St George's University Hospitals NHS
NHS Foundation Trust

Public Board Papers

29 November 2018

Trust Board Meeting
Part 1 – Public

Date and Time: **Thursday 29 November 2018: 10:00 – 12:45**

Venue: **Barnes, Richmond and Sheen Rooms, Queen Mary's Hospital**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the site**	**Board Members**	-	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 25 October 2018**	**Gillian Norton** Chairman	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
10.35	**1.5**	**CEO's update**	**Jacqueline Totterdell** Chief Executive	Inform	Report
QUALITY & PERFORMANCE					
10:45	**2.1**	**Quality and Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
11:00	**2.2**	**Integrated Quality & Performance report**	**James Friend** Director of Delivery, Efficiency & Transformation	Inform	Report
11:10	**2.3**	**Winter Plan**	**Ellis Pullinger** Chief Operating Officer	Inform	Report
11:20	**2.4**	**Elective Care Recovery Programme**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
11:25	**2.5**	**Cardiac Surgery Update**	**Andrew Rhodes** Acting Medical Director	Update	Report
FINANCE					
11:35	**3.1**	**Finance and Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
11:50	**3.2**	**Month 7 Finance Report**	Tom Shearer Deputy Chief Financial Officer	Update	Report
STRATEGY					
12:00	**4.2**	**Trust Strategy Highlight Report**	**Suzanne Marsello** Director of Strategy	Inform / Discuss	Report
GOVERNANCE					
12:05	**5.1**	**GDPR Progress Report**	**Andrew Grimshaw** Chief Financial Officer	Assure	Report
CLOSING ADMINISTRATION					
12:15	**6.1**	**Questions from the public**	-	-	Oral
	6.2	**Any new risks or issues identified**	**All**	-	-

	6.3	**Any Other Business**	**All**	-	-
	6.4	**Reflection on meeting**	**All**	-	Oral
12:25	**PATIENT/STAFF STORY**				
The patient, her husband and her baby were involved in a serious road traffic accident. The patient was flown to St George's Hospital. Her baby was being breastfeed but she experienced difficult in arrangements for him to stay with her. A complaint was received raising numerous concerns regarding the hospital's policies and practice concerning breastfeeding. The response to her complaint outlined a number of actions.					
12:45	**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 20 December 2018, 10.00 – 13.00

Hyde Park Room, 1st Floor, Lanesborough Wing

Trust Board
Purpose, Meetings and Membership

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

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

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
Ellis Pullinger	Chief Operating Officer	COO
Sally Herne	Quality Improvement Director, NHS Improvement	QID
Secretariat	**Designation**	**Abbreviation**
Sheila M Murphy	Interim Head of Corporate Governance	IHCG
Jill Jaratina	Interim Assistant Trust Secretary	IATS

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting
Part 1 (Public)

Thursday 25 October 2018, 10.00 – 13.00, Hyde Park Room, 1st Floor, Lanesborough Wing

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Financial Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
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
James Friend	Director of Delivery, Efficiency and Transformation	DDET
APOLOGIES		
Jacqueline Totterdell	Chief Executive Officer	CEO
SECRETARIAT		
Sheila M Murphy	Interim Head of Corporate Governance (Minutes)	IHCG

Feedback from Board Walkabout

Members of the Board gave feedback on the departments visited, which included the Simulation Suite, Haematology and Oncology Outpatients, Neurology Outpatients, the Fracture Clinic, the Surgical Admissions Lounge, Cardiac Investigations and the Cardiac Catheterisation Laboratory, Lanesborough Theatres and radiology, Pathology, the Spiritual Care Centre, the Macmillan Cancer Care, Bereavement Services, the restaurant, and Gunning Ward.

The CN commented on the enthusiasm of staff in the Simulation Suite, one of the first such centres in the country. It could create various scenarios including those of actual SIs to assist with learning and multidisciplinary training. The CN questioned whether best use was being made of the facility as only 50% of training slots were being filled as a result of staff not being released to attend. In Haematology and Oncology Outpatients there had been issues with “bare below the elbows” which had been addressed. Vacancies remained a problem and required staff to work flexibly. Space for staff was also lacking. The Friends and Family tablet was not working but would be replaced the following day.

The DS reported that staff in the restaurant were happier being directly employed by the Trust. A CQUIN was on target to ensure healthy products accounted for 80% of all sales. Fruit was provided at cost price and only three sugary drinks were sold. Patient feedback was being sought to make further improvements. The environment required improvement and Ann Beasley queried whether some of the revenue from the CQUIN could be used to address this. The DEF responded that the FM contract was coming up for renewal and this could be explored. The fracture clinic lacked adequate staff facilities; the sister's office was used as a clinical room and a clinical room was being used for storage. There were no separate facilities for children. The DS commented that the introduction of virtual telephone clinics had gone well.

Tim Wright reported on the Surgical Admissions Lounge noting that the area was very busy. Improving the space would improve flow of patients. There was only one toilet for all staff and no staff room. Cerner was being used but staff had said it would be helpful for this to be used for pre-assessment, but this was not in the plan. Gunning Ward was very proud to have been the first ward to achieve gold accreditation and maintain this. Cerner smart boards were in use and implementation had gone smoothly.

Sir Norman Williams reported on the visit to Cardiac Investigations and the Cardiac Cath Labs. Cardiac Investigations had a high DNA rate and he queried whether text messages would assist with addressing this. Additional space was needed, with inpatient echo examinations being a particular stress point. A number of staff were from EU countries and they had concerns about the effect of Brexit. Some staff commented that the current issues in cardiac surgery had needed to be addressed and there were now signs of improvement.

Stephen Collier stated that he was encouraged by his visit to South West London Pathology (SWLP). There were 400 dedicated staff working 24/7, seven days per week. The facility was considered to be one of the largest laboratories in London with very strong leadership. The equipment and premises were of a high standard and SWLP were gripping commercial opportunities with growth in all areas. Neurology Outpatients was a good facility. Corridors were clean and patient notes were secured. The area would, however, benefit from a kiosk facility. Stephen Collier commented text messages to patients needed to be clearer about where they needed to go for appointments.

Sarah Wilton and Kevin Howell fed back on their visit to Lanesborough Theatres and radiography. Delays to theatre start times were an issue, partly caused by delays in transfers. The availability of scanned notes was also an ongoing problem. The arrival area for children was regarded as too clinical. An issue with the image intensifier was to be raised. Staff commented on the need for a new CT scanner, an intervention theatre and for a network system that could hold information required for imaging, specifically for trauma reports, as it was difficult to report within the one hour target given the unreliability of the current equipment.

Jenny Higham and James Friend had visited the Spiritual Centre, Macmillan Cancer Support and Bereavement Services. Staff were passionate about their work but commented that the Spiritual Care Centre environment was very poor. Macmillan Cancer Support's environment worked well and provided a hub for cancer nurse specialists and some bereavement support space. Macmillan was setting up a cam-chat for patients further down the pathway to discuss experiences with new patients. The Bereavement Service was working on the issue of communication between doctors and relatives, and training was planned.

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed Dr Sally Herne as the new NHSI Improvement Director. It was noted that the CFO was deputising for the CEO who was unable to attend the Part 1 Board meeting and that the DCA would join the meeting later.
Declarations of Interest	
1.2	No new declarations of interest were made.
Minutes of Meeting held on 27 September 2018	
1.3	The minutes of the meeting held on 27 September 2018 were agreed as an accurate record.
Action Log and Matters Arising	
1.4	The Board reviewed the action log and agreed to close those actions proposed for closure. It also noted the following updates: • TB.28.06.18/85: There was an item on the agenda to consider the diversity and inclusion strategy and it was therefore agreed that a planned workshop on the issue should be deferred so that progress against the strategy could be reviewed. The item remained open. • TB.26.07.18/87: This would remain open as the item would be considered by the Quality and Safety Committee in November. • TB26.07.18/94: A date for the Board workshop on the BAF workshop should be found as soon as possible. The DHROD commented that, following the Board's discussion in September, thank you cards had been prepared to thank staff for their work and these were now ready to be sent out.
CEO's Update	
1.5	The CFO, deputising for the CEO, noted that the NHS Long Term Plan would have significant implications for the Trust, particularly in relation to the national tariff. The new Secretary of State had a focus on IT and the CFO acknowledged that considerable work was needed to improve the Trust's IT systems. The staff survey had been launched earlier in the month and would close at the end of November. The Q2 Staff Friends and Family Test had highlighted some concerns; the CEO was engaging with staff and emphasising the importance of recognising staff for their contributions. The CFO welcomed the appointment of Amerjit Chohan as the new Chief Executive of the ST George's Hospital Charity, and thanked Paul Sarfaty for his support as Interim CEO. Ann Beasley asked if there was a link between the recent IT outages and Cerner deployment and whether there had been sufficient stress testing considering the challenges with the Trust's IT infrastructure. The CFO stated that stress testing had taken place and that the outages related to specific infrastructure issues. IT issues and Cerner deployment were monitored closely by the Trust Executive Committee and Informatics Governance Group. Tim Wright commented he had discussed these issues with the Chief Information Officer and it was clear that there was still a lot of work to be done in this area. The Board noted the Report.

QUALITY & PERFORMANCE	
2.1	**Quality and Safety Committee Report**
	Sir Norman Williams, Chair of the Committee, presented the report. There had been sustained improvement in the majority of indicators in the Quality Improvement Plan. Performance on responding to complaints within 40 days had fallen, though the quality of responses was improving. Overall, the Committee was assured that the CQC action plan 'must' and 'should dos' were currently on target. There had been no MRSA cases for 14 months and though there had been some cases of C.difficile this remained below the national threshold. The Committee had been made aware of a possible never event involving plasma transfusion which was in the process of further investigation prior to classification. It was noted that seven of the eight cancer targets were achieved but that the 62 day target looked challenging. The Committee had received its first offender healthcare report and noted that the CQC had found that the regulations were being met. The Looked After Children Annual Report had also been received for the first time, having been commissioned by Wandsworth CCG. It was noted that the Trust's performance on the provision of care plans was poor compared with the previous year and needed to improve. Sir Norman Williams noted that cardiac surgery had been discussed in detail, and noted that the subject was on the Board agenda. The MD confirmed that that the possible never event concerned a blood infusion which had not resulted in harm but he observed that a similar event had taken place six months ago raising the issue of whether learning had been acted on. In response to a question from Ann Beasley, Sir Norman Williams stated that there was no obvious explanation for the increase of complaints. Sarah Wilton raised a concern that the Board had been informed action was being taken to improve complaints but it appeared not to have had the intended effect. The CN explained that complaints could be challenging and a number of factors had contributed to delays. The Chairman noted that this was a work in progress and that the Board needed to see sustained progress. Ann Beasley also raised a concern in relation to performance in producing healthcare plans for looked after children. The CN confirmed that this was being closely monitored. The Chairman commented she had been assured by the CN's responses to similar questions at the Quality and Safety Committee. The Board noted the report.
2.2	**Integrated Quality & Performance Report**
	The DDET provided an overview of the IQPR focusing on productivity and activity. He noted that the number of day case and elective operations for September was 4,843. Performance on outpatient first appointments was ahead of expectation. Theatre touch time utilisation was tracked weekly and was currently performing at 77% against an 85% target. There remained a focus on reducing on the day cancellations for non-clinical reasons and ensuring that all patients were rebooked within 28 days; there had been significant improvement in August where 84.1% of patients had been rebooked within 28 days. The CN reported on the continued focus on Friends and Family by wards; this had produced good feedback but the response rate could have been better. The CN drew attention to the indicators that would be included in the maternity dashboard going forwards and noted that the missing VTE data for September was 96.7%. The MD reported on the mortality slide noting that both the Trust level mortality indicators (SHMI and HSMR) remained lower than expected compared with national patterns. HSMR weekend data was increasing but the MD stated that this may be due to the method of reporting. The Chairman expressed concern and Sarah Wilton commented that it would help to be able to understand better what lay behind the changes. In response to a question on waiting

	lists, the Chairman commented that there was no doubt there had been progress. The DHROD commented on Workforce, noting that the vacancy rate was now 10.4%. It was anticipated that the proportion of staff with completed appraisals would improve with the introduction of a new IT solution. There had been a steady decline in agency staff, with the Trust well below the £21.3m ceiling set by NHSI. The Board noted the report.
2.3	**Elective Care Recovery Programme Update**
	The COO presented the report and confirmed that the Trust had started shadow reporting on RTT in preparation for a planned return to national reporting in the new year. The Trust was ahead of trajectory with a continued reduction in the PTL and improvements in a number of data quality metrics. The COO also gave an update on the revised Trust-wide training which had been agreed and rolled out earlier in the month. Further details would be provided to the Board the following month. **Action TB.25.10.18/01: Update on the roll out of training to be provided next month.** The Board noted the report.
2.4	**Cardiac Surgery Report**
	The MD presented the report, which provided an update on recent developments in the cardiac surgery service. Since early September patients requiring the most complex cardiac surgery had been treated at other London hospitals. Lower activity levels could be sustained for a period but could not be continued indefinitely as there would come a point where surgeons became deskilled. It also had significant financial implications. The service remained the focus of external scrutiny both from the Quality Summits and the Independent Scrutiny Panel appointed by NHSI. The service was safe but also required considerable internal oversight. Sarah Wilton asked about the longer terms plans for cardiac surgery across South London. The MD said that there were discussions as part of the Operational Delivery Network and updates would be brought to the Board. The Chairman commented on the importance of the management of data and effective governance. The MD agreed and noted that the service was due to implement a new data management system, Dendrite, by the end of November and staff training was already underway. In response to a question from Sir Norman Williams, the MD explained that the loss of five junior doctors in September had been a challenge but the recruitment of additional trust grade doctors had been undertaken which was preferable to relying on agency staff. The Chairman commented that the Trust was working closely with NHSI, NHSE and the CQC in managing risks and was being well supported by King's and Guy's and St Thomas'. The Board noted the report.
2.5	**Patient Partnership and Engagement Strategy**
	The CN informed the Board that the Strategy had been developed with the new Patient Partnership and Experience Group. It had been widely consulted on and feedback had been incorporated, including feedback from Governors. In responding to a question from the DS, the CN explained that the Trust had not had an effective structure for engaging patients for a number of years and the new group had helped address this. The CN highlighted that the strategy had been co-produced with patient representatives and the Quality and Safety Committee had recommended it to the Board. The Board agreed the strategy.
2.6	**Transformation update: Q2 report**
	The DDET presented the report and noted that progress remained on track. He commented

	that the aim was to move items from the transformational to the operational remit as soon as practical as had happened with medical records. There had been a lot of focus on the roll out of virtual clinics and the Trust was on track to deliver CQUIN requirements for the year. The roll out of one-way text reminders for outpatient appointments was almost complete and reducing DNA rates was a priority. Discharging patients before 11 am was important but remained a challenge; AMU had improved and maintained the midday threshold and was now looking to achieve 10am discharges. The CN commented on the potential of the Continuity of Carer initiative to deliver better outcomes and reduced length of stay. It was noted that this had initially been funded locally and the CN asked whether central funding would be forthcoming. The CFO observed that a fundamental challenge for any transformation project was early funding and maintaining engagement of staff. In relation to ICT, Tim Wright commented that it was important to focus on the development and delivery of the ICT strategy. Ann Beasley asked about the mental health CQUIN and for clarification of the Trust's position on patients presenting with mental health issues. The DDET confirmed discussions had taken place with South West London and St George's Mental Health NHS Trust to see if assessments could be undertaken at the Springfield site. Its leadership team was looking at whether the patients needing full assessment could be moved to Springfield for the first assessment and then transferred for admission if necessary. The Board noted the report.
2.7	**Learning from Deaths Q2 report**
	The MD presented the report and noted the Trust was working to establish a new medical examiner system by the nationally mandated deadline of April 2019. Between July and September 2018 there had been 342 deaths and the Mortality and Monitoring Committee (MMC) had conducted independent reviews of 284 deaths. External mortality signals had been raised in primary hip replacement, adult cardiac surgery, general intensive care and hip fractures. On adult cardiac surgery, members of the MMC were working to support NHSI with its external review of mortality. The Summary Hospital-level Mortality Indicator (SHMI) from April 2017 to March 2018 had been published recently, which had shown that the Trust was categorised as lower than expected, one of 15 Trusts nationally in this category. In response to a question from Sarah Wilton, the MD clarified that the HMSR data related to deaths in hospital and SHIMI looked at all deaths within 30 days of admission. Ann Beasley sought clarification on the figures and the number of cases where harm was identified in the treatment provided. The CN confirmed that the number of deaths involving problems with healthcare provided was at the lower end of the national average. Sir Norman Williams stated that lessons needed to be learnt from avoidable deaths and said that it was important errors were reported. The MD commented that a review was underway to allow patients and families to participate in the SI process. The Board agreed the recommendations in the report.
FINANCE	
3.1	**Finance and Investment Committee Report**
	Ann Beasley, Chair of the Committee, presented the report and noted that the Committee had a particular focus on the risks it monitored on behalf of the Board; activity levels, productivity, performance, and the Trust's financial position. With regard to ICT, Ann Beasley noted that mitigation was in place but significant improvements were needed and the Committee would receive a more detailed report at its next meeting. The Committee had been very concerned about the deterioration in the Trust's financial position and the under-delivery against plan. The Trust would not meet the year end target deficit of £29m and would not therefore attract

