 hour / 6 times yearly
- IPC Study Days – 1 day / twice yearly
- Medical Students (MBBS4 Programme) – 1 hour / 4 times yearly
- Midwifery IPC update – 1 hour / every other month
- NNU IPC update – 1 hour / every other month
- Trust Induction Hand Hygiene Training – 45 minutes to one hour / weekly

Annual IPC update training (45 minutes to 1 hour session)

- Dietetic Service
- HMPW clinical staff
- Learning Disability Team
- Physiotherapists
- QMH Amputee/Neuro Therapy Team
- Surgical outpatients
- Theatre staff team day

As required IPC update training (30 minutes to 1 hour session)

- F1 induction
- F2 IPC teaching
- Physicians' Associates
- Cardiac Surgery
- IV Therapy
- Outbreak wards
- Wards – hand hygiene
- Norovirus training
- Influenza training
- Porters
- Phlebotomists

Training was delivered to nurses and midwives, junior medical and dental staff, medical and nursing students, healthcare scientists, therapists, estates and other ancillary staff.
The details of attendees, topics covered and venues are held on electronic staff record (ESR).

4. Additional Events and sessions

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

Antimicrobial Stewardship

Key achievements in 2017-18

Full achievement of parts 2c and 2d of the National Serious Infection CQUIN

Parts 2c and 2d of the Serious Infection CQUIN are a continuation of the 2016-17 Antimicrobial Resistance CQUIN with the aim to reduce total and broad-spectrum antibiotic and ensure antibiotics are reviewed within 72 hours of initiation.

This aims to reverse previous trends of significant increases in both antibiotic consumption and resistance within England and avoid further increases in the prevalence of difficult to treat, multidrug resistant infections.

St George's University Hospitals is one of a small proportion of Trusts in England to have achieved all 4 quality measures in parts 2c and 2d of the CQUIN, which has secured £694,000 of income. Reductions in usage were significantly above the targets imposed with particularly large reductions in broad-spectrum antibiotics usage (24% for piperacillin-tazobactam and 17% for carbapenems). These reductions in consumption were paralleled by an £80,000 reduction in expenditure. Details are shown in tables 17 and 18 below.

Part A: Reduction in antibiotic consumption per 1000 admissions
Target: To reduce consumption of the following to 1% below 2013-14 levels

	Table 17: Antibiotic Defined Daily Doses/1000 admissions						
	17-18 Q1	17-18 Q2	17-18 Q3	17-18 Q4	17-18 FY Total	Baseline (2016) & Target	% Change (from 16-17)
Total Antibiotic consumption	6086	6100	6003	5748	5984	2% reduction from 6488	**8% ↓**
Piperacillin-tazobactam consumption	61	57	75	68	65	1% reduction from 87	**24% ↓**
Carbapenem consumption	100	108	95	79	95	1% reduction from 115	**17% ↓**

Part B: Proportion of antibiotic prescriptions for sepsis reviewed within 72 hours
Target: To increase the proportion to 90% by Q4.

	Table 18: Proportion of Antibiotic Prescriptions Reviewed within 72 hours			
	17-18 Q1	17-18 Q2	17-18 Q3	17-18 Q4
Trust proportion reviewed	100%	99%	89%	96%
Target	25%	50%	75%	90%

Improved use of Clinical Informatics to Optimise Stewardship Activities
A decision support tool has been implemented on iClip to support review of antibiotic prescriptions within 72 hours. This has improved the proportion of patients with a documented review on wards using iClip (91% compared to 67% in wards using paper records). Audit work has shown that patients with a documented review are more likely to receive optimal antibiotic treatment.

Real-time worklists of patients on antibiotics have been established in the electronic prescribing and medicines administration system to improve efficiency on the antibiotic stewardship rounds.

Antibiotic consumption data was produced at speciality level for the first time in 2017/18, with total and selected broad-spectrum antibiotic use is shown in figures 6-9. This has enabled identification of areas with high consumption for further investigation to target stewardship activities in 2018/19.

Figure 6: Total Antibiotic Consumption by Speciality (DDDs)

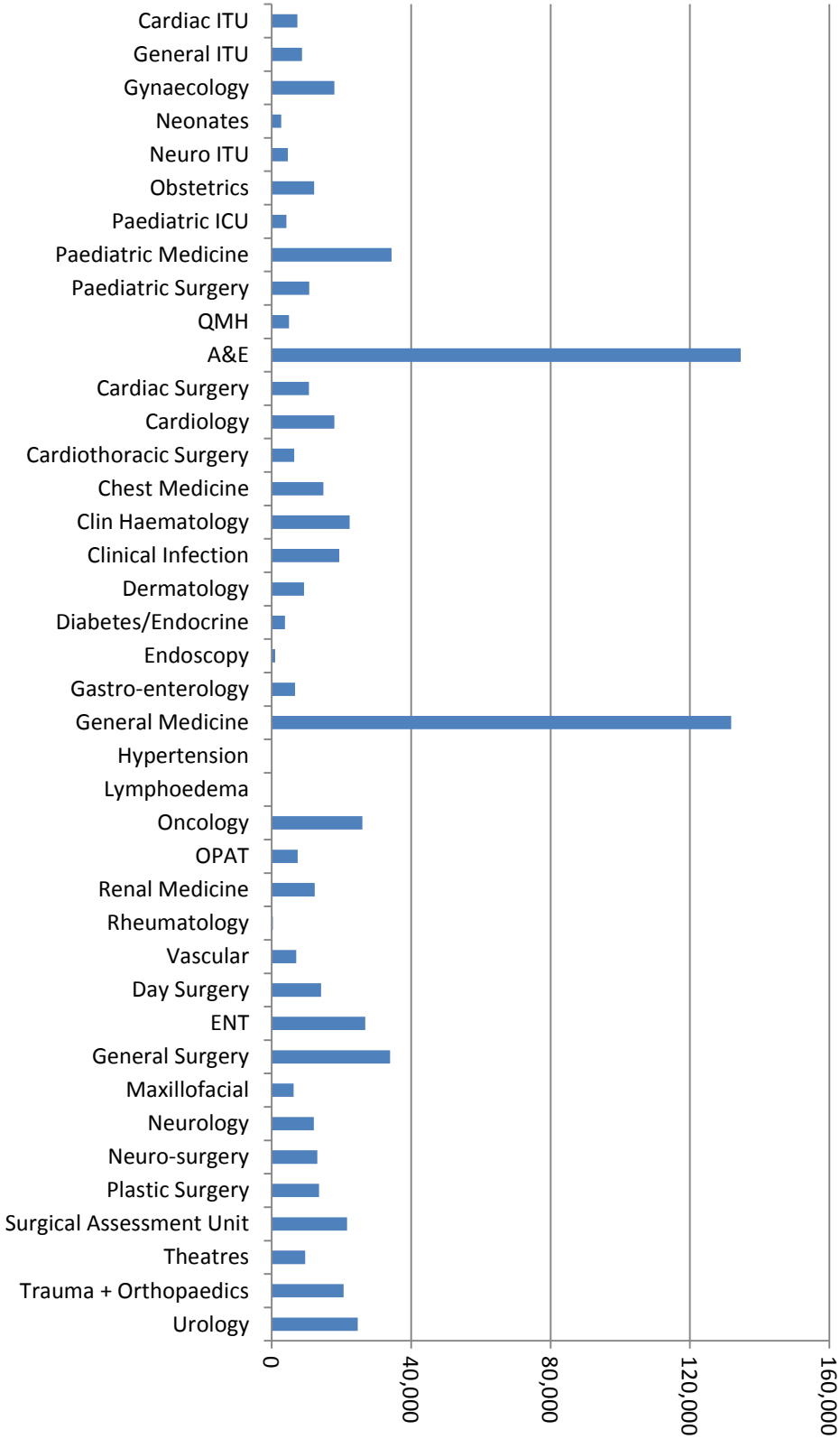


Figure 7: Carbapenem Consumption by Speciality (DDDs)

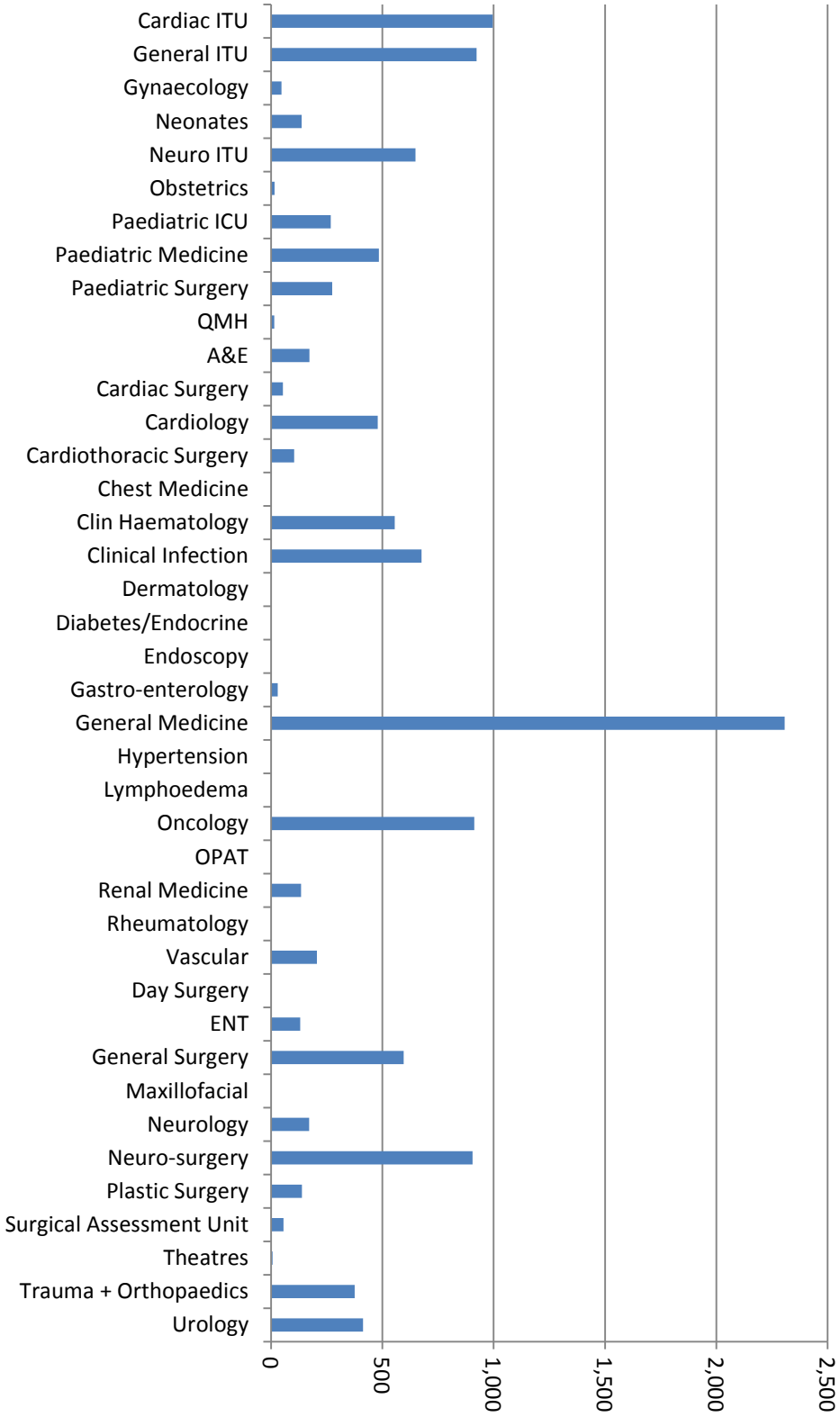


Figure 8: Piperacillin-Tazobactam Consumption by Speciality (DDDs)

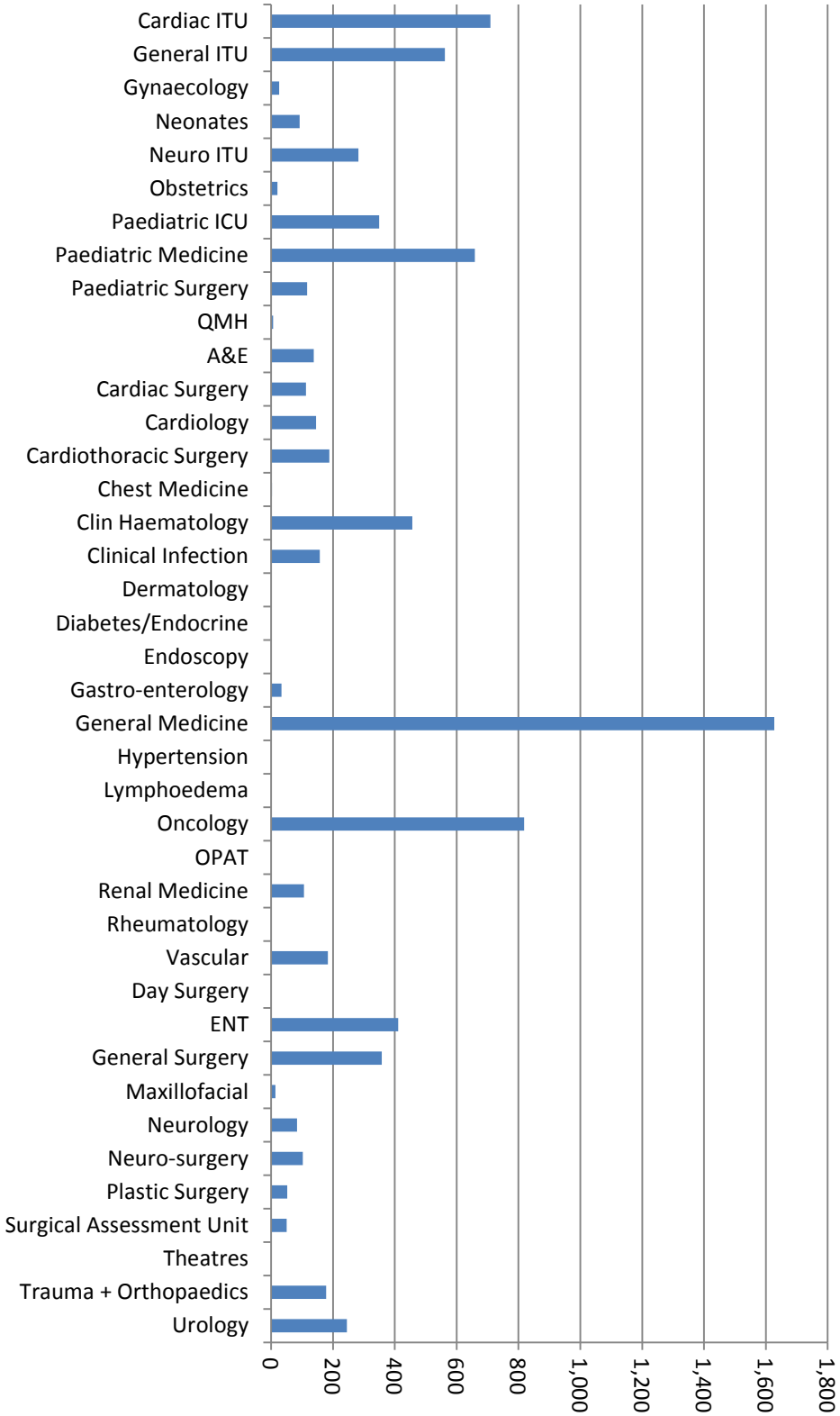
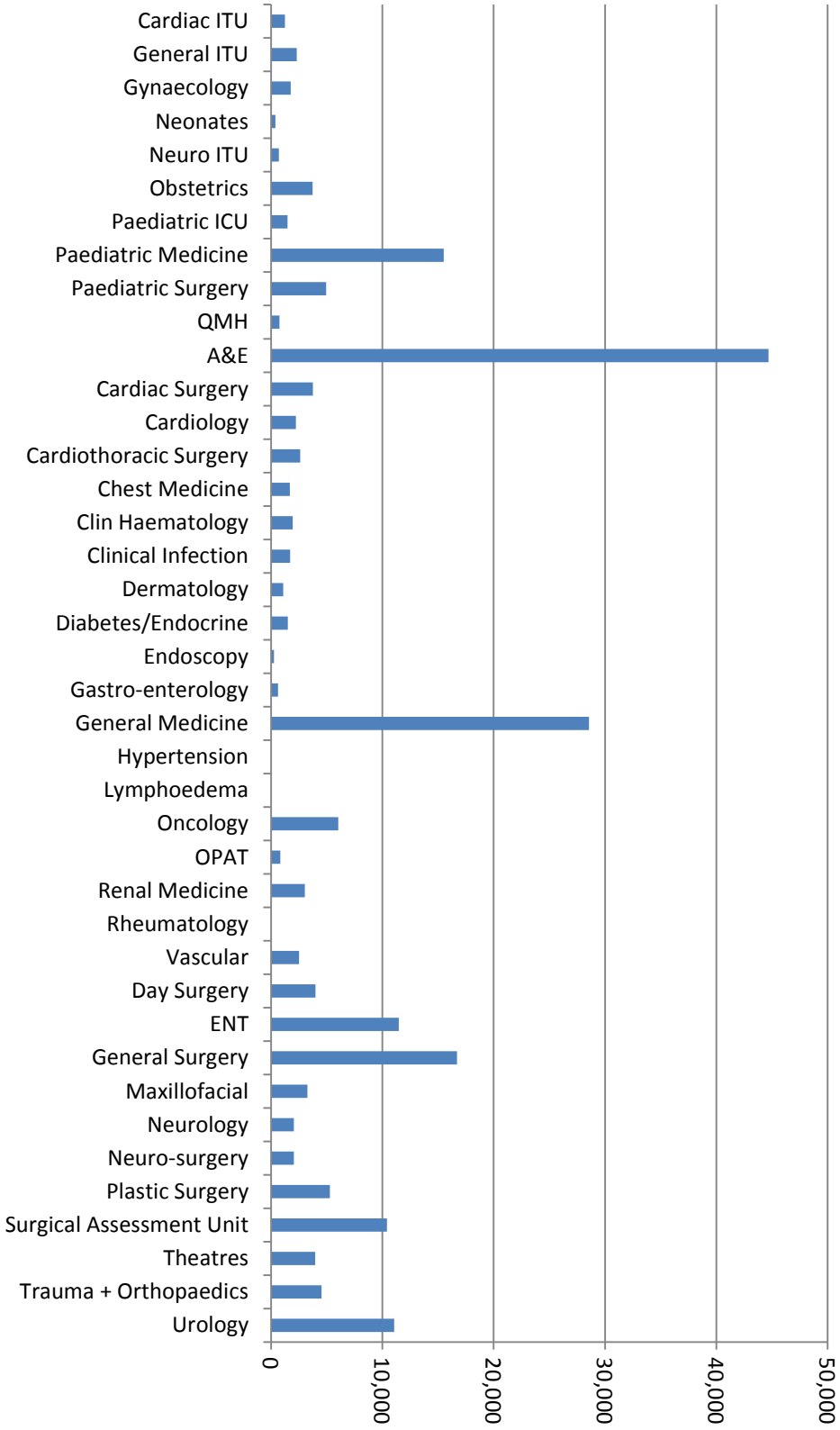


Figure 9: Co-amoxicalv Consumption by Speciality (DDDs)



Implementation of part-pack dispensing
Supply of antibiotics in original packs (with advice to discard the remainder of the pack once completing the course) has been standard practice within the Trust since the introduction of automated dispensing (2007). This limits ability to reduce antibiotic consumption and risks inappropriate antibiotic use initiated or continued unnecessarily at patient level. In October 2017 this practice was changed to supply the exact quantities of antibiotic prescribed to patients. This has significantly reduced our antibiotic consumption and contributed to achievement of CQUIN targets and reductions in costs (figure 1).

Improved Antimicrobial Stewardship Education
Antimicrobial Stewardship Education is now included within the mandatory infection control online training module for all clinical staff. Infection control link nurses were educated on antimicrobial stewardship in face-to-face teaching sessions and recruited as nursing stewardship champions.

Formulary and Guideline Updates
Ceftolozane-tazobactam was added to the formulary as a treatment option for multi-resistant Gram negative infection and pivmecillinam added for resistant urinary tract infections. Guidelines for diabetic foot infections, antibiotic use in obstetrics and gynaecology were added to microguide (app and web-based guideline portal) in addition to updates of guidelines currently available.

Ongoing Stewardship Activities

Trust Antibiograms
Microbiology data are analysed annually to inform empiric treatment options. No significant changes in resistance patterns were seen in 2016 (most recent data) compared to the previous financial year. These are shown on the next 3 pages.

Organisms from Blood Cultures (2016)	Number of patients	Antibiotics																				
		Amikacin	Amoxicillin	Co-Amoxiclav	Cefotaxime	Ceftazidime	Ciprofloxacin	Clindamycin	Colistin	Ertapenem	Erythromycin	Flucloxacillin	Gentamicin	Meropenem	Piperacillin-Tazobactam	Rifampicin	Teicoplanin	Tetracycline	Trimethoprim	Vancomycin	Co-Amoxiclav/Gentamicin	Co-Amoxiclav/Amikacin	Piperacillin-Tazobactam/Amikacin
Enterobacteriacae	176	97.2	11.1	55.1	83.3	85.8	79.6		89.9	97.7			88.6	100	90.9				63.4	R	89.2	99.4	100
	n	176	150	176	120	176	175		169	176			176	176	175				175		175	176	172
Staphylococcus epidermidis (CNS)	202			16.5			37.4				26.2	16.5	55.4			86.6	84.6	67.9	29.7	100	55.4		
	N			200			182				202	200	186			202	13	112	182	199	184		
Escherichia coli	103	97.1	39.3	51.5	84.6	87.4	72.8		100	99			86.4	100	90.3				52	R	87.4	99.0	100
	N	103	89	103	78	103	103		102	103			103	103	103				102		103	101	101
Staphylococcus aureus	58			85.7			85.4	91.1			74.1	85.7	93.1			98.2	96.2	92.9	77.8	100	92.9		
	N			56			41	45			58	56	58			58	26	56	54	58	56		
Staphylococcus hominis (CNS)	67			10.9			75				20.9	10.8	91.7			98.5		60.5	40.7	100	94.6		
	N			64			52				67	65	60			66		43	59	67	56		
Staphylococcus capitis (CNS)	44			6.8			70.3				59.1	6.8	51.3			100		85.7	66.7	100	51.3		
	N			44			37				44	44	39			43		28	39	44	39		
Staphylococcus haemolyticus (CNS)	30			3.4			22.2				10	3.4	34.5			90		52.2	34.5	100	32,1		
	N			29			27				30	29	29			30		23	29	28	28		
Streptococcus pneumoniae	11		90		100						81.8												
	N		11		11						11												
Pseudomonas aeruginosa	24	100	R	R		95.7	91.7		100				95.8	87.5	87.5					R			100
	N	24				23	24		11				24	24	24								24
Klebsiella pneumoniae	33	97	R	75.8	77.8	78.8	78.8		96.6	100			90.9	100	93.8				75.8	R	90.9	100	100
	N	33		33	22	33	22		29	33			33	33	33				33		33	32	31

Organisms from Clean Urines (2016)		Antibiotics																	
	Number of patients	Amikacin	Amoxicillin	Co - Amoxiclav	Cefotaxime	Cefpodoxime	Ceftazidime	Ciprofloxacin	Ertapenem	Flucloxacillin	Fosfomycin	Gentamicin	Meropenem	Nitrofurantoin	Piptazobactam	Trimethoprim	Vancomycin	Co-Amoxiclav / Gentamicin	Co-Amoxiclav/Amikacin	Piptazobactam/Amikacin#
Enterobacteriaceae - All	1300	99.7	28.8	86	55.5	86.8		81.7	99		85	89		81.4	89.1	57.7	R	96.6	100	100
	n	289	1297	1297	261	1297		1299	89.7		286	1299		1297	411	1297		1297	287	289
Escherichia coli	835	100	35	90.4	46.2	85.5		77.4	99.9		94.3	87.8		95.8	88.8	55.0	R	97.2	100	100
	n	176	834	834	173	834		834	176		175	834		834	350	834		834	176	176
Enterococcus sp.	280		79.9		R		R	0	R				R	88.4		1.9	92			
	n		268					259						267		264	264			
Coliforms	153		9.2	92.2		98.7		96.7				98.7		91.5	93.1	81.7	R	99.3		
	n		153	153		153		153				153		153	29	153		153		
Proteus sp.	151	97	44.4	88.7	87.1	96.7		86.1	100		75.8	88.7		1.3	100	42.4	R	97.4	100	100
	n	33	151	151	31	151		151	33		33	151		151	43	151		151	33	33
Pseudomonas sp.	101	100					98	88.1				97	97		98.0		R			100
	n	100					101	101				101	101		101					100
***Streptococcus agalactiae* (Group B Streptococcus)**	57		100	100				0						93		86				
	n		40	36				36						57		57				
Coagulase Negative Staphylococcus	63		14.8	38.7						38.7		71		100		58		71		
	n		61	62						62		62		49		50		61		
Staphylococcus aureus	17		17.6	82.4						82.4		88.2		100		93.3		94.1		
	n		17	17						17		17		15		15		17		

	Gram Positive Organism
	Gram negative Organism
	Protected Antibiotic
	Routinely used antibiotics
	≥ 90% of isolates susceptible
	70-90% susceptible
	<70% of isolates susceptible
R	Intrinsic Resistance
	Antibiotic not routinely tested in this organism.