	Provider Sustainability Funding (PSF). A number of factors had contributed to this, but key among them were cardiac surgery, failure to meet planned activity levels, shortfalls in delivery of the CIP, and medical staffing. Cash was being managed well but the financial position would have implications for cash which would need to be discussed with NHSI. The Committee had been encouraged by a presentation from the clinical director of vascular surgery showing what the team had done to understand the unit's income and expenditure. The Committee was also encouraged about the progress in procurement. In response to a question from Jenny Higham, there was a discussion about how CIPs would be achieved. Ann Beasley explained that some CIPs were not delivering the savings that had been identified. The CFO commented that work was continuing with care groups to support the planned £50m CIP savings target and there remained confidence in the deliverability of the CIP target as a whole. It was important to continue to identify new CIPs to mitigate against any under-delivery. Sir Norman Williams asked why the target deficit would not be met. The CFO explained the factors driving deviation from plan and noted that the Trust was developing plans to improve the year end financial position. The Board noted the report.
3.2	**Month 6 Finance Report**
	The CFO presented the report and commented that extensive work was being undertaken to improve the financial position. The Trust was reporting a pre-PSF deficit of £29.5m at the end of September, £6.2m adverse to plan. Income was adverse to plan by £4.7m and expenditure overspent by £1.5m. Q2 PSF income had not been achieved. Action was being taken to support the cash position. Discussions were taking place with NHSI about the deterioration in the Trust's financial forecast. In response to a question from Sarah Wilton on the capital bid to NHSI, the CFO explained that typically any additional funds did not become available until later in the year and that, while some funding could be anticipated, there was no guarantee and it was necessary to work on projects at risk. The Chairman commented that the deterioration in performance was a significant concern and one which was shared by NHSI. The Board noted the Trust's financial performance as set out in the report.
WORKFORCE	
4.1	**Workforce and Education Committee Report**
	Stephen Collier, Chair of the Committee, presented the report. In relation to the Staff Friends and Family Test, the Committee was concerned to see a reversal of the previously steady improvement in responses during Q2, which was the first time the results had fallen. The Committee had discussed the underlying causes. Work was required to address these and would be looked at carefully over the next quarter. Face-to-face engagement with staff was essential as was acknowledging the depth and number of challenges facing the Trust. The Committee had considered the diversity and inclusion strategy and had recommended this to the Board. With regard to the ethnicity pay gap, comparatively the Trust was in a reasonable position in relation to other trusts but there were deep seated variations in particular staff groups which needed to be addressed. Stephen Collier explained that there were, however, a number of areas of encouragement. The Trust was continuing to work on developing new types of staff groups such as physician assistants and nursing associates which would allow the Trust to work differently in the future. The Chairman commented that the report was very good and provided an assessment of the assurance taken by the Committee. In response to a question from the DDET about pay gaps, the DHROD commented that there was no equivalent data for LGBT as staff did not always wish to give such information. The Chairman commented

	that the CEO would have wanted to express concerns about the staff friends and family test scores. The DHROD explained that work was going on to address the causes and the CEO was planning further engagement with staff. Plans for improving the culture of the organisation would be brought to the Board soon. The Board noted the Report.
4.2	**Diversity and Inclusion Strategy**
	The DHROD presented the Workforce Diversity and Inclusion Strategy which had been considered by the Workforce and Education Committee and highlighted the four strategic aims. Celia Oke, Workforce Diversity and Inclusion Manager, commented that establishing a solid foundation was essential in order for the Trust to become a champion of diversity. Tangible goals, targets and ownership across the Trust were necessary. This would involve launch of the Diversity and Inclusion Network and events to raise awareness, engage and educate staff as well as setting targets for a reduction in bullying and harassment and the introduction of a reverse mentoring programme. Sarah Wilton commented that she was very supportive of the strategy and asked about baseline levels at the shortlisting stage of recruitment. Ann Beasley also asked for clarification on the targets. The DHROD commented that discussion had taken place at the Committee on the right level to pitch the targets, and possibly these were not sufficiently challenging. Stephen Collier explained that from his perspective the strategy was a starting point to be reviewed at the end of the year. Sir Norman Williams commented on the number of BME staff who were referred to professional regulators. He highlighted the need for training for those involved in investigations and tribunals and emphasised that the Board needed to have confidence in the practicalities of the plan. Tim Wright commented that the plan was clear and concise and stated that the key would be to ensure it was communicated effectively to staff. The CFO stated that the CEO was fully committed to the strategy and was working with the wider executive team to support and deliver it in practice. The Board agreed the strategy and implementation plan.
STRATEGY	
5.1	**Corporate Objectives 2018 – 19: Quarterly Update**
	The DS presented the report which provided an update on the delivery of the corporate objectives as agreed by the Board at its meeting in June 2018. Of 45 objectives, 19 were rated green, 17 amber and 9 red which represented a deterioration since Q1. The DS explained that the majority of amber and red rated objectives did not pose a material risk to the achievement of the objectives by year end with the exception of ED performance, theatre productivity, RTT, reduction in the deficit, and review of estates. The Chairman commented that these had been expected but it would be important to consider how slippage may affect the year end position. The CFO stated that the report would go back to the Trust Executive Committee to address the highlighted issues. **Action TB.25.10.18/02: report to return to TEC for further consideration of the issues presenting a material risk to the delivery of the strategic objectives.** The Board noted the report.
5.2	**Trust Strategy Highlight Report**
	The DS presented the report and noted that actions were currently on track. Although the paper highlighted that the communication and stakeholder engagement workstream was behind schedule this had been resolved. In response to a question from Sarah Wilton the DS confirmed dates for Wandsworth engagement events had been revised and the DS would

	ensure these were readvertised. **Action TB.25.10.18/03: DS to ensure dates for the Wandsworth engagement events are readvertised.** The Board noted the report.
GOVERNANCE	
6.1	**Audit Committee Report**
	Sarah Wilton, Chair of the Committee, presented the report and stated that the Committee was pleased to see the number of outstanding internal audit actions reducing. The Committee had considered five internal audit reports, two of which gave limited assurance. These were the Friends and Family Test where current systems were not operating effectively, and Outpatients where an action plan had now been agreed. With regard to counter fraud, the Committee heard that sample testing of qualifications was being undertaken. The Committee had received a report on whistleblowing and would consider an internal audit on Freedom to Speak Up at its next meeting in January. In response to a question from Jenny Higham, the CFO explained that there were no specific problems with staff qualifications; this was an important area to consider and on which there was a national focus. In relation to whistleblowing, the DCA agreed there was a need for greater clarity in the relationship between whistleblowing and Freedom to Speak Up which he and the DHROD were currently considering ahead of the Audit Committee discussion in January. The Board noted the report.
6.2	**Board Assurance Framework**
	The CN presented the report and stated that there had been no changes to the risk scores from Q1 to Q2 and no deterioration in assurance ratings over this period. However, the assurance rating for Strategic Risk 2 had improved from limited to partial assurance from Q1 to Q2 as a result of the work undertaken through the Elective Care Recovery Programme. The CN noted that new risks related to cardiac surgery had been added to the Divisional and Corporate Risk Registers, which concerned quality, financial and reputational issues. These contributed to the strategic risks on the BAF but had not impacted on the scoring. There was discussion about whether Strategic Risk 5, which had a risk score of 16, was scored appropriately given the Trust's financial position. The CFO observed that there were four distinct elements to SR5 and explained that an average had been taken of the contributing risks in determining the score. The Chairman suggested that given the material changes to the financial forecast, it may be appropriate to increase the score. **Action TB.25.10.18/04: Risk score for BAF Strategic Risk 5 to be re-considered by the Finance and Investment Committee at its meeting in November.** In light of the Board's recent discussions around culture, the DHROD commented that Strategic Risk 8 – currently scored at 10 – seemed low. There was discussion about whether the risk scoring should be increased but it was agreed that the Workforce and Education Committee should consider this at its next meeting in December and any changes should be brought back to the Board for approval. **Action TB.25.10.18/05: Workforce and Education Committee to review Strategic Risk 8 at its meeting in December.** A wider discussion followed about the wording of the risks as currently expressed on the BAF, and it was agreed that this should be considered at the forthcoming Board workshop. In terms of the strategic risks reserved to the Board (SR 9, 16, and 17), the Board noted the current risk rating and agreed the assurance ratings and assurance statements. For the remaining risks assigned to Committees, the Board noted the risk score and the assurance

	ratings and statements as agreed by the relevant Committees.
6.3	**Board sub-Committee Terms of Reference**
	The DCA presented the report, noting that in line with good governance practice work was underway to review the terms of reference of all Board sub-Committees. The changes proposed to the Finance and Investment Committee (FIC) and Audit Committee were minor and had been considered by the respective Committees. It was proposed that all NED-chaired Board sub-Committees, with the exception of the Audit Committee, should include the Trust Chairman as an *ex officio* member. Subject to adding the DS and DHROD to cast list of regular attendees for FIC, the Board approved the terms of reference.
CLOSING ADMINSTRATION	
7.1	**Questions from the Public**
	A member of the public asked whether the two cardiac surgeons suspended in August were suspended specifically for reasons of patient safety. The Chairman noted that that the surgeons involved were excluded rather than suspended which was an important distinction. The Chairman explained it was not appropriate to go into the details of the surgeons' exclusion in a public forum but she confirmed that the reason was not specifically in relation to patient safety. The DCA read out a question submitted by Hazel Ingram who had praised the care she received at St George's and in particular from the receptionist in the ED. While there were aspects of her care that could have been managed better, overall she was very satisfied with her care.
7.2	**Any new risks or issues**
	No new risks or issues were identified.
7.3	**Any Other Business**
	No items were raised.
7.4	**Reflection on meeting**
	The DDET commented that the room was not conducive to Board meetings, given the low temperature and high levels of noise externally. The DEF stated that he was looking into alternative venues. Ann Beasley welcomed the balance on the agenda between papers concerned with the future direction of the Trust and those concerned with the present. Sarah Wilton commented that the quality of the debate was aided by the fact that the Board papers had been circulated in a timely manner, and the Chairman underscored the importance of papers being submitted on time. In relation to the BAF, the DS commented that this had been a very useful discussion as was the earlier item around culture.
	Patient Story
	The Chairman welcomed Eglionna Treanor, a gastroenterology patient at the Trust, and Mark Soomaroo from the gastroenterology team. Eglionna had suffered for many years with irritable bowel syndrome before diagnosis. On attending the Trust a clinician had commented that she would be taken care of which had greatly reassured her, but she had also had less positive engagement with another clinician and she had lodged a complaint. A response to the complaint was received after four months informing her that the matter had not been addressed as the clinician had left the Trust, which was very disappointing. Eglionna

	commented that although her condition stabilised she suffered a relapse at which time it was suggested she would need a colectomy. Her Registrar had requested further blood tests and following treatment with infusions she was currently asymptomatic. It was at this point it was identified that she had been taken off azathioprine when this should not have happened. This was subsequently restarted which had a positive effect. Mark Soomaroo commented on improvements that had been made that would have made Eglionna's admission a better experience. At the request of the Chairman, Mark explained how he would normally deal with a complaint. The MD explained that he would also expect the complaint to be shared with the clinician and a response obtained. The CN acknowledged the communication and other issues identified, such as being wheeled around the hospital backwards, needed to be addressed, as did the issue of why her azathioprine had been stopped. The Chairman commented there were clearly certain areas where Eglionna's experience could have been better and that there had been periods of ineffective communication. The DDET commented he was pleased that the Triple Access Assessment had been used and that there was now an electronic decision outcome which would reduce the length of time for clinic letters to be issued. The Board thanked Eglionna and Mark for sharing their experiences.

Date of next meeting: Thursday 29 November 2018 at 10:00 at Queen Mary Hospital

Trust Board Action Log Part 1 - November 2018

Action Ref	Theme		Due	Lead	Commentary	Status
TB. 28.06.18/85	**Workforce & Education Committee Report**	Diversity and inclusion Board seminar to be arranged	26.07.18	DHROD & DCA	Added to Board workshop plan for 2019/20	PROPOSE FOR CLOSURE
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	To be considered at QSC meeting in December.	OPEN
TB. 26.07.18/94	**Board Assurance Framework**	Board workshop on BAF to be arranged	30.08.18	CN/DCA	Date confirmed for 17 January 2019	PROPOSE FOR CLOSURE
TB. 25.10.18/1	**ECPR**	November report to include update on roll out of training.	20.12.18	COO	ECPR on agenda	PROPOSE FOR CLOSURE
TB. 25.10.18/2	**Corporate Objectives 2018-19: Quartely update**	Report to return to TEC for further consideration of issues presenting a material risk to the delivery of the strategic objectives.	29.11.18	DS	Agenda item for TEC 05/12/2018	OPEN
TB. 25.10.18/3	**Trust Strategy Highlight Report**	DS to ensure dates for the Wandsworth engagement events are advertised.	29.11.18	DS	Events widely advertised by Comms Team, staff external stakeholders, GP surgeries, Trust membership, NEDs and Council of Governors.	PROPOSE FOR CLOSURE
TB. 25.10.18/4	**Board Assurance Framework**	Risk score for BAF Strategic risk 5 to be reconsidered by the Finance & Investment Committee at its meeting in November	20/12/2018	CN	Discussed at FIC on 22 November. Tobe considered further at FIC on 13 December 2018. Scores to be brought back to Board as part of Q3 update in January	OPEN
TB. 25.10.18/5	**Board Assurance Framework**	Workforce & Education Committee to review Strategic risk 8 at meeting in December	20/12/2018	DHROD	Scores to be brought back to Board as part of Q3 update in January	OPEN

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 November 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:	Information		
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 – November 2018

In this month's report to the Trust Board, I want to begin by welcoming Dr Richard Jennings, Chief Medical Officer to his first Trust Board meeting as an observer. Richard takes on the role officially on 3 December.

I also want to take this opportunity to say thank you once again to Professor Andy Rhodes for the enormous contribution he has made as Medical Director since he took on the role in 2016.

The key updates this month are:

Cardiac surgery at St George's:

Last week, we announced that Mr Steven Livesey would be joining the Trust on 3 December to provide leadership for our cardiac surgery service in the medium term.

Steven joins us from University Hospital Southampton NHS Foundation Trust, where he has worked as a senior cardiac surgeon for a number of years.

His appointment represents a positive step forward for the Trust, and the service, after a difficult and challenging few months.

Steven's appointment has been endorsed by NHS Improvement, our regulator, and I am confident he will play a key role in helping us provide a safe, credible and comprehensive service for the communities we serve.

I am grateful to our cardiac surgery staff for their patience and co-operation – and I am sure Steven's appointment will be well received, and viewed as a key part of the improvement journey the service is clearly on.

We have already achieved a huge amount in recent weeks – for example, we have now moved to a consultant of the week 'best practice' model; and brought two additional surgeons into the service. All new cardiac surgery cases are also now reviewed by a multi-disciplinary team on a daily basis.