Antibiotic Audits
Quarterly audits on antibiotic prescribing were undertaken in 2017-18. These included audits by medical staff (Q1 and Q3) participation in the Global Point prevalence Survey (Q2) and an additional point prevalence survey conducted by the pharmacy department (Q4). Results are summarised below.

Table 19

Performance Measure	Q1	Q2	Q3	Q4	Target
Proportion of in-patients on anti-infectives	N/A	30%	N/A	29%	-
Duration documented on drug chart	86%	79%	89%	80%	95%
Indication on drug chart (%)	92%	95% (audited as recorded in medical record)	89%	84%	95%
Indication in notes (%)	94%		97%	85%	95%
Compliance with guidelines, micro advice or according to cultures	89%	91%	96%	92%	95%
Protected antibiotics used according to policy	N/A	N/A	N/A	96%	95%
Cultures taken prior to starting antibiotics	87%	N/A	76%	85%	-
Evidence of review of antibiotics in notes at 72h	78%	N/A	64%	74%	95%
Antibiotics continued for >7 days have a clear justification for prolonged prescribing in notes	N/A	N/A	N/A	98%	95%

N/A – performance measure not collected in this audit

The annual Intravenous to Oral switch Audit was conducted on 6 wards with high incidence of intravenous antibiotic use (Amyand, Florence Nightingale, Gray, Cavell, Holdsworth and Caroline) in Q3. Thirty Three patients (23% of those audited) were on intravenous antibiotics of whom 31% (10 patients) met the criteria for IV to oral switch. On follow up 90% of these patients were switched to oral antibiotics within 48 hours of the audit.

Antimicrobial Stewardship Rounds
Multidisciplinary antimicrobial stewardship rounds are conducted three times a week for antibiotics and once per week for antifungals on the adult wards by microbiology and pharmacy. Paediatric infectious diseases and pharmacy conduct weekly stewardship rounds on the paediatric wards. Senior pharmacists also review prescribing practices on every ward each month and feedback to the clinical teams. On the adult antibiotic stewardship rounds interventions were made to optimise antibiotic therapy for 437 patients over 136 ward rounds.

Laboratory Support

The Infection Prevention and Control Team continues to receive excellent support from the Medical Microbiology laboratory, now part of South West London Pathology (SWLP). The laboratory provides a comprehensive service including for screening alert organisms and diagnosis of MRSA bacteraemias, *Clostridium difficile* infection, influenza and norovirus. The laboratory also has access to specialist tests including molecular epidemiology analyses by referral to the Central PHE laboratories based at Colindale and the PHE London Regional laboratory that was based at Barts and the London. This service moved to PHE Cambridge during the year 2016-17.

Support from Public Health and Commissioners

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

The IPC team are also very grateful for the advice and support received from Sheila Loveridge, Infection Prevention and Control Lead and Associate Partner for Quality and Clinical Governance at the South East Commissioning Support Unit.

Acknowledgements:

This report reflects the fundamental approach to infection control that operates across the Trust in being very much a team effort. Principle authors and contributors of the different sections on the annual report are as follows:

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The Infection Prevention and Control Team would like to record their thanks to many colleagues throughout the Trust for their continuing assistance.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board (Part 1)		
Date:	27 September 2018	**Agenda No**	**2.5**
Report Title:	Elective Care update		
Lead Director/ Manager:	Ellis Pullinger Chief Operating Officer		
Report Author:	Matthew Davenport, Deputy Director Elective Care		
Presented for:	Update		
Executive Summary:	This is the monthly update on Elective Care to the public Trust Board. The purpose of this paper is to provide assurance in the Trusts ability to demonstrate readiness to commence shadow reporting for a period of 3 months. This will also include advising our regulators to commission a full return to reporting assessment within Q3 2018/19 with the aim in go live with reporting nationally in Q4 2018/19. This currently only applies to the Tooting site with a future R2R decision required for the Queen Mary's Site subject to a successful deployment of Cerner. This paper will specifically look at the progress made in - Performance – continued reduction in overall PTL size, Reduced long waiting patients, improvements in 5 data quality metrics. - Validation – additional validation resources is expected to come online in October 2018. This will support our overall data quality and support our ability to demonstrate readiness to report nationally. - Training – A training strategy has been agreed in principle. This outlines the method of training and the material being used to deliver the training. Training will be provided to existing staff and form part of induction for all staff joining the organisation. The roll out of training is formally due to start in October. We are currently offering electronic learning modules and targeted training which will continue.		
Recommendation:	The Trust Board is asked to receive this report and note the recommendation to commence shadow reporting.		
Trust Strategic Objective:	Treat the patient, treat the person Right Care, Right Place, Right Time		
CQC Theme:	Well-led, Safe, Caring and Responsive		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Risk:			
Legal/Regulatory:	Referral to treatment standard is a regulatory target		
Resources:	Elective Care programme		
Previously Considered by:	Monthly update received by the Trust Executive Committee and Quality and Safety sub- Committee	Aug 2018	
Equality Impact Assessment:	N/A		
Appendices:			

Elective Care Recovery Programme Update

Trust Board (Part 1)

1) Treating Patients

- The Trust continues to use and develop its five patient tracking lists (PTL's). They are as follows:

1) Active (the live PTL)
2) Planned
3) Active Monitoring
4) Diagnostics
5) Cancer

- A daily refreshed PTL is available to all staff. This includes length of wait at patient level. Continued focus is on the longer waiting patients and the overall number of long waiting patients is reducing. As reported at the August Board the total incomplete PTL size is ahead of trajectory. September to date is seeing further improvements and remains ahead of trajectory.
- As part of phase one of validation, all patients who required an appointment have been seen. Additional work is underway for those patients who did not respond. Section 3 of this report will provide more detail.
- There has been a reduction in the number of long waiting patients on the PTL.
- The Trust is ahead of trajectory for a number of data quality metrics as agreed with our regulators.
- The trust has seen an increased number of patients being booked for treatment and our overall utilisation is increasing.

2) Validation

- Following approval at Trust Board for additional validation support, the operational team are working alongside procurement to commission external validation support throughout Q3 2018/19.

3) Training

- A new training implementation strategy has been approved in principle.
- Training is to be provided for all new staff joining the organisation from October.
- Training for existing staff will also be provided from October.
- Training is currently being delivered within the existing ICLIP roll out training programme at the Tooting site.
- Targeted training is also currently being provided. This follows themes identified through our audit process.
- The completion of the RTT e-learning modules has been mandated by each of the Divisional management team and is being tracked through the new weekly Access Meeting.
- The uptake for our staff completing the RTT e-learning modules remains a concern and is too low at 70.2% against a target of 85%.

4) **Clinical Harm Review Update**

Further to the August Board paper, this paper provides an update on the additional validation being undertaken by GP practices.

- To date all Practices have agreed to participate in reviewing their patients and the Practices have been securely sent their patient information. The outcome from the review was that only 24 patients date have been identified as possibly needing further investigation these patients have been clinically validated by services and of the 24 patients, only 2 needed further review and both patients have been seen. To date there have been no cases of clinical harm identified as a result of this process.

- Crucially the Trust now has a 'live' Patient Tracking List (PTL) as from February 2018 that tracks and manages all patients that are referred to the Trust for diagnosis and treatment.

Phase 2 Current and Historical Validations

Good progress is being made on the validation of historical validation.

- By definition this cohort of patients is significantly lower risk than the cohort within Phase 1.

- The initial validation work undertaken by Cymbio identified 10,000 patients who appeared to have an 'inconclusive' pathway – i.e. no definitive outcome from their last contact with the Trust in order to confirm that their episode of care could be closed. Of the 10,000 patients, 4,000 appeared to be on the St George's site, 6,000 at Queen Mary's.

- Following further internal validation to remove patients with an appointment after October 2017 and patients on 'active monitoring' the total number of inconclusive records across both sites from the original 10,000 is now 3,676 (1,831 at St George's and 1,845 at Queen Mary's.)

- QMH have reviewed all of their records. There has been no harm identified.

- SGUH are looking to validate the remaining patients by the end of October.

- By definition Phase 2 patients are a much lower risk cohort of patients and no clinical harm requests have been received.

5) Return to Reporting

The Trust Board took the decision to stop reporting its referral to treatment waiting times in 2016. Every non-reporting Trust is expected to agree and deliver a 'return to reporting' plan so it is able to assure itself that it can report RTT waiting times accurately to the public once the decision has been taken to do so. The Trust aim is to return to reporting in Q4 of 2018/19.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	September 2018	**Agenda No**	**2.6**
Report Title:	Quality Improvement Academy		
Lead Director	James Friend, Director of Delivery Efficiency & Transformation		
Report Author:	Martin Haynes & Dr Mark Hamilton		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Update		
Executive Summary:	The paper gives a broad overview of the Quality Improvement Academy to inform the Board of its origin, purpose, activity and future planning. The Academy was formed in part to help the Trust exit Quality Special Measures by building improvement capability in teams doing work through education, coaching and the application of improvement methods. To do that it has been supported by special measures monies from NHS Improvement to form a strategic partnership with the Institute for Healthcare Improvement to help guide and accelerate that journey. To academy has been successful in building energetic and enthusiastic pathfinder groups that have led early improvement work, who are now disseminating their learning and support to other groups. Through this work we have also learnt the scale of the challenge we face in creating the psychological safety and conditions necessary to do the work of improvement. This is not surprising or unanticipated but important the board is sighted on how we are actively tackling these challenges. There is a clear work plan ahead for the next year including delivering ongoing training and education, building capability in teams to function well and continuing to create a lasting way of working for St. George's that will help us to deliver outstanding care every time for our staff and patients. The academy is grateful for the Board's continued support and recognises the scale of the journey we have embarked on.		
Recommendation:	For the Board to note the intentions and progress of the Academy to date. For the Board to continue to support the short and long term aims of the Academy. For the Board to continue to support the creation of conditions to do the work of improvement. To acknowledge the challenges this way of working brings and		

	the sustained efforts needed to embed it in the organisation		
Supports			
Trust Strategic Objective:	Right Care, Right place, Right Time, Balance the Books, Invest in the Future Build a Better St George's, Champion Team St George's, Develop Tomorrow's Treatments Today		
CQC Theme:	Safe, Effective, Well Led		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:			
Equality Impact Assessment:			

1.0 Purpose

The purpose of this paper is to update the Trust Board on the origin, ambition and activity of the Quality Improvement Academy. To highlight work done to date and to provide clarity and transparency on the challenges the organisation faces to embed improvement work into its day to day working.

2.0 Background & Context

Building a better St. George's needs real and lasting change to happen and quality improvement is a key part of how that change will occur. But to do that we need to train, support and invest in our staff to make continuous quality improvement what we do every day.

Quality improvement is not a workstream, nor does it happen overnight, it is a change of mindset underpinned by improvement methods and tools. The academy is here to provide what we need to make that change happen and ensure the Trust creates the right conditions for long term success.

The academy was formed in part to help the Trust exit special measures for quality and has been supported by special measures monies from NHSi to form strategic partnerships to help accelerate that journey. Currently the team is supported by a small group of experts from the Institute of Health Improvement (IHI) who provide strategic guidance, technical training and coaching support.

The core of the QIA improvement methodology is drawn from the IHI Model for Improvement and Framework for Safe, Reliable and Effective Care; this will be described as The St George's Way.

Appendix 1 – Story So Far, What We Do & our Driver Diagram

Over the medium to long term the role of the academy is to continue to develop the capability and capacity of the Trust to create a way of working that has the best of improvement methods, behaviours and techniques into our St. George's way that will positively impact the culture of how we do and think about work.

Critically our QI approach is multi-professional, collaborative and collegiate. We are building a community of improvers who will share learning across the trust and support each other to realise the full potential of QI.

Core QIA Team

The core team comprises two full time members of staff (Martin Haynes, Improvement Methodology and Alison Benincasa, Quality Improvement Director) and three part time clinical colleagues (Dr Mark Hamilton, Associate Medical Director, Dr Carolyn Johnston, Consultant Anaesthetist, Deborah Dawson, Consultant Nurse and Ashley Harvey, Project Lead/Support), Robert Bleasdale (Deputy Chief Nurse).

3.0 Self-Assessment Against CQC Quality Improvement Framework

Embedding quality improvement into a trust as large as St George's is very much a long-term process, so it is helpful to assess ourselves (and have a baseline position) against the CQC framework.

Successful organisations such as East London Foundation Trust have taken over 5 years to build their capability and capacity in improvement and are rated as an outstanding Trust year after year. Their guidance is as follows:

What do we mean by a 'QI approach'?
'Quality improvement' is not the same as 'improving quality'. All provider organisations will be making efforts to improve quality, and this can be done in many ways – including planning (resourcing, restructuring, commissioning, and training), assurance (periodic checks of quality through audit or inspection), control (continuous monitoring of quality with interventions when necessary).
Quality improvement is the use of a systematic method to involve those closest to the quality issue in discovering solutions to a complex problem. It applies a consistent method and tools, engages people (both staff in clinical/corporate teams and patients/service users/families) more deeply in identifying and testing ideas, and uses measurement to see if changes have led to improvement.

St George's Baseline CQC Assessment

No	CQC Assessment Criteria / Evidence Required	Baseline Assessment (Sept 18)	Our Evidence	Actions / Next Steps
1	Quality strategy available on website and intranet that explicitly mentions quality improvement and sets the organisation's quality improvement goals.	2	QI referenced on dedicated intranet page, but content requires updating to reflect more accurately reflect rationale, approach and case studies to encourage staff engagement	Development of St George's Way (QIA) intranet content. Maintain link with Strategy team and adjust content as corporate strategy develops.
2	Quality appears to be the priority at the Board from agenda and minutes, with a specific report on quality that is accessible publicly.	2	QSC oversight of GIRFT projects QSC & TEC review of QIP dashboard	Development of QIA report
3	The Board looks at data as time series analysis, and makes decisions based on an understanding of variation	2	Some evidence on QIP dashboard and reports to QSC, but not yet consistently applied/widely understood across the trust	Progress use of time series (SPC) reporting, including QIP dashboard, Comm Cells
4	Clear and consistent improvement method for the organisation, and demonstrable across all areas/operations of the organisation.	2	Core methodology agreed, but in early stages of education/application	Publication of St George's Way TEC team training / coaching in QI methodology (their own project) Promote QI methodology for GIRFT & QIP project teams Extend us of Life QI project management platform
5	Presence of a central team dedicated to supporting quality improvement, with expertise in the improvement method and tools.	1	Core QIA team in place with broad health and private sector transformation / quality improvement experience Senior QIA leadership training plan St Georges Charity application for Innovation	Agree QIA team development plans Recruit to Innovation Navigator role
6	Plan for building improvement skills at all levels of the organisation, with a large proportion of the organisation (and at all levels) having developed improvement skills.	2	Completed formal IHI training of 40+ staff Monthly QIA training workshops in place Exploring QI support options for GIRFT improvement projects QIA developing wider implementation/education approach	Explore options to upskill 'pathfinder' QI teams Structure QI training programme, initially targeted at GIRFT/QIP project teams, care group leads and key members of divisional triumvirates
7	Structures in place to oversee quality improvement work, with multiple executive directors involved in regular provider-level overview.	3	Monthly (internal) TEC progress report / review by Exec Sponsor Monthly (internal) CEO review with QIA leadership team Established relationships with local HIN	TEC / senior leading coaching in use of QI methodology Agree how to incorporate QI reporting into POM structures
8	Robust, regular and local support in place across all areas of the organisation to support teams using QI to solve complex quality issues.	2	QIA coaching support in place for established project teams Monthly Improvers Network Meeting to share learning / challenges across project teams Bi-Weekly Support Meetings with IHI project team	Secure senior leadership time to coach QI teams Train CGLs to actively lead QI projects

No	CQC Assessment Criteria / Evidence Required	Baseline Assessment (Sept 18)	Our Evidence	Actions / Next Steps
9	Quality improvement work across the organisation demonstrates alignment – projects at team level align with strategic objectives for the organisation.	3	No formal structure yet in place as initial projects portfolio was based upon local improvement ideas to evidence value of QI approach across trust. Consistent QI methodology covered in leadership programmes- forward managers, Band 6 nurses, foundation doctors etc.	Engage with strategy team and divisional leaders to understand QI requirement as part of future strategy/business plans Explore options to integrate QI approach as part of future CIP development process
10	Demonstrable use of measurement on a routine basis to monitor progress of QI work against outcomes and ensure sustained improvement.	2	Project teams being coached to use time series reporting where possible and QIA supporting teams to use Life QI application as central application for performance reporting/analysis	Implementation of Life QI project management / reporting platform Develop/implement QIA report
11	All Executive team and clinical leaders are able to talk about their role in leading quality improvement, supporting teams in their quality improvement work and developing a context and culture within the organisation for quality improvement to occur	3	Limited levels of exec clinical leader education completed to date. QIA developing Yr 1 activity / education plans to build wider understanding/engagement of senior leaders	See actions for TEC, CGLs and divisional leaders above.
12	A majority of staff across multiple areas of the organisation and from a variety of backgrounds are able to talk about the provider's quality improvement approach, how they have been involved and the difference it has made.	3	QI approach is in its infancy at St George's. This ambition will take a minimum of 3 years to achieve meaningful understanding/spread across the trust	Consider measurement as part of staff survey Longer term options to include QI projects as part of personal development planning and promotions process Ensure QI is embeded in our Quality strategy

Scoring Guidelines	
1	Fully Compliant
2	Some Evidence
3	Not Compliant

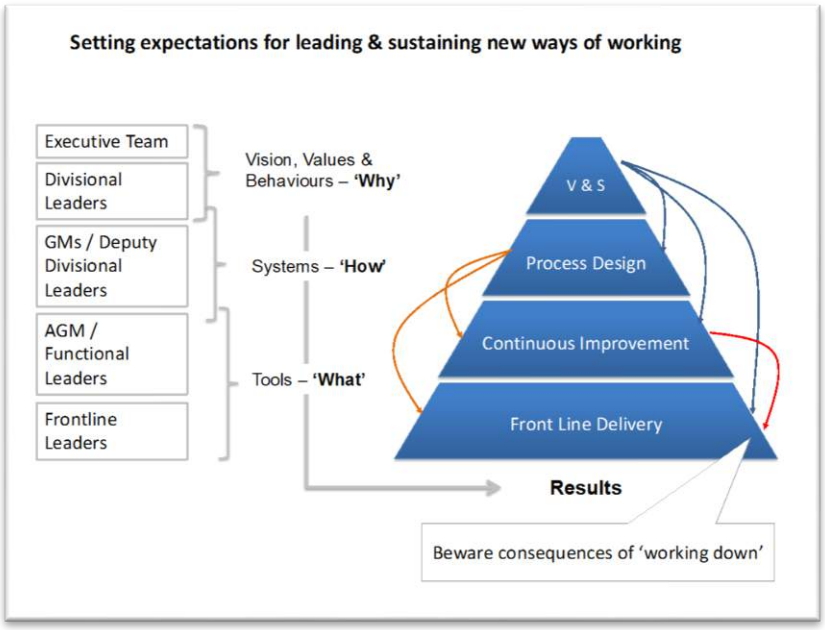
4.0 Key Activity Summary

The following is a summary of some of the key QIA highlights and development activities over the past five months (not exhaustive):

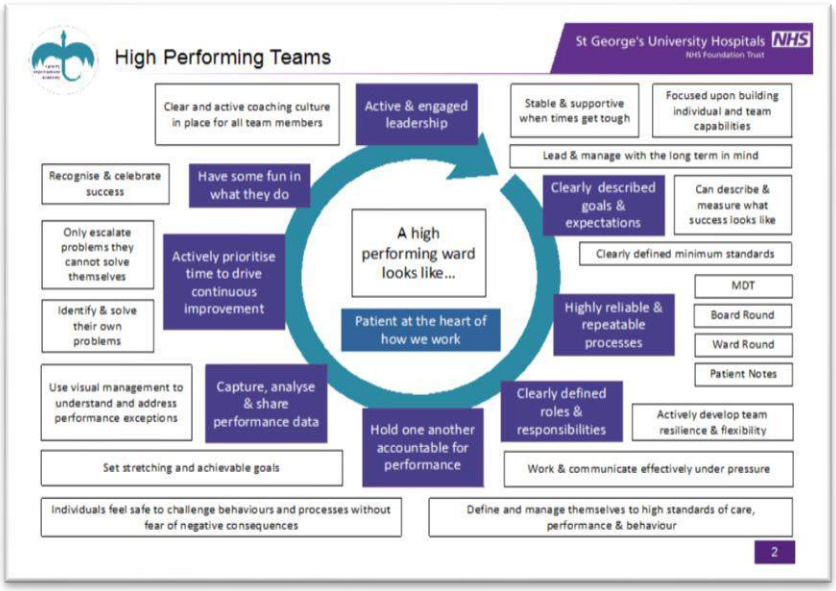
Creating the Infrastructure

- Development of the QIA year one workplan & Development of communications and stakeholder plan
- Development of High Performing Teams / Minimum Standards frameworks (currently to support the Unplanned & Admitted Patient Care programme). The following two slides are examples from the St George's Way High Performing Teams framework.

Creating the conditions for effective QI leadership



Characteristics of high performing teams



- Integration of GIRFT reporting within the QIA, including ongoing reviews with project teams to determine potential QIA support requirement
- Development of QI partnership links with local HIN, Medical Director of HIN to attend partnership board quarterly and Health Foundation Q community (piloting #plotthedots data for improvement training with NHSI)
- Secured placement for HEE Deloitte fellow- doctor in training undertaking 1 yr training with Deloitte then returning to St Georges to undertake improvement and transformation work for one year
- Review and agreement of QIA support for 2018/19 Quality Improvement Plan.
- Support from the Health Foundation to develop large scale pathway improvements and become a Flow Coaching Academy
- Identification of TEC improvement project (release time in meetings to support QI activities).
- Creation of bespoke programs of support for executive and non-executive board members

Building Momentum & Learning in Real Time

- Real time coaching support for QI project teams including:
    - Roll out of TEP across all wards
    - Rationalisation of range, reduction of waste and improved order of nutrition products
    - Enhancements to daily theatre huddles to improve start times and communications
    - Improvements to ways of working for nurse in charge role within ED (further work commenced for consultant in charge & patient flow co-ordinator roles)

Building our Internal Capability

- 4-day quality improvement training workshops (in partnership with IHI colleagues) delivered to 40+ staff, including clinical, nursing and operational staff
- Submission to St George's Charity (in partnership with local HIN) for appointment of Innovation Navigator role to support QI activity (Appendix 6)
- Short listed for Flow Coaching Academy
- Other training, facilitation, QI coaching provided to:
    - System-wide Multi-Agency Discharge Event reviews
    - Staff and public strategy workshops
    - ED improvement workshops
    - SCNT complex complaint problem solving
    - Enhancing cancer skills nursing (Macmillan partnership programme) QI teaching and facilitation- teams conducting improvement work for cancer patients including improving tracheostomy patient communication, improving pre-11am discharges, developing cancer diagnosis documentation for nursing handover
    - Foundation school (FY1 and FY2), South London school of anaesthesia trainee teaching sessions
    - Measurement for Improvement- introduction to control charts session
    - QI half day session on PGEC developing leaders and and ward leadership programmes
- Two faculty members enrolled into improvement coach programme

As awareness of the QIA spreads, the team has recently initiated a Rolling Conversations report to capture potential new work requests to the QIA. In large part they come from existing relationships with QIA team members, but a number have also been direct referrals from Trust Executive Committee members (Appendix 2)

There are many positive examples of QI progress, but there have also been a number of challenges to progress:

- Project team resource availability has presented real challenges during the summer holiday period and some team members have felt pressured to undertake operational duties ahead of QI project activity. This has caused concern across the group as they are anxious to demonstrate the potential of QI in making life easier for their colleagues/patients
- The 'executive & project team collaboration' has not been particularly successful with both sides declaring challenges in contacting one another. Similarly, the project teams have shared concerns/reticence to contact their executive sponsor. This has led to a change in the implementation plan and review of further change cycles with more support being aligned to the executive.
- QIA team resource is increasingly stretched to provide direct training and coaching support and whilst simultaneously investing time developing the quality management infrastructure (website, frameworks, templates, training / coaching resources, etc).
- QIA capacity to undertake detailed assessment/prioritisation of GIRFT projects and/or QIA support opportunities. This also includes monthly GIRFT progress reporting.