Despite these improvements, it is essential that we continue to rebuild confidence in the service – and, whilst there is clearly a huge amount still to do, I am pleased at the progress we have made in recent months.

Our patients:

We continue to work hard to improve the experience of patients using our services. This is particularly true of patients with cancer, due in large part to our partnership with Macmillan.

Last week, I attended a special event in Wimbledon to celebrate this partnership, and the difference it has made to patients.

At the event, I was lucky enough to speak to patients who have been treated by our staff, who are either in remission, or continuing to receive care. All were universal in their praise of the service we provide, and the role different staff have to play in their recovery or ongoing care.

Since 2015, Macmillan has funded support workers to assist and complement the work of our Clinical Nurse Specialists.

They also helped establish our Acute Oncology Care Unit, which is helping to give cancer patients rapid access to specialist care, and avoiding our Emergency Department if clinically appropriate.

These are just two of the initiatives that Macmillan have helped us put in place, for which we are extremely grateful.

I also attended an event last week as part of our 'New beginnings' project to improve the experience of women who give birth in our operating theatres.

I heard first-hand from women who have had both good and less good experiences of giving birth in this way at St George's – and it was great to hear how our staff are going to work with them to make improvements, such as making the theatre environment feel less clinical, and improved communication between theatre staff and women giving birth.

Initiatives such as this show the lengths to which our staff go to improve the experience of patients in our hospital – which is a big part of the overall care we provide, and in line with one of our organisational objectives to 'treat the patient, treat the person.'

Our performance:

Operational performance is still not where it needs to be, with 90.11% of patients seen, admitted or discharged from the Emergency Department at St George's in October.

However, the Trust met 6 of 7 cancer targets during September, which is positive – and we continue to meet the national target for the number of patients waiting no longer than 6 weeks for a diagnostic test.

Of course, as the weather worsens, we expect greater demand on the services we provide, and our winter plan will help focus efforts, and ensure we use beds and resources as effectively as we possibly can.

The roll-out of iClip at St George's continues at pace, and we expect all inpatient wards to be completed by the end of this month. This has so far proved a worthwhile investment, with positive feedback from staff, despite the inevitable teething problems we see on some wards.

Financially, I am naturally concerned at the position we find ourselves in at the end of October. We need to rectify the situation – and at pace – if we are going to reduce spending, whilst also delivering our cost improvement plans.

I am pleased, however, that our vacancy rate in October was below 10% for the first time in many, many months. By removing some of the blocks staff face when recruiting, we have managed to reduce our vacancy rate whilst also reducing agency spending, which is set to be under £17 million for the year (compared to a high of £43 million in 2016/17).

Our people:

I want to briefly touch on the decision we made last month to financially support EU staff who choose to apply for settled status.

We have over 1,200 EU staff, and the decision to meet the costs associated with the scheme was not a difficult one - simply because, despite our financial position, we value the contribution they make day in, day out for our patients.

It has been really positive to see the response to this decision from many of our EU staff, and I am pleased they feel like core members of the team here at the Trust.

I also want to mention the achievements of our staff, and the many different teams and services that make up Team St George's. Our Theatres Improvement Programme has seen some really positive results, with the number of times operations have been re-arranged dropping from over 23% to 15%. In addition, the number of patients eligible for – but not having – pre-operative assessments dropped from 29.9% to 3%. This is a fantastic achievement, and the end result of a huge amount of hard work involving both clinicians and managers.

Finally, one of our teams – based here at Queen Mary's – was also victorious at the Health Service Journal awards last week. We won the Acute Sector Innovation category award for the RAPID prostate pathway we have helped establish between ourselves, the Royal Marsden, Imperial and Epsom and St Helier. Our team, based at Queen Mary's and led by Mr Hasan Qazi, Consultant Urological Surgeon, play a key role in the pathway, and walked away as winners on the night. A nomination for a HSJ award is highly sought after, so this is a huge achievement, and for one of our teams to be part of a winning nomination makes me feel especially proud.

Other business:

I can confirm that there has been one use of the Trust seal since the last Trust Board meeting. This related to the extension of a lease for a property on Deer Park Road, South Wimbledon, which is where the Trust's Clinical Engineering Department are located.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 November 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 22 November 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:	Relevant risks considered		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Quality and Safety Committee Report – November 2018

Matters for the Board's attention

The Quality and Safety Committee met on Thursday 22 November 2018 and agreed to bring the following matters to the Board's attention:

1 Quality Improvement Dashboard

The Committee discussed the QIP dashboard and noted improvements in reporting on Duty of Candour, a fall in the number of avoidable pressure ulcers, and in outpatient first attendances. However, performance on the 4 hour Emergency Department Operating Standard and number of discharges before 11 am had either deteriorated or showed no signs of improvement. The Committee considered that in a number of areas progress had plateaued as had the pace of improvement, particularly in relation to culture, leadership and staff engagement. The Committee expressed concern about this and in the variations in performance reported. It noted also the recent appointment of Sally Herne as the new NHSI Quality Improvement Director.

2 CQC Inspection Update

The Committee heard from the Trust's Quality Improvement Director that there were a number of green actions that had not progressed to blue because of a lack of assurance evidence being provided. The Committee expressed concern at the slow progress on receipt of such evidence and asked that a detailed timeline be presented to the next Committee setting out when actions are due, what the Trust needs to achieve and when.

3 Integrated Quality & Performance Report

The Committee was concerned to hear that there had been two never events in October 2018, one of which concerned the inadvertent injection of a patient with tap water. Neither of these had resulted in significant harm to the patient and both are being investigated under the Trust's normal Serious Incident investigation processes, the outcomes of which the Committee will wish to review and ensure that the appropriate learning takes place. The Committee was also alerted to a further incident that had happened that week involving a prescribing error in which the regularity of the administration of heparin was changed. The Committee heard that there had been an increase in norovirus specifically involving one ward and it was assured that this was being closely monitored. After a challenging couple of months, the incidence of C.difficile infection had stabilised following the higher levels seen earlier in the year; these were currently at 20 cases in the year to date, which was above threshold, against a target of 30 for the year as a whole. The Committee was also concerned to hear that there had been an increase in falls from 136 in August to 141 in September and 181 in October and it was keen to understand the underlying reasons for this. The Committee expressed concern about the HSMR rate at the weekend. It also discussed stranded and super stranded patients, and the need to improve discharge of patients by 11 am. In addition, the Committee heard that the Friends and Family Response Rates were poor for the outpatients department and that this was being addressed.

4 Pressure Ulcers: Changes to National Reporting

The Chief Nurse presented the change in classification around pressure ulcer reporting which the Committee discussed and noted.

5 Elective Care Recovery Programme Update

The Committee heard from the Chief Operating Officer noting the RTT trajectory was on target. It was highlighted that a number of bariatric patients exceeding the 52 week wait

may be referred to other providers to help clear the backlog and reduce the risk of an increasing number of patients exceeding 52 weeks (currently 150). The Committee asked for assurance that appropriate governance was in place at the organisations to which patients may be treated. The Committee noted that there would be a further discussion about RTT at the Board.

6 Cardiac Surgery Update

The Committee was informed by the Acting Medical Director that an external clinical lead for the service, Mr Stephen Livesey, has been appointed and would start in the Trust in early December 2018. His appointment would provide leadership and independent assurance of the progress necessary to ensure that the safety and effectiveness of the Service for patients were sustained. The Committee discussed and noted its support of action being taken as set out in the Report and also noted that this issue would be discussed further at Board.

7 Patient Safety & Quality Group Report

The Committee noted that there was an improvement in the Duty of Candour reporting for October at 87% from 82% in August. The importance and benefit of the ward accreditation scheme was discussed. The Committee expressed concern about the status of the outpatient areas specifically that of the 19 departments 10 required improvement and 9 were bronze suggesting further work was required.

8 Water Safety Report

The Committee heard that there continued to be problems with water quality at the Trust and that a number of mitigating actions had been taken across the site, including by adding filters to all taps. The continuing problems were exemplified by St George's University of London and Moorfields NHS Foundation Trust which had raised concerns about the water system. The Estates team was looking into the issues and discussion had taken place with the University and Moorfields providing assurance to them that mitigation actions were being put in place.

9 Annual Complaints Report 2017/18

The Committee was informed of the method of triaging complaints based on the complexity and severity of the complaint and that those resolved in under 48 hours had been removed from the data. The Committee noted there had been an improvement in the number of complainants expressing dissatisfaction with the response from the Trust reduced from a range of 8% to 11% in the first half of the year to 3% to 5% in the second half of the year. The Committee highlighted the need for areas of learning arising from complaints to be identified. It was agreed that clarification was required of the terms Upheld, Partly Upheld and Not Upheld of which the Committee would be informed.

Sir Norman Williams
Committee Chair

26 November 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 November 2018	Agenda No.	2.2
Report Title:	**Integrated Quality and Performance Report**		
Lead Director / Manager:	James Friend		
Report Author:	Kaye Glover & Emma Hedges		
Presented for:	Information		
Executive Summary:	This report consolidates the latest management information and improvement actions across our quality, patient access, performance and workforce objectives. The report is set out in a balanced scorecard approach identifying each of the four perspectives. An Executive Summary of key points to note is set out at the beginning of the report.		
Recommendation:	The Board is requested to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient, Treat the Person Right Care, Right Place, Right Time		
CQC Theme:	Safe Caring Responsive Effective Well Led		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal / Regulatory:	The trust remains in Quality Special Measures based on the assessment of the Regulator NHS Improvement		
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Previously Considered by:	Quality & Safety Committee Finance & Investment Committee	**Date:** **Date:**	**22/11/18** **22/11/18**
Appendices:	Integrated Quality and Performance Report		

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 29 November 2018
Reporting period – October 2018

Outstanding care, every time

Balanced Scorecard Approach

St George's University Hospitals NHS
NHS Foundation Trust

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 ↑				

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

October 2018

Daycase and Elective Surgery operations

Actual
5,162

Target 5,653

Discharges before 11am

Actual 16.59%

Target 30%

Four Hour Emergency Standard

Actual
90.11%

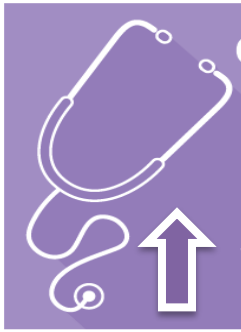
Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
97%

Target
95%

Outpatient First Appointment



Actual 18,207

Target 18,390

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
91%

Target
88%

Activity Summary

St George's University Hospitals NHS
NHS Foundation Trust

The table below compares activity to previous months and year to date 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	
		Oct-17	Oct-18	Variance	Plan Oct-18	Variance	YTD 17/18	YTD 18/19	Variance	Plan YTD	Variance
ED	ED Attendances	14,169	14,279	0.78%	14,398	-0.82%	97,371	98,041	0.69%	99,390	-1.36%
Inpatient	Elective & Daycase	4,718	5,162	9.41%	5,653	-8.69%	32,115	33,835	5.36%	35,423	-4.48%
	Non Elective	3,954	4,269	7.97%	4,247	0.51%	27,228	27,987	2.79%	29,250	-4.32%
Outpatient	OP Attendances	55,252	60,001	8.59%	61,207	-1.97%	367,521	389,822	6.07%	388,271	0.40%

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

Source: SLAM

Executive Summary – October 2018

St George's University Hospitals NHS
NHS Foundation Trust

Our Outcomes

- The area of greatest delivery challenge to the Trust is around Emergency Flow where we continue to see increased attendances through the emergency department and non elective admissions. Four hour operating standard performance has been varied throughout the month. Bed Occupancy has been much higher and many days were started with negative bed capacity where predicted admissions outweighed the number of discharges. Focus remains on reviewing our long length of stay patients where increases have been seen across the month.
- Whilst our Elective activity volumes are close to plan and there is more assurance around data capture there is still capacity to increase utilisation across our theatres. An activity recovery plan is in place to provide assurance over the aspects of the delivery control framework and sets out eleven key improvements required.

Finance and Productivity

- Elective and Daycase activity is currently showing below plan however there is a considerable level of post month data catch up. Cases per session are below previous highs in Cardiothoracic, Oral & Maxillofacial Surgery and as a Trust below the same period last year. Theatre touchtime utilisation is tracked weekly and is currently performing at 78% against the 85% threshold targeted. The number of daycase procedures per working day has seen a positive increase compared to the same period last year, treating on average fourteen more patients per working. Overall planned care operations per day are up by 11 year to date compared to 2017.

Our Patients

- The Trust has reported two Never Events in the month of October, in one of these incidents medication was a significant factor.
- The Trust reported three patients with attributable Clostridium Difficile infection in October, against an annual target set at 30 cases in 2018/19. The Trust is reporting twenty cases year to date and is above the threshold trajectory for the period between April and October.
- Both the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected compared to national patterns.

Process

- Performance against the Four Hour Operating Standard in October was 90.1%, which was below the monthly improvement trajectory of 93%. The improvement trajectory requires the delivery of 93% performance in November 2018 and relies upon continued improvement in the experience for patients not requiring admission.
- The Trust achieved six of the seven national mandated cancer standards in the month of September, continuing to achieve 14 day standard, and on re-allocation, the 62 day compliance.
- Focus remains on reducing on the day non clinical cancellations and ensuring that all patients are rebooked within 28 days, in October 83.3% of our cancelled patients were re-booked within 28 days.

Our People

- The Trust Vacancy rate has been achieved in the month of October reporting 9.3% against a target of 10%
- Staff sickness remains above the trust target of 3% for the month of October.
- Non-medical appraisal rates have remained in line with previous months. Performance in October was 69.7% against a 90% target.
- For October, the Trust's total pay was £42.24m. This is £0.43m adverse to a plan of £41.81m
- Total agency cost in October was better than plan by £0.09m

Length of Stay

Non Elective Length of Stay (General and Acute Beds)

Directorate	Apr-17	May-17	Jun-17	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	Sep-18	Oct-18	Discharges in the last month	Average length of Stay 2017-18	Average length of Stay 2018-19	Variance	Trend
Acute Medicine	2.8	2.7	3.0	2.8	3.1	2.8	2.9	3.0	3.2	3.4	3.5	2.8	2.9	2.7	2.6	2.7	2.6	2.6	2.6	2,633	3.0	2.7	-0.32	
Cardiothoracic	10.4	8.2	8.0	8.7	8.6	8.5	8.2	9.2	8.8	9.4	8.3	9.0	9.0	8.7	7.8	8.5	8.9	8.6	8.8	312	8.8	8.6	-0.16	
Childrens & Women	3.7	4.1	3.5	3.4	3.5	3.4	2.5	2.6	2.3	2.7	2.7	2.5	2.5	2.5	2.4	2.5	2.4	2.3	2.4	1768	3.5	2.4	-1.10	
Neurosciences	9.5	8.1	7.4	10.4	8.0	10.7	10.1	9.5	10.6	9.4	8.7	10.6	8.9	10.6	11.6	9.4	9.6	7.0	7.0	273	9.4	9.2	-0.27	
Senior Health	5.6	10.8	11.3	12.2	13.6	19.3	19.2	8.9	9.5	9.9	9.3	8.4	11.3	10.2	11.8	7.4	12.0	7.8	7.7	128	11.5	9.7	-1.77	
Specialist Medicine	7.0	6.9	8.3	7.9	6.2	8.4	7.0	6.8	9.7	7.7	9.7	7.6	6.1	9.3	7.3	6.4	8.7	6.6	6.2	268	7.7	7.2	-0.52	
Surgery & Trauma	4.1	4.3	4.1	4.8	4.3	4.4	5.0	4.6	4.4	4.8	5.0	4.3	4.6	4.0	4.6	3.7	5.0	4.4	4.4	890	4.5	4.4	-0.12	
Therapeutics	8.2	14.3	7.0	8.2	12.8	18.0	20.7	7.8	17.2	6.1	7.5	13.2	9.8	9.8	3.6	19.2	8.3	13.1	24.8	23	11.8	12.6	0.89	
Grand Total	**4.4**	**4.3**	**4.3**	**4.5**	**4.3**	**4.4**	4.1	4.0	4.2	4.3	4.4	4.0	4.0	3.9	3.9	3.7	4.0	3.5	3.6	**6,295**	**4.5**	**3.8**	-0.65	

Briefing

- The non elective length of stay data is based on the patients discharged date from the hospital.
- Over the last twelve months patients admitted to the hospital via an emergency pathway spend on average 4.4 days in a hospital bed, this includes patients with a zero length of stay. At Trust level this remains in line with National Model Hospital data.
- Compared to the previous year the Trust has seen a reduction in length of stay across all Directorates improving bed workflow and reducing the number of patients waiting for a hospital bed to become available from the Emergency Department
- The implementation of a fully embedded ambulatory care unit within Acute medicine continues to enable rapid access to same day assessment, diagnostics and treatment and increased usage of the discharge lounge.