5.0 Actions/Priorities During Quarters 3 & 4

Acknowledging the increasing demands of the QIA team, they have developed a workplan for quarters 3 & 4. The team will need to be selective in the range of new projects it can support and will undertake a monthly demand/capacity review to work priorities. This process will be guided by a need to continuously build QI capabilities across the trust, address current operational challenges in cardiac surgery & ED and continue development of the QIA infrastructure (The St George's Way). Work will be assessed and prioritised against the four aforementioned improvement themes:

- Building the infrastructure
- Developing our internal capabilities
- Building momentum
- Learning in real time

Work Planning

The team is currently reviewing the 'long list' work plan (see appendix 4), but the following captures some of the known priorities for Q3 & Q4

- Review 'long list' workplan and assign resources against in line with trust priorities
- Attendance at IHI Patient Safety Executive Development programme (Martin Haynes, Mark Hamilton & Elizabeth Palmer)
- Orlando Health site visit by CEO & CMO/AMD (in partnership with IHI) to deeply understand how a multi-site hospital has implemented QI into its organisation, enabling them to reduce harm by 50%, improve patient & staff satisfaction and create 185 days cash in hand.
- Focused QIA project support for cardiac surgery services
- Focused QIA project support for ED teams (initially integrated shift management processes for consultant in charge, nurse in charge and patient flow coordinators)
- Roll out of structured QIA training programme (to include potential ½ day introductory workshops for GIRFT & QIP project teams)
- Facilitation of TEC team to complete their own QI improvement project
- Systematic roll out of Life QI application to manage/report all QI projects
- Roll out of St George's Way (intranet, QI frameworks & tools, etc)

- Complete first implementation cycle of High Performing Teams / minimum standards frameworks as part of UAPC programme
- Complete recruitment to Innovation Navigator role
- Deliver Patient Safety & Quality Improvement Week (November 2018)
- Develop and agree plans to introduce two trust wide QI programmes: Joy in Work & Psychological Safety
- Develop meaningful QIA reporting framework that captures both quantitative and qualitative performance data
- Attendance at IHIs Health Improvement Alliance Europe in October 18

6.0 Conclusion

For the early 'pathfinders' our improvement approach (the St George's Way) has created a genuine enthusiasm amongst them for QI in St George's and despite some difficult resource challenges, the teams remain committed to deliver demonstrable quality improvements and are keen to do so with the active support of their executive sponsors.

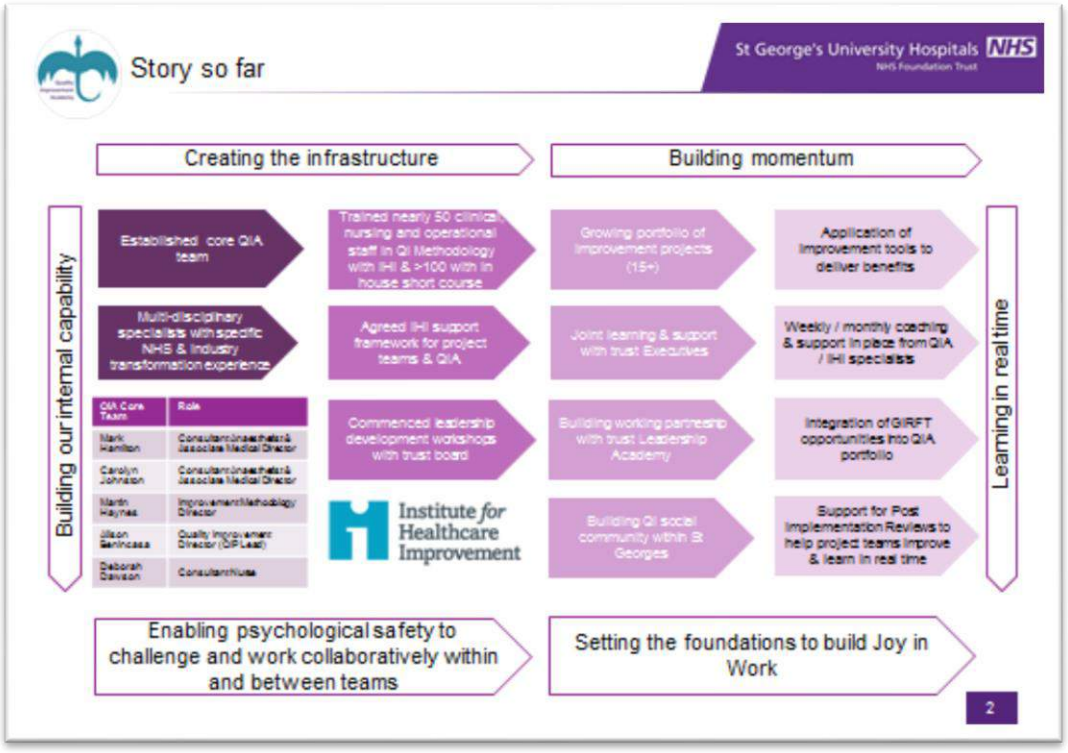
The past four months have highlighted the need for more structured and active engagement between the QIA and senior leaders. Collectively we need to create more time to understand and lead QI activities in the trust. The proposed TEC improvement project (to release time spent in meetings) will help provide a more detailed understanding of the QI approach / language and create capacity for senior leaders to coach and support QI projects. It is also important that we actively step forward to ensure leaders/managers create dedicated time for teams to undertake their improvement projects. **In short, the real priority is to continue creating the conditions for change and implementation of QI across St George's.**

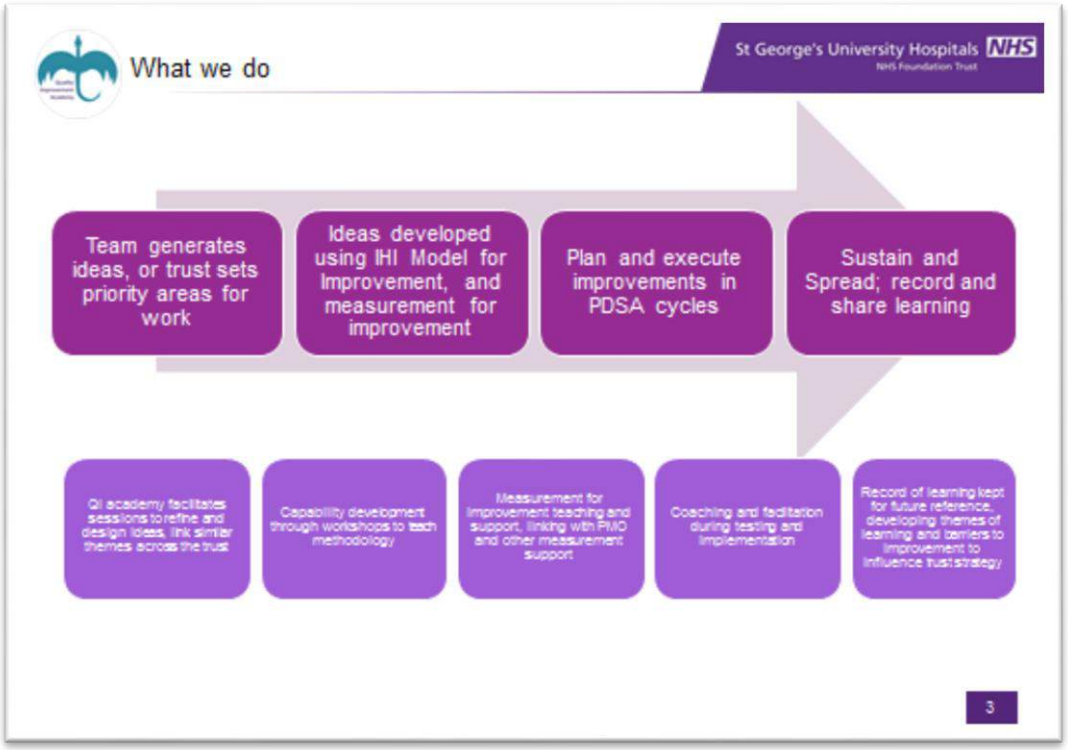
The focus for quarters 3 & 4 must be to consolidate and extend the reach of our early 'pathfinders' and develop a new cohort of improvers from amongst our key clinical/operational leaders to support QI projects (including QIP and GIRFT opportunities).

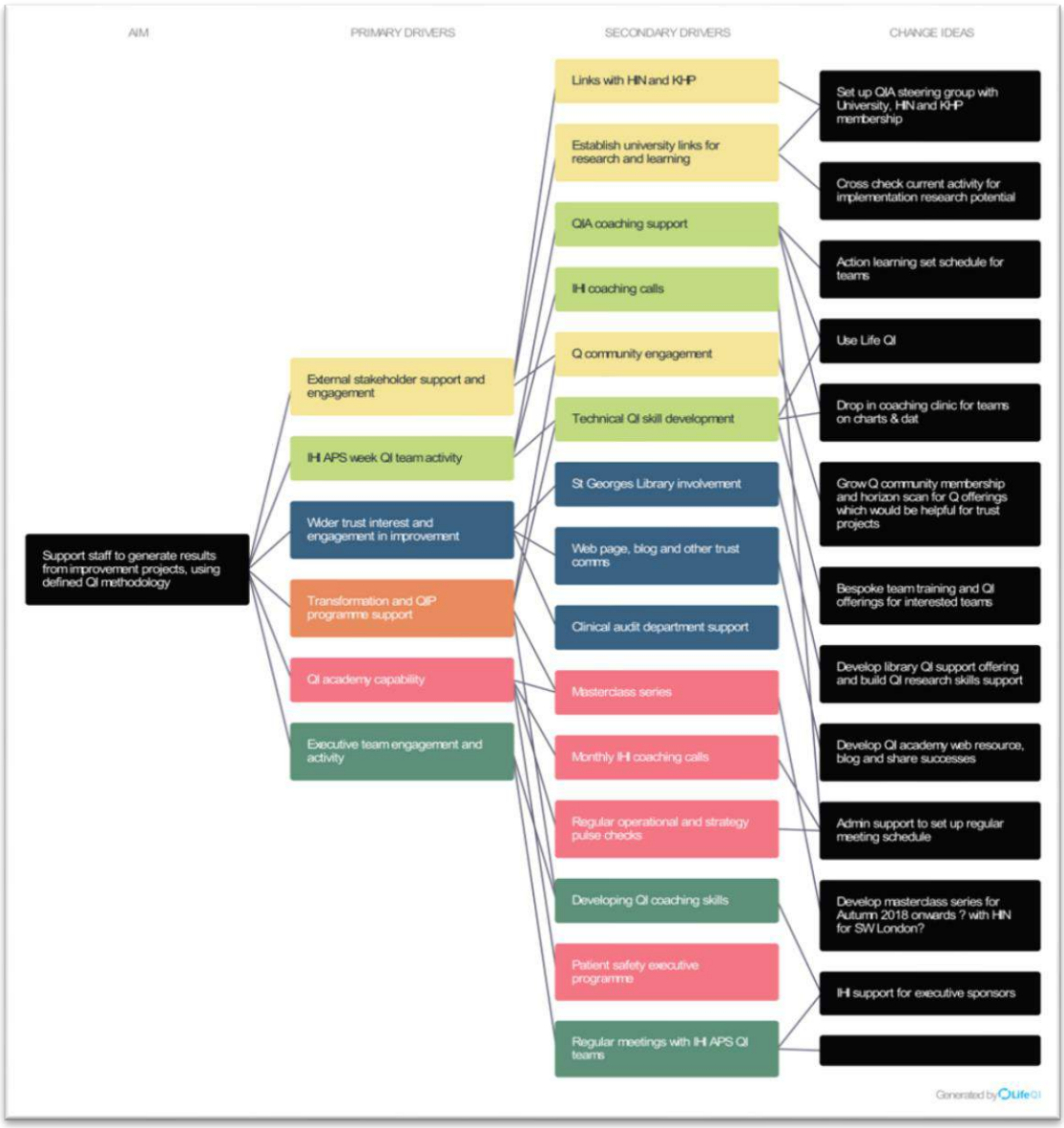
The academy is grateful for the ongoing support of the Trust Board and recognises the need to continue to bring not only the tools and techniques of improvement to St. George's but also the needed behavioural changes that will lead to real and lasting change that out patients and staff deserve.

Appendix 1

QIA story so far & what we do & first driver diagram






AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
CHANGE IDEAS
Support staff to generate results from improvement projects, using defined QI methodology
External stakeholder support and engagement
IHI APS week QI team activity
Wider trust interest and engagement in improvement
Transformation and QIP programme support
QI academy capability
Executive team engagement and activity
Links with HIN and KHP
Establish university links for research and learning
QIA coaching support
IHI coaching calls
Q community engagement
Technical QI skill development
St Georges Library involvement
Web page, blog and other trust comms
Clinical audit department support
Masterclass series
Monthly IHI coaching calls
Regular operational and strategy pulse checks
Developing QI coaching skills
Patient safety executive programme
Regular meetings with IHI APS QI teams
Set up QIA steering group with University, HIN and KHP membership
Cross check current activity for implementation research potential
Action learning set schedule for teams
Use Life QI
Drop in coaching clinic for teams on charts & dat
Grow Q community membership and horizon scan for Q offerings which would be helpful for trust projects
Bespoke team training and QI offerings for interested teams
Develop library QI support offering and build QI research skills support
Develop QI academy web resource, blog and share successes
Admin support to set up regular meeting schedule
Develop masterclass series for Autumn 2018 onwards ? with HIN for SW London?
IHI support for executive sponsors
Generated by QLife QI

Appendix 2

Projects Portfolio – not all projects can / will be supported by the QIA, as resources are assigned based upon operational priority and team capacity

Source	Specialty / Function	Project / GIRFT Improvement Theme	Current Status / Commentary
IHI APS	CWDT	Improvement in the completion of MCCD & coroners' referrals within the 24 hour timeframe	Active
IHI APS	SCNT	Addressing the role of human factors in improving patient safety outcomes within the cardiac catheter labs	On hold
IHI APS	MedCard	E-triage / ERS (Vascular)	On hold
IHI APS	Trust	Increase the number of discharge summaries sent to the GPs (95% within 24 hours)	Closed - now part of UAPC programme
IHI APS	CWDT	To implement safety culture and safety SAFE paediatric wards & teams	Active
IHI APS	Trust	Starting the conversation for the end of life care planning	Active
IHI APS	Trust	Timely responses to complaints	Active
IHI APS	Trust	Transparency / openness within patients / families when things go wrong	Active
IHI APS	SCNT	Improving theatre lists start times	Active
IHI APS	SCNT	To ensure 90% of patients are on the surgical pathway within three months	Active
IHI APS	MedCard	To reduce number of non-admitted breaches in the ED, resulting in 98% performance everyday	On hold
Dragons Den	CWDT	Nutrition - reduce spend on products	Active
ED	MedCard	Consultant in Charge shift management	Active
Transformation	Unplanned and Admitted Patient Care	ED Processes	
Transformation		Inpatient (ward) processes	
Transformation		Discharge processes	
Transformation		Conversion to UTC	
Transformation	Planned Care Programme	Outpatients (technology: ERS, Netcall, Text Reminders, etc)	
Transformation		Outpatients clinic redesign (virtual clinics, etc)	
Transformation		Clinic moves	
Transformation	Clinical Records	Clinical records (due to move to business as usual)	
Transformation	Maternity	Maternity transformation	
QIA	MedCard	Dementia bus stop	
CEO/MD	Cardiac Surgery	To support teams in work to improve	New project under development

Appendix 3

Rolling Conversations / Engagements

Week Ending	Conversation Subject	QIA Team Member	Next Steps (If necessary)
17-Aug	Patient complaint resolution workshop with Vicky Morrison, our patient and c20 staff from surgery & neuro wards. Followed earlier 5 Why problem identification workshops	Martin	Write up as simple PIR
17-Aug	Presentation of HPT to MedCard senior nursing leads	Martin	None
18-Aug	Initial presentation of High Performing Teams approach to Operational Delivery Group	Martin	Follow up meeting with Jo Dale
17-Aug	Request from Hasan Cartigan (learning & development) to explore how QIA might help improve trust induction process	Martin	Meeting set for 22/8 QIA to run process mapping workshop to prioritise PSDA improvement projects (likely Oct 18)
17-Aug	Meeting with Sam Greenhouse to scope our 1 day QI workshop for Ward Managers on 16/10	Martin & Mark	Draft workshop outline by 3/9
17-Aug	Delivered QI workshop to cancer nurses (c11 staff)	Carolyn	
17-Aug	Meeting with Tony Addy & Jacqui Bishop to discuss options for improving emergency theatre access	Carolyn	
17-Aug	Meeting with Jane Kelly - 'Who is my consultant?' based on idea from our former COO and current NED via James Friend	Martin	Explore options to include improved guidance into ward booklets and potential meeting with former COO & NED
17-Aug	CC with Beth on progress with dietetics work and progress with pharmacy navigator	Mark	Need to capture good stuff she has done already and see where program decision with pharmacy went
17-Aug	Meeting with Merton LMC focus group	Alison	
17-Aug	High level overview of QIA in SGUH at trust induction meeting	James	
17-Aug	High level presentation of HPT to Lisa Pickering	Martin	
24-Aug	High level presentation of HPT to UAPC programme board	Martin	
24-Aug	High level presentation of HPT to Jo Dale, including potential fit with iClip roll out	Martin	
24-Aug	Meeting with Charlotte James to discuss possible QIA support for maternity team building workshop in November	Martin	
24-Aug	Offer to support ENT complaints resolution process at trust wide comm cell	Martin	Meeting with Elizabeth Palmer, Vicky Morrison & Kath Brooks to agree next best steps
24-Aug	NED involvement with joy in work program wirh staff engagement grOUP	Mark	design some training for him and bring a piece of work togethre he can be involved with actively
24-Aug	Rodney smith failing accreditation with Bryony and Jane E. Have offered Academy support to give ward manager some 1:1 support and potential to do some QI work with them to support getting out of Bromze accreditation	Mark	Follow up with Bryony to see if help offer taken up
24-Aug	DW Jane E re rogress on their QI plan - they are struggling to find time to get together byt have done some tests of chagneg	Mark	Us to follow up with Donna re help needed and Life QI status
31-Aug	Email intro to Stella Roberts (new head of midwifery)	Martin	Set up introductory meeting and ideas for QI involvement around GIRFT / model hospital activity
31-Aug	Request from Gemma Phillips and Paul Holmes to help improve ED performance variability	Martin	Prep meeting with Paul & Gemma to be followed by meeting with ED consultants 31/8
31-Aug	Meeting with Bernie Kennedy to explore options to make greater use of QI approach in discharge workstream (and engage Bernie as core part of QI team)	Martin	
31-Aug	Preliminary discussion with Deirdre Baker to include weekly Finance measures in trust wide comm cell	Martin	Follow up meeting with Deirdre and propose explore options for use of SPC charts
07-Sep	Conversation with Andy Rhodes ref possible support for cardiology services	Martin	Needs wider converstion on priorities
14-Sep	Presentation of HPT to Surgery management team	Martin	
14-Sep	Request for QI training workshop for second cohort of ward managers	Martin	Confirm date & capacity to deliver
14-Sep	Request for team development workshop/support from Vicky Morrison (for ward about to be downgraded to requires improvement on WAF)	Martin	

Appendix 4

'Long List' Work Plan

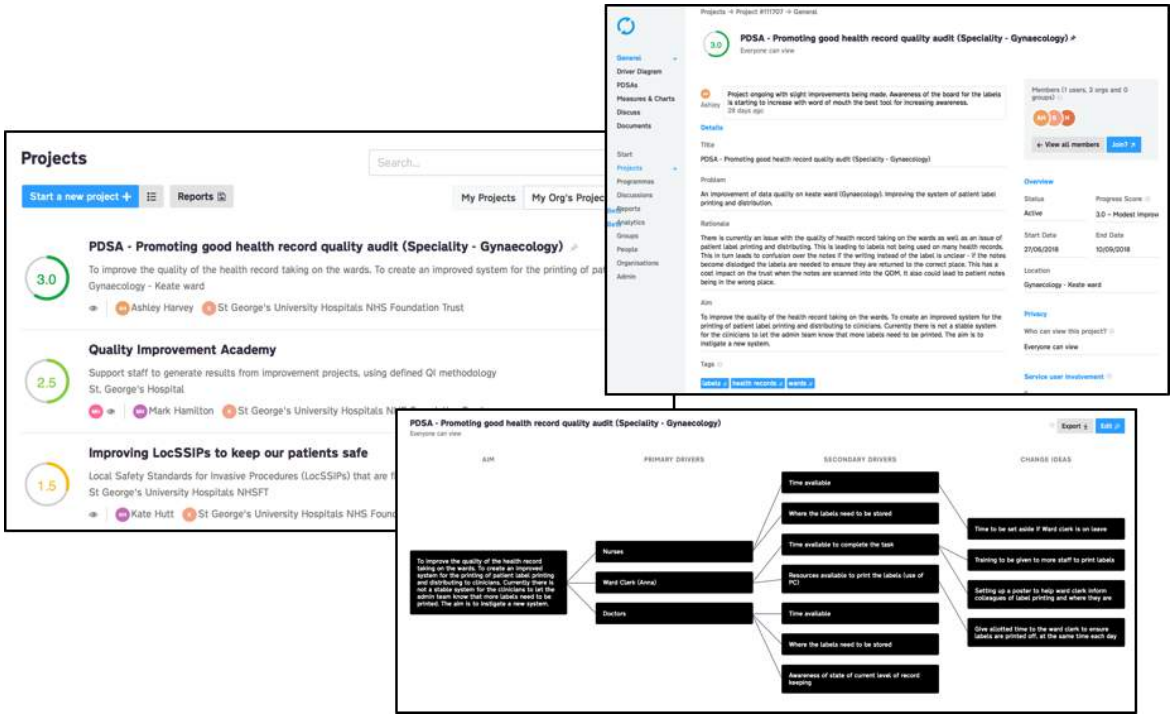
Key
1 = Not Started
2 = In Progress
3 = Completed

Point of Delivery	Description / Task	Current Status
Q2 2018	Application for NHSI Funding (2)	2
	Health Foundation Grant (£30k)	2
	Shortlisted for Flow Coaching Academy	3
	IHI site visit 4th & 5th Sep	3
	Evaluation of QIA Exec engagement with IHI Teams	3
	Executive Patient Safety Course Boston 20th-28th Sept	2
	Defined improvement methodology	2
	Formal review of QIP & QIA support requirements	1
	Develop TEC reporting pack	2
	Integrated QIA / QIP Comms Plan (v1)	2
	Established portfolio of projects	2
	Establish QIA meetings/governance structure	3
	Complete self-assessment against CQC evaluation framework	3
	Education of cancer nurses (n=11, P+3)	3
	Point of care foundation in maternity	2
	Establish relationship with HIN	2
	Complete weekly contact updates in Delivery Board	3
Q3 2018	Confirm areas now using SPC reporting	1
	QIA training for CGLs / CDs	1
	Proactive sharing of project success via comms	2
	HIN Navigator role	2
	Plans for ImproveWell	1
	QIA team development plan	2
	HIAE 30th & 31st Oct	2
	Quality Week (Nov 18)	1
	Enhance use of time series data (SPC)	2
	>50% of GM trained in data for Improvement	1
	Ward Manager QI workshop 16/10	2
	Set up exemplar visits	2
	Blog!	1
	Mass QI inoculation for QIP teams	1
	Agree working fit between QIA and Sims team	2
	Update driver diagram	2
	Publishing & promotion of CJ SPC & MFI workshops	2
	Agree stakeholder management plan	
	Mandate exec / middle mgmt. QIA education	1
	Enhance use of SPC in CommCell(s)	2
	Use of bronze, silver, gold QIA accreditation	2
	Agree QIA 1-6 support model	1
	Formal QIA introduction at trust induction	2
	Proactive use of SPC in QIP dashboard/reporting	2
	Development plans for Deborah & Alison	2
	Formalise learning system (for web & staff use…)	
	Enhancing cancer nursing	2
	Life QI for reporting (ELFT example)	1
	Joy in work	1
	Psychological Safety	1
	High performing teams	2
	Breaking the Rules Week	1

Appendix 5

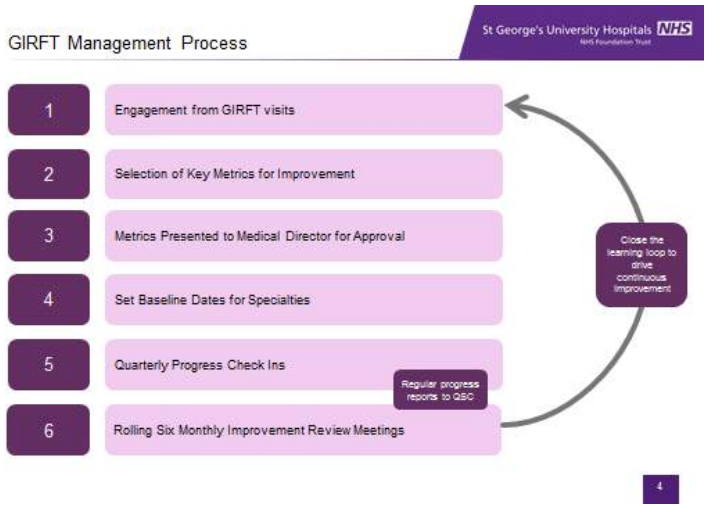
Image of Life QI Project Management / Reporting Platform

The Life QI platform enables teams to collaborate on single/multiple projects and gather learning from similar projects undertaken by other trusts. As a trust we can see all current projects and the QIA team is able to review projects in detail and assess where their support is most needed.



Appendix 6

GIRFT Governance Process (under QIA) and GIRFT Opportunity List



The following table highlights the range of potential GIRFT improvement opportunities. Care Group Leads have met with the London GIRFT team and agreed local project priorities.

Specialty	Finding	Trust per GIRFT	England per GIRFT	Trust Updat
MaxFax	Children - % of elective procedures (excluding day case) with no procedure (crude cancellation rate)	11.46%	6.76%	5.88%
MaxFax	Daycase rate - excision of lesion of lip	87.50%	96.90%	61.11%
MaxFax	Daycase rate - excision / destruction of lesion of mouth	28.57%	81.42%	5.88%
MaxFax	Excision of submandibular or sublingual gland shortfall to British Association of Day Surgery daycase rate recommendation	30.00%		#DIV/0!
MaxFax	Daycase rate - Surgical removal of impacted / buried tooth / teeth	88.69%	97.10%	86.45%
MaxFax	Daycase rate - Enucleation of cyst of jaw	42.86%	88.11%	30.00%
MaxFax	Daycase rate - Biopsy / sampling of cervical lymph nodes	38.98%	73.43%	28.26%
MaxFax	Trauma Surgery for fractured mandible - mean length of stay for Wednesday admissions over other days	1		#VALUE!
MaxFax	Trauma Surgery for fractured mandible - mean pre-operative length of stay for Wednesday admissions over other days	0.5		0.38
MaxFax	Short Stay (0-1 day) (%) - elective - Other orthopaedic surgery procedure on bone on the face	76.32%	90.24%	81.82%
ENT	Daycase Rate - Septoplasty of nose - Adult	66.3%	77.2%	60.29%
ENT	Daycase Rate - Tonsillectomy - Adult	62.0%	70.1%	43.31%
ENT	Daycase Rate - Diagnostic endoscopic examination of pharynx, Larnyx + biopsy - Adult	59.7%	87.0%	23.29%
ENT	Daycase & OP with procedure Rate - Polypectomy of internal nose - Adult	66.7%	72.6%	31.82%
ENT	Daycase Rate - Tonsillectomy - Paediatric	42.6%	55.8%	23.92%
ENT	Daycase Rate - Adenoid Surgery - Paediatric	74.5%	87.4%	50.00%
ENT	Adult - Elective overnight ENT spells with a procedure - % spells with surgery on day of admission	88.3%	93.9%	96.98%
ENT	Paediatric - Elective overnight ENT spells with a procedure - % spells with surgery on day of admission	73.6%	95.1%	96.01%
ENT	HRG WH50B Procedure not carried out for other or unspecified reasons as a % of all elective	6.0%	3.1%	0.03%
ENT	% of spells with non-elective readmission within 30 days - Adult - Tonsillectomy	26.4%	18.5%	#DIV/0!
ENT	% of spells with non-elective readmission within 30 days - Head & Neck Cancer diagnosis - following Major Surgical Resectio	22.8%	12.1%	#DIV/0!
ENT	Average length of stay for Oropharynx major surgical resection spells with LoS > 1 day	17.1	11.3	#DIV/0!
ENT	Average length of stay for adult benign thyroid procedures with LoS > 0 day	2.5	1.8	#DIV/0!
ENT	Average length of stay for adult benign parathyroid procedures with LoS > 0 day	1.9	1.6	#DIV/0!
ENT	Average length of stay for adult benign parotid gland procedures with LoS > 0 day	1.9	1.6	#DIV/0!
ENT	Average length of stay, paediatric removal from auditory canal with LoS >0 day - all specialities	2.0	1.3	**1.00**
ENT	% zero length of stay, paediatric removal from cavity of nose - all specialties	61.0%	80.0%	98.11%
ENT	Average length of stay, adult D142 with LoS >0 day - all specialties	1.67	1.11	**1.00**
ENT	Average length of stay , adult D171 with LoS >0 day - all specialties	2.00	1.14	**1.17**
ENT	% zero length of stay, adult D172 - all specialties	0.0%	55.0%	100.00%
ENT	Paediatrics activity , % zero LoS, D241	0.0%	29.0%	0.00%
ENT	Adult fixture spells + OP procedures in any speciality - % day case / OP procedure	94.6%	96.2%	93.55%
ENT	Paediatric fixture spells - % day case / OP procedure	50.0%	85.9%	50.00%
ENT	E036 Septoplasty on nose NEC - % zero length of stay, adult E036 - all specialties	66%	77%	77.14%
ENT	Average length of stay, adult E036 with LoS >0 day - all specialties	1.33	1.21	**2.00**
ENT	Intranasal Ethmoidectomy - % zero length, adult E142 - all specialties	55%	73%	54.55%
ENT	Intranasal Ethmoidectomy - average length of stay, adult E142 with LoS >0 day - all specialties	2.80	1.22	**1.67**
ENT	Excision of lesion of maxillary - % zero length of stay E132 with FESS or FENS - adult, all specialty	50%	76%	50.00%
ENT	Intranasal ethmoidectomy - % zero length of stay E142 with FESS or FENS - adult, all specialty	55%	73%	54.55%
Urology	Deferred Treatment - Average total length of stay (days both original and subsequent admission)	6.76	5.62	**#DIV/0!**
Urology	Patients under the care of a urologist with diagnosis of urinary tract stones - % undergoing surgery (PCNL, ESWL, or Ureterscopy) during original admission	1.32%	5.57%	11.73%
Urology	Deferred Treatment - % undergoing surgery during a subsequent admission (within 1 year)	17.49%	21.83%	**#DIV/0!**
Urology	Procedure that should be performed as a daycase - Adult circumcision	80.67%	87.96%	0.00%
Urology	Procedure that should be performed as a daycase - Adult hydrocele surgery	71.79%	78.37%	-
Urology	Procedures that could be performed as a daycase - Male bladder outflow surgery (TURP/BNI/laser prostatectomy)	0.00%	5.22%	0.00%
General Surgery	General surgery average length of stay (days) - adult elective activity - Cholecystectomy	1.09	0.91	**1.60**
General Surgery	General surgery average length of stay (days) - adult elective activity - Anti-reflux procedures, laparoscopic	6.08	2.38	**2.67**
General Surgery	General surgery average length of stay (days) - adult elective activity - Primary inguinal hernia, bilateral, laparoscopic	0.63	0.40	**0.45**
General Surgery	General surgery average length of stay (days) - adult elective activity - Primary inguinal hernia, bilateral, non-laparoscopic	1.19	0.69	**0.90**
General Surgery	General surgery average length of stay (days) - adult elective activity - Primary inguinal hernia, unilateral, laparoscopic	0.61	0.28	**0.80**
General Surgery	General surgery average length of stay (days) - adult elective activity - Primary inguinal hernia, unilateral, non-laparoscopic	2.1	0.35	**1.03**
General Surgery	General surgery average length of stay (days) - adult elective activity - Recurrent inguinal hernia, bilateral, non-laparoscopic	7.00	0.80	**2.00**
General Surgery	General surgery average length of stay (days) - adult elective activity - Incisional hernia, non-laparoscopic, with mesh	4.78	3.41	**6.28**
General Surgery	General surgery average length of stay (days) - adult elective activity - Splenectomy	19.00	6.11	**10.00**
General Surgery	Percentage of activity delivered in a daycase setting - Cholecystectomy	25.00%	51.00%	28.78%
General Surgery	Percentage of activity delivered in a daycase setting - Anti-reflux procedures, laparoscopic	0.00%	10.00%	0.00%
General Surgery	Percentage of activity delivered in a daycase setting - Incisional hernia, non-laparoscopic, with mesh	7.00%	21.00%	0.00%
General Surgery	Percentage of activity delivered in a daycase setting - Incisional hernia, laparoscopic, with mesh	0.00%	18.00%	12.50%
General Surgery	Percentage of activity delivered in a daycase setting - Incisional hernia, non-laparoscopic, without mesh	8.00%	34.00%	-
General Surgery	Percentage of activity delivered in a daycase setting - Incisional hernia, laparoscopic, without mesh	0.00%	24.00%	-
General Surgery	Percentage of activity delivered in a daycase setting - Primary inguinal hernia, unilateral, laparoscopic	0.54	0.78	50.00%
General Surgery	% of readmissions following an elective admission within 30 days - Hartmanns	100.00%	15.00%	-
General Surgery	General Surgery activity - average length of stay (days) - Acute diverticulitis	17.68	13.41	**1.39**
General Surgery	General Surgery activity - average length of stay (days) - Acute appendicitis	4.03	3.58	**4.21**
General Surgery	General Surgery activity - average length of stay (days) - Acute cholecystitis	13.33	6.86	**5.71**
General Surgery	General Surgery activity - average length of stay (days) - Large bowel obstruction	18.73	16.72	**11.28**
General Surgery	General Surgery activity - average length of stay (days) - Oesophageal-gastric	14.25	10.68	-
General Surgery	General Surgery activity - average length of stay (days) - Emergency laparoscopy, with definitive procedures	16.45	11.18	-
General Surgery	General Surgery activity - average length of stay (days) - Appendicectomy, non-laparoscopic	5.82	3.90	**6.13**
Orthopaedics	Hip Procedure - Primary hip replacement Length of Stay	14.06	4.96	**14.61**
Orthopaedics	Knee Procedure - Primary knee replacement Length of Stay	18.73	4.87	**10.00**
Orthopaedics	Knee Procedure - Revisional knee replacement Length of Stay	14.5	8.38	**31.88**
Orthopaedics	Knee Replacement - Knee ligament reconstructor (open or arthroscopic) Length of Stay	2.03	0.80	**0.54**
Orthopaedics	Shoulder Procedure - primary shoulder replacement Length of Stay	9.00	3.29	-
Orthopaedics	Shoulder Procedure - shoulder subacromial decompression (open or arthroscopic) Length of Stay	17.00	0.39	**4.00**
Orthopaedics	Shoulder Procedure - shoulder rotator cuff repair (open or arthroscopic) Length of Stay	3.00	0.66	**1.00**
Orthopaedics	Foot and Ankle Procedure - complex reconstruction foot procedure Length of Stay	6.50	2.32	**13.50**
Orthopaedics	Hip arhtroplasty or open reduction of femur following admission for fractured neck of femur - average length of stay (days)	19.79	18.16	**16.92**
Orthopaedics	Overall best practice tariff achievement fragility hip fracture	27.40%	63.43%	-
Cardiothoracic Surgery	Average length of stay, Degenerative mitral valve disease repair	13.7	12.4	**10.18**
Cardiothoracic Surgery	Average pre-op days for urgent aroticvalve procedures for patients with stenosis	11.4	8.2	**11.44**
Cardiothoracic Surgery	Urgent aortic valve procedures for patients with stenosis - % having surgery within 3 days	24.2%	44.7%	37.50%
Cardiothoracic Surgery	Average length of (LoS) and bed day indicators - Excess bed days as % of total ned days * - elective spells	4.7%	3.9%	1.05%
Obstetrics & Gynaecolo	Benign Hysterectomy - Median Length of Stay (Vaginal Subgroups)	3	2	**3**
Obstetrics & Gynaecolo	Open hysterectomy for uterine or endometrial cancer - Median length of Stay	6	3	**3**
Obstetrics & Gynaecolo	Laparoscopic hysterectomy for uterine or endomertial cancer - Median Length of Stay	3	2	**2**
Obstetrics & Gynaecolo	Open hysterectomy for cervical cancer - Median Length of Stay	6	3	
Obstetrics & Gynaecolo	Open procedures for ovarian cancer - Median Length of Stay	8	4	**5**
Obstetrics & Gynaecolo	Laparoscopic procedures for ovarian cancer - Median Length of Stay	3	1	**1.5**
Obstetrics & Gynaecolo	Total and partial vulvectomy - Median Length of Stay	13	3	**4**

Appendix 7

Extract From HIN Navigator Role Application

What difference will your project make; how many patients will benefit?

Whilst the QIA is in its infancy, its leadership team is actively engaged in educating and coaching staff at all levels to embrace new ways of working, meaning the portfolio of quality improvement activities grows on a weekly basis. The Innovation Navigator role provides a fantastic opportunity to explore and drive additional improvements that were hitherto unknown or without perhaps without an active champion to bring them to fruition.

There is huge potential to reach significant numbers of patients, but at least in the near term, the Innovation Navigator will play a pivotal role in prioritising new ideas and working with key clinical, operational and academy colleagues to implement new technologies, products and ways of working for the benefit of our patients and staff.

The approach to accessing innovation in the NHS has become increasingly challenging; creating frustration for innovators who see the NHS as an interesting environment for demonstrating the value of their products, for patients who often have to wait long periods of time before medical devices, technology and pharmaceuticals are available, and for clinicians who are frustrated by the multiple barriers to both approval and adoption of innovations.

This Navigator will aim to make the following difference:

- Help to foster an environment that speeds up the adoption of innovative products and pathways.
- Support St George's staff (clinicians / General Managers, etc) to implement innovations to improve pressing challenges / demand – for example, improve patient flow, improve self-management, safety medical devices.
- Help to push through business cases for funding innovations that will provide return on investment for St George's.
- Have an impactful role in fostering a rich innovation pipeline which develops products and pathways that meet the needs of St George's.
- Play a key role as part of the trust's Quality Improvement Academy (and our 'Quality Improvement Improvers Community) in shaping how new innovations are introduced and embedded across St George's

What are the objectives of your project? Please list between two and four measurable outcomes that you will report on, if the grant is awarded. Be sure to refer to the benefit to patients.

1. Identify at least 10 clinical challenges / needs that would be amenable to innovative products or technologies as part of the solution. Challenges will be matched to the Innovation Exchange run by the HIN that to identify companies with health solutions (eg. Digital platforms) . These solutions are then be matched to the challenges and promoted to the teams at St Georges. Possible benefits to patients include:

- Access to self-care health applications
- Real time data access
- Innovative medical devices
- Better communication and access to shared care planning
- Improved patient flow, reduced waiting lists

2. Work with the St George's Quality Improvement Academy to raise the profile of internal and external innovations, through the design, development and delivery of 4 quarterly innovation days.

3. Support the implementation of piloting 5 innovations at St Georges working with the transformation and/or clinical teams locally, and sharing best practice from other implementations from the Health Innovation Network.

4. Use of behaviour insight techniques to test ways to tackle challenges through innovative products and technologies

Meeting Title:	Trust Board		
Date:	27th September 2018	**Agenda No**	**2.7**
Report Title:	Annual Safeguarding Children's Report April 2017 – March 2018		
Lead Director/ Manager:	Avey Bhatia – Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Michele Okuda, Named Nurse for Safeguarding Adults, Bill Turner – Head of Safeguarding		
Presented for:	Assurance		
Executive Summary:	The annual safeguarding report details the systems and processes in place to safeguard children in acute and community services. The report demonstrates the Trust is committed to the safeguarding of children and promoting their welfare in line with the statutory requirements of the Children's Act. The report highlights some of the key areas of work and areas of challenge for the Safeguarding Children's team over the previous financial year, as well as seeking to set out key future pressures, challenges and opportunities for the Adult Safeguarding Children Service at the Trust. This report is focused on activity over the past financial year, but also references changes and developments to the Service which are either planned, or already underway. The key issues to note in the report are: • That the team has successfully recruited to all roles following an independent review of the Safeguarding Team, which included the appointment of a Head of Safeguarding • The Trust is discharging the required statutory responsibilities as outlined in the Children's Act 2004 • There are clear lines of accountability, responsibility and governance which has been strengthened by the full integration of acute and community safeguarding teams. • Training at all levels is good but requires on going focus to achieve compliance in Prevent and maintain compliance in all other areas. • Training at all levels including the bespoke training are comprehensive and in line with the requirements of the recommendations in the safeguarding children and young people Intercollegiate document. • Provision of supervision for staff needs to be increased and a central mechanism for recording this to be implemented, this is under review. • The Trust is fully committed to partnership working and is an integral part of the wider Multi Agency Safeguarding Hub (MASH) and a key member of the Local Safeguarding Children's Boards. • All Trust safeguarding policies, procedures and guidance documents are up to date • The Trust is compliant with its duty to report cases to the Local Authority Designated Officer (LADO) and the increased awareness of the role has been noted in the Wandsworth Annual Report. • The Trust has implemented alert systems for Child Protection and FGM		

Recommendation:	The Trust Board is asked to receive and discuss this report and raise any concerns in terms of further assurance required.		
Supports			
Trust Strategic Objective:	- Treat the patient – treat the person - Right care, right place, right time		
CQC Theme:	Safe / Caring / Well Led		
Single Oversight Framework Theme:			
Implications			
Risk:	If proper systems and processes and governance not in place failure to meet statutory requirements and potentially put children at risk.		
Legal/Regulatory:	Compliance with: (i) Heath and Social Care Act 2008 (ii) Section 11 Children's Act 2004 (iii) Working Together 2015 (iv) Regulation 13: Safeguarding service users from abuse and improper treatment		
Resources:	No additional resources required or requested.		
Previously Considered by:	Quality Committee Patient Safety and Quality Committee	**Date:**	20/09/18 17/07/18
Appendices:	Nil		

Safeguarding Children – Trust Annual Report 2017/18

1. Introduction

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

This safeguarding duty may be enacted in the context of the administration of patient care directly, or by the Trust participating in multiagency safeguarding practice, such as sharing information with a local authority or attending a strategy meeting relating to a specific child. However, it is extremely important to note that the Trust's safeguarding duties also extend to children and young people who are not patients at the Trust, if, for example, the Trust receives information or obtains evidence which might indicate that a child or children are potentially at risk of 'significant harm'.

In this context, the Trust's duties principally relate to sharing information with relevant agencies, and participating in multiagency safeguarding processes. These duties will apply whether or not the names and details of the children are known or not. It is important to reference this duty as it will apply to Trust staff who seldom or never work with children as part of their day to day duties. In essence, our Safeguarding duties as a Trust relate to all children, regardless of where or with whom they reside, and whether or not they have used any Trust services.

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

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

The Pan London Procedures, to which all NHS Trusts are obliged to follow, are updated on a six monthly basis, and contain detailed information to guide operational responses to specific situations and concerns. The Royal Colleges also publish and update policies relevant to Safeguarding in an Acute Health setting.

This report provides a summary of activity with regard to safeguarding children's activity at the Trust and highlights how St George's responds to and reports on concerns and allegations of abuse and neglect and how we ensure that safeguarding is integral to everyday practice.

2. Safeguarding Team Structure

The financial year 2017/18 has been one of significant change in the safeguarding children's team at the Trust, with a new Named Nurse for Safeguarding Children joining in December 2017 and a new Head of Safeguarding (covering both children and adults) in January 2018. The expansion of the team has provided an opportunity not only to work more effectively and ensure that we meet our statutory obligations, but also to facilitate reflective practice in respect of ensuring that our safeguarding duties are met in the most effective way possible, so as to contribute most effectively to outcomes for vulnerable children, young people and their families.

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

Job Title	Band	WTE	Role comments
Head of Safeguarding – Adults & Children	8B	1 wte	The post holder is responsible for leading the Safeguarding Children and Safeguarding Adults function at the Trust, therefore approximately 0.5 of the post holder's time specifically relates to Safeguarding Children. The postholder works closely with Named and Designated professionals within the Trust, CCG and local authority to ensure the Trust fully discharges its Safeguarding responsibilities. The postholder is extensively involved in partnership work, including but not confined to Safeguarding Children and Safeguarding Adult Boards. *(This is a relatively new post which the postholder commenced in January 2018)*
Named Doctor – Safeguarding Children	Cons	0.3 wte	Responsible for clinical/medical advice on complex safeguarding cases across the Trust, working closely with the Head of Safeguarding and the Named Nurses in this respect, as well as acting as point of contact for Doctors with Safeguarding related query. At St George's the Named Doctor also leads a detailed programme of Safeguarding education/seminars (complementary to the Level 3 Safeguarding course) which is accessible to all doctors and nurses across the Trust. Like colleagues, the postholder is also extensively involved in partnership working.
Deputy Named Doctor – Safeguarding Children	SpR	0.1 wte	Deputises for the Named Doctor, and also participates in Safeguarding activity alongside colleagues from the Safeguarding team. .
Named Nurse for Safeguarding Children (Acute Services)	8A	1 wte	Responsible for clinical advice and guidance to all Trust staff on Safeguarding matters, both on specific cases and operationally. Responsible for the Trust's Level 3 training offer in respect of Children's Safeguarding, and oversees the development in the Trust's safeguarding children's work and for overseeing the provision of Safeguarding supervision to Nursing and Therapy staff across the Trust. The postholder is extensively involved in partnership working.
Clinical Nurse Specialist for Safeguarding Children	7	2 wte	The Clinical Nurses specialists provide advice and support to staff on all children's safeguarding issues and are visible presence on wards (in the Emergency Department and Paediatric Wards). The Clinical Nurse Specialists are often involved in referrals to Local Authorities regarding safeguarding matters as well as taking part in case specific partnership meetings such as Strategy meetings and Child Protection conferences.
Clinical Nurse Specialist – Domestic	7	1 wte	This post works across the Trust on Safeguarding activity which may relate to children or adults, but is managed

Violence and FGM			within the Safeguarding Children's team to which most of the operational activity relates
Safeguarding Administrator	3	1 wte	This post holder covers both the Children and Adults functions.
Named Nurse for Safeguarding Children (Community)	8A	0.6wte	The main focus of this role is acting as the Safeguarding Lead in respect of School Nursing services, which the Trust currently provides.
Paediatric Liaison Health Visitor	7	1 wte	This role provides a liaison service for all children's attendances to ED.
Administration (Paediatric Liaison and community services)	5	1.8 wte	These roles provide administrative support to the community
Clinical Midwife Specialist	7	1 wte	Provide specialist safeguarding support to maternity services.

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

It is also important to note that two voluntary sector teams work within the Trust, and work closely with the Safeguarding Team, these being Redthread and the Independent Domestic Violence Advisor.

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

***Redthread*:**
Redthread are a high profile charity providing support to young people with a range of vulnerabilities. Redthread have five youth work staff (including a team leader) and an administration manager based in the Children's Emergency Department .

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

Redthread provide the MOPAC funded Youth Violence Intervention Programme (which operates in each of London's major trauma centres, (and it is for this work they are probably best known) but they also provide a young women's worker who works with young women affected by domestic abuse, child sexual exploitation and a range of other issues. The Head of Safeguarding attended Redthread's recent Annual Conference and is to work in closer partnership in the year ahead.

It is noted that Redthread, beyond core clinical services, are the main agency providing services to young people over the age of 18 with additional vulnerabilities who use Trust services as young adults are over the age at which the Safeguarding Children's team work. The vast majority of these young adults, despite their vulnerability would not meet the criteria under the Care Act 2014 to receive an Adult Safeguarding service.

3. Policies and Governance:

The Chief Executive Officer (CEO) has overall responsibility for the safeguarding of children and there is a clear line of accountability in place. The Chief Nurse, on behalf of the CEO

has the responsibility to ensure that health's contribution towards safeguarding children and promoting their welfare is discharged effectively throughout the whole organisation and that St George's University Hospitals NHS Foundation Trust is represented on the Local Safeguarding Children's Boards (LSCBs).

The Chief Nurse is responsible for;

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

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

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

The Trust has an internal Safeguarding Children's Committee, which is chaired by the Chief Nurse and Director of Infection Prevention and Control, and attending by key leads across the Trust, within standing invitations extended to the Designated Nurse and Doctor at the CCG. The committee currently meets monthly and enables strategic leads to maintain oversight of services, providing support and challenge where required. Staff in the Safeguarding Team hold regular operational meetings with the Emergency Department, the Neonatal Department and with Midwifery, and are able to attend specific staff meetings upon request. The Trust also has an Female Genital Mutilation (FGM) Working Group, and staff from the Team will attend ad hoc or time limited groups as required (i.e. re Child Protection Information Standard implementation (CP-IS) which allows the national flagging of children on protection plans). This Annual Report is updated on a biannual basis for the Safeguarding Children's Committee.

The Safeguarding team are working on developing a Safeguarding specific version of 'eG' to be cascaded to all Trust staff, and the Head of Safeguarding is always available as a point of contact for colleagues across the organisation with operational or strategic queries, questions or concerns about Safeguarding practice.

A weekly list is compiled by the Clinical Nurse Specialist for Safeguarding Children of all children who are inpatients at the Trust with whom the Safeguarding Team is currently substantially involved and is circulated to the Chief Nurse and relevant nursing managers, as well as to the Head of Safeguarding and Named Doctor for Safeguarding Children.

An area for future development for the service will be undertaking some work across London to identify best practice, and to gain a better overview of how Safeguarding Teams in different Trusts are structured.

This is a time of significant change in the Trust, and of particular relevance to the Safeguarding Team has been the transfer of a number of community services away from the Trust, alongside a future plan to disinvest from the provision of further community services.

It will be important for the Safeguarding Team to clearly understand these changes as they unfold, to ensure that there is continuity of safeguarding service provision, and the Head of Safeguarding is working closely with strategic and commissioning leads to ensure that this occurs.

It should be noted that the Trust may retain certain Safeguarding duties/obligations in relation to services which we no longer provide; for example if there is a Serious Case Review relating to the provision of Health Visiting services (which transferred out of the Trust in January 2018) the Trust would still need to provide a report to the review panel.