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.
- The Trust have held two successful "Minimum Standards for enabling patient flow and High Performing team" combined workshop event with engagement from clinicians, nursing and therapy staff. Minimum Standards for enabling patient flow is a clinician led framework that facilitates the safe discharge of patients who no longer require acute care and enables admission for those that do
- Commenced the roll out of the live tableau new real time non-assigned bed report to help operational colleagues identify bed availability
- The Trust is deploying iClip (Cerner Millenium) to the rest of the inpatient wards. This consists of electronic medical & nursing documentation (clindocs) and electronic Prescribing and Medicines Administration (ePMA).

Length of Stay

Elective Length of Stay (Excluding Daycase)

														Average length of Stay			
Directorate	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Discharges in the last month	2017-18	2018-19	Variance	Trend
Cardiothoracic	4.8	4.4	4.4	4.5	4.2	4.8	4.1	4.0	4.4	4.1	4.4	2.9	3.8	190	4.6	4.0	-0.62	
Childrens & Women	2.4	2.1	3.6	2.8	2.0	2.1	2.3	3.2	2.7	2.2	2.1	3.1	2.4	98	2.7	2.5	-0.15	
Neurosciences	7.5	9.8	11.3	11.9	7.8	12.7	8.7	7.3	12.8	7.1	8.9	10.0	8.1	170	10.1	9.0	-1.10	
Surgery & Trauma	4.4	4.5	4.0	4.4	3.1	3.2	3.8	4.1	3.7	3.3	4.3	3.4	3.6	448	3.9	3.8	-0.18	
Grand Total	**4.8**	**5.2**	**5.4**	**5.7**	**4.1**	**5.2**	**4.6**	**4.6**	**5.5**	**4.1**	**4.8**	**4.7**	**4.4**	**906**	**5.1**	**4.7**	-0.39	

Briefing

- Over the last twelve months patients admitted to the hospital via an elective pathway spend on average 4.9 days in a hospital bed, a reduction in length of stay has been observed compared to the previous years meaning patients can be discharged home earlier following their procedure.
- The Trust has observed significant improvement within Neurosciences compared to last year reducing the length of stay of our planned patients by one day.

Outpatient Productivity

First Outpatient Attendances (average per working day)

Directorate	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	First Outpatient Attendances per working day 2017-18	2018-19	Variance	Variance	Trend
Cardiothoracic & Vascular Services	62	72	53	65	59	60	59	62	66	57	54	58	56	66	59	-7	-10.8%	
Childrens Services	49	51	44	50	47	40	41	50	49	42	42	50	45	47	46	-1	-2.2%	
Neuro	89	98	81	91	85	86	87	83	83	73	67	81	84	82	80	-3	-3.1%	
Renal & Oncology	26	25	21	23	24	22	25	27	30	24	25	23	26	23	26	2	10.1%	
Specialist Medicine	142	156	129	151	152	148	139	153	157	142	129	143	140	144	143	-1	-0.6%	
Surgery	283	279	240	249	248	245	265	271	300	264	253	270	276	256	271	15	5.8%	
Womens Services	82	79	76	81	74	69	82	85	92	89	85	89	77	80	86	6	7.6%	
T&O	44	54	40	51	47	54	55	56	60	62	50	55	52	50	56	5	10.9%	
Other	31	35	31	33	35	32	37	38	43	38	34	36	34	54	37	-17	-31.5%	
Total	**808**	**849**	**715**	**794**	**771**	**756**	**790**	**827**	**880**	**791**	**737**	**804**	**792**	803	803	0.2	0.0%	

Follow Up Outpatient Attendances (average per working day)

Directorate	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	FollowUp Outpatient Attendances per working day 2017-18	2018-19	Variance	Variance	Trend
Cardiothoracic & Vascular Services	113	119	96	119	107	98	121	116	113	107	100	117	99	110	110	0	0.1%	
Childrens Services	82	88	73	82	81	70	72	81	73	77	76	87	79	78	78	0	-0.6%	
Neuro	96	116	98	112	104	107	114	113	113	109	105	122	115	102	113	11	10.8%	
Renal & Oncology	209	204	193	206	197	191	205	217	228	229	219	248	241	209	227	18	8.6%	
Specialist Medicine	461	494	442	500	489	499	500	520	501	508	477	533	504	482	506	25	5.1%	
Surgery	361	367	327	361	346	332	354	374	357	349	336	357	347	351	353	2	0.6%	
Womens Services	38	40	36	41	40	36	43	40	38	34	35	40	37	39	38	-1	-1.6%	
T&O	83	87	75	79	73	76	84	81	82	86	77	82	85	80	82	2	2.7%	
Other	51	44	41	47	48	42	56	57	55	55	52	56	52	50	55	5	9.4%	
Total	**1,541**	**1,623**	**1,437**	**1,612**	**1,545**	**1,496**	**1,598**	**1,659**	**1,613**	**1,618**	**1,534**	**1,720**	**1,620**	1,554	1,623	69	4.5%	

Briefing

- Across the Directorates, First Outpatient attendances averaged 792 per working day, with a number of services slightly below monthly SLA plan for the month, which we will expect to increase once coding has been completed. The RAG rating applied compares to the SLA plan per working day.
- Follow-up attendances on average are in line with previous months activity and remains above plan, meaning that the new to follow up ratios are above where we need them to be against target. This is particularly seen within Diabetes, Respiratory and Neurosciences. Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.

Actions

- Central Booking Services implementing daily outpatient booking targets per specialty.

Productivity

Outpatient Productivity

First and Follow Up DNA Rates (by month)

Directorate	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	DNA patients in the last month	Patients not attending rate 2017-18	Patients not attending rate 2018-19	Variance	Trend
Cardiothoracic & Vascular Services	9.4%	9.6%	9.6%	9.9%	9.3%	10.3%	10.8%	10.2%	9.4%	12.2%	10.2%	9.4%	11.5%	333	8.8%	10.5%	⇧ 1.7%	
Childrens Services	11.5%	12.1%	13.3%	11.5%	12.4%	13.3%	16.0%	14.1%	12.9%	14.2%	13.1%	10.0%	11.3%	351	10.4%	13.1%	⇧ 2.7%	
Neuro	8.3%	7.3%	8.0%	9.3%	9.7%	9.2%	10.8%	10.9%	8.5%	9.5%	9.4%	10.0%	10.6%	455	8.4%	10.0%	⇧ 1.6%	
Renal & Oncology	10.4%	10.1%	10.9%	11.8%	11.2%	10.6%	10.6%	11.0%	8.1%	11.1%	11.0%	10.5%	10.4%	375	10.8%	10.4%	⇩ -0.4%	
Specialist Medicine	11.9%	10.5%	12.2%	12.3%	12.7%	11.7%	14.3%	13.1%	11.3%	11.4%	11.8%	11.6%	12.6%	1,642	13.0%	12.3%	⇩ -0.7%	
Surgery	9.6%	10.0%	10.1%	10.3%	10.1%	10.7%	12.1%	11.7%	9.0%	10.9%	10.9%	10.2%	12.1%	1,665	10.9%	11.0%	⇧ 0.1%	
Womens Services	7.5%	7.4%	9.6%	7.9%	7.2%	8.4%	8.6%	8.7%	7.3%	8.4%	9.8%	8.2%	8.7%	692	9.9%	8.5%	⇩ -1.4%	
T&O	10.7%	11.0%	11.4%	12.0%	12.6%	12.0%	11.8%	13.7%	8.4%	9.2%	11.0%	10.7%	10.4%	362	9.3%	10.7%	⇧ 1.4%	
Other	10.6%	12.7%	12.0%	10.6%	11.5%	14.0%	10.0%	9.5%	11.6%	12.9%	13.8%	12.5%	14.4%	1,460	10.0%	12.1%	⇧ 2.1%	
Total	10.4%	10.3%	11.0%	11.1%	11.2%	11.5%	12.6%	12.0%	10.1%	10.9%	11.3%	10.6%	10.5%	7,335	10.2%	11.1%	⇧ 0.9%	

First and Follow Up Ratio

Directorate	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	First to FollowUp Ratio 2017-18	First to FollowUp Ratio 2018-19	Variance	Variance	Trend
Cardiothoracic & Vascular Services	1.81	1.66	1.80	1.84	1.80	1.63	2.06	1.87	1.72	1.86	1.85	2.01	1.75	1.68	1.87	0.19	⇧ 11.6%	
Childrens Services	1.68	1.74	1.68	1.65	1.74	1.76	1.75	1.60	1.47	1.86	1.82	1.74	1.77	1.69	1.72	0.03	⇧ 1.8%	
Neuro	1.07	1.19	1.20	1.24	1.23	1.24	1.31	1.36	1.36	1.49	1.57	1.51	1.37	1.24	1.42	0.18	⇧ 14.6%	
Renal & Oncology	7.94	8.28	9.39	8.77	8.07	8.67	8.38	8.08	7.64	9.75	8.89	10.58	9.17	9.02	8.93	-0.10	⇩ -1.1%	
Specialist Medicine	3.25	3.17	3.44	3.30	3.22	3.38	3.60	3.40	3.19	3.59	3.71	3.72	3.59	3.35	3.54	0.20	⇧ 5.9%	
Surgery	1.27	1.31	1.36	1.45	1.40	1.35	1.34	1.38	1.19	1.32	1.33	1.32	1.26	1.37	1.31	-0.07	⇩ -4.8%	
Womens Services	0.47	0.50	0.47	0.51	0.54	0.52	0.52	0.47	0.42	0.38	0.41	0.45	0.48	0.49	0.45	-0.04	⇩ -8.4%	
T&O	1.86	1.59	1.86	1.56	1.56	1.40	1.51	1.44	1.38	1.38	1.55	1.50	1.61	1.60	1.48	-0.12	⇩ -7.7%	
Other	1.64	1.25	1.34	1.43	1.35	1.31	1.49	1.50	1.30	1.43	1.51	1.58	1.52	1.05	1.48	0.42	⇧ 39.9%	
Total	**1.91**	**1.91**	**2.01**	**2.03**	**2.01**	**1.98**	**2.02**	**2.01**	**1.83**	**2.04**	**2.08**	**2.14**	**2.05**	**1.94**	**2.02**	**0.09**	⇧ 4.5%	

Briefing

- The Netcall text reminder service was implemented during June and the Trust have now started two way text reminder pilots for a number of clinic types within Plastics and Dermatology.
- Compared to the previous year the Trust is seeing an increase in patients not attending their outpatient appointments with a number of services above threshold. For the month of October 10.5% of patients did not attend, this on average is 320 patients per working day.
- Renal & Oncology, Specialist Medicine and Womens Services have seen a reduction in DNA rates compared to last year.

Actions

- A review is underway to identify any relationship between the period of notice given to patients and their propensity to not attend
- One way text reminders are fully live and two way is now being piloted

Theatre – Touch Time Utilisation

Theatre Utilisation

Main List Specialty	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Number of Patients in the last month
Cardiothoracic	89%	81%	76%	69%	74%	64%	79%	81%	75%	74%	69%	70%	72%	69
ENT	79%	74%	71%	70%	75%	77%	75%	81%	77%	80%	84%	76%	77%	153
General Surgery	80%	83%	78%	79%	78%	77%	79%	78%	80%	82%	79%	82%	80%	214
Gynaecology	79%	76%	77%	84%	77%	78%	77%	77%	77%	83%	81%	73%	83%	144
Neurosurgery	83%	86%	76%	81%	77%	83%	76%	87%	80%	74%	84%	78%	76%	180
Oral and Maxillo Facial Surgery	72%	81%	50%	82%	76%	62%	58%	71%	73%	89%	75%	82%	63%	20
Paediatric Dentistry	56%	61%	61%	51%	46%	57%	62%	53%	50%	53%	58%	55%	56%	49
Paediatric Surgery	79%	74%	83%	79%	78%	74%	78%	82%	80%	81%	78%	75%	74%	129
Plastic Surgery	79%	75%	71%	68%	68%	69%	73%	74%	73%	77%	75%	75%	77%	216
Renal Medicine & Surgery	75%	68%	74%	77%	74%	79%	67%	76%	71%	72%	78%	61%	67%	31
Trauma & Orthopaedics	87%	96%	80%	82%	86%	80%	87%	76%	85%	84%	79%	82%	88%	152
Urology	80%	82%	74%	75%	79%	79%	77%	84%	78%	88%	84%	84%	85%	241
Vascular Surgery	78%	73%	66%	65%	75%	77%	77%	77%	76%	72%	68%	74%	76%	62
Grand Total	**81%**	**81%**	**75%**	**75%**	**76%**	**77%**	**77%**	**80%**	**78%**	**79%**	**79%**	**77%**	**78%**	**1,660**

Theatre Average Cases per Session

Main List Specialty	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend
Cardiothoracic	1.5	1.5	1.3	1.6	1.5	1.5	1.6	1.6	1.8	1.8	1.5	1.3	1.4	
ENT	1.8	1.6	1.5	1.7	1.4	1.6	1.8	1.9	1.8	1.7	1.8	1.7	1.7	
General Surgery	2.0	1.9	2.0	1.7	1.8	1.9	1.9	1.9	1.8	1.8	1.7	1.7	1.8	
Gynaecology	2.4	2.5	2.2	2.3	1.9	2.5	2.4	2.3	2.3	2.7	2.6	2.5	2.6	
Neurosurgery	1.3	1.3	1.1	1.2	1.2	1.2	1.2	1.2	1.1	1.1	1.1	1.0	1.0	
Oral and Maxillo Facial Surgery	3.2	3.2	1.9	3.9	3.6	3.3	3.0	3.6	3.0	4.0	3.7	3.9	3.1	
Paediatric Dentistry	3.7	4.7	3.8	3.6	4.0	4.3	4.3	3.7	4.2	4.0	3.8	4.1	3.9	
Paediatric Surgery	2.5	2.6	2.5	2.5	2.6	2.7	2.4	2.6	2.4	2.6	2.6	2.7	2.6	
Plastic Surgery	2.3	2.1	1.9	2.0	1.9	2.2	2.2	2.0	2.0	2.0	2.2	2.2	2.1	
Renal Medicine & Surgery	1.5	1.4	1.7	1.5	1.8	1.3	1.8	1.5	1.7	1.4	1.4	1.3	1.6	
Trauma & Orthopaedics	1.8	1.8	2.0	1.7	1.8	1.5	1.6	1.4	1.6	1.6	1.5	1.6	1.9	
Urology	1.8	1.8	2.1	1.8	1.8	2.0	2.1	2.1	2.1	2.0	2.1	2.1	2.1	
Vascular Surgery	1.2	1.1	1.0	1.0	1.2	1.2	1.2	1.3	1.0	1.1	1.2	1.2	1.1	
Grand Total	1.9	1.8	1.7	1.7	1.7	1.8	1.8	1.8	1.8	1.8	1.8	1.7	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. Daily huddles are now in place to review booking targets with the patient pathway coordinators, this is having a positive impact reaching out target booking numbers in early November and increasing Day Surgery Utilisation to 87%.