At present the Paediatric Liaison Health Visiting Team are part of the community service provision at the Trust, but work within the acute service, and discussions are ongoing regarding the future of this service which makes an important contribution to the Trust's Safeguarding work.

4. **Referrals and activity**:

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

Month	Number of referrals
April	19
May	46
June	41
July	37
August	25
September	30
October	34
November	25
December	22
January	59
February	54
March	40

Some of the themes that are initiating the referrals from acute services are:

- Children attending A&E following self-harm
- Children admitted to hospital due to safeguarding concerns
- Alcohol / drug abuse
- Children attending following attempted suicide
- Suspected gang related activity
- Attendances requiring referral to mental health

Following a review of referral process the Safeguarding team have now instigated a central secure email to ensure that they receive all copies of referrals that are made to the children's team.

This will act as a useful exercise in mapping levels of activity, establishing patterns of referrals and concerns relevant to partnership safeguarding activity and will enable the Safeguarding Team to quality assure all referrals so we know that information is being shared actively and proportionally with local authority partners. Currently approximately 80% of referrals to local authority children's social care departments originate from the Emergency Department, however we aspire to have much more nuanced and sophisticated data in this area by the time of the next Annual Report. It is notable that whereas in the Emergency Department referrals to the Local Authority may essentially be notifications (i.e. informing them of the nature of the admission and the source of concern following an ED attendance and subsequent discharge) referrals in relation to children or young people who are inpatients or outpatients are likely to be more detailed, and in general the Trust will expect to be part of the Safeguarding plan for as long as the child is a patient and where appropriate, beyond.

The majority of referrals from the Trust are from the Emergency Department, with whom the Safeguarding team holds regular operational meetings, and has an excellent working relationship. It the coming year it will be important to maintain these relationships whilst ensuring that the Safeguarding Team operates as a truly 'Trust wide' service. The team has also contacted local Multiagency Safeguarding Hub (MASH) managers to request that they escalate any concerns they have about poor quality referrals to the Named Nurse for Safeguarding Children.

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

5. **Section 11 duties:**

The Trust has obligations under section 11 of the Children Act 2004 to work with local partners to ensure our functions are discharged having regard to the need to safeguard and promote the welfare of children. The Trust has historically participated in the section 11 exercises convened by Merton and Wandsworth LSCBs in a range of different ways, and in the year ahead we intend to ensure that 'section 11 duties' are complied with in such a way as to closely link to children's outcomes. We will be reviewing our section 11 activity via the Safeguarding Committee and in partnership with colleagues at the two LSCBs of which we are members. In light of the pending changes to LSCBs the form which section 11 activity takes in the future may be subject to change, and the Safeguarding Team will be keen to focus on manageable activity with a clear link to children and young people's outcomes. We are also including section 11 activities as part of our internal audit programme.

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

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

tendency for Serious Case Reviews to cover patients from a wider area than that to which the hospital also provide a District Hospital service.

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

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

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

1.1.2 A Serious Case Review must always be initiated when:

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

1.1.3 Thus cases meeting **either** of these criteria must always trigger a Serious Case Review:

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

The Trust is currently a participant in three serious case reviews, although this figure only relates to cases in which the decision to convene a Serious Case Review has formally been made by the Chair of the relevant Local Safeguarding Children's Board.

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

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

Type B: Reviews relating to patients admitted to the Trust (potentially for considerable periods of time) *following* injuries or abuse sustained prior to admission, which subsequently

become the subject of a Serious Case Review. The Trust is currently involved in two such reviews.

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

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

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

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

7. Training and Staff Knowledge

Across community and acute there are comprehensive training packages in place which are in line with the recommendations of the Safeguarding children and young people Intercollegiate document (March 2014). Staff are assessed on what level of training is required depending on which department they will be working in, however, all staff are required to have Level 1 training. Level 1 training is part of MAST on line and is mandatory for all staff each year, while level 2 children's safeguarding training is available as both face to face sessions and e-learning. As well as core training the team also deliver bespoke training for staff groups as required.

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

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

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

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

Level	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Level 1	89%	87%	90%	91%
Level 2	82%	79%	81%	84%
Level 3	87%	85%	85%	87%

Compliance by division – Level 3 (L3) as of May 2018

Division	No. of compliant Staff	Total no. requiring training	Compliant (%)
Children and Women's Diagnostic and Therapy Services Division	682	808	84%
Community Services Division	74	80	93%
Corporate Division	3	3	100%
Medicine and Cardiovascular Division (ED)	204	240	85%
Research and Development Division	3	4	75%
Surgery & Neurosciences Division	38	38	100%
Overall for the Trust	1004	1173	85.6%

Within the Community division safeguarding children Level 3 is a whole day session (7.5hrs) with key safeguarding priorities for Wandsworth. In addition the community SG named nurse provides half day sessions on FGM, CSE, DV and record keeping for all community practitioners.

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

In the Acute services safeguarding children Level 3 has increased to a whole day session (7.5 hours) and incorporates specialist topics i.e. FGM, Child Sexual Exploitation (CSE) and raising an awareness of PREVENT. The Safeguarding team are currently making arrangements to roll out half day sessions on domestic abuse which will be available for all Trust staff.

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

8. Supervision:

Health professionals are in a good position to identify safeguarding concerns and the needs of individual children. Effective safeguarding supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect on their

decisions and the impact of their decisions on children and their family *(Working Together Safeguard Children March 2015).*

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

The 4 main functions of supervision are;

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

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

9. Partnership Working:

Following the passage of the Children and Social Work Act 2017, the present moment is a significant period of change, at a strategic level, in terms of how partners work together to Safeguard children. Of significance, Local Safeguarding Children's Boards will cease to exist around September 2019, to be replaced by '*Local Safeguarding Arrangements' agreed between the Local Authority, the Police and "Health*". Both our local boards (Wandsworth and Merton) are at different stages in the process of considering what these new arrangements might be. At this moment in time it seems most important to record that it is important that the Trust continues to make an appropriate contribution towards local partnership safeguarding and that the transition to the new arrangements do not cause safeguarding to stall in any way, given the potential for children and young people to be put at risk of harm should this occur.

The Trust is an active participant in both Merton and Wandsworth's Safeguarding Children's Boards. The Trust has been particularly active in the Wandsworth board, which has been important as Wandsworth Children's Services were judged to be 'Inadequate' by Ofsted in an Inspection in November 2015 and the Trust has unsurprisingly wished to make the fullest possible contribution to the improvement of services in Wandsworth. OFSTED have recently re-inspected Wandsworth's Services and a full copy of the inspection report has been made available, rating them as 'Require Improvement'. Merton's Children's services were the subject of an extremely positive inspection in July 2017.

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

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

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

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

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

One area of partnership working which remains a challenge is in respect of Housing, particularly in respect of homeless families or patients who have an additional housing need due to a medical condition or disability. Whilst queries to the Safeguarding team about a child who cannot be discharged, or whose discharge is delayed due to what is in effect a Housing matter are relatively infrequent, when they do occur they are often highly complex and challenging to resolve.

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

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

Head of Safeguarding will continue to monitor the potential impact of these developments at the Safeguarding Boards.

The Safeguarding Team have recently developed closer links between Safeguarding counterparts at Moorfields Eye Hospital who provide a number of services on the St George's site, as there are some areas in which a closer working relationship would be beneficial.

In general, and as would be expected, the Trust has strongly developed partnership working arrangements, and regular contact at a range of levels with both Wandsworth and Merton Councils and Safeguarding Children's Boards

It is notable however that both the Children and Adults Safeguarding Teams are increasingly asked to provide input in relation to a number of patients from a wider range of boroughs, specifically (but not exclusively) Lambeth, Croydon and Surrey; these being areas in which we have fewer current links. Developing more effective operational and strategic links with these boroughs is a priority for the future.

10. Child Protection Medicals:

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

A recent audit demonstrated that the Trust is responding promptly and effectively to requests for medical examinations from the Local Authority (referrals are made by Social Workers as part of a 'section 47 child protection investigation') however it highlighted the need for referrals to be made promptly and efficiently. This important and sensitive area of work will be an important area for continued review.

11. Child Death Overview Panel:

Given the Trust's status as a large teaching hospital, sadly there will always be a significant number of children who are patients at the Trust and sadly pass away following being admitted to the Trust. In the 2017/18 financial year for example 52 children died at the hospital, and overall these children lived in sixteen different local authority areas. Of these 52 deaths, 14 were recorded as unexpected. (i.e. not expected to occur within the 24 hours prior to the death). The staff who support Wandsworth Child Death Overview Panel are based at the Trust, who produce a separate annual report, work closely with the Safeguarding Children's Team at the Trust.

The statutory processes surrounding the review of Child Deaths are currently in a state of change, following the passage of the Children and Social Work Act 2017 and are moving from being a Local Authority led, to a Health led process. It is also likely that CDOPs will move to covering a larger number of local authority areas, and in doing so will review more child deaths (and hopefully thereby have a greater oversight of issues, trends and areas of concern).

12. **Liaison with the Local Authority Designated Officer:**

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

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

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

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

It is of note that the Wandsworth LADO Annual Report for 2017-2018 notes that health professionals (including the Trust) demonstrated greater awareness of the LADO role, and made increased use of the LADO for consultation and advice. The priority in the coming year will be to build on this improvement and develop and extend our own assurance and review mechanisms in this key area.

13. Domestic Violence:

- The Trust employs a Clinical Nurse Specialist for Domestic Violence and Female Genital Mutilation, who works in close partnership with a Senior Independent Domestic Violence Advisor who is an employee of Victim Support based on site at St George's. Both these staff members can be contacted by staff across the Trust, and work either directly with patients who may be experiencing domestic abuse, either during their time in hospital, or after they have been discharged, or provide advice and guidance to staff to support them in patient care in relation to domestic violence.

- The Independent Domestic Abuse Advisor (who is not a Trust employee) is also able to provide advice and support to staff experiencing domestic violence in their personal life.

- There is also a Clinical Midwife Specialist for Domestic Abuse works closely with the team when required.

- The Clinical Nurse Specialist has both an operational and strategic role, and the team are working to ensure that staff across the Trust are aware of the support and expertise the postholder can provide. The postholder is also involved in delivering the Trust's training offer but the team is considering ways of extending this.

- The Clinical Nurse Specialist is also the Trust's MARAC lead (Multiagency Risk Assessment Conference) and takes part in three local MARACs (each London Borough has its own MARAC). As an Acute Trust having contact with a very large number of patients this is a key part of the role, and a significant demand on the Clinical Nurse Specialist's time. [please see below for an explanation of MARAC]

- Each borough MARAC is essentially a multiagency body which is set up with the purpose of increasing the safety, health and well-being of victims/survivors, adults and their children
- Determine whether the alleged perpetrator poses a significant risk to any particular individual or to the general community
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reduce repeat victimisation
- Improve agency accountability, and
- Improve support for staff involved in high-risk domestic abuse cases *(taken from Richmond upon Thames MARAC website, June 2018)*

14. Child Protection Information System (CP-IS)

The Child Protection Information Sharing project (CP-IS) is a national system which is in the process of being rolled out, and is designed to ensure that health staff working in unplanned care settings, such as emergency departments, are notified when a child or young person attends, who is the subject of a child protection plan anywhere in England, or is looked after by any English local authority. In practice, the omission addressed by CP-IS is principally around children and young people who are in the care of their parents or family members, as the looked after status of a child or young person in care attending hospital with a foster carer or children's home employee should always be disclosed as a matter of course, whereas parents or carers of children and young people living in a state of identified risk (and who are subject of a child protection plan) may not always disclose this information and may indeed present to hospitals outside their local area as a deliberate strategy to avoid safeguarding interventions.

Currently St George's receives lists of children from local authorities in our local and neighbouring areas which are manually uploaded. The main St George's site has been 'live' with CP-IS since June 2018, and so clinical IT systems will now notify staff of the existence of a child protection plan *where the local authority holding the plan is also live with CP-IS.* This currently includes most local authorities around London, and many nationally, but does not include our most local local authorities, Merton and Wandsworth. The Trust is in dialogue with both local authorities and NHS Digital around this outstanding issue and the Head of Safeguarding is available as a point of contact for any staff queries about the system.

The walk in centre at Queen Mary's is not yet live with CP-IS and the site management, the Head of Safeguarding and the IT department are working together to bring the site into a state of compliance as soon as possible. As there is a wider plan to launch the Cerner Millennium system at Queen Mary in the next year (this system has more optimal configuration with CP-IS than current systems in use at Queen Mary's) this will be an interim solution.

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

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

15. Female Genital Mutilation (FGM):

The Trust's work in the area of FGM prevention has developed during the course of the year, and the Trust now employs a full time Clinical Specialist Midwife for FGM and Perineal Health, who works in close partnership with the Clinical Nurse Specialist for Domestic Violence and FGM (who leads on FGM issues outside of the maternity department). The NHS and other public bodies have been on a public 'learning journey' in relation to female genital mutilation in recent years and there have been a number of important changes for Acute Trusts to respond to.

The Trust has now implemented the FGM-IS system, led by NHS Digital, which is a Smartcard based system designed to add an indicator to the Health records of a female infant or child with a family history of FGM. The Trust also uses our Enhanced RATE system to record contact with patients with FGM, and, along with all Trusts nationally, share anonymised data with NHS England about the number of patents seen at the Trust who have undergone FGM. Over and above the foregoing, the Safeguarding team also ensures that FGM is treated as a Safeguarding issue where required.

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

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

16. The Prevent Strategy

Prevent (short for 'Preventing Radicalisation' work conducted under the auspices of the Government's counter-terrorism strategy) work at the Trust encompasses both the Children's and Adults team and engagement with the NHS England Regional Prevent Co-ordinator as well as local partnerships.

A key theme of Prevent work in the Trust is seeking to improve uptake of Prevent training, which is a statutory requirement. In May 2018 the Trust launched the Level 3 Prevent Training as an E-learning product, which we anticipate, alongside a communications strategy and engagement with managers, will enable the Trust to meet our 85% compliance target agreed with the CCG by September 2018.

The Head of Safeguarding is the Trust Prevent lead and the contact person for referrals. As there is a general lack of published information regarding the role of Acute Trusts in the Prevent strategy it is important for the Trust Lead to develop and maintain the existing working relationship with NHS England Regional Prevent Lead to ensure that we are up to date with any developments, as well as horizon scanning more generally.

The new online training seeks to ensure that staff are aware that Prevent activity is not exclusive to adherents of any specific religion or ideology, and also highlights the growing

importance of the far-right terrorist threat. The principal reference to the NHS in the Government's updated Counter Terrorism Strategy (Contest: Home Office (June 2018) refers in the main to Mental Health services but Prevent nonetheless remains an important area of the Trust's work.

Prevent Level 1 Training Compliance – Adults 2018/19								
Lead Director	Feb	March	April	May	as of 17/07	2018/2019 Target	Forecast August 2018	Date expected to meet standard
CN	50%	64%	70%	73%	77%	85%		August

Prevent Level 3 Training Compliance – Adults 2018/19								
Lead Director	Feb	March	April	May	As of 17/07	2018/2019 Target	Forecast August 2018	Date expected to meet standard
CN	50%	57%	63%	70%	73%	85%		August

17. The wider picture/contextual safeguarding

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

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

Key risks and challenges for the service at present include:

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

- There is much publicised national and regional increase in serious youth violence, which obviously has a direct impact Trust services, the Safeguarding team and our internal partners such as Redthread

- A number of local authorities with whom we work are experiencing significant issues in relation to the provision of Children's Services (specifically Croydon and Surrey) and there is a potential for considerable impact on the Safeguarding Team at the Trust. More positively Wandsworth Children's services are on an improvement profile and continue to maintain a sizeable team of social workers based at the Trust, which significantly enhances our capacity to responding swiftly and appropriately to Wandsworth Children with a Safeguarding need.

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

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

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

- Work on some recent cases has identified ways in which the Trust could work more proactively and cohesively with partner agencies in respect of children and young people with whom there is an identified and significant safeguarding need. Whilst we are confident that all safeguarding duties have been complied with, review of cases has identified avenues for improved working in the future; for example instance in which information could have been shared on a more proactive basis, or where a comprehensive medical opinion in relation to a specific presentation could have been provided at a somewhat earlier stage. It is highly likely that all agencies working on individual, complex/high profile safeguarding cases could identify areas of improvement in a reflective audit, and it is important that in the Safeguarding team that we set a clear example for accountable and reflective practice in this regard.

19. Conclusion:

In essence the work of the Safeguarding Children' team encompasses four strands, and all areas will need to be considered and addressed in the Service Development Plan, which will need to take into account available resources.

i) Operational safeguarding work; i.e. the provision of advice, active involvement in identified safeguarding cases (ranging for limited to extensive involvement) and the provision of Safeguarding Children's training.

ii) 'Strategic' safeguarding work: developing practice across the Trust to ensure that systems, processes and workplace culture create an environment in which Safeguarding matters can be identified, and when they are identified, effectively addressed. This involves developing

internal and external working relationships, the review of available resources and ensuring that quality assurance mechanisms are agile and fit for purpose.

iii) Quality assurance and reporting: There are a considerable volume of reporting requirements in respect of the Safeguarding Children's team, including CCG and local Safeguarding Children Boards as well as to NHS England (who are sent quarterly figures on priority areas such as FGM and Prevent) and where required the CQC and through internal governance processes within the Trust.

iv) Partnership safeguarding activity: This involves 'formal' Safeguarding Partnerships at Local Safeguarding Children's Boards but also the development and maintenance of effective working relationships between organisations. As identified earlier in the report, the Trust would benefit from developing partnerships or closer working relationships with a wider range of local authorities specifically Lambeth, Surrey and Croydon.

It is hoped that this report gives an indication of the depth and complexity of the work undertaken by the Safeguarding Children's team, and provides assurance that there are appropriate structures and training in place to support high quality safeguarding practice across the Trust.

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

In the coming months we will also be reviewing our internal governance, our relationship and audit structures, including a review of the Safeguarding Children Committee, chaired by the Chief Nurse and Director of Infection Prevention and Control, to ensure that the Committee's work is as effective as possible. As part of this review we will be approaching our CCG colleagues to ensure that our working relationship and reporting structures are as productive and strategic as they can be.

We are also keen to focus partnership working activity, within the available capacity of the team, into activity which has a clear focus on improving outcomes, and which is successful in doing so. The Team take part in a variety of London wide discussions with Safeguarding Children's colleagues in provider Trusts and seeking to capture best practice regionally will be a theme of the year ahead.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 September 2018	**Agenda No**	**3.1**
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 20 September 2018.		
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 – September 2018

1.0 Matters for the Board's Attention

1.1 Estates Report- the Director of Estates & Facilities noted an update on the key areas of Estates. These include:

- Facilities Management- this includes reviewing the Atkinson Morley Wing contract, the latest on the Premises Assurance Model (PAM) Review, and progress on land sale options
- Health & Safety- this includes the latest on health & safety audits across the trust, training courses undertaken, and review of policies.
- Estates- this includes an update on electric fans purchased for the summer heatwave, progress on winter planning and the latest on the water safety plan.
- Capital Projects- this identifies latest progress on the projects for Lanesborough Wing Generators, Moorfields theatres, Dental Simulation and the Pharmacy robot.

The Director of Estates & Facilities noted that progress on the land sale at the Doddington Health Centre was subject to discussions with commissioning colleagues.

1.2 Emergency Care Update- the Deputy COO updated on the latest A&E performance data and trajectories for quarter 2. She also noted the changes made and planned in head of nursing and clinical director roles, and the extra presence of senior members of the Emergency Department and General Medicine areas on the 'shopfloor' to support breach avoidance.

Committee members agreed that the extra senior support for the department was a time-limited solution as they would be taken away from their existing job plan. This linked to a broader cultural issue within the Trust.

1.3 Elective & Daycase update- the Director of Delivery, Efficiency & Transformation informed the committee on the plans to recover Elective activity and income. He noted the changes in approach to elective activity governance, following the reduction in elective income in July. Some of the changes implemented included:

- Increasing the number of patients booked for the following six weeks
- Booking targets per specialty
- Enhanced daily/weekly monitoring groups

Committee members noted the improvements in approach, although the trust remains behind plan.

1.4 Financial Position & forecast at M5- the Deputy CFO noted the £2.4m adverse variance in August and £4.1m to date. He noted the challenge to delivering the financial plan, reliant on mitigation in the following areas:

- Theatre productivity
- Ward Nursing, Consultants & Junior Doctor controls
- Additional CIP
- Discretionary expenditure

The committee reflected on the position to date, and observed that the year-end plan is achievable but challenging. The Deputy CFO noted that the finance department would focus on a bottom up forecast in the coming weeks, which would include a clear understanding of the impact of the Cardiac Surgery situation.

1.5 Cash Management- the Director of Financial Operations noted the cash position as in-balance at the end of month 5, which is a combination of reduced payments, reduced receipts and reduced borrowing. Borrowings are expected to increase to planned levels in the coming months.

The committee noted the progress on historic debt collection and observed the positive performance in cash management at present.

1.6 Financial Planning 2019/20- the Director of Financial Planning noted the timelines to commence the planning process for 2019/20, while national guidance is awaited. The Director of Strategy noted the link to the Trust Corporate Objectives and the approach of meeting with services to agree specialty plans and activity projections.

The committee noted the importance of engaging in lessons learnt from the previous planning round, and noted the good progress to date in constructing the plan.

1.7 NHS England Specialist Services tender- the committee was updated on the retendering of the NHSE service portfolio for the trust of c£230m (the current contract excluding pass-through drugs and devices).

The committee agreed that the tender submission would be made by the trust to provide these services in the future.

1.8 Genomics Tender - the committee was updated on the Genomics tender process, where the laboratory service would have been decommissioned on 1st October. This has recently been confirmed as delayed for 6 months as no funding or contract is in place.

The committee observed the excellent work done by the Genomics department in challenging circumstances, and agreed that the service should continue as no agreement is in place.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 20 September 2018 for information and assurance.

Ann Beasley
Finance and Investment Chair, Trust Chairman
September 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**27th September 2018**	**Agenda No.**	**3.2**
Report Title:	**M05 Finance Report**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Michael Armour & Tom Shearer		
Presented for:	Update		
Executive Summary:	Overall the Trust is reporting a deficit to date of £20.5m at the end of Month 05 (August), which is £4.1m adverse to plan. Within the position, income is adverse to plan by £2.8m, and expenditure is overspent by £1.3m.		
Recommendation:	The Trust Board notes the trust's financial performance to date in August.		
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:	The Finance & Investment Committee	Date	20/09/18
Appendices:	N/A		

Financial Report Month 5 (August 2018)

Chief Finance Officer

27th September 2018

Executive Summary – Month 5 (August)

St George's University Hospitals NHS
NHS Foundation Trust

Note: All figures and commentary in this report refer to the revised Trust plan submitted to NHS Improvement on 20th June.