Actions

- 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. A newly developed tool will be introduced to robustly look at the list planning process.
- 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.
- Increase to baseline Patient Pathway Coordinator (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 %.
- Daily Huddles with Pathway Coordinators have commenced reviewing daily booking targets and identifying on the day issues with services

Number of Elective Patients treated per Working Day

														Average No. of Patients per month			
Months	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**2017-18**	**2018-19**	**Variance**	**Discharges for month**
Cardiology & Cardiac Surgery	8.0	9.0	7.3	6.9	7.8	8.7	7.4	7.9	8.7	6.3	7.6	7.3	6.5	7.8	7.4	-6%	149
Clinical Haematology	0.3	0.6	0.7	0.5	0.3	0.8	0.7	0.5	0.7	0.6	0.7	0.7	0.4	0.6	0.6	5%	9
Endoscopy & General Medicine	0.5	0.3	1.0	0.7	0.6	0.4	0.9	0.5	1.2	0.4	0.5	1.0	0.5	0.6	0.7	17%	12
ENT	6.9	5.7	5.2	5.2	5.4	5.6	3.7	5.0	5.3	3.7	3.3	5.6	5.9	5.9	4.6	-21%	136
General Surgery	5.3	6.6	6.0	5.2	6.2	6.9	5.0	4.9	5.5	3.8	4.4	6.3	6.6	5.7	5.2	-9%	151
Gynae & Obstetrics	3.0	2.9	2.6	2.4	3.1	3.9	3.2	2.5	2.9	2.4	2.8	2.6	2.9	3.2	2.7	-14%	67
Max Fax & Dental	2.5	2.9	3.1	3.6	3.4	3.0	3.2	3.2	3.0	1.6	2.8	3.4	3.3	2.8	2.9	6%	77
Neuro Surgery	5.3	6.3	4.7	5.1	5.7	6.5	6.0	6.2	6.1	5.7	5.0	6.7	5.9	5.7	5.9	4%	136
Neurology	1.6	1.6	1.6	1.2	1.8	1.4	1.5	1.2	1.5	1.5	1.5	1.9	1.6	1.5	1.5	1%	36
Oncology	1.0	0.9	0.7	0.2	0.6	0.6	1.0	0.8	0.7	0.8	0.8	0.6	0.7	1.0	0.8	-25%	17
Paediatric Medicine	1.0	1.0	0.7	0.6	0.6	0.5	1.6	0.8	1.2	0.4	1.9	0.4	0.7	0.8	1.0	20%	15
Paediatric Surgery	1.9	2.0	2.1	1.9	1.9	1.6	1.6	2.0	1.8	1.8	1.5	1.9	1.4	1.9	1.7	-11%	32
Plastic Surgery	6.4	7.0	6.8	5.1	5.9	6.4	5.0	5.6	4.8	2.3	2.0	4.1	3.4	6.1	3.9	-37%	79
Renal Medicine	1.1	0.8	0.9	0.8	1.1	1.0	1.1	1.1	1.6	1.0	1.1	1.1	1.0	1.2	1.1	-8%	22
Trauma & Orthopaedics	3.0	3.0	3.3	2.9	2.2	4.0	3.0	2.1	2.0	2.0	2.5	2.7	2.2	3.1	2.4	-23%	50
Urology	6.0	5.6	4.8	4.7	6.0	6.8	7.6	6.1	6.1	4.6	5.5	7.1	6.9	7.0	6.3	-10%	159
Vascular Surgery	2.5	2.3	2.8	2.7	3.9	3.7	3.2	3.4	2.8	2.5	2.8	2.7	2.6	2.8	2.9	2%	60
Other	3.4	4.2	3.8	3.7	4.0	4.2	3.4	4.1	4.5	3.8	3.4	3.3	3.0	3.9	3.6	-7%	69
Grand Total	**59.7**	**62.7**	**58.1**	**53.6**	**60.1**	**66.0**	**58.5**	**58.0**	**60.5**	**45.2**	**50.2**	**58.9**	**55.5**	**61.5**	**55.2**	-10%	**1,276**

Briefing

- There has been a recent switch of activity from Elective Ordinary to Elective Daycase of approximately twelve patients per day year on year.
- 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

- 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 commenced on the 20th August for the centralised PPC team and is fully up to speed.

St George's University Hospitals NHS
NHS Foundation Trust

Number of Patient Daycases per Working Day

														Average No. of Patients per month			
Months	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**2017-18**	**2018-19**	**Variance**	**Discharges for month**
Cardiology & Cardiac Surgery	9.3	8.5	6.8	8.0	8.9	6.9	7.5	8.4	8.3	9.2	7.7	8.4	7.3	8.5	8.1	-4%	169
Clinical Haematology	1.5	1.5	1.1	1.5	2.4	2.1	1.1	1.6	1.5	1.1	0.7	1.5	1.3	1.6	1.3	-21%	29
Endoscopy & General Medicine	51.8	49.2	53.3	46.2	51.2	50.4	54.1	60.3	59.8	55.3	55.2	55.3	54.7	52.8	56.4	7%	1,258
ENT	3.1	3.1	2.8	2.3	2.6	1.8	2.5	3.9	3.3	5.3	4.5	3.4	3.0	3.1	3.7	18%	70
General Surgery	4.2	4.5	3.8	4.2	4.5	3.7	4.5	4.7	5.1	5.0	4.4	4.9	3.2	4.1	4.5	10%	74
Gynae & Obstetrics	8.3	7.9	5.9	7.4	7.1	7.2	6.7	7.0	7.4	9.0	7.8	7.7	8.5	7.1	7.7	9%	196
Max Fax & Dental	2.9	4.0	3.0	2.7	3.4	2.7	3.2	3.5	3.3	5.1	3.4	4.0	3.1	3.2	3.7	14%	71
Neuro Surgery	3.7	2.9	2.6	2.7	2.9	3.0	3.4	2.5	3.2	3.5	3.1	3.3	3.1	3.0	3.1	5%	72
Neurology	21.0	27.3	21.4	23.8	21.0	20.8	23.7	23.0	26.4	24.4	22.5	23.9	28.6	22.4	24.6	10%	658
Oncology	0.9	1.7	1.4	1.5	1.2	1.1	0.7	1.1	1.1	1.0	0.9	1.1	0.9	1.6	1.0	-38%	20
Paediatric Medicine	8.0	8.2	7.9	9.0	8.3	6.8	8.5	9.4	7.2	9.6	7.6	9.2	10.1	8.3	8.8	7%	232
Paediatric Surgery	8.1	7.8	5.1	6.3	6.9	7.1	6.9	6.0	6.8	6.5	7.1	8.0	7.5	6.8	7.0	2%	173
Plastic Surgery	7.3	8.5	7.5	8.0	8.8	8.2	11.2	13.1	12.9	15.1	17.2	14.7	12.8	7.8	13.8	77%	295
Renal Medicine	3.2	2.9	3.6	3.8	3.1	2.7	4.3	4.3	4.1	3.5	4.2	4.2	3.7	3.3	4.0	23%	84
Trauma & Orthopaedics	4.0	4.6	4.6	4.2	3.8	4.4	4.4	4.9	4.7	5.8	4.0	3.5	3.7	4.1	4.4	8%	86
Urology	5.7	6.0	6.8	5.7	4.5	3.7	4.1	5.1	7.1	8.4	6.1	6.3	5.1	4.8	6.0	25%	118
Vascular Surgery	2.6	2.6	2.1	2.3	2.4	2.3	2.2	2.6	1.5	2.3	1.6	2.0	2.5	2.2	2.1	-5%	57
Diabetes/Endocrinology	1.6	1.6	1.4	1.4	1.5	0.8	2.0	2.3	1.5	1.7	1.9	2.0	1.9	1.6	1.9	16%	43
Other	7.5	8.8	7.4	8.2	9.3	9.0	8.8	11.3	10.5	10.5	9.8	9.2	7.9	7.9	9.7	23%	181
Grand Total	**154.7**	**161.6**	**148.5**	**149.1**	**153.5**	**144.8**	**159.4**	**175.1**	**175.9**	**182.1**	**169.6**	**172.3**	**169.0**	**154.2**	**171.9**	**11%**	**3,886**

Daycase as a percentage of all Activity	72%	72%	72%	74%	72%	69%	73%	75%	74%	80%	77%	75%	75%

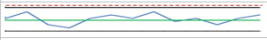
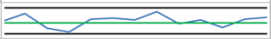
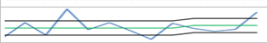
Briefing

- The number of daycase procedures per working day has seen a positive increase compared to the same period last year, treating on average fourteen more patients per working.

Actions

- Bespoke scheduling manuals for Day Surgery Unit services to support activity will be rolled out to inpatient services as phase 2

Patient Safety

Indicator Description	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend (12 months)
Number of Never Events in Month	0	1	0	0	1	0	2	1	0	0	0	0	0	2	
Number of SIs where Medication is a significant factor	0	0	0	0	0	0	1	0	0	0	0	0	0	1	
Number of Serious Incidents	8 / mth	4	6	2	1	4	5	4	6	3	4	2	4	5	
Serious Incidents - per 1000 bed days	N/A	0.16	0.24	0.08	0.04	0.18	0.19	0.17	0.26	0.13	0.17	0.09	0.18	0.20	
Safety Thermometer - % of patients with harm free care (all harm)	95%	94.9%	95.0%	95.1%	94.9%	94.8%	94.3%	93.1%	95.3%	96.5%	94.9%	95.7%	96.3%	95.1%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.7%	98.1%	98.5%	98.9%	97.9%	98.5%	97.8%	98.0%	98.7%	98.5%	98.2%	99.0%	98.3%	
Percentage of patients who have a VTE risk assessment	95%	96.1%	96.4%	96.0%	95.4%	96.3%	96.0%	95.9%	95.8%	96.0%	96.9%	96.4%	96.2%		
Number of Patient Falls	N/A	122	157	127	189	140	157	138	117	155	143	136	141	181	
Falls (Moderate and Above Severity)	N/A	2	1	3	1	2	2	3	1	1	1	1	0	1	
Number of patient falls- per 1000 bed days	N/A	4.89	6.23	5.17	7.49	6.15	6.05	5.77	5.01	6.70	6.11	5.91	6.26	7.40	
Acquired Category 2 Pressure Ulcers	N/A	7	16	13	16	13	12	2	6	10	20	15	9	12	
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.28	0.64	0.53	0.63	0.57	0.46	0.08	0.26	0.43	0.85	0.65	0.40	0.49	
Avoidable Category 3 & 4 Pressure Ulcers	0	0	0	0	0	0	0	5	0	2	2	3	2	0	
Avoidable Category 3 & 4 Pressure Ulcers per 1000 bed days	0	0.00	0.00	0.00	0.00	0.00	0.00	0.21	0.00	0.09	0.09	0.13	0.09	0.00	
Acquired Category 3 Pressure Ulcers			15	6	9	6	6	11	4	6	5	3	2	1	
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Briefing

- Two Never Events were reported in October, in one of these incidents medication was a significant factor.
- Five Serious Incidents (SIs) were reported in October, with a total of twenty-eight SIs year to date.
- The number of falls reported in September was 181, of the falls reported one patient sustained moderate harm.
- All grade 3 and 4 pressure ulcers that are acquired at the Trust have had an rapid response review completed. These are reviewed by a panel chaired by the Chief Nurse to establish their avoidability. In October no patients acquired a grade 3 or grade 4 pressure ulcer that was found to be avoidable.

- 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 the NHSI Pressure Ulcer Collaborative and has focused on two wards. An improvement has been seen on these wards with no grade 3 or 4 pressure ulcers in recent months. The programme will be rolling out to other wards.

Infection Control

Indicator Description	Threshold	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD Actual	YTD Theshold	Trend (12 months)
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	
Cdiff Incidences (in month)	30	4	0	0	0	1	2	6	1	3	3	2	2	3	20	18	
MSSA	25	1	2	3	0	3	1	2	2	1	1	2	1	4	13	15	
E-Coli	60	6	2	5	5	5	5	1	9	6	4	3	4	2	29	35	

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 October the Trust reported three cases, totalling 20 cases year to date.
- The Trust annual threshold for E coli is 60 for 2018-19 and year to date the Trust has reported 29 cases, 2 of which occurred in October.
- 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 a total of 4 incidents in the month of October and remain below threshold.

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

The Trust is anticipating an NHSI collaborative to reduce E Coli infections, representation from this group includes colleagues from partner organisations and is multi professional

Mortality and Readmissions

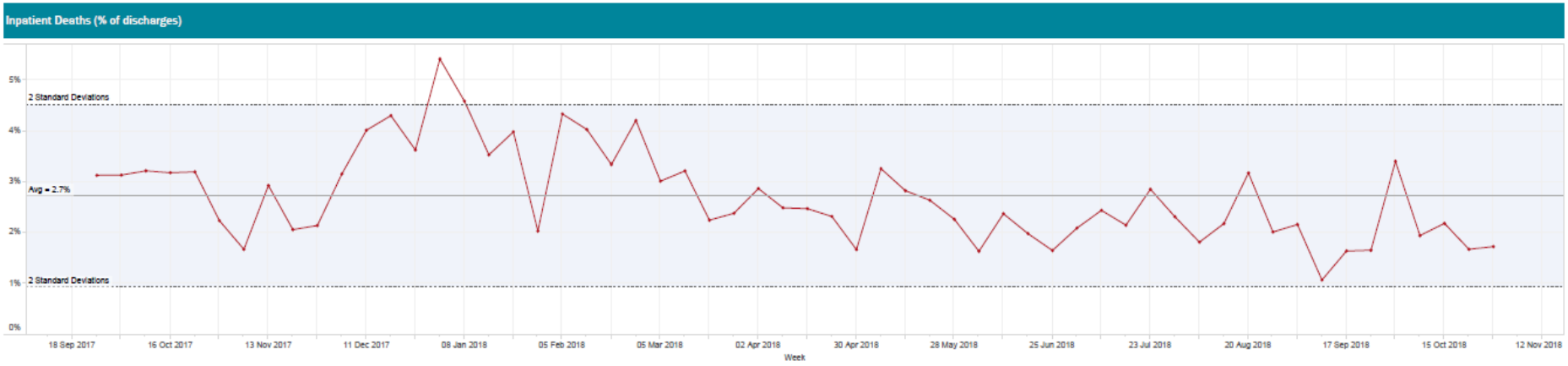
Indicator Description	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Sep-17 to Aug 2018	Trend
Hospital Standardised Mortality Ratio (HSMR)	78.9	86.1	90.1	72.6	97.3	93.8	106.3	94.9	86.7	79.5	69.8	80.3	86.8	
Hospital Standardised Mortality Ratio Weekend Emergency	89.5	93.7	101.2	78.8	107.9	123.7	121.5	113.8	78.2	97.6	79.5	72.2	96	
Hospital Standardised Mortality Ratio Weekday Emergency	68.8	75.5	88.3	76.2	95.3	84.9	95.6	79.7	87.1	82.5	67.6	78.1	82.6	

Indicator Description	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend
Summary Hospital Mortality Indicator (SHMI)	0.84	0.84	0.84	0.84	0.84	0.83	0.83	0.83	0.83	0.82	0.82	0.82	0.84	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	10.2%	9.2%	9.4%	8.9%	9.0%	9.2%	8.7%	8.8%	8.3%	8.90%	8.10%	8.30%		

Please note SHMI data is reflective of the period April 2017 to March 2018 based on a rolling 12 month period (published 20th September).
HSMR data reflective of period August 2017 – July 2018 based on a monthly published position (published 22nd November).
Mortality Green Rag Rating is reflective of periods where the Trust are better than expected, non-Rag Rating is where the Trist are in line with expected rates.

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 ofmortality signals in cardiac surgery, general intensive care and total hip replacement surgery that are under investigation as well as a number of more discretediagnostic and procedure codes from Dr Foster that are reviewed monthly by the Mortality Monitoring Committee.