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £20.5m at the end of August, which is £4.1m adverse to plan. **The position includes £1.7m of Q2 PSF income, of which £1.2m is dependent on the Trust negating the £4.1m financial variance by the end of Q2 (next month).** Within the position, income is adverse to plan by £2.8m, and expenditure is overspent by £1.3m. There also remains an element of income estimation in the position which will need to be validated ahead of freeze dates.	£4.1m Adv to plan	£1.7m Adv to plan
Income	Income is reported at £2.8m adverse to plan year to date. Elective is the main area of lower than planned performance; with shortfalls in volume being offset by pricing gains in other areas. Non-SLA income is also adverse to plan, with shortfalls in commercial Pharmacy partially offset by underspends in drugs, and SWLP income fully offset by reduced Non Pay cost. There is also a shortfall in private patients income.	£2.8m Adv to plan	£2.4m Adv to plan
Expenditure	Expenditure is £1.3m adverse to plan year to date in July. This is caused by Non Pay adverse variance of £2.0m (although a large proportion of this is offset in Income as pass-through is over-performing). Unfilled vacancies are leading to the favourable variance in pay, and CIP under delivery is causing most of the remaining adverse variance in non-pay.	£1.3m Adv to plan	£0.6m Fav to plan
CIP	The Trust planned to deliver £14.3m of CIPs by the end of August. To date, £12.9m of CIPs have been delivered; which is £1.3m behind plan. Income actions of £4.1m and Expenditure reductions of £8.8m have impacted on the position.	£1.3m Adv to plan	£0.9m Adv to plan
Capital	Capital expenditure of £12.1m has been incurred year to date. This is £1.9m below plan YTD. The position is reported against the internally financed plan of £18.5m. This does not include DH capital loans (to be secured) of £29.65m.	£1.9m Fav to plan	£2.3m Fav to plan
Cash	At the end of Month 5, the Trust's cash balance was £3.3m, which is better than plan by £0.3m. The Trust has borrowed £17.3m YTD which is £2.2m less than plan. As reported last month the Trust did not request a loan drawdown for August but has a confirmed loan draw down of £3.2m for September and has requested £0.75m for October. If approved the October drawdown will maintain cumulative borrowings to M07 in line with plan. The borrowings drawn this year are subject to an interest rate 3.5%.	£0.3m Fav to plan	£4.8m Fav to plan
Use of Resources (UOR)	The Regulators Financial Risk Rating. At the end of August, the Trust's UOR score was 4 as per plan. This has been rated Amber even though it is on plan due to the adverse level of the score.	Overall score 4	Overall score 4

Contents

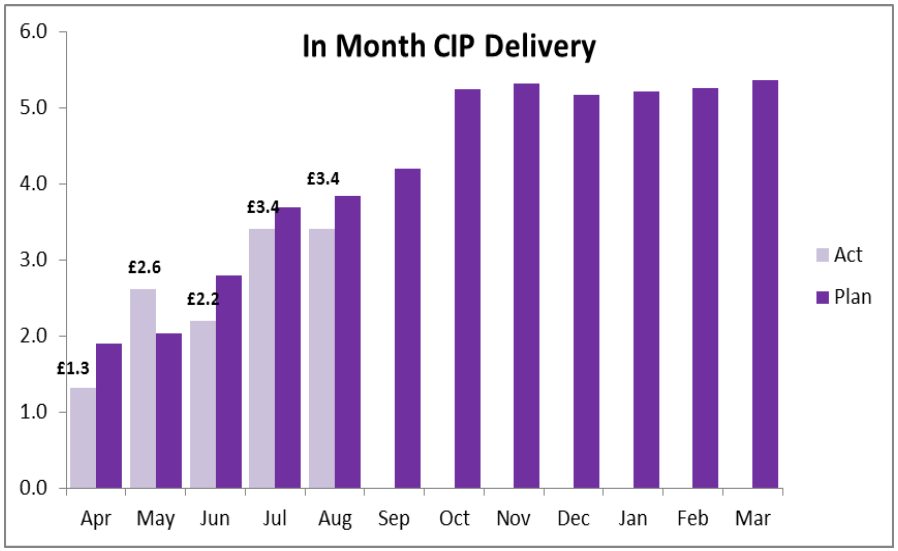
1. Month 5 Financial Performance

			Full Year Budget (£m)	M5 Budget (£m)	M5 Actual (£m)	M5 Variance (£m)	M5 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF	**Income**	SLA Income	666.3	53.6	53.6	0.0	0.0%	272.9	270.8	(2.1)	(0.8%)
		Other Income	156.0	15.1	14.7	(0.4)	(2.6%)	67.1	66.5	(0.7)	(1.0%)
	Income Total		**822.3**	**68.7**	**68.3**	**(0.4)**	**(0.5%)**	**340.0**	**337.2**	**(2.8)**	**(0.8%)**
	Expenditure	Pay	(509.7)	(42.9)	(43.2)	(0.4)	(0.9%)	(215.8)	(215.3)	0.5	0.2%
		Non Pay	(307.6)	(25.7)	(27.4)	(1.7)	(6.7%)	(130.3)	(132.3)	(2.0)	(1.5%)
	Expenditure Total		**(817.3)**	**(68.5)**	**(70.6)**	**(2.1)**	**(3.1%)**	**(346.1)**	**(347.6)**	**(1.5)**	**(0.4%)**
	Post Ebitda		(34.0)	(2.8)	(2.8)	0.0	1.2%	(13.9)	(13.7)	0.2	1.2%
Pre-PSF Total			**(29.0)**	**(2.7)**	**(5.1)**	**(2.4)**	**(90.5%)**	**(19.9)**	**(24.0)**	**(4.1)**	**(20.6%)**
PSF			12.6	0.8	0.8	0.0	0.0 %	3.6	3.6	0.0	0.0 %
Grand Total			**(16.4)**	**(1.9)**	**(4.3)**	**(2.4)**	**(131.5%)**	**(16.4)**	**(20.5)**	**(4.1)**	**(25.1%)**

Trust Overview

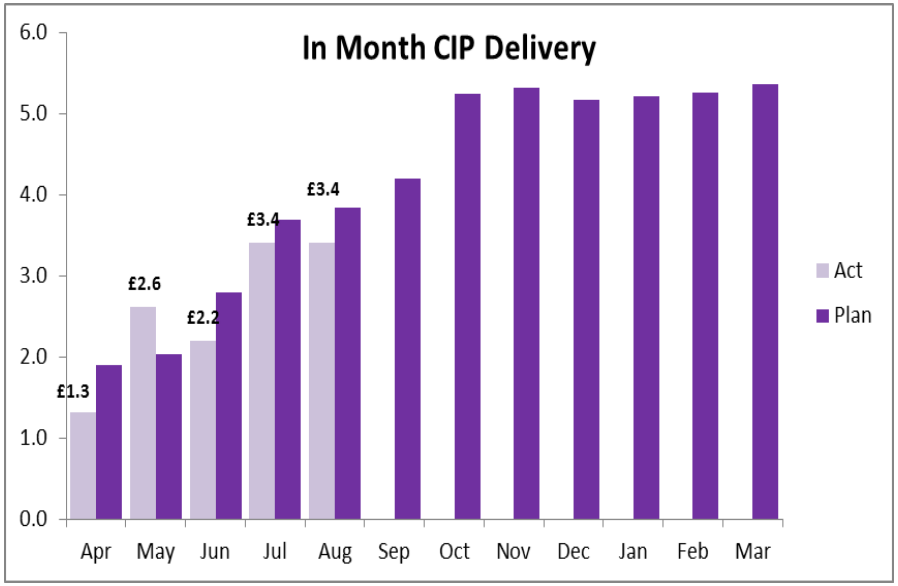
- Overall the Trust is reporting a deficit of £20.5m at the end of Month 5, which is £4.1m behind plan.
- **SLA Income** is £2.1m under plan. The main area of note is Elective where a material adverse variance (£3m) which is driven by lower than planned volume. Although in-month it is on plan, approximately £1.3m of favourable variance is owing to pass-through income.
- **Other income** is £0.7m, which is primarily Commercial Pharmacy income shortfall. This is partially offset by reduced Non-Pay expenditure.
- **Pay** is under plan by £0.5m. All major staff groups are under spending with the exception of medical pay. It should be noted that within staff groups there are areas of over as well as under spending.
- **Non-pay** is £2.0m overspent, with an in-month adverse variance of £1.7m caused mainly by pass-through income. Additional pressure is due to costs associated with Cardiac Surgery issues, and increased electricity spend due to the warm summer months.
- **PSF Income** is on plan, as the Trust has met the pre-PSF control total target and the A&E target for Q1 and are expecting to meet these in Q2. The NHSI assessment of Q2 performance is made for M6 reporting, so does not take into account the adverse variance against control total in July. Financial performance makes up 70% of PSF contribution, A&E the remaining 30%. **The value of PSF income reported in M4 & M5 is £1.7m, with £1.2m of this dependant on recovering position against plan for Q2.**
- **CIP delivery** of £12.9m is £1.3m behind plan. The Clinical Divisions' shortfalls have been partially offset by Overheads and Central schemes. Delivery to plan is:
  - Pay £0.1m adverse
  - Non-pay £0.5m adverse
  - Income £0.7m adverse

2. Month 5 CIP Performance



CIP Delivery Overview

- At the end of Month 5, the Trust is reporting delivery of £12.9m of savings /additional income through its Cost Improvement Programme.
- This is against an external plan for to have delivered £14.3m of savings/ additional income by Month 5 (overall delivery is adverse of plan by £1.3m).
- The adverse year to date variance is driven by the under delivery of savings/income improvements within the Clinical Divisions, against their CIP plans, for example:
  - Continued adverse performance against elective income SLA targets has restricted some specialties ability to generate benefit from productivity related CIP plans
  - On-going challenges within Critical Care to flex staffing rotas in order to meet demand, which is driven by fluctuating levels of bed occupancy



Year End Forecast & Actions

- Under a 'do nothing' scenario current divisional forecasts indicate that £47.9m of improvements will be delivered by 31st March 2019; resulting in a £2.1m shortfall against the Trust's £50m CIP Target.
- The impact of the current CIP forecast shortfall and additional material CIP risks (e.g. Clinical Divisions not achieving current CIP forecasts and challenges relating to the devolvement of central income and procurement schemes) will be managed through a range of recovery actions (the CIP Recovery Plan).
- The net impact of these actions, when assessed for their likelihood, should enable the Trust to deliver a total of £50m CIPs in year. Details are provided in the full Month 5 CIP Update Report.
- In addition to the CIP Recovery Plan, stretch targets have been set for Income recovery and Pay savings. These form part of the Trust's overall financial recovery plan to support delivery of its financial control total.

3. Balance Sheet as at Month 5

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**377.2**	**380.8**	**379.7**	**1.1**
Stock	**6.4**	6.0	7.3	-1.3
Debtors	**112.3**	107.8	107.7	0.1
Cash	**3.5**	3.0	3.3	-0.3
Creditors	**-118.4**	-124.5	-130.1	5.6
Capital creditors	**-15.4**	-4.6	-7.0	2.4
PDC div creditor	**0.0**	-0.3	-0.3	0.0
Int payable creditor	**-0.7**	-2.6	-2.5	-0.1
Provisions< 1 year	**-0.2**	-0.2	-0.2	0.0
Borrowings< 1 year	**-57.7**	-58.3	-57.7	-0.6
Net current assets/-liabilities	**-70.2**	**-73.7**	**-79.5**	**5.8**
Provisions> 1 year	**-1.0**	-0.8	-0.9	0.1
Borrowings> 1 year	**-241.6**	-258.9	-256.0	-2.9
Long-term liabilities	**-242.6**	**-259.7**	**-256.9**	**-2.8**
Net assets	**64.4**	**47.4**	**43.3**	**4.1**
Taxpayer's equity				
Public Dividend Capital	**133.2**	133.2	133.2	0.0
Retained Earnings	**-167.9**	-184.9	-189.0	4.1
Revaluation Reserve	**97.9**	97.9	97.9	0.0
Other reserves	**1.2**	1.2	1.2	0.0
Total taxpayer's equity	**64.4**	**47.4**	**43.3**	**4.1**

M01-M5 YTD Balance Sheet movement

- Fixed assets are £1.1m lower than plan due to lower capital spend than plan.
- Stock reduced in month by £0.3m but remains £1.3m higher than plan due mainly to increase in Pharmacy stock. In advance of a new pharmacy robot being commissioned in August, stock levels were increased to reduce risk to supply. The new robot will be fully functional in August at which point pharmacy stock levels should start to reduce.
- Overall debtors are £0.1m lower than plan.
- Creditors are £5.6m higher than plan relating mainly to the rescheduling of the payment of NHSPS rental charges. The Q1 charges will be paid in September.
- The cash position is £0.3m better than plan due to the temporary benefit of the deferral of CNST premiums and also late invoicing by NHS Property Services.
- The Trust has borrowed £17.3m YTD for deficit financing which is £2.2m less than plan. The Trust will drawdown £3.2m for September and has requested a £0.75m for October to support deficit funding. This will maintain borrowing in line with the plan. The deficit financing borrowings are subject to an interest rate 3.5%. Also borrowings for new finance leases are lower than plan.
- The Trust has not drawn down any capital loans to date. A capital bid for approx £27.9m was submitted to NHSI at the end of August.

4. Month 5 YTD Analysis of Cash Movement

	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Cash balance 01.04.18	**3.5**	**3.5**	**0.0**
Income and expenditure deficit	-16.9	-21.0	-4.1
Depreciation	9.8	9.8	0.0
Interest payable	4.4	4.3	-0.1
PDC dividend	0.3	0.3	0.0
Other non-cash items	-0.1	-0.1	0.0
Operating deficit	**-2.5**	**-6.7**	**-4.2**
Change in stock	0.4	-0.9	-1.3
Change in debtors	6.4	4.6	-1.8
Change in creditors	4.1	11.6	7.5
Net change in working capital	**10.9**	**15.3**	**4.4**
Capital spend (excl leases)	-22.6	-20.3	2.3
Interest paid	-2.6	-2.6	0.0
PDC dividend paid	0.0	0.0	0.0
Other	-0.2	0.0	0.2
Investing activities	**-25.4**	**-22.9**	**2.5**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	19.5	17.3	-2.2
Capital loans	0.0	0.0	0.0
Loan/finance lease repayments	-3.0	-3.2	-0.2
Cash balance 31.08.18	**3.0**	**3.3**	**0.3**

M01-M5 YTD cash movement

- The cumulative M5 I&E deficit is £21m, £4.1m adverse to plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £21.0m, depreciation (£9.8m) does not impact cash. The charges for interest payable (£4.3m) and PDC dividend (£0.3m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £6.7m.
- The operating deficit variance from plan of £4.2m in cash is due to timing of creditor payments primarily for the CNST premiums and other NHS bodies.
- Working capital is better than plan by £4.4m.
- The Trust has borrowed £17.3m YTD which is £2.2m less than plan. The Trust did not draw down in August but has a drawdown for September of £3.2m and requested £0.75m for October. This will be in line with the cumulative YTD plan. The borrowings are subject to an interest rate of 6% for the amounts drawn up to October 17 and 3.5% for the amounts drawn since November 17.

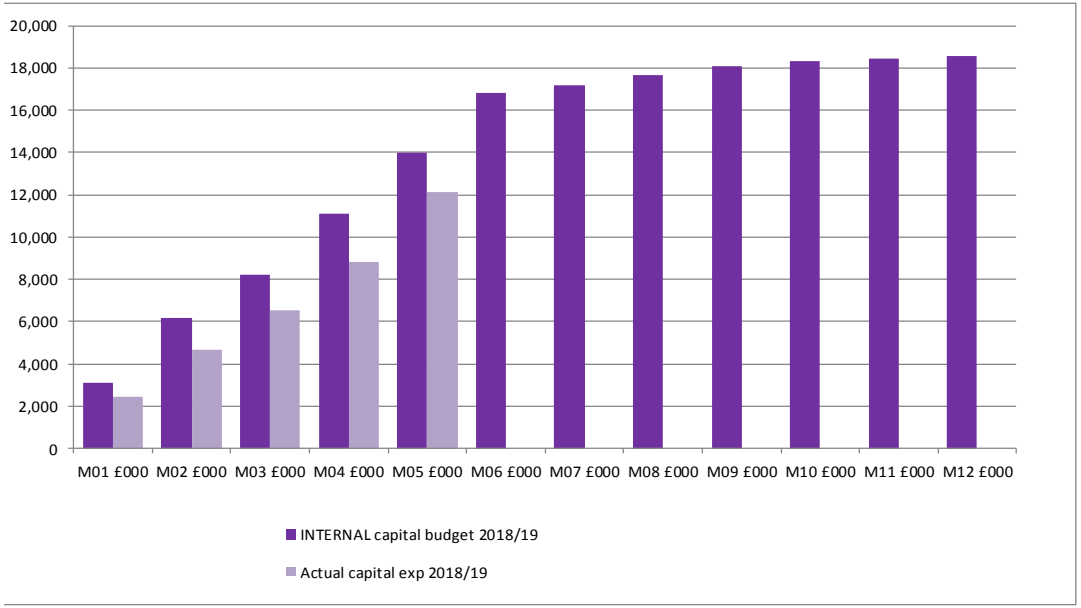
August cash position

- The Trust achieved a cash balance of £3.3m on 31 August 2018, £0.3m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 17 week cash flow submitted last month. The Trust continues to benefit from the agreed deferral of CNST premiums and also from late invoicing of material rental charges from NHSPS. **The Trust will remain dependent on monthly borrowing from DH given the continuing I&E deficit.**

5. Capital Spend against the £18.5m internal budget

Spend category	Internal Budget £000	M05 YTD budget £000	M05 YTD exp £000	M05 YTD var £000
Infrastructure renewal	**5,732**	**4,279**	3,725	554
IT	**3,015**	**2,637**	2,730	-93
Medical equipment	**1,890**	**1,134**	789	345
Major projects	**5,756**	**4,340**	3,451	889
Other	**888**	**520**	475	45
SWLP	**545**	**457**	100	357
Urgent £11.8m March 2018 projects	**711**	**644**	866	-222
Total	**18,538**	**14,011**	12,136	1,875

INTERNAL capital budget 2018/19 (excl bid - not approved) and YTD exp



- The Trust's internally funded capital expenditure budget for 2018/19 is £18.5m
- The Trust has incurred capital expenditure of £12.1m in the first four months of the year against the YTD internal capital budget of £14m
- The main component of the year to date under spend relates to the biggest project – the Lanesborough wing stand-by generators project (Infra Renewal category) which is under spent by £0.6m as at M05. The project is behind schedule but is forecast to come within budget and so the M05 YTD underspend represent a temporary timing difference.
- Within the Major Projects category the Dental lab is £0.3m under spent (slippage). The medical equipment under spend relates to a short delay in the replacement of existing leased equipment.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M5 YTD)	Actual (M5 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	3
Agency rating	1	1

Basis of the scoring mechanism

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of August, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. The internal Trust cap is lower than the external cap of £21.3m.
- The distance from plan score is worked out as the actual % I&E deficit (6.00%) minus planned % I&E deficit (4.80%). This value is -1.20% which generates a score of 3.
- Distance from plan score in this report refers to the Trust plan submitted to NHS Improvement on 20th June.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	27th September 2018	**Agenda No**	**4.1**
Report Title:	A Framework of Quality Assurance for ROs and Revalidation – Annual Report to the Trust Board.		
Lead Director/ Manager:	Professor Andrew Rhodes, Medical Director		
Report Authors:	Ms. Karen Daly, Responsible Officer and Associate Medical Director Claire Low, Medical HR Manager, Nicola McDonald, Revalidation Support Officer		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Approval		
Executive Summary:	As a Designated Body, St George's University Hospitals NHS Foundation Trust and its Responsible Officer (RO) have statutory responsibilities that are monitored by NHS England. These responsibilities include the oversight of annual appraisal of the medical employees of the trust and the monitoring of their fitness to practice. This report contains the "Framework of QA for ROs", a statutory NHSE document which informs the Trust Board and supports the Statement of Compliance which requires signing and returning to NHSE. **Key messages** In April 2018 medical revalidation entered its sixth year. Following the phased implementation of revalidation submissions across England (20% doctors in year 1 and 40% each in year 2 and 3), the majority of licensed doctors should have been revalidated by March 2016 and are beginning to be revalidated for the second time. Several areas of our medical appraisal and revalidation process have been identified as needing to be tightened up in order to ensure that the medical personnel are fit to practice at our institution. This paper describes some of those areas.		
Recommendations:	The Trust Board is asked to approve the attached "Framework for Quality Assurance for Responsible Officers" in order that the CEO may sign the attached statement of compliance for return to NHSE. The Board will be asked to accept this standardised annual report, which follows an annual audit submitted to NHS England in May 2018, covering the period 1 April 2017 to 31 March 2018. The Board will be asked to approve the "Statement of Compliance" confirming that St George's University Hospitals NHS Foundation Trust is in compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).		

Supports			
Trust Strategic Objective:	1. Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. 2. Refresh the Trust's strategy, to develop a sustainable service model with a clear and consistent message. 3. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safety, Effectiveness, Responsive, Caring and Well Led		
Single Oversight Framework Theme:	Medical workforce support and development		
Implications			
Risk:	Failure to develop our current systems will contribute to poor medical engagement and failure to retain medical staff. There will be limited alignment of medical staff development with Trust strategy and objectives.		
Legal/Regulatory:	If we do not improve our appraisal systems there is a risk that recommendations to GMC for revalidation are not robust and we will also invite scrutiny from NHSE. This leaves the trust open to regulatory challenge and potential legal challenge.		
Resources:	The paper describes a number of areas where additional resources may be required in future. These will be requested through the standard trust processes.		
Previously Considered by:	Workforce and Education Committee	**Date**	09/08/2018
Equality Impact Assessment:	N/A		
Appendices:	• AOA Comparator • Statement of compliance		

A Framework of Quality Assurance for ROs and Revalidation – Annual Report to the Board.

1.0 PURPOSE

1.1 Each year every designated body (DB) is required to submit a standard annual organisation audit (AOA) to NHS England for comparison against responses from designated bodies of a similar type, as well as all designated bodies in England. The AOA forms part of the Framework of Quality Assurance (FQA), to the Higher Level Responsible Officer (NHS England London) and the overarching programme of quality assurance of the systems and processes underpinning medical revalidation

1.2 As a Designated Body, St George's University Hospitals NHS Foundation Trust and its Responsible Officer (RO) have statutory responsibilities that are monitored by NHS England. The purpose of this paper is to satisfy the Board that the Trust works within a Framework of Quality Assurance and to confirm to NHS England that the Trust is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and confirm by submitting a signed Statement of Compliance.

2.0 BACKGROUND

2.1 Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

2.2 Medical Revalidation is a process, not a single event. By providing specific types of supporting information at each annual appraisal over the revalidation cycle, each doctor should, through reflection and discussion at appraisal, have demonstrated their practice against all 12 attributes outlined in the GMC's separate guidance, *Good medical practice Framework for appraisal and revalidation*.

3.0 GOVERNANCE ARRANGEMENTS

3.1 Every licensed doctor is responsible for updating the GMC with their DB details via their GMC online account. Each DB can then view who has connected to their organisation via the GMC revalidation portal "GMC Connect", and view each doctor's revalidation history and revalidation submission date to maintain internal appraisal and revalidation databases.

The Revalidation Support Officer (RSO) reviews these connections monthly. The RO submits revalidation recommendations via this portal.

3.2 **The Trust has purchased an electronic Revalidation Management System (RMS), which will routinely send doctors reminders of when their appraisal is due, manually updates records and databases and manually produces data reports for appraisal and revalidation. From November onwards all Doctors due appraisal will use the new system and all previous appraisals and other relevant documentation will be uploaded by the end of Q3 of 18/19.**

4.0 MEDICAL APPRAISAL

4.1 *Appraisal and Revalidation Performance Data*

4.11 At present the RSO maintains an appraisal and revalidation spread sheet of all licensed doctors who have connections to SGH and therefore SGH is responsible for supporting their appraisal. This spread sheet, used in conjunction with the Medical Appraisal Guide (MAG) form, provides the overview of the medical revalidation process. The RSO saves each appraisal that is received by email, updates the doctor's Electronic Staff Record (ESR) and updates the spread sheet.

4.12 Using the appraisal and revalidation spread sheet, each month the RSO produces a report of who is due/overdue an appraisal in order to send reminders to doctors and to produce a report of who is overdue to circulate to Clinical Leads to manage. The RSO records reasons for delayed/missed appraisals and escalates to the RO and Medical Director as appropriate. Any early concerns of non-engagement i.e. outside of 4-week revalidation notice period is escalated to the GMC.

4.13 The RSO manually compiles data for the quarterly appraisal reports and the annual organisational audit for NHS England.

4.14 The Medical Appraisal Annual Organizational Audit (AOA) submitted to NHS England for 2017/2018 recorded 857 doctors with a prescribed connection to St George's University Hospitals NHS Foundation Trust NHS Trust (SGH) as of 31st March 2018. The AOA recorded the appraisal compliance for all doctors with a prescribed connection as 75.6%. **Compliance has decreased since the 2016/2017 AOA (82.2%) which had previously shown compliance had increased year on year (81.5% in 2015/2016 and 62.7% in 2014/2015). It is the view of the RO that this is multifactorial. Factors may include increasing numbers (+40) of Trust Doctors many of who are new**

to the UK and not familiar with the requirement for appraisal, increased pressure on medical staff to deliver on performance targets over the last year and a low prioritisation of appraisal over clinical demand and a lack of capacity for the RSO to send reminders and updates owing to increasing numbers of Doctors needing revalidation and other commitments during this past year.

4.2 *Appraisers*

4.21 The Trust currently has a pool of 172 trained medical appraisers which means we are within the national guidelines of between 1:5 and 1:20 per connected doctor. The Trust delivered two new appraiser workshops in 2016 and one in February 2018. All existing appraisers have completed refresher training via e-learning modules. It is anticipated that we will continue to run one new appraiser workshop per year, and make refresher e-learning mandatory on a 3-yearly basis.

4.3 Quality Assurance

4.31 The current process for quality assuring appraisals is limited to the time of Revalidation. A selection of individual appraisal files is reviewed by the RO prior to a revalidation recommendation being submitted to the GMC. The RO completes a revalidation checklist for each recommendation that is made. This provides assurance that:

- The appraisal “inputs” provided are available and appropriate.
- The appraisal “outputs” i.e. agreed personal development plan (PDP), appraisal summary and output statements are complete and to an appropriate standard
- Key items identified within the appraisal “inputs” as needing discussion during the appraisal are included in the appraisal “outputs”

4.4 Access, Security and Confidentiality

4.41 Doctors use the Medical Appraisal Guide (MAG) form for their annual appraisal. The instructions within the MAG remind Doctors to take care to abide by local confidentiality, data security and information governance protocols to remove all personally identifiable data. Once the MAG is agreed by appraiser and appraise, it is sent to the RSO to keep on file and is only shared with the RO and others as appropriate.

4.5 Clinical Governance

4.51 The RSO checks DATIX and provides information about logged complaints within the appraisal period to each individual doctor prior to their appraisal. Confirmation is sent to individuals that they have/have not been named in any complaints. This ensures appropriate reflection where applicable.

4.52 Doctors are asked to obtain information on complaints from other organisations they work in, to ensure appropriate reflection in their appraisal where applicable but we do not routinely approach other organisations for assurance prior to appraisal.