Admissions via ED

Maternity

Definitions	Format	Target	Oct '17	Nov '17	Dec '17	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18	Oct '18	Trend
Total number of women giving birth- (per calendar day)	Number	5000 per yr	14	13	12	13	12	13	14	14	13	13	13	15	13	
% of all deliveries where caesarean section occurred	%	<31%	29.0%	29.6%	24.1%	23.0%	23.9%	25.3%	26.3%	28.1%	28.0%	25.1%	23.2%	23.8%	26.8%	
% deliveries with emergency c-section including no Labour)	%	<21%	17.0%	16.5%	12.4%	12.6%	12.7%	12.9%	13.9%	14.7%	14.9%	14.9%	10.3%	10.5%	11.8%	
Number of hours in the month that Carmen Suite closed	%	0													6	
% of all births in which woman sustained a 3rd or 4th degree tear	%	<5%	3.5%	2.3%	2.7%	4.9%	3.8%	3.4%	3.8%	3.5%	3.5%	5.1%	4.5%	3.3%	2.0%	
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	%	<4%	2.1%	2.0%	3.0%	2.0%	3.2%	2.1%	1.9%	2.8%	1.7%	2.4%	3.6%	1.8%	2.0%	
Number of term babies (> 34 weeks), with unplanned admission to NNU	Number		13	11	10	10	10	7	7	12	12	2	17	11	8	
Supernumerary Midwife in Labour Ward	%	>95%													95.16%	
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	Number	>2	1	1	0	1	0	0	0	2	2	0	0	0	2	
Number of babies still born at term (37 weeks+)	Number	<3	0	0	1	1	1	0	0	1	1	1	0	0	0	
Number of babies still born at term (28 to 36 weeks and6 days)	Number	<3	0	0	1	1	1	0	2	2	0	1	0	1	0	
Number of babies still born at term (24 to 27 weeks and 6 days)	Number	<3	0	0	1	1	0	4	1	0	0	0	3	1	3	
Number of babies born alive who die within (7 days of birth)	Number	<3	0	0	0	2	4	1	1	0	1	1	3	1	2	
% women booked by 12 weeks and 6 days	%	90%	70.9%	73.2%	72.9%	59.6%	65.6%	66.1%	57.7%	61.4%	67.9%	75.0%	77.8%	82.6%	75.9%	

Briefing

In October 399 women birthed, producing 406 babies. This number was below the target of 417 births per month, but followed a very busy September.
The total caesarean section rate remained well below the national average at 26.8% and Post Partum Haemorrhage, 3rd and 4th degree tears and still birth rates were also in line with our expected standards.

Despite significant staffing challenges in the month, a supernumerary co-ordinator was available on over 95% (59 out of 62) of shifts in the months. The Carmen Birth Centre was on divert on 6 occasions with staff deployed elsewhere. This was due to it either having no activity or high activity on the Delivery Suite. We did not capture how many women birthed on Delivery Suite as a result of these closures, but it will be closely monitored as our aim is always to ensure place of birth options for women at all times. Both of these metrics will form part of the Safe Care reporting from December.

The performance on booking women by 12+6 has plateaued and being a tertiary referral unit together with late referrals will affect this target. There is a renewed focus on antenatal care as part of the Maternity Transformation Programme, and this along with the launch of the Continuity of Carer teams will ensure that the performance on this metric will continue to be closely monitored.

Actions:

- Review definitions for HIE and systems for capturing data to ensure that correct numbers are being reported.
- Based on above review, instigate a review of cases if numbers fall outside of expected norms
- Continue to monitor staffing across the service with a plan for responsive recruitment

Patient Experience

St George's University Hospitals NHS
NHS Foundation Trust

Patient Voice

Indicator Description	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend
Emergency Department FFT - % positive responses	90%	86.4%	84.1%	86.5%	82.2%	81.0%	81.4%	84.0%	85.0%	85.5%	83.7%	84.6%	83.5%	84.2%	
Inpatient FFT - % positive responses	95%	96.5%	95.7%	95.6%	94.7%	96.0%	96.3%	97.2%	97.3%	97.1%	96.7%	96.6%	96.3%	97.0%	
Maternity FFT - Antenatal - % positive responses	90%		100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	97.2%	100.0%	100.0%	100.0%	100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	
Maternity FFT - Postnatal Ward - % positive responses	90%	92.6%	96.0%	100.0%	99.0%	90.4%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	98.7%	100.0%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100%	91.6%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%		
Community FFT - % positive responses	90%	98.9%	95.7%	96.5%	99.2%	93.3%	98.3%	97.1%	98.5%	98.3%	98.0%	98.4%	99.5%	95.6%	
Outpatient FFT - % positive responses	90%	96.3%	94.3%	98.2%	97.6%	96.1%	98.4%	97.3%	97.3%	97.4%	97.4%	97.1%	96.3%	94.9%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		96	77	68	90	80	94	96	85	79	120	96	93	90	
PALS Received		198	305	262	290	236	259	264	317	292	337	294	335	416	

Briefing

- ED Friends and Family Test (FFT) – The score has seen a slight increase in October reporting 84.2% in the recommended rate.
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 97% in October 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.
- All complaints are assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days. Complaints with a 25 day response time have been within 5-6% of trajectory for the past two months, it is disappointing to see that performance has dropped in September to 57% and has not met the trajectory. For 40 day complaints received in August 58% were responded to within the timescale. There were three 60 day complaints received in July 2018, two met the response deadline achieving performance of 66%, in August there was one 60 day complaint, it was responded to within timescale achieving performance of 100%
  .

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.

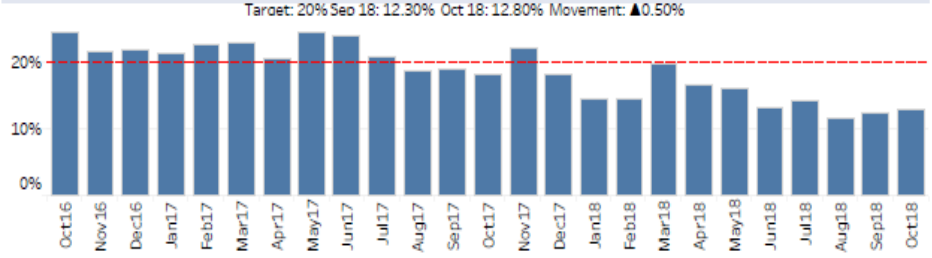
Patient Voice

CARING – Friends and Family Test

--- Target ¢ MetricMeasure Percentage Neutral

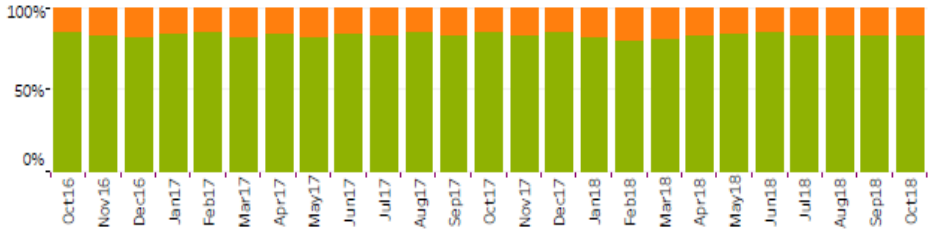
A&E Friends & Family Response Rate

Target: 20% Sep 18: 12.30% Oct 18: 12.80% Movement: ▲0.50%



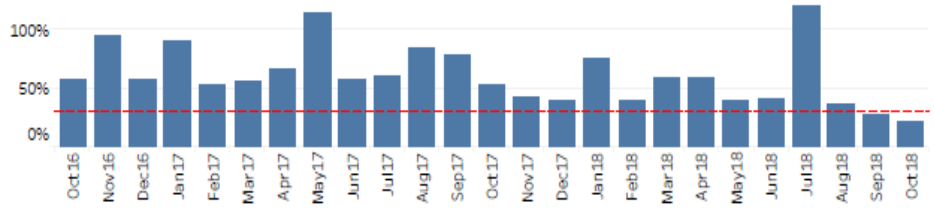
A&E Friends & Family Recommend Rate

The expected target is 90%



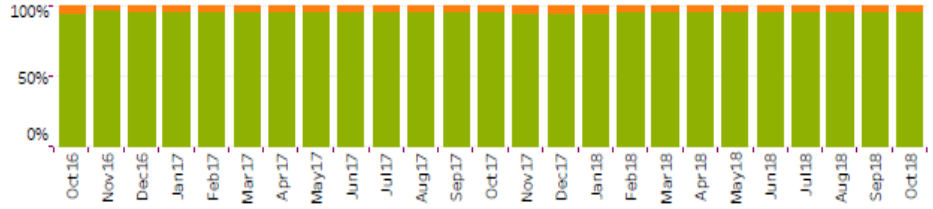
IP Friends & Family Response Rate

Target: 30% Sep 18: 27.20% Oct 18: 20.60% Movement: ▼-6.60%



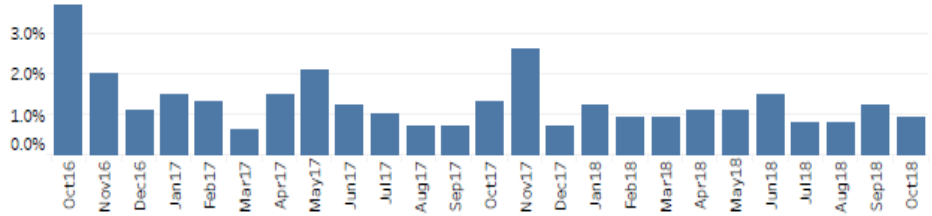
IP Friends & Family Recommend Rate

The expected target is 95%



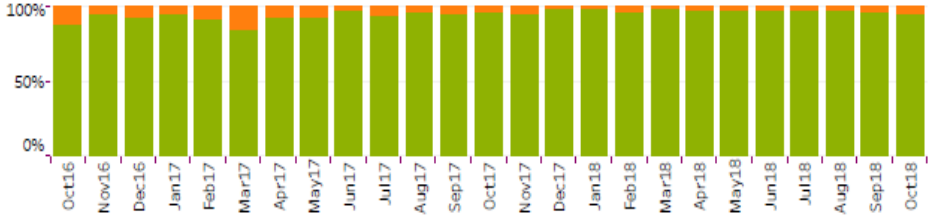
OP Friends & Family Response Rate

Target: 20% Sep 18: 1.20% Oct 18: 0.90% Movement: ▼-0.30%



OP Friends & Family Recommend Rate

The expected target is 90%

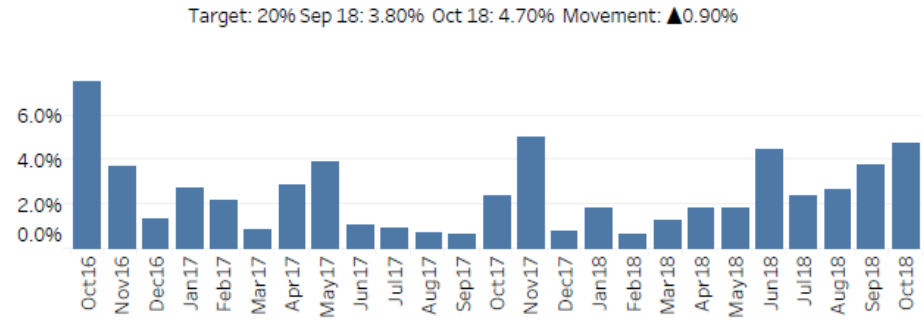


Patient Voice

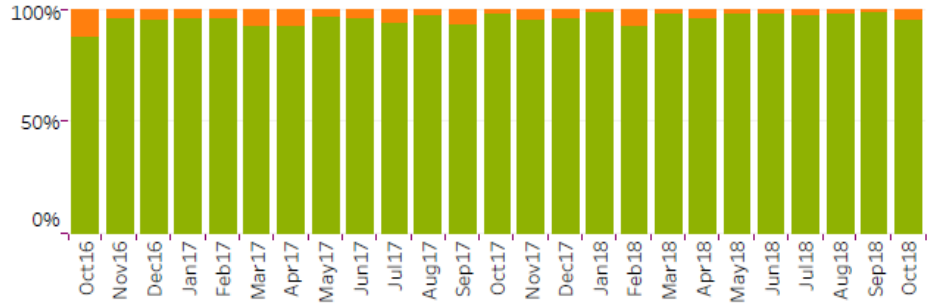
CARING – Friends and Family 2

--- Target ¢ MetricMeasure Percentage Neutral

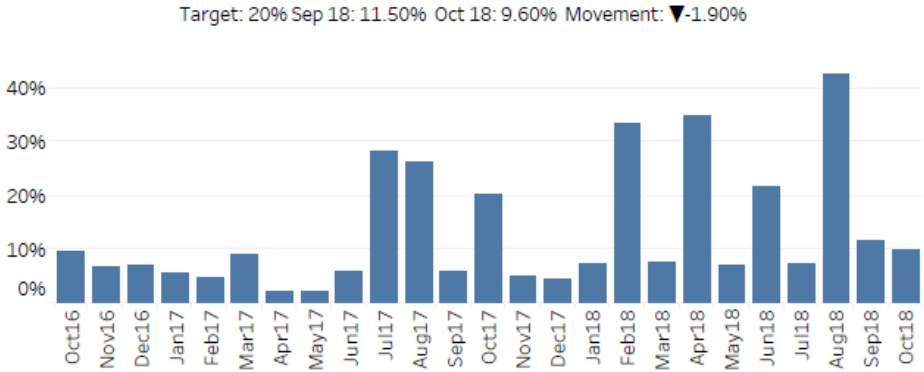
Community Friends & Family Response Rate



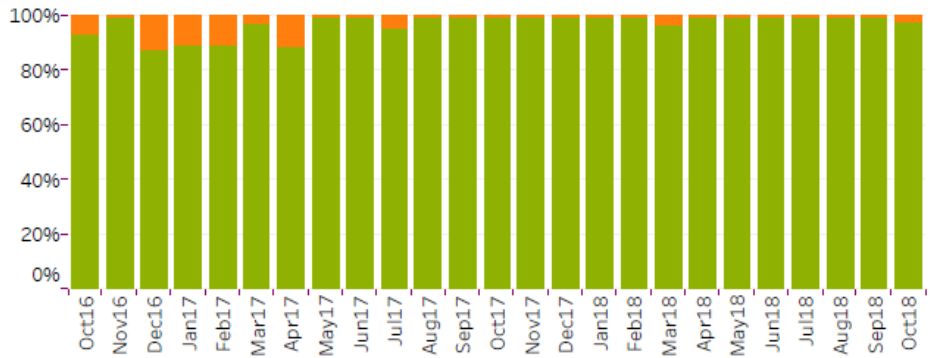
Community Friends & Family Recommend Rate
The expected target is 90%



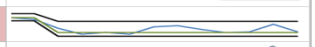
Maternity (Birth) Friends & Family Response Rate



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



Emergency Flow

Indicator Description	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend
4 Hour Operating Standard	95%	88.0%	87.2%	85.0%	83.0%	83.5%	81.6%	88.4%	93.3%	93.6%	93.3%	91.1%	90.3%	90.1%	
Patients Waiting in ED for over 12 hours following DTA	0	0	1	0	0	0	2	1	1	0	1	0	1	0	
Time to Treatment (number of patients seen within 60 minutes)	60%	54.2%	54.2%	54.1%	51.7%	52.2%	52.6%	61.5%	63.5%	65.5%	63.7%	70.3%	64.1%	69.5%	
Admitted patients with a length of stay 7 Days or Greater		348	362	376	373	337	343	355	308	324	315	316	301	325	
Ambulance Turnaround - % under 15 minutes	100%	49.9%	49.0%	44.3%	41.0%	42.2%	41.0%	45.0%	45.7%	43.6%	42.0%	42.3%	46.4%	42.5%	
Ambulance Turnaround - % under 15 minutes (London Average)	100%	45.1%	46.1%	42.1%	41.4%	42.2%	41.1%	45.2%	45.7%	47.4%	46.7%	48.1%	52.6%	47.4%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	57	82	112	180	135	105	92	65	72	75	85	109	111	
Ambulance Turnaround - % under 30 minutes	100%	97.4%	96.2%	94.8%	91.3%	93.2%	94.5%	95.3%	96.8%	96.3%	98.5%	95.5%	94.1%	94.5%	
Ambulance Turnaround - % under 30 minutes (London Average)	100%	91.9%	91.7%	91.6%	86.7%	87.4%	87.5%	88.8%	91.9%	93.7%	93.1%	92.2%	92.5%	92.2%	
Ambulance Turnaround - number over 60 minutes	0	0	0	2	3	3	10	1	0	0	0	2	3	0	

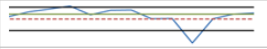
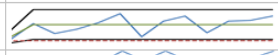
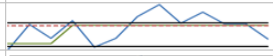
Briefing

- Performance against the Four Hour Operating Standard in October was 90.1%, which was below the monthly improvement trajectory of 93%. The improvement trajectory requires the delivery of 93% performance in November 2018 and relies upon continued improvement in the experience for patients not requiring admission.
- Urgent and Emergency Care Attendances in October were 0.5% 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. The number of patients admitted via the Emergency Department has increased by 10% compared to October 2017 (14 patients per day) and with bed occupancy increasing the focus remains on reducing long length of stay patients.
- Four Hour Operating Standard performance for patients requiring admission in October has seen an improvement of 8% compared to the same period last year, however performance has decreased going in to the winter period.
- Key issues included delays in the Emergency Department assessment process, bed availability, treatment to decision waiting times and four hour operating standard for patients referred to specialties, which fell to 70% in October.

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
- Flu Point of Care Testing to be re-launched for the Winter period, with the aim of reducing delays in the management of Flu, reducing the turnaround times from a minimum of 90 minutes to 18 minutes

Cancer

Indicator Description	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	94.0%	96.1%	97.3%	98.5%	94.8%	96.7%	96.8%	93.1%	93.3%	83.0%	93.1%	95.0%	95.5%	1,128	
Cancer 14 Day Standard Breast Symptomatic	93%	98.2%	99.6%	98.0%	97.3%	95.9%	96.5%	96.8%	94.4%	79.4%	22.2%	55.2%	86.4%	97.9%	233	
Cancer 31 Day Diagnosis to Treatment	96%	96.2%	98.1%	96.9%	97.4%	98.2%	99.3%	96.5%	98.4%	99.0%	97.0%	98.4%	98.5%	99.0%	201	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	82.4%	94.1%	96.9%	94.3%	94.6%	100.0%	95.5%	100.0%	95.7%	94.1%	95.0%	96.6%	100%	37	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	92	
Cancer 62 Day Referral to Treatment Standard	85%	76.7%	85.5%	80.8%	86.8%	77.8%	80.8%	88.1%	92.3%	85.9%	89.6%	85.7%	85.7%	80.6%	51.5	
Cancer 62 Day Referral to Treatment Screening	90%	93.0%	78.4%	92.7%	93.9%	86.1%	89.1%	95.2%	80.8%	92.7%	84.6%	73.8%	91.6%	94.1%	25.5	

Briefing

- The Trust met six of the seven Cancer standards in the month of September, continuing to achieve 14 day standard and maintaining returning to compliance against all Breast Symptomatic standards.
- Performance against 62 day standard was reported at 80.6% overall, reporting a total of ten patients treated passed the 62 day target of which a number of these were due to late referrals from other providers. Positively on the Trust's internal and reallocated position the national standard of 85% was met and year to date performance is currently at 89.41%.

62 Day wait for First Treatment- GP referral to treatment (actual and internal performance)			
Month	Target	Actual Performance	Internal Performance
Apr-18	85%	92.3%	96.7%
May-18	85%	85.9%	87.1%
Jul-18	85%	85.7%	89.4%
Aug-18	85%	85.7%	89.1%
Sep-18	85%	80.6%	85.0%

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.

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	No of Patients
Brain	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	100.0%	-	0
Breast	93%	94.1%	97.4%	98.4%	98.2%	96.0%	96.5%	93.9%	94.8%	91.9%	61.2%	87.4%	97.5%	94.5%	127
Children's	93%	100.0%	100.0%	71.4%	100.0%	87.5%	100.0%	100.0%	80.0%	100.0%	100.0%	90.9%	-	100.0%	5
Gynaecology	93%	91.1%	90.8%	95.0%	97.6%	98.0%	96.8%	94.3%	94.9%	91.9%	86.1%	91.7%	90.8%	81.9%	83
Haematology	93%	100.0%	96.8%	100.0%	94.7%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	20
Head & Neck	93%	90.6%	99.1%	99.4%	98.4%	100.0%	97.6%	100.0%	100.0%	97.5%	92.3%	93.0%	95.6%	99.3%	136
Lower Gastrointestinal	93%	94.6%	97.4%	97.7%	99.3%	95.2%	100.0%	97.8%	94.1%	90.3%	67.5%	94.7%	98.9%	94.3%	230
Lung	93%	94.1%	97.7%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	96.3%	90.9%	97.6%	94.7%	95.2%	21
Skin	93%	93.4%	95.0%	95.5%	97.9%	92.7%	94.8%	95.9%	94.1%	93.8%	92.7%	93.3%	92.9%	97.4%	346
Upper Gastrointestinal	93%	98.8%	98.5%	99.0%	100.0%	89.0%	97.3%	95.3%	85.2%	88.1%	89.9%	96.6%	93.9%	96.7%	60
Urology	93%	96.4%	93.3%	97.1%	98.9%	95.0%	95.1%	98.2%	81.3%	92.9%	96.5%	95.2%	93.1%	96.8%	100

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	No of Patients
Brain	85%	100.0%	-	100.0%	-	-	-	-	-	-	-	-	-	-	0
Breast	85%	91.7%	100.0%	95.2%	100.0%	71.4%	100.0%	88.9%	94.1%	84.6%	91.7%	90.9%	78.9%	100.0%	8.5
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	50.0%	83.3%	75.0%	67.0%	80.0%	77.8%	0.0%	100.0%	80.0%	100.0%	75.0%	100.0%	80.0%	5
Haematology	85%	88.9%	100.0%	-	100.0%	88.9%	83.3%	81.8%	100.0%	63.6%	100.0%	100.0%	88.9%	75.0%	4
Head & Neck	85%	87.5%	78.6%	81.8%	71.0%	100.0%	83.3%	80.0%	100.0%	90.0%	75.0%	72.7%	81.8%	80.0%	5
Lower Gastrointestinal	85%	66.7%	100.0%	80.0%	100.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	71.4%	83.3%	66.7%	3
Lung	85%	72.2%	72.7%	41.2%	33.0%	90.9%	57.1%	100.0%	100.0%	87.5%	83.3%	71.4%	66.7%	28.6%	3.5
Skin	85%	93.8%	90.9%	91.7%	93.0%	86.7%	100.0%	100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	84.6%	13.5
Upper Gastrointestinal	85%	0.0%	100.0%	84.0%	100.0%	33.3%	57.1%	66.7%	87.5%	33.3%	80.0%	100.0%	78.9%	50.0%	2
Urology	85%	77.4%	100.0%	72.7%	91.0%	60.7%	70.0%	96.7%	80.5%	84.6%	84.9%	85.7%	88.2%	92.9%	7
Other	85%	-	-	-	-	-	-	-	-	-	-	-	100.0%	-	0

Diagnostics

Indicator Description	Threshold	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend
6 Week Diagnostic Performance	1%	0.3%	1.9%	0.1%	0.1%	0.0%	0.2%	0.2%	0.2%	0.3%	0.3%	0.2%	0.4%	0.2%	
6 Week Diagnostic Breaches	N/A	22	143	6	10	3	17	15	14	25	24	15	30	18	
6 Week Diagnostic Waiting List Size	N/A	7,072	7,534	6,440	6,884	7,232	7,075	7,956	7,735	7,809	7,236	6,946	7,617	7,593	

Indicator Description	Threshold	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend
MRI	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.4%	0.0%	0.3%	0.1%	0.2%	
CT	1%	0.3%	0.1%	0.0%	0.1%	0.0%	0.3%	0.1%	0.0%	0.3%	0.0%	0.0%	0.0%	0.2%	
Non Obstetric Ultrasound	1%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.1%	0.6%	0.0%	
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%	0.7%	0.0%	0.0%	
Audiology Assessments	1%	0.0%	17.4%	0.0%	0.0%	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Echocardiography	1%	0.3%	0.8%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	
Electrophysiology	1%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.0%	0.0%	0.3%	0.9%	0.0%	0.4%	0.2%	0.0%	0.0%	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%	0.0%	0.0%	
Urodynamics	1%	16.7%	6.7%	0.0%	0.0%	0.0%	9.1%	5.0%	23.9%	6.3%	26.5%	0.0%	13.9%	14.6%	
Colonoscopy	1%	1.1%	0.0%	0.0%	0.0%	0.6%	0.7%	0.6%	0.4%	0.0%	0.0%	0.0%	0.0%	0.7%	
Flexi Sigmoidoscopy	1%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cystoscopy	1%	4.0%	1.8%	1.5%	2.8%	0.7%	0.0%	1.0%	0.8%	3.0%	1.8%	4.4%	2.6%	3.0%	
Gastroscopy	1%	0.0%	0.8%	0.4%	0.0%	0.0%	1.8%	1.0%	0.0%	0.0%	1.8%	0.0%	0.3%	0.0%	

Briefing

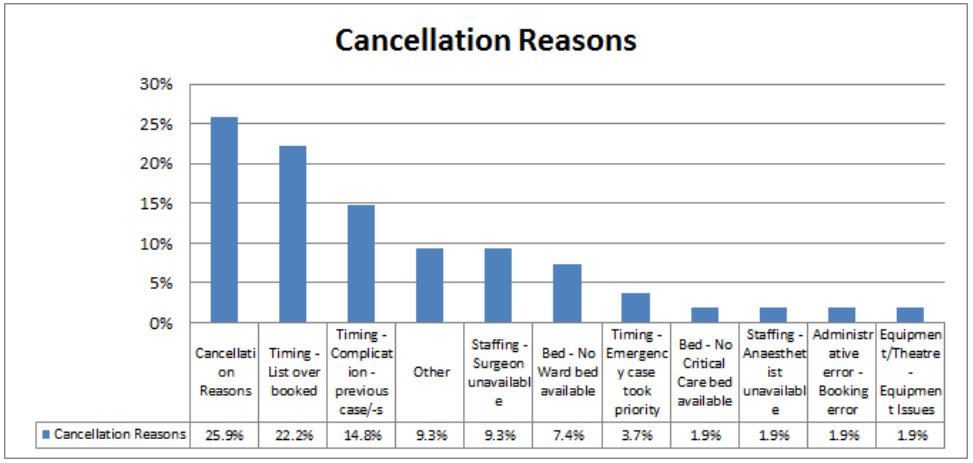
- The Trust has continued to achieve performance in October reporting a total of eighteen patients waiting longer than 6 weeks, 0.2% of the total waiting list.
- Compliance has been achieved in all modalities with the exception of Urodynamics with seven patients waiting beyond six weeks. An action plan has been agreed that will increase capacity by two sessions per month in early November.
- Performance continues to be monitored through the weekly performance meetings.

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend
Number of on the Day Cancellations		52	86	100	94	55	86	64	87	42	54	44	55	54	
Number of on the Day cancellations re-booked within 28 Days		34	76	67	76	48	76	60	80	33	51	39	48	45	
% of Patients re-booked within 28 Days	100%	65.4%	88.4%	67.0%	80.9%	87.3%	88.4%	93.8%	92.0%	78.6%	94.4%	88.6%	87.3%	83.3%	

Briefing

- In October 83.3% of our on the day cancelled patients were-rebooked within 28 days.
- Of the 54 cancellations reported, 48% were due to timing issues including lists being overbooked and complication with previous case.

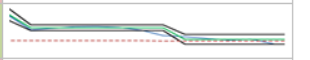
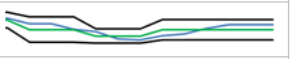


Actions

- 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

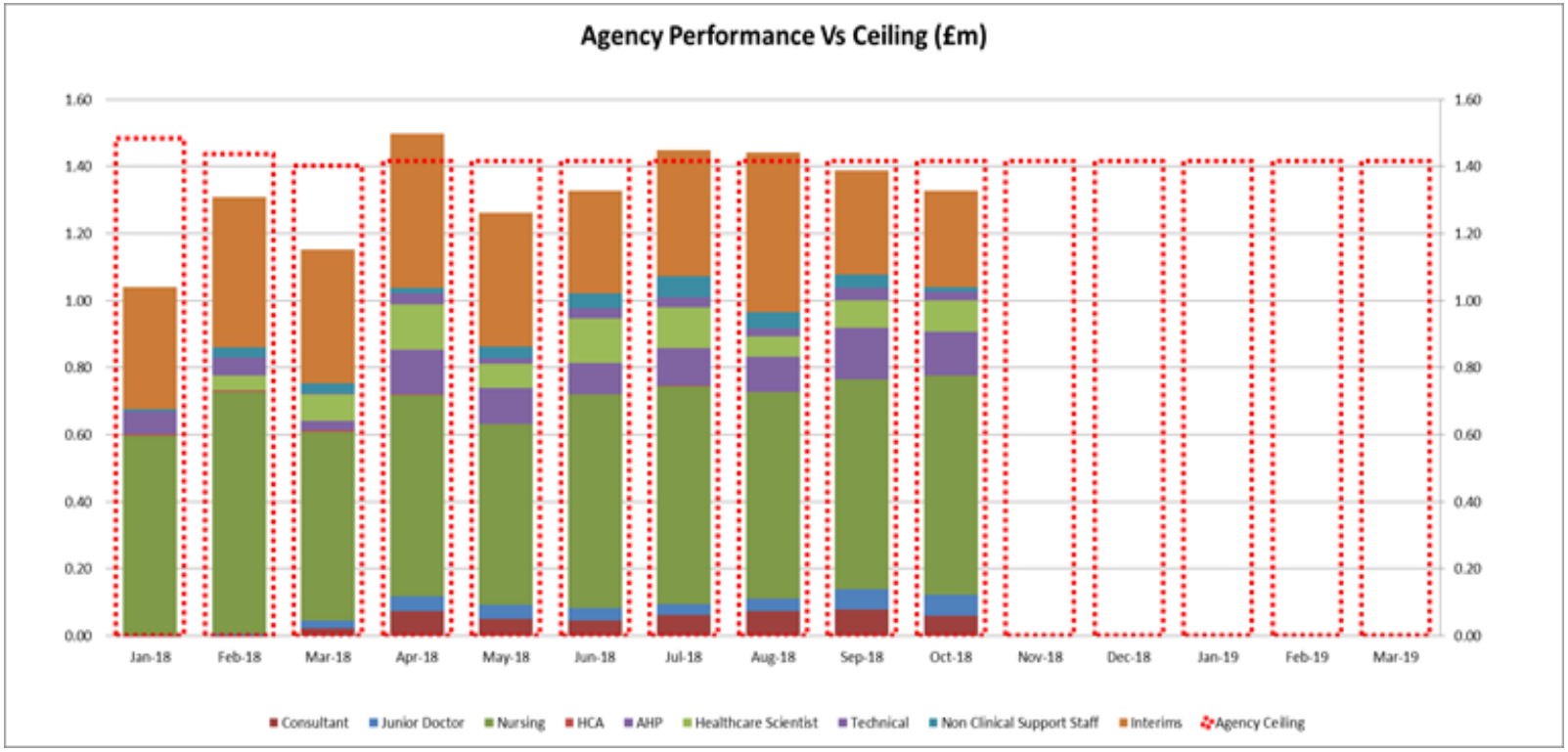
Indicator Description	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Trend
Trust Level Sickness Rate	3%	3.4%	3.8%	3.6%	4.1%	4.0%	3.6%	3.2%	3.2%	3.6%	3.5%	3.5%	3.4%	3.7%	
Trust Vacancy Rate	10%	16.1%	12.7%	13.0%	13.4%	13.5%	13.3%	12.6%	11.3%	11.0%	10.6%	10.2%	10.4%	9.3%	
Trust Turnover Rate* Excludes Junior Doctors	13%	18.5%	18.3%	18.4%	17.9%	17.6%	17.2%	16.9%	17.0%	17.3%	17.4%	17.1%	16.6%	16.6%	
Total Funded Establishment		9,808	9,470	9,474	9,515	9,540	9,497	9,469	9,318	9,242	9,239	9,160	9,180	9,165	
IPR Appraisal Rate - Medical Staff	90%	80.7%	80.0%	78.9%	79.6%	76.9%	72.2%	81.1%	81.3%	79.9%	77.7%	Not currently provided			
IPR Appraisal Rate - Non Medical Staff	90%	73.5%	70.2%	70.2%	67.2%	65.9%	61.6%	61.2%	63.4%	64.6%	67.6%	69.7%	69.7%	70.5%	
% of Staff who have completed MAST training (in the last 12 months)		86%	87%	86%	87%	87%	87%	87%	87%	87%	89%	88%	88%	88%	
Ward Staffing Unfilled Duty Hours	10%	6.1%	6.6%	7.8%	7.7%	7.9%	8.9%	6.5%	5.1%	4.9%	5.8%	5.5%	6.7%	6.6%	
Safe Staffing Alerts	0	1	2	2	4	1	1	1	0	2	0	0	0	0	

* Excludes Junior doctors

Briefing

- The Trust Vacancy rate has been achieved in the month of October reporting 9.3% against a target of 10%
- The Trust sickness level has remained above target of 3% reporting 3.7% in the month of October.
- Mandatory and Statutory Training figures for October were recorded at 88%. Compliance has been maintained during a period where we have seen large numbers of Junior Doctors and newly qualified nurses joining the organisation.
- Medical Appraisals rates are being reviewed and will not be reported this month.
- Non-medical appraisal rates have seen an increase in the month of October with a performance of 70.5% against a 90% target.
- Percentage of Staff vaccinated against seasonal Influenza is 63% as at the 14th November 2018.