4.53 Transfer of information requests are sent to other organisations in which individuals work, prior to revalidation, to confirm they have no fitness to practice concerns.

4.54 Transfer of information may be sent to the RO or person with clinical governance responsibility, for any other organisations in which a doctor works, to notify any fitness to practice concerns. These are logged against the Doctors appraisal to ensure inclusion in the next appraisal.

4.55 DATIX is checked for a record of SUI/Adverse events and these are notified to the Doctor ahead of appraisal.

4.56 Incidents notified to the RO are sent to the RSO for logging and inclusion in the next appraisal.

5. REVALIDATION RECOMMENDATIONS

The number of revalidation recommendations between April 2017 and March 2018 totalled 64.

- 60 Recommendations were submitted on time.
- Two recommendations were submitted late due to the doctors not updating their designated body details until after the submission date
- Two recommendations were submitted late due to administration error (revalidation at a weekend)
    - The number of recommendations to revalidate totalled 28.
    - The number of recommendations to defer totalled 36.
    - There were no recommendations of Non-Engagement.

6. RESPONDING TO CONCERNS AND REMEDIATION

6.1 Medical Staff at St George's are managed under the Maintaining High Professional Standards policy. This is the disciplinary policy for Medical and Dental Staff. In addition to this policy, there is a monthly meeting attended by the Medical Director, the Deputy Director of HR, Associate Medical Director (HR), Medical HR Manager and Divisional HR Manager (where appropriate) whereby current or possible formal cases are monitored to ensure sufficient progress. The RO meets regularly with Liaison Officers from the GMC and PPAS.

7. RISK and ISSUES

7.1 Key Findings from the AOA

The 2017 AOA comparator showed SGH as an outlier in certain areas. There have been improvements this year in some of those areas.

7.11 The Designated Body and the Responsible Officer

RO has sufficient funds, capacity etc. to carry out responsibilities of the role

In 2017, SGH response to this statement was "No" compared to 93.9% of DBs who answered "yes". This year we were able to answer "yes". The RO now has more time in her job plan and we are in the final stages of implementing an e-appraisal system. The RO is recruiting 3 appraisal leads who will have an important role in QA.

DB has commissioned/undertaken an independent review of its processes

In 2017 SGH response to this statement was "No" compared to 80.8% of DBs in the same sector who answered "yes". This year we were able to answer "yes" as an internal audit was carried out in April 2018.

7.12 Section 2 - Appraisal

Every doctor has an explanation record for missed appraisal

A formal explanation for every doctor is not recorded; however, a note is made where an explanation is given. The current process is to circulate a monthly audit of overdue appraisals to Clinical Leads; however, it is only when a doctor is 3 months overdue that a formal explanation would be required by the RO.

Quality assuring a sample of inputs and outputs

Quality assurance is currently only provided by the RO and RSO reviewing the available data. There is no process embedded into our system to provide external quality assurance of this methodology.

Appraisers are supported in their role
Appraisers are suitably trained; however, there is currently no mechanism for monitoring and managing the performance of appraisers including appraisal calibration events and feedback from doctors on their appraisers.

7.13 Section 3 – Monitoring Performance
Monitoring fitness to practise of doctors
In 2017 SGH response to this statement was “No” compared to 96% of DBs in the same sector who answered “yes”. This answer arose from the observations of the RO of the functioning of the existing processes in the Trust and discussion with the responsible officers of other Trusts and the NHSE and NHSI representatives. This year we were able to answer “yes” due to the fact that complaints and significant events are now linked to individuals’ names on the DATIX system. This gives the RSO an ability to provide a report to the Doctor ahead of appraisal and provides a mechanism for the RO to triangulate information from different sources and potential “early warning’ of fitness to practise issues.

7.2 Additional findings

7.21 Policy and Guidance

- There is inconsistent ownership of the process of appraisal by Clinical Leads.
- There is no clear process for allocation of appraiser to doctor
- There is a lack of understanding by individual doctors and Clinical Leads of what is deemed an acceptable reason for delaying/missing an appraisal.
- There is no clear escalation process set out for doctors who do not engage in annual appraisal.
- Although significantly improved from previous years, some individual doctors and Clinical Leads remain unclear on the appraisal process for non-training non-Consultant grade doctors, particularly when they have come out of/going into training.

7.22 Appraisal and Revalidation Performance Data
The RSO currently uses an Excel spread-sheet to record completed appraisals. This makes it extremely difficult to produce data on appraisal and revalidation for the Trust and the quarterly and annual audits that NHS England requires. We are at the implementation phase of a Revalidation management system. When installed and fully functioning this will automate

reminders and reporting and act as a repository for appraisal inputs. This will improve accuracy and timeliness of reports.

7.3 Quality Assurance

7.31 The Trust needs to improve the quality of medical appraisal to comply with national regulations for medical appraisal and revalidation, including the statutory duty of the Trust as a Designated Body and of the RO to make recommendations to the GMC about a doctor's revalidation status.

7.32 Quality assessment of appraisal inputs (supporting information and reflection provided by Doctor) and outputs (agreed PDP, appraisal summary and statements provided by appraiser) only takes place shortly before revalidation when the RO reviews the portfolio. This is time consuming and not sustainable now that there are several years to review.

7.33 There is no mechanism for monitoring and managing the performance of appraisers.

7.4 Clinical Governance

Triangulation of the information held by the risk, governance and complaints bodies need to take place.

8.0 NEXT STEPS

8.1 The Medical Appraisal Policy review has been put on hold pending the introduction of the new Revalidation management system. The updated policy will clarify who is responsible for what and who they are accountable to. It will also outline processes and associated timescales for having an appraisal, requesting a postponement of appraisal and escalating early concerns of non-engagement. From this, the RO can begin to implement a quality assurance process to improve both inputs and outputs of the appraisal.

8.2 The RO is working with the clinical divisions to appoint three senior appraisal leads who will assist the RO in the appraisal process and provide leadership and support to the Trust appraisers. This team will work together to develop a quality assurance process for the revalidation and appraisal mechanisms.

8.3 An Appraisal and Revalidation advisory group has been set up to triangulate data to support the RO with making recommendations. It will also identify ways to improve the quality of appraisal inputs and the information that the

trust provides for individual doctors. It will improve the efficiency and robustness of revalidation recommendations.

9.0 RECOMMENDATIONS

9.1 The Board are asked to accept this annual report and audit. This report will be shared with NHS England along with the quarterly information reports and annual audit.

9.2 The Board are asked to approve the “statement of compliance” confirming that St George’s University Hospitals NHS Foundation Trust, as a designated body is in compliance with the Revalidation regulations.

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27 July 2018

Our Ref: 896

Publications Gateway Reference 08225

Ms Karen Daly
Responsible Officer
St George's University Hospital NHS Foundation Trust

Dear Ms Daly

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for: 896 - St George's University Hospital NHS Foundation Trust

I am writing to thank you for submitting a return to the NHS England 17/18 Annual Organisational Audit (AOA) exercise.

Please find enclosed a report setting out your response to the exercise. The report also compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The AOA exercise is designed to help designated bodies assure themselves and their boards (or equivalent management bodies) that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, and the arrangements for medical appraisal and responding to concerns, are in place and are effective. It also provides a mechanism to assure NHS England that the processes supporting medical revalidation have been implemented and work properly.

In this fifth year of the AOA, and the ninth consecutive year of monitoring medical revalidation, I am pleased to report a continuing upward trend, not only in the overall appraisal rate, but also an improvement of the system in general. This is extremely reassuring and I would like to thank you once again for your continued work to ensure that thorough revalidation and clinical governance processes are in place across the healthcare system.

On reviewing the results presented below, designated bodies should produce an action plan to address any development needs that are identified. If you need support in improving any element of your revalidation systems, your local revalidation team (contact details below) can help you.

Your higher level responsible officer	Dr Vin Diwakar
Your local revalidation team's lead contact	Ray Field
Your local revalidation team's contact details	england.revalidation-london@nhs.net

Board-level accountability for the quality and effectiveness of these systems is important and this report, along with the resulting action plan, should be presented to the board, or an equivalent management body. It is also good practice to include the report in an NHS organisation's Quality Account.

This letter has been sent to the responsible officer recorded in the AOA return at 31 March 2018. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the Chief Executive of the organisation. If there are any changes to notify, or you have any queries, please contact your local revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies.

A more detailed report including the anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

I would like to take this opportunity to thank you for providing assurance to your higher level RO, and to NHS England, of your processes.

Further information on revalidation can be found at www.england.nhs.uk/revalidation

Yours sincerely

Doctor Mike Prentice
Revalidation Lead
NHS England

cc: Your higher level responsible officer

cc: Your local revalidation team's lead contact

YOUR ANNUAL ORGANISATIONAL AUDIT

Analysis is based on the total of 834 returns from designated bodies (DBs) to the 2017/18 Annual Organisational Audit (AOA) exercise for the year ending 31 March 2018

The following information is presented as per your own AOA submission.

Name of designated body:	St George's University Hospital NHS Foundation Trust
Name of responsible officer:	Ms Karen Daly
Sector:	Acute hospital/secondary care non-foundation trust
Prescribed connection to:	NHS England (Regional Team - London)

Please note:

a) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your local revalidation lead:

Ray Field at england.revalidation-london@nhs.net.

b) Only the questions asked are presented below. Please refer to AOA 2017/18 for the full indicator definitions if required.

2017/18 AOA indicator SECTION 1: The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 55	All sectors: Total DBs: 834
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.	Yes	55 (100.0%)	823 (98.7%)
1.5	Where a conflict of interest or appearance of bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?	No	This question is not applicable to many DBs	
1.6	In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.	Yes	52 (94.5%)	814 (97.6%)
1.7	The responsible officer is appropriately trained and remains up to date and fit to practice in the role of responsible officer.	Yes	54 (98.2%)	819 (98.2%)
1.8	The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.	Yes	54 (98.2%)	826 (99.0%)
1.9	The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.	Yes	55 (100.0%)	818 (98.1%)

2017/18 AOA indicator SECTION 1 (cont.): The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 55	All sectors: Total DBs: 834
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.10	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.	Yes	55 (100.0%)	826 (99.0%)
1.11	The governance systems (including clinical governance where appropriate) are subject to external or independent review.	Yes	55 (100.0%)	820 (98.3%)
1.12	The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation. (*including peer review, internal audit or an externally commissioned assessment)	Yes	48 (87.3%)	656 (78.7%)

2017/18 AOA indicator SECTION 2: Appraisal		Your organisation's response	Same sector: DBs in sector: 55	All sectors: Total DBs: 834
2.1	**Number of doctors with whom the designated body has a prescribed connection as at 31 March 2018**	No. of doctors (in organisation)	Total no. of doctors (in SAME sector)	Total no. of doctors (across ALL sectors)
2.1.1	Consultants	517	17387	51297
2.1.2	Staff grade, associate specialist, specialty doctor	20	4066	12060
2.1.3	Doctors on Performers Lists	0	1	46972
2.1.4	Doctors with practising privileges	0	9	2065
2.1.5	Temporary or short-term contract holders	320	5901	21455
2.1.6	Other doctors with a prescribed connection to this designated body	0	111	6325
2.1.7	**Total number of doctors with a prescribed connection**	857	27475	140174

2017/18 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 55	All sectors: Total DBs: 834
		Completed appraisals (Measure 1a & 1b)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had a completed annual appraisal between 1 April 2017 – 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	431 (83.4%)	93.2%	92.7%
2.1.2	Staff grade, associate specialist, specialty doctor	14 (70.0%)	87.7%	88.9%
2.1.3	Doctors on Performers Lists	N/A	100.0%	94.7%
2.1.4	Doctors with practising privileges	N/A	88.9%	93.0%
2.1.5	Temporary or short-term contract holders	203 (63.4%)	80.6%	82.8%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	91.0%	87.1%
2.1.7	**Total number of doctors who had a completed annual appraisal**	648 (75.6%)	89.6%	91.3%

2017/18 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 55	All sectors: Total DBs: 834
		Approved incomplete or missed appraisal (Measure 2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had an Approved incomplete or missed appraisal between 1 April 2017 – 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	10 (1.9%)	3.3%	4.3%
2.1.2	Staff grade, associate specialist, specialty doctor	1 (5.0%)	7.3%	7.5%
2.1.3	Doctors on Performers Lists	N/A	0.0%	4.8%
2.1.4	Doctors with practising privileges	N/A	0.0%	5.5%
2.1.5	Temporary or short-term contract holders	53 (16.6%)	10.6%	11.2%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	4.5%	9.8%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	64 (7.5%)	5.4%	6.1%

2017/18 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 55	All sectors: Total DBs: 834
		Unapproved incomplete or missed appraisal (Measure 3)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had an Unapproved incomplete or missed annual appraisal between 1 April 2017 – 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	76 (14.7%)	3.6%	3.0%
2.1.2	Staff grade, associate specialist, specialty doctor	5 (25.0%)	5.0%	3.6%
2.1.3	Doctors on Performers Lists	N/A	0.0%	0.6%
2.1.4	Doctors with practising privileges	N/A	11.1%	1.5%
2.1.5	Temporary or short-term contract holders	64 (20.0%)	8.9%	6.0%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	4.5%	3.1%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	145 (16.9%)	4.9%	2.7%

2017/18 AOA indicator SECTION 2 (cont.): Appraisal		Your organisation's response	Same sector: DBs in sector: 55	All sectors: Total DBs: 834
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
2.2	Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded.	No	This question is not applicable to many DBs	
2.3	There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group).	Yes	55 (100.0%)	810 (97.1%)
2.4	There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.	No	54 (98.2%)	815 (97.7%)
2.5	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.	Yes	54 (98.2%)	809 (97.0%)
2.6	The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection.	Yes	53 (96.4%)	814 (97.6%)
2.7	Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.	No	52 (94.5%)	801 (96.0%)

2017/18 AOA indicator SECTION 3: Monitoring Performance and responding to concerns SECTION 4: Recruitment and Engagement		Your organisation's response	Same sector: DBs in sector: 55	All sectors: Total DBs: 834
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
3.1	There is a system for monitoring the fitness to practice of doctors with whom the designated body has a prescribed connection.	Yes	55 (100.0%)	824 (98.8%)
3.2	The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns) which is ratified by the designated body's board (or an equivalent governance or executive group).	Yes	55 (100.0%)	820 (98.3%)
3.3	The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.	Yes	54 (98.2%)	818 (98.1%)
3.4	The designated body has arrangements in place to access sufficient trained case investigators and case managers.	Yes	53 (96.4%)	775 (92.9%)
4.1	There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).	Yes	55 (100.0%)	821 (98.4%)

2017/18 AOA indicator SECTION 5: Comments		Your organisation's response
5.1	1.5 Conflict of interest is Medical Director is RO's line manager. RO is actively seeking alternative RO. This will be resolved asap. 1.6 Answered "no" last year. RO now has more SPA time in job plan and the Trust is currently undergoing a procurement process to purchase an e-appraisal system. Also in process of recruiting 3 appraisal leads to support RO. 1.12 Medical Appraisal and Revalidation was subject to an internal audit in April 2018. 2.1 Introduction of new e-appraisal system will enable more intuitive reporting. 2.2 No formal explanation recorded, although notes are made where an explanation is given. Clinical leads are provided with reports to that effect. 2.3 There is a policy in place, however it is pending a review. This has been on hold pending introduction of e-appraisal system to then "re-launch" medical appraisal and revalidation. 2.4 RO quality assures at point of revalidation. Will implement formal process in line with revised medical appraisal policy and introduction of appraisal leads. 2.7 Will implement formal process in line with revised medical appraisal policy and introduction of appraisal leads. 3.1 Answered "no" last year. Linking on Datix has significantly improved.	

Designated Body Statement of Compliance

The board of St George's University Hospitals NHS Foundation Trust can confirm that:

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Comments: RO appointed in May 2016 – training attended in November 2015.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Comments: The GMC Connect database is reviewed regularly

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Comments: Yes. In order to meet national requirements of 1:5 to 1:20

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Comments: Carried over from previous year, SGH still needs to implement a quality assurance process to include recruitment of appraisal leads and appraiser feedback and calibration events.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Comments: At present the MAG is used for all medical appraisals. The new RMS will use a MAG equivalent. There is a review of those overdue their annual appraisal.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Comments: Doctors are able to access the above information from a variety of sources. For example, the RSO routinely checks Datix for complaints and SUIs and provides information to doctors.

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: Formals processes include referral to occupational health, MHPS, NCAS and/or GMC liaison.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: Where doctor works for multi-organisations, information is transferred from RO to RO using the MPIT form.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

Comments: Medical Staffing Team carry out the 6 NHS Employment Check Standards that outline the type and level of checks employers must carry out before recruiting staff into NHS positions.

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes.

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _
[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27th September 2018	**Agenda No.**	**4.2**
Report Title:	Fit and Proper Persons (FPP) Quarterly Update Report		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Report Author:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Presented for:	Assurance & Update		
Executive Summary:	The Board has requested that the HRD continues to provide a quarterly update on FPP compliance against Regulation 5 during the year 2018/19 until such time that the CQC finds that Fit and Proper Persons checks of Directors are in place. The purpose of this paper is to give the Board on-going assurance that the Trust remains fully compliant with Regulation 5. Fit and Proper Persons: Directors.		
Recommendation:	That the Board is asked to note the current assurance around the Fit and Proper Persons assessment. That the Board request that the HRD&OD now provides an annual update on FPP compliance against Regulation 5		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-Led)		
Implications			
Risk:	Failure to meet the FPP requirements could result in further regulatory actions being taken against the Trust		
Legal/Regulatory:	The requirement to meeting the FPP test is outlined in Regulation 5: Fit and Proper Persons		
Resources:	No additional resources required		
Previously Considered by:	Board and Executive Directors	**Date:**	Quarterly - Feb 18
Equality Impact Assessment:	Not undertaken. Policy applied to every Board member		
Appendices:	Appendix A - Exec and Non Exec FPPR compliance list		

St George's University Hospitals NHS
NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust's Compliance with Regulation 5: Fit and Proper Persons

Trust Board – 27 September 2018

1.0 PURPOSE

1.1 The purpose of this paper is to give the Board on-going assurance that the Trust continues to be fully compliant with Regulation 5. Fit and Proper Persons: Directors

2.0 BACKGROUND

2.1 The Trust was served a Section 29A Warning Notice in August 2016 due to breaches in the implementation of this regulation and subsequently agreed enforcement undertakings with NHS Improvement in November 2016 to make the required improvements.

3.0 OUTLINE OF KEY ISSUES

CQC unannounced inspection - May 2017

3.1 The CQC undertook an unannounced follow-up inspection in May 2017 to assess the Trust's compliance with the Section 29A Warning Notice, including compliance with the Fit and Proper Persons regulation. CQC continued to find non-compliance against this regulation and they raised a number of wider governance concerns in relation to the false assurance received by the Trust Board and regulators.

4.0 NHSI Concerns and Requirements

4.1 NHS Improvement indicated that they took the concerns raised by the CQC very seriously.

4.2 NHSI considered the options available to them and in advance of considering whether any further regulatory action should be taken.

4.3 In their letter, NHSI asked that a number of rapid improvements be made to ensure compliance with this regulation, which have all been formally actioned. They also asked that additional assurance mechanisms are put in place to ensure that the FPP improvements are fully embedded.

4.4 As part of the assurance process they requested that the Board ask the HRD to provide a quarterly update on FPP compliance against Regulation 5 during the year 2017/18 and annually thereafter.

4.5 The Board has request that the HRD continues to provide a quarterly update on FPP compliance against Regulation 5 during the year 2018/19, until such time that the CQC finds that Fit and Proper Persons checks of Directors are in place.

5. CQC Inspection

5.1 The St George's University Hospitals NHS Foundation Trust CQC report was published in July 2018 and they confirmed that the "**Fit and Proper Person checks of directors were in place**". (p14)

6. Future Developments

6.1 Health Minister, Stephen Barclay has indicated that he wants to widen the Fit and Proper test for NHS directors to include a legal duty to act on victimisation, so they can be removed from their post if they fail to stop harassment or discrimination.

7. Recommendation

It is recommended:-

7.1 That the Board notes that the Trust continues to be fully compliant with Regulation 5. Fit and Proper Persons: Directors.

7.2 That the Board request that the HRD&OD now provides an annual update on FPP compliance against Regulation 5.

Appendix A

Name	Fit and Proper Persons Test - Declaration Form	Employment History	References	Professional Registration	Expire/Revalidation Date	Essential Qualifications/ Copies	Occupational Health	Right to Work	Identity Check	DBS/Criminal Conviction Checks	Search of Insolvency and Bankruptcy Register	Search of Disqualified Directors	Social Media Search	Complete		FPPR Met
Jacqueline Totterdell	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Avey Bhatia	✓	✓	✓	✓	20/11/2020	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Andrew Rhodes	✓	✓	✓	✓	28/07/2023	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Harbhajan Brar	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Andrew Grimshaw	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
James Friend	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Ellis Pullinger	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Suzanne Marsello	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Kevin Howells	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Stephen Jones	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Gillian Norton	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Norman Williams	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Ann Beasley	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Jenny Higham	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Sarah Wilton	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Stephen Collier	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Tim Wright	✓	✓	✓	N/A		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	27 September 2018	**Agenda No.**	**4.3**
Report Title:	**2017 NHS National Staff Survey Action Plan - Update**		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources & Organisational Development		
Report Authors:	Harbhajan Brar		
Presented for:	Discussion / Update		
Executive Summary:	The purpose of this report is to provide the Trust Board with an overview of the actions taken to date in response to the 2017 staff survey and to give the Board an overview of the preparations being made for the 2018 NHS Staff Survey.		
Recommendation:	It is recommended that the Board note progress being made against our Staff Survey Action plan.		
Supports			
Trust Strategic Objective:	Champion St George's, supporting our staff, listening to staff, staff engagement, equality and diversity, bullying and harassment, leadership, values.		
CQC Theme:	Well led criteria.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	Failure to address the key findings of the 2017 staff survey will result in a significant component of our workforce feeling 'disengaged' and undervalued for their contributions to the safe and effective care of our patients.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Board	**Date:**	
Equality Impact Assessment:	N/A		
Appendices:	N/A		

Staff Engagement Action plan 2017 - 2018

1.0 Purpose

1.1 The purpose of this report is a) update the Board on the Staff Survey action plan, following the publication of the 2017 NHS Staff Survey and b) to outline the preparations being made in readiness for the 2018 NHS Staff Survey.

2.0 Background

2.1 In January 2018, the Director of HROD provided members of the Board (in Part 2) with a copy of the draft (2017) Management Report outlining our 2017 NHS Staff Survey results, which were at that time embargoed until end of March 2018.

2.2 In his part 2 report he notified members of the Board that our final response rate was 51.5%, which was up from the 40.4% in 2016 and the 31% in 2015. He informed the Board that this response rate was the best response rate among all Acute and Community Trusts undertaking the Picker survey

2.3 The headline messages were that we did:-

- significantly better than the average on 8 questions (7 in 2016),
- significantly worse than average on 42 question (60 in 2016) and
- average on 38 questions (21 in 2016)

2.4 Board members will recall that the results of the 2016 NHS Staff Survey were a difficult read for the Trust.

2.5 In March 2018 members of the Board were then provided with a comprehensive report on the 2017 Staff Survey - see Annexe 1 - which also outlined our intention to update our Staff Survey Action plan that was produced in response to the 2016 Staff Survey results.

3.0 2017 NHS Staff Survey Results - Pan London Analysis

3.1 At the August WEC meeting the DHROD also provided members with an analysis of how our Trust compared with the other 36 Trusts within the London area.

3.2 The data showed that a great majority of strong performers on these measures were community, specialist acute or mental health trusts. Excluding these groups, the stronger acute performers in London are:-

- Chelsea and Westminster
- Guy's and St Thomas'
- Homerton
- Kingston
- UCLH

3.3 The analysis also showed that a small number of Trusts account for the vast majority of statistically significant improvements in results between last year's survey and this. The four trusts with 10 or more significant improvements are:

- Chelsea and Westminster
- North East London
- St Georges
- West London Mental Health.

4.0 Key Deliverables from the 2017 Action Plan

4.1 The Workforce and Education Committee have received regular updates on progress being made against our 2017 Action Plan.

4.2 Some of the key deliverables against our original 2017 action plan are outlined in Annexe 3.

4.3 The results on the 2017 survey have been reviewed and our 2017 Staff Engagement action plan was updated with additional actions - see Annex 2.

4.4 In total, we have identified 25 actions, of which most are now business as usual, and only 6 actions from the 2017 survey have not yet been started.

4.5 Progress against the action plan is reported to WEC on a quarterly basis.

Area for improvement	Number of actions	B	G	A	R	Not yet started	Overall progress since last report
1.Improving Staff Engagement	9	3	2	0	0	4	↑
2.Addressing Bullying and Harassment	6	3	3	0	0	0	↑
3.Improving Equality and Diversity	10	4	4	0	0	2	↑
TOTAL number of actions and RAG	**25**	**10**	**9**	**0**	**0**	**6**	↑

KEY:
BLUE - business as usual **GREEN** - on track **AMBER -** deadline missed, mitigation plan in place
RED - deadline missed ↑ - Progress made ↔ - No progress made

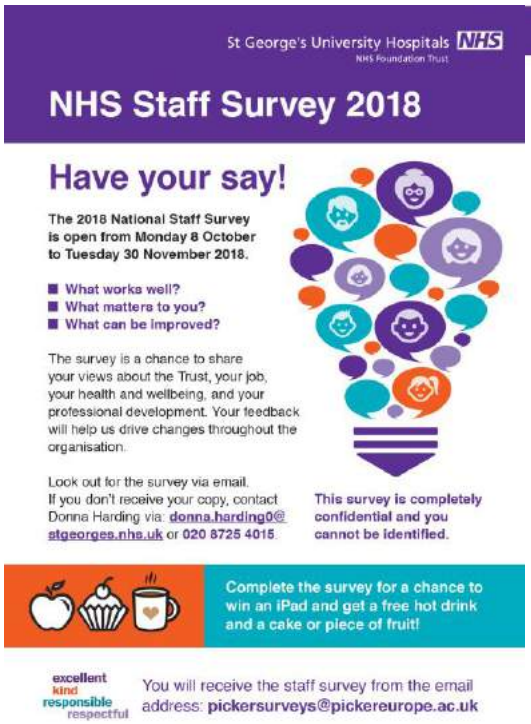
5. Staff Survey 2018

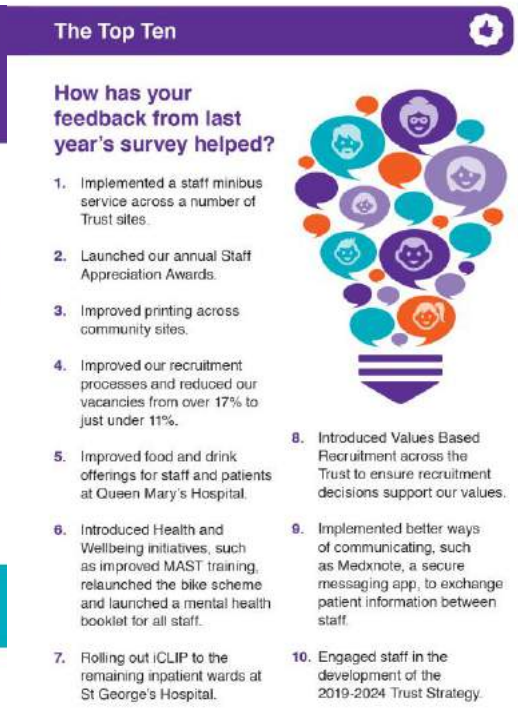
5.1 The 2018 NHS staff survey will run from 8th October 2018 to 30th November 2018 and is expected to report in March 2019.

5.2 We will be promoting the survey by running a comprehensive communication campaigns via eG You, eG St George's, By George, My George (staff app), the intranet, bespoke posters, Yammer (staff social networking site), pop-up banners, attendance and distribution of leaflets at staff events such as our Staff Engagement Lunches (September), H&W event (September 2018), Flu Campaign (September 2018), Freedom to Speak Up (October 2018), Black History Month (October 2018) and QIP Week (November 2018).

5.3 In addition, promotions will be led via all staff communications, H&W and Staff Engagement Champions, Senior Leaders' Briefing/Core Briefing, Jacqueline's weekly message, Twitter, Facebook and Screensavers.

5.4 Examples of our leaflets are reproduced below and these include providing feedback on what actions we have taken in response to the 2017 results.





5.5 We are permitted to have 4 additional local questions and we are going to ask the following:-

- **D&I** - St. George's in an inclusive environment where individual differences are valued and respected - Strongly Agree; Agree; Neither agree or disagree; Disagree; Strongly disagree

- **Values (1)** - Do your managers communicate the Trust values when communicating with a) patients and b) colleagues? Yes/No; Yes/No.

- **Values (2) -** Do your colleagues communicate the Trust values when communicating with a) patients and b) colleagues? Yes/No; Yes/No

- **H&W** - Which of these H&W initiatives have you found useful in assisting you and/or your colleagues' general mental health and wellbeing?

- Please tick all that apply.
  1 *staff mental health booklet*
  2 *a staff mental health event*
  3 *a monthly staff mental health Q&A on eG*
  4 *the inclusion of Wellness Action Plans within the Appraisals process*
  5 *None have been useful*

5.6 In line with what we did last year, which was well received, we are going to offer a free hot drink and snack for all eligible staff who complete the survey. The snack will include a cake or a healthy option such as piece of fruit, packet of nuts or a yogurt.

5.7 We have sponsorship for these catering costs from Ingredients at SGH and Sodexo in QMH. We will also be distributing snacks to a number of our Community sites for all eligible staff who complete the survey. In addition, we will offer one individual to receive a prize draw at the end of the survey period.

5.8 We have set ourselves a target to better our 2017 response rate of 51.6% and would like to achieve over 60% in 2018.

Annex 1

National NHS Staff Survey 2017

Introduction

1. The embargo on the National NHS Staff Survey results was lifted on Tuesday 6th March 2018 and the reports were formally released to the public. This year (2017) 4,312 questionnaires were completed out of 8,375 eligible staff at the Trust thus achieving a response rate of 51.5%. This is an improvement on last year (2016) when our response rate was 40.4%. The average response rate for Picker 'Acute Community' organisations was 43%.

2. In summary, the Trust performed significantly better than in 2016 and our scores were higher than the national average for combined acute and community Trusts. Our top 5 ranking and bottom 5 ranking scores are summarised in the table below.

Table 1: Top Five and Bottom Five Ranking Scores 2017

	2016/17		2017/18		
	St Georges	National Average	St Georges	National Average	Improvement/ deterioration
Response rate	40.4%	42.3%	51.5%	43.0%	Improvement
Top 5 ranking scores					
KF13. Quality of non-mandatory training, learning or development	4.10	4.07	4.11	4.06	Improvement
KF12. Quality of Appraisals	3.19	3.11	3.19	3.11	No Change
KF18. % of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their line manager, colleagues or themselves	53%	55%	53%	53%	No Change
KF29. % of staff reporting errors, near misses or incidents witnessed in last month	91%	91%	90%	91%	Deterioration
KF24. % of staff/colleagues reporting most recent experience of violence	68%	67%	71%	67%	Improvement
Bottom 5 ranking scores					
KF19. Organisation and management interest in and action on health and wellbeing	3.41	3.61	3.49	3.41	Improvement
KF14. Staff satisfaction with	3.15	3.28	3.22	3.27	Improvement

resourcing and support					
KF26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months	32%	23%	30%	24%	Improvement
KF10. Support from immediate line managers	3.63	3.74	3.65	3.76	Improvement
KF9. Effective team working	3.67	3.78	3.67	3.74	No change

3. One of the initial action points is to provide further data analysis on the staff groups such as nursing and medicine and a review of the verbatim comments that staff provided (617 in total) to consider the key themes and to add further detail to the quantitative aspects of the survey.

4. From the 2016 survey, a Staff Engagement working party was established in 2017 and was led by an independent senior manager to devise a corporate action plan to include three key action points; Bullying and Harassment, Staff Engagement and Equality and Diversity. See Appendix 1 for actions taken. At the same time the divisions were asked to review their division/directorate data to enable them to devise 2 or 3 local action points that added to the corporate action plan.

5. This paper outlines the initial outputs from the 2017/18 data analysis and a brief summary of the areas to be covered further to the priorities above for consideration by the working group:

   - Addressing Personal Development
   - Increasing Organisational Development Interventions
   - Management Development

Personal Development – Appraisal Process

6. The main areas across the Trust which were Score < 3% below benchmark in the 2017 survey under "**My personal development**" were:

   - Appraisal/review definitely helped me improve how I do my job
   - Clear work objectives definitely agreed during appraisal
   - Appraisal/performance review: training, learning or development needs identified

7. Compared to the 2016 survey where the main areas across the Trust which were Score < 3% below benchmark were the same and this shows that these areas are still requiring some improvement according to Staff.

   - Appraisal/review definitely helped me improve how I do my job
   - Clear work objectives definitely agreed during appraisal
   - Appraisal/performance review: training, learning or development needs identified

8. With an overall score of 3.19 out of 5 for the quality of appraisals, this is down 0.01 from last year's survey showing that the Trust has not improved on this area. However, it is key to note that the Trust is above the National 2017 acute and community Trust score for quality of appraisals which stands at 3.11 out of 5.

9. It is important to consider feedback from Managers throughout the Trust that the appraisal process is complicated and that finding the paperwork can be a difficulty, with there being a call for it to be moved to an online system.

10. Many Managers state that they do not have time to complete the appraisals for their staff members and that the system to confirm it has been completed is flawed and often does not report accurately the outstanding appraisals.

11. As case study from NHS direct, (appendix 2) where their feedback on appraisals was that there were a large number staff having not been appraised and 41% of those that had did not find it helpful or leaving them feeling very valued. NHS direct felt that they needed to focus on making simplifying the appraisal so that all was preserved that was good about it and they could focus on those areas.

12. NHS direct used an online appraisal system and made the appraisal more of an on-going event than just a yearly occasion, encouraging staff to feel confident in using the online system to keep everything up to date.

13. To do this NHS direct developed a brand that emphasises the fresh new idea and simple approach to 60 minute appraisals. The Managers were trained in how to have appraisal discussions and there were soft skills workshops for Managers in holding appraisal discussions. There was also a fun recognition scheme developed to stimulate healthy internal competition.

14. The appraisals were then aligned with the on-going 1-1s so that Managers did not have to feel forced into holding appraisals on a set date annually and the progression plan could be visited throughout the year.

15. NHS direct stated that this was led by the Chief Executive who used the online appraisal system and was working well throughout the organisation. NHS direct stated that having new branding with a simplified approach to appraisals helped to step away from the old system and have a more effective system.

Your Organisation - Organisational Development Interventions

16. In regards to staff engagement in the organisation it is positive to see that the 2017 score was 3.75, up by 0.05 from 2016 when it was 3.70. The national average for combined acute and community trusts was 3.78, which indicates that although there is room for improvement, the Trust is doing some good work in relation to making their staff feel more engaged.

17. The main areas across the Trust which were Score < 3% below benchmark in the 2017 survey under "**Your Organisation**" were:

- Would recommend organisation as place to work
- Patient/service user feedback collected within directorate/department

In the 2016 survey the areas in which the Trust Score < 3% below benchmark in this area were:

- Organisation acts on concerns raised by patients/service users
- Would recommend organisation as place to work

18. Although the organisation being recommended as a place to work still comes up as one of the key areas within "Your Organisation" that is below the benchmark it is important to note that it stands at 3.74 out of 5 which is an increase of 3.61 from 2016. The national average score for combined acute and national Trusts was 3.75, with the best score being 4.18.

19. The friends and family test has echoed that there has been an overall increase in the number of staff who would recommend the Trust as a place to work, with it increasing from 74% to 77% over the last year.

20. How the Organisation acts on concerns raised by patients/ service users remains below the benchmark figure and as a main concern, much like the 2016 survey. It is well documented that in order for staff to feel engaged they want to feel that they have a voice and are heard.

21. Effective use of patient/ service user feedback collected within the directorate/ department also remained as a main area where the Trust scored below the benchmark with a score of 3.70 compared to the best 2017 score of 3.93. The 2016 result was 3.69, so there shows little change.

Your Manager – Management

21. The main areas across the Trust which were Score < 3% below benchmark in the 2017 survey under "**Your Managers**" were:

- Immediate manager encourages team working
- Immediate manager gives clear feedback on my work
- Immediate manager supportive in personal crisis
- I know who senior managers are

22. Compared to the 2016, survey where the main areas across the Trust which were Score < 3% below benchmark shows that there is still some improvement required on immediate managers encouraging team working. The 2017 highlights that staff feel that there is more concern for them between their immediate manager than the Senior managers within the Trust. Although "I know who senior managers are" still scores on the < 3% below benchmark, there is an improvement to the figures from 2016.

- Immediate manager encourages team working
- Communication between senior management and staff is effective
- Senior managers act on staff feedback

23. These figures show that there needs to be some improvement in staff and the immediate managers relationship and it would be hoped that by having restarted the HR training "Passport to effective people management" in January 2018, that this will

give Manager's the toolkit to be able to hold these feedback conversations and know what support that they can offer.

Staff Groups

24. The below table shows the staffing groups response rate and the area which was the highest scores on the < 3% below benchmark. This has been compared to the 2016 survey and is detailed below:

Staff Group	Number of Respondents	Main area of concern 2017	Main area of concern 2016
Allied Health Professionals	608	Your Organisation	Your Managers
Scientific and Technical/Healthcare Scientists	463	Your Managers	Your Organisation
Medical and Dental	416	Your Organisation	Your Managers
Nurses, Midwives and Nursing Assistants	1420	Your Health, Wellbeing and Safety at Work	Your Health, Wellbeing and Safety at Work
Other Groups (admin and clerical)	944	Your Personal Development/ Your Managers	Your Personal Development/ Your Managers

25. Nursing and midwifery were the highest group of respondents with their main concern within the area of Your Health, Wellbeing and Safety at work being that only 56% had not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public.

Verbatim comments

26. The survey provides staff with an opportunity to add in any additional comments they would like to make. We received around 617 comments and an analysis of these showed the most common themes to be:

Theme	
Working Conditions	• Environment • Equipment • Retention and Turnover • Recruitment processes • Career Development • Motivation and Morale • Pay • Flexible working • Worklife Balance
Management Development	• Senior Management
	• Line Management
	• Change Management

Living the Values	• Bullying and Harassment
Reward Strategies	• Recognising long service and pay)
Diversity and Inclusion	• Fairness/Opportunity
Health & Wellbeing	• Change Management
	• Staff Support/Stress & Anxiety
Strategic Direction	• Communication

Some representative comments against each of these themes can be found in appendix 3.

Next Steps

27. The staff survey results are in the main encouraging in terms of there being an emphasis on individual and organisation development but there is much work to do in the day to day operational areas, in particular within the theme of working conditions. It would not be possible to make progress on every area of concern, therefore, the recommendation to the Staff Survey Action Plan Working Party is to confirm that we have identified the correct areas for targeted action. An updated action plan can be developed with input from the Working Party to support this targeted work and publicised widely through the organisation so that staff know their views have been heard and taken seriously.

Appendix 2: Actions taken to address Bullying and Harassment, Staff Engagement and Equality and Diversity

Over the past year actions have included:

Action	What we did
Addressing Bullying and Harassment	
Tackling Unhelpful Behaviours – Role model behaviours at all levels; commit very clearly to the Trust's values	-Values Based Recruitment training for all staff -Set out expectations at induction and discuss and reinforce at 1:1s and appraisal -Introduced 360º reviews for all middle managers and above -Development Centres between March and June 2018 for top 250 leaders; each manager will receive a 360º review including self-reflection and peer feedback. -Promoted awareness of internal bullying and harassment helpline and LIAiSE (Listening into Action is Staff Engagement). -Review and promote the Trust Values Policy.
Introduce Positive Event Reporting – use the same rigorous process, to learn from positive events, as we do to learn when things go wrong	-Wider roll out of Greatix across the Trust -Showcase our successes via ByGeorge -Case studies of best practice promoted via ByGeorge and other communication routes
Improving Staff Engagement	
Recruited Engagement Champions – from staff who have offered to be involved; ask for their help in monitoring the delivery of our plan; to keep involved and to generate on-going ideas to connect the leadership of the Trust with front line staff	-Asked staff to take part in the 'Would you like to join us for lunch' events. -Set up monthly review meetings and invite the staff who attended for lunch and who want to remain involved, our 'engagement champions', to attend. -Feedback on the findings of the review meetings to the workforce and education committee.
Out and About with the Executive Team – visits to different area each month, publish plan, never cancel, no agenda, informal; Team Talk with the Chair and Chief Executive, for a cross section of staff	-Identified areas to be visited a month in advance and publish plans. -Communications facilitate invitations to attend Team Talk. -Create an email free Friday – the last Friday of the month.
Relaunched Listening	-Organised and delivered Big Conversations in September and

into Action (LiA) – hold Big Conversations x4; use LiA to celebrate good news; revitalise staff awards, tied into the 3 key focus areas and based on the Trust values and behaviours	October 2017 -Implemented greater use of Greatix -Increase visibility of values awards -Review and refresh annual long service awards event
Improving Equality and Diversity	
Rolled out Values Based Recruitment – Roll out values based recruitment; using very clear behaviours and empower managers to be confident in not recruiting, because of poor behaviours. Have an Executive Champion.	-Established an Executive champion for 'recruiting the best.' -Updated our recruitment paperwork to support structured application -All recruiting managers to attend values based recruitment training
Commit to Improving Understanding – and ensure compliance with all relevant policies at all levels, working with senior leaders, clinical and non-clinical to ensure they understand their responsibilities to adhere to the policies and to implement them	-Set our expectations at induction -Discuss and reinforce at 1:1s and appraisal -Policies reinforced at 1:1s and appraisal
Have strong, consistent leadership and empower all staff in equality and diversity – have champions ensure high visibility of diverse staff, gender, age, sexuality, race, job role, length of service, unsung heroes. Have a high visible campaign when the values are refreshed, that clearly shows a 'new way' at St George's	-Identified a Board level lead (non-Executive Director) and an Executive lead. -Board and Executive lead to attend at least 4 staff engagement events per year. -The 2017/18 Workforce Race Equality Standard (WRES) Action Plan has been agreed by the Board and on the intranet and internet. -WRES working party meetings taking place on a monthly basis. -Diversity and Inclusion Manager appointed
Tell our story, powerfully and positively – make equality and diversity part of the story of St George's recovery	-Developed communication strategy and track its delivery -Engagement Plan launched in Quality Improvement week -Printed document supported by posters and leaflets -Section on intranet now live -Communications strategy in place

Appendix 3

BLUE = business as usual
GREEN = on track
AMBER = deadline missed, mitigation plan in place
RED = deadline missed

Staff Engagement Plan 2017- 2019: Progress August 2018

What do we want to do: We want to engage staff, and focus on **three key areas to:** 1. Improve Staff engagement 2. Address Bullying and harassment 3. Improve Equality and diversity	**How do we want to do it:** Regular, active listening 1. Provide consistent and stabile leadership and engagement 2. Empower staff at every possible level 3. Lead by example 4. Be honest

1.0 Improving staff engagement	Led by	By when and for review	Target audience	How are we going to do it?	What difference will it make?	Progress update	BRAG
COMPLETED ACTION 2017-18 **Recruit engagement champions**	Staff engagement working party	October 2017	All staff			Monthly review meetings; quarterly reports to workforce and education committee	**B**
COMPLETED ACTION 2017-18 **Out and about with the executive team**	Execs	September 2017	All staff			Minimum of monthly visits to clinical and non-clinical areas; Team Talk; email free Friday	**B**
COMPLETED ACTION 2017-18 **Re-launch Listening into Action (LiA)**	LiA lead and LiA sponsor group	January 2018	All staff			Held x4 Big Conversations; Staff values awards revitalised; Staff Appreciation Awards ceremony	**B**
ON-GOING ACTION 2017-18 to 2018-19 **1.1 Implement wider use of Greatix**	Divisional leads	March 2019	All staff	Run a short project affiliated with the Quality Improvement Academy	Share learning; Staff understand benefits of using proven methodology applied to positive, as well as challenging events	**IN PROGRESS** Awareness raised via DGBs and via eG St George's	**G**
NEW ACTION 2018-19 **1.2 Develop a staff**	Staff engagement working party	March 2019	All staff	Task and finish group approach to design of staff	Provide information to support new starters in the work place	Not yet started	

engagement pack for new starters				engagement pack and contents, supported by charitable bid			
NEW ACTION 2018-19 **1.3 Develop a staff engagement wall**	Staff engagement working party	March 2019	All staff	Identify an area of wall in a suitable location SGH	Provide themed messages on a monthly basis	Not yet started	
NEW ACTION 2018-19 **1.4 Develop a congratulations card system to acknowledge length of service**	Staff engagement working party	March 2019	All staff	Send a congratulations card from the executive team to recognise length of service	Staff feel valued	Not yet started	
NEW ACTION 2018-19 **1.5 Take more staff stories to Trust Board**	Staff Engagement Steering Group	September 2018	Trust Board to all staff	Staff identified as Inspirational Leaders by the Trust Values award system	Staff feel valued and increased awareness at Trust Board	Not yet started	
NEW ACTION 2018-19 **1.6 Encourage increased ownership of the Staff Engagement Plan at divisional level**	Divisional leaders	March 2019	All staff	Develop staff engagement plans at divisional level and provide progress quarterly updates to the Staff Engagement Working Party	Staff feel more involved and aware of staff engagement activities with a particular emphasis on the implementation of effective team meetings	**IN PROGRESS** DGB presentations of Staff Engagement Plan and requested divisional action plans	**G**

2.0 Addressing bullying and harassment	**Led by**	**By When and for review**	**Target audience**	**How are we going to do it?**	**What difference will it make?**	**Progress update**	**BRAG**
COMPLETED ACTION 2017-18 **Tackle unhelpful behaviours**	Managers supported by HR	March 2018	All staff			Set out expectations at induction and discuss and reinforce at 1:1s and appraisal; awareness raising of Freedom to Speak Up Guardian	**B**
COMPLETED ACTION 2017-18	HR	March 2018	All staff			Included in the printed Staff	

Promote awareness of internal bullying and harassment helpline and Liaise						Engagement Plan, on the posters and leaflets; will continue to be updated in internal communications	**B**
COMPLETED ACTION 2017-18 Implement values based recruitment	HR	March 2018	All staff			Training sessions made available for staff; all recruitment activity is now values based	**B**
ON-GOING ACTION 2017-18 to 2018-19 **2.1 Develop a charter of behaviours**	Staff Engagement Group	March 2019	Execs to managers to all staff	External funding bid to support transformation of organisational culture	All staff committed to role modelling expected behaviours	Bid successful. Scoping work re implementation to commence.	**G**
NEW ACTION 2018-19 **2.2 Extend the provision of 360° reviews to all staff who manage staff**	Divisional leaders	March 2019	All staff	Extend current access to 360° reviews to all staff who manage staff	Enable staff to comment on peers, superiors and for people who manage staff an awareness of unwanted behaviours and the positive change that they are required to undertake	**IN PROGRESS** Reminder email circulated and communication via eG You	**G**
NEW ACTION 2018-19 **2.3 Increase the communications and awareness of mediation between individual staff members and groups of staff**	HR	March 2019	All staff	Include in divisional staff engagement action plans	Increase the numbers of staff who benefit	**IN PROGRESS** Reminder email circulated and communication via eG You	**G**

3.0 Improving equality and diversity	**Led by**	**By when and for review**	**Target audience**	**How are we going to do it?**	**What difference will it make?**	**Progress update**	**BRAG**
Roll out values based recruitment	HR	March 2018	New starters			Values based recruitment implemented; Our executive champion is Director of	**B**

						Workforce and OD, Harbhajan Brar	
Commit to improve understanding, and ensure compliance with all relevant policies at all levels	Training and development	March 2018	All staff			Policies set out at induction and reinforced at 1:1s and appraisal	**B**
Have strong, consistent leadership and empower all staff in equality and diversity.	Executive lead	December 2017	Impacting all staff			Non-executive lead: Gillian Norton, Chair Executive lead: Director of Workforce and OD, Harbhajan Brar	**B**
Tell our story, powerfully and positively	Comms	March 2019	All staff, patients and external audiences			Communications strategy in place	**B**
ON-GOING ACTION 2017-18 to 2018-19 **3.1 Launch a mentoring scheme for staff**	Training and development	March 2019	All staff, especially those in challenged areas	Develop and implement a trust wide mentoring scheme	Mentoring builds momentum and St George's seen as centre of excellence	Scoping of the resources currently being worked up by training and development team	**G**
NEW ACTION 2018-19 **3.2 Include living our values as part of the staff engagement pack for new starters in 1.2 above**	Staff engagement working party	March 2019	All staff	Task and finish group approach to design of staff engagement pack and contents, supported by charitable bid	Provide information to support new starters in the work place	Not yet started	
NEW ACTION 2018-19 **3.3 Include key messages on a monthly basis for inclusion on the staff engagement wall in 1.3 above**	Staff engagement working party	March 2019	All staff	Identify an area of wall in a suitable location SGH	Provide themed messages on a monthly basis	Not yet started	

NEW ACTION 2018-19 **3.4 Establish staff group representative of key characteristics to celebrate and support**	D&I lead	March 2019	All staff	Hold a big conversation to establish the best way forward	Staff from all key groups feel listened to and supported in their workplace	**IN PROGRESS** D&I lead has commenced discussions in the Trust	**G**
NEW ACTION 2018-19 **3.5 Participate in national Diversity and Inclusion week**	D&I lead	May 2018	All staff	Hold events at St George's Hospital and QMH	Raise awareness amongst staff and initiate discussion about potential developments	Completed	**G**
NEW ACTION 2018-19 **3.6 Develop a D&I Strategy**	D&I lead	March 2019	All staff	D&I to lead engagement with staff and develop a Trust wide D&I Strategy for sign off at Workforce and Education Committee and the Trust Board	The Trust has a clear and agreed direction of travel	**IN PROGRESS** D&I lead has commenced discussions in the Trust	**G**