Agency Use



- The Trust's total pay for October was £42.24m. This is £0.43m adverse to a plan of £41.81m.
- 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 October was £1.33m or 3.1% of the total pay costs. For 2017/18, the average agency cost was 4.2% of total pay costs.
- For October, the monthly target set was £1.42m. The total agency cost is better than the target by £0.09m.
- Agency cost reduced by £0.06m compared to September. There has been decreases in Non Clinical Support (£0.03m), Interims (£0.03m) and AHP (£0.02m), which is offset by increased substantive and bank costs. There has been increases in Nursing (£0.03M) across the non-ward areas.
- The biggest area of overspend was in Healthcare Scientist, which breached the target by £0.01m.

Meeting Title:	**Trust Board**		
Date:	29 November 2018	**Agenda No.**	2.3
Report Title:	**Trust Winter Plan 2018/19**		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Authors:	Ellis Pullinger, Chief Operating Officer Brendan McDermott, Head of Site Operations		
Presented for:	Approval		
Executive Summary:	**1) Trust Winter Plan 2018/19** The Trust Winter Plan for 2018/19 follows the same format and purpose as the plan approved by Board for the 2017/18 winter. The plan is co-ordinated through the Trust's site operations centre with appropriate standard operating procedures for key service areas/issues (e.g. Emergency Department, Critical Care and cold weather alerts). The Board is asked to note that the main editorial change to the Winter Plan (but not change in process) to the nationally used 'OPEL' framework categories which indicate the different levels of 'alert' status of the Hospital and sector when it experiences high demand. In simple terms, the Trust has switched from using escalation status by colour (green, amber etc) to Opel 1,2 etc. **2) Trust Flow and Bed Occupancy Recovery Plan (implementation from the 19th November 2018)** The Trust delivered performance of 90.11% against the 4-hour emergency care waiting time target in October 2018. Performance has since deteriorated significantly in November 2018 and has been running at below 85% in the first 3 weeks of the month. As a result, the Trust has implemented a recovery plan (as agreed at Executive Committee and Finance and Investment Committee) to improve flow and emergency care performance at pace. This paper details the actions to be taken across the three work streams of the Emergency Department, inpatient and discharge processes. **3) Winter Ward** The Trust's bed demand and capacity modelling indicates a bed gap across the Medicine Division of circa 40 beds in January and February 2019 even after taking into account the benefits of the Ambulatory Care model. In response the Trust Executive has approved the flexible opening of 22 beds on the newly refurbished Dalby Ward from the 1st January 2019 (based on demand only). This section of the paper will reference how the Trust, working in partnership with other system providers, will		

	help mitigate the further gap in bed capacity by providing care in other settings out of hospital.		
Recommendations:	1) The Trust Board is asked to approve the winter plan 2018/19. 2) In addition to the Winter Plan, the Board is asked to note the two decisions made by the Trust Executive Committee in support of the Winter Plan's delivery. The two decisions made are as follows: Trust Flow and Bed Occupancy Recovery Plan (implementation from the 19th November 2018). Winter Ward: The Trust will open an additional 22 beds on Dalby ward from 1st January 2019 on an incremental basis and only according to patient demand.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person. Right care, right place, right time.		
CQC Theme:	Safe, Effective, Responsive, Well-led		
Single Oversight Framework Theme:	Operational Performance, Leadership and Improvement, Quality of Care		
Implications			
Risk:	Emergency Care Performance is on the Divisional risk register		
Legal/Regulatory:	NHS Operating Standard.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	TEC – October and November 2018
Appendices:	N/A		

1. Purpose of the Trust Winter Plan 2018/19

The purpose of the Trust's Winter Plan is to provide guidance to Trust staff helping to ensure the Trust provides a pro-active response to increasing capacity pressures both within the Emergency Department and in the organisation as a whole. This will ensure there is organisational flow at the beginning and end of the patient's pathway. The objective of this plan, compiled into a Standard Operating Procedure (SOP) is to ensure there is clarity about how site / beds are managed at St. George's Hospital and provide clarity around roles and responsibilities both within the site management team and divisions.

Operational escalation systems and protocols vary considerably from one local health economy to another. A single national system (Operational Pressures Escalation Levels Framework Version number: 1.0 First published: 31st October 2016 by NHS England) was introduced to bring consistency to local approaches, improve management of system-wide escalation, encourage wider cooperation, and make regional and national oversight more effective and less burdensome. This SOP has been updated to reflect this national guideline. The system-wide escalation levels are available in Appendix 1. St. George's capacity management matrix has been aligned with the OPELs framework.

The SOP has been formulated to ensure patient safety, to support the patient experience and to enhance the patient pathway (emergency & elective). The SOP has been designed so that it can be quickly implemented and the impact of actions taken can be quickly realised. The actions are expected to ensure that flow is sustained for emergency patients within the Emergency Department by releasing bed capacity to maintain patient flow allowing patients access to the "Right place at the right time" whilst also ensuring patients who are being admitted electively are done so in a timely manner, again into the correct clinical area at the right time.

The purpose of this document is to provide a proactive hospital escalation plan to ensure consistent and appropriate actions are taken, in all Divisions, to optimise the management of patient flow at all times by creating sufficient bed capacity to meet patient demand. This will be achieved by ensuring defined actions are taken in times of escalation.

The full Trust winter plan is filed in the Reading Room of Boardpad.

In order to support the recovery of the current emergency care performance (in response to the deterioriation in performance in November to date) an additional plan on improving bed flow and bed occupancy has been approved by the Trust Executive. Please see section 2.

2. Trust Flow and Bed Occupancy Recovery Plan (implementation from the 19th November 2018)

2.1 The Trust delivered 90.11% emergency care waiting time performance against a target of 93% for October 2018. Performance has deteriorated significantly in November 2018 and is currently 84.84% as at 15th November 2018 against a target of 93% for the month.

2.2 The Trust is behind trajectory for Q3 with performance of 88.38% against a target of 92% for the quarter. Year to date for 2018/19, performance stands at 91.04% against the trajectory to deliver 92% across the year as at 15th November 2018.

2.3 The Trust's bed occupancy has risen steeply and is currently at 96% on average for November (excluding critical care). This is above 92.5% which is the level at which it is considered safe and conducive to good flow and emergency care performance. Across medicine and senior health wards, bed occupancy at midday is 99.16% for November which is significantly affecting flow.

2.4 Non-elective length of stay has increased from 10.5 days in October to 13.3 days in November across 6 medicine and senior health wards excluding the Acute Medical Unit. It is acknowledged that this will be due in part due to a slowdown in ward processes due to the Cerner deployment across inpatient wards as staff get used to utilising the new system. Across medicine and senior health, the Trust's bed model indicates a bed capacity deficit of 28 beds in November.

2.5 Admitted performance has seen a 10% deterioration in November to 60.22% compared to 70.29% in October against a plan to deliver a minimum of 80% performance. Non-admitted performance is 88.16% compared to 93.49% in October, against national expectation to deliver 99% performance.

2.6 Performance across paediatric pathways has also proved challenging due to staffing issues within the service, impacting upon bed availability. Admitted performance has deteriorated to 45.22% in November 2018 and non-admitted performance is 86.83%.

Recovery Plan Detail

2.7 The Trust has implemented a 'Command and Control' structure under the leadership of the Chief Operating Officer with immediate effect in order to reduce bed occupancy to a safe level and to support the recovery of flow and emergency care performance. This structure is set up to run Monday to Friday in standard working hours with an agreement for it to be extended to overnight shifts (Monday 26th November to Wednesday 28th November initially) to assess what further actions are required to deliver improved flow and patient care. The plan will be supported by clinical, nursing and managerial leaders who will provide oversight of the actions across 3 key areas of the unplanned and admitted patient care pathway, including the Emergency Department (ED), Inpatient Processes and Discharge Processes. Table 1, as below, describes the clinically-led steps that are being taken, in addition to the on-going actions and implementation of the Trust's emergency care improvement 15 Point Plan. The Trust Board has reviewed this 15 point plan earlier in the year.

2.8 The Trust will also invite senior leadership and on-site presence from the CSU to work alongside the COO to ensure the support of system partners to the Trust to reduce occupancy and improve flow.

2.9 It is expected that collectively these actions will enable to Trust to return to delivering emergency care performance in line with the trajectory target of 90% in December 2018 and improve performance to as close as possible to 90% in November 2018. In addition, the Trust is planning to open up to 22 additional beds from 1 January until the end of March 2019, subject to demand (please see section 3 in this paper). Triggers to inform the decision as to when/if this additional capacity should be opened are being developed with support from the Emergency Care Improvement Programme. These triggers will be agreed through the Trust Executive Committee in December 2018.

Table 1

Initials used for action owners as opposed to the use of full names as this paper is in the public Board papers

Trust Flow and Bed Occupancy Recovery Plan – November 2018			
1) Emergency Department (including Children's ED) **Clinical Lead: Sunil Dasan, Clinical Director** **Nursing Lead: Bev Critchlow, Head of Nursing** **Management Lead: Gemma Phillips, General Manager**			
Action	**Outcome**	**Owner**	**Timeframe**
Allocation of a Senior Clinician to each area within the ED to provide senior leadership and decision making in line with ED winter plan. To deliver this, an additional registered Nurse and Medical Assistant will be required, 7 days a week. Fill rate is good.	Improve non-admitted performance to minimum of 90%. Aim return to delivery of 95% non-admitted performance consistently. Improve overall emergency care performance to minimum 90% in December in line with trajectory, in conjunction with inpatient and discharge	SD BC	28th November 2018 – 1st March 2019

	processes actions.		
Improved use of chairs within Nye Bevan Unit for patients referred to surgical services in line with agreed SOP.	Reduce ED assessment and capacity breaches and improve flow within the ED.	BC	19th November 2018
Review and re-allocation of nurses within existing establishment during daytime hours to support triage/streaming in Children's ED. This is required due to increasing volume of patients and bed capacity challenges leading to risks to patient safety.	Ensure triage within 15 minutes of arrival to Children's ED, improving patient safety and flow within the department.	BC	December 2018.
Dedicated ED porter to work with diagnostic imaging to be delivered within existing establishment.	To improve flow within the ED and patient experience.	MP	28th November 2018
Advanced Nurse Practitioner for children's respiratory medicine to attend Children's ED at 8.30am and 3pm daily, 5 days a week.	To support timely assessment and transfer of children where necessary.	AW	19th November 2018

2) Inpatient Processes

Clinical Lead: Rhonda Sturley, Clinical Lead UAPC and Consultant Orthogeriatrician and Physician
Nursing Lead: Jenni Randal, Head of Nursing
Management Lead: Gemma Phillips

Action	Outcome	Owner	Timeframe
Senior Clinical and Nursing time to be released to provide clinical challenge as part of daily Board Rounds and rapid implementation of Red 2 Green principles across medical and senior	Reduce LOS and bed occupancy across medicine and senior health. Reduce number of stranded (>7 day	LP/MA	19th November 2018

health wards. 1 medical and 1 senior health ward to be supported each week for next 3 weeks. Daily senior attendance at board rounds to include review of stranded patients with >7 day LOS. Senior clinical and nursing leads will be supported by admin follow through on actions identified during board rounds. Board round will include clinical challenge of patients considered not medically fit for discharge to consider alternatives to the patient remaining in an acute bed (e.g. diagnostic to be completed as an OP, IVABs to be given in community, community therapies).	LOS) and super stranded (>21 day LOS) patients. Aim to increase the number of patients identified as definite discharges by 8.30am every day. Increase number of pre-11 discharges.		
Increase SWLP lab support in morning to ensure rapid processing of bloods from AMU and Cavell. Redeployment of phlebotomists within existing resources to provide 2 support delivery.	Rapid turnaround of blood tests, supporting clinical decision making and both non-admitted and admitted performance. Expect increase in pre-11 discharges additional 2-3 per day from AMU and 2 on Cavell ward. Reduced AMU bed occupancy at midday.	BP	19th November 2018
Proactive in-reach to wards by Diagnostics team to identify and resolve diagnostic delays delaying discharge.	Reduce LOS and bed occupancy through reducing time to diagnostics.	RB	15th November 2018
Pharmacy huddle to take place daily following 8.30am site meeting, to include representation for all teams and on-call staff. Staff will be moved to support actions from the	To support timely discharge and prevent delays due to medication issues. To improve flow and bed occupancy.	VK	15th November 2018

morning huddle, in particular to support discharges. Staff will be reallocated to prioritise patients at the front door to ensure no gaps. Additional flexible resource will be allocated as necessary. Discharge lounge has a Transcribing/Prescribing pharmacist – this person will also facilitate patient transition to the discharge lounge from an inpatient bed by reaching out (and coordinating their medicines needs as necessary) – Bleep 7873			

3) Discharge Processes

Clinical Lead: Jane Evans, SRO for UAPC (Clinical Lead to be identified for discharge processes work stream)
Nursing Lead: Richard Lloyd Booth, Deputy Chief Nurse
Management Lead: Gemma Phillips, General Manager

Action	Outcome	Owner	Timeframe
Roll out of Transfer of Care bureau pilot from 4 wards to all 7 medical and senior health ward, focusing on complex discharges.	Clear structure and process for supporting complex discharges.	RL-B	19th November 2018
In-reach support to wards will be provided by therapies, releasing staff from outpatient areas as a temporary measure to support discharge.	Reduce LOS and bed occupancy across medicine and senior health. Reduce number of stranded (>7 day LOS) and super stranded (>21 day LOS) patients.	SR/PH	19th November 2018

A weekly review of stranded patients will take place with Executive leadership from COO, including presentation of stranded patients to multi-agency panel by a Consultant/SpR and Ward Manager for each ward. The review meeting will be conducted in line with NHSI guidance on stranded patient review.	Reduce LOS and bed occupancy across medicine and senior health. Reduce number of stranded (>7 day LOS) and super stranded (>21 day LOS) patients.	JE EP	22nd November 2018
Identification of patients who no longer require an acute bed through daily Board Rounds to be escalated to COO as Gold Command to request support from system partners to resolve delays and enact and bring forward winter capacity plans, including spot purchasing, provision of additional quick start care packages.	Reduce LOS and bed occupancy across medicine and senior health. Reduce number of stranded (>7 day LOS) and super stranded (>21 day LOS) patients.	GC ED	19th November 2018
Targeted support to reduce repatriations (currently 28 repatriations across Trust, equivalent to 1 ward). Daily target for repatriations to be set with COO to COO conversations and support from CSU if required.	Aim to repatriate minimum of 4 patients every day, with support of CSU if required to reduce occupancy to a safe level that supports flow on the SGH site	EP	14th November 2018

3. Winter Ward

3.1 The Trust Executive has approved the opening of 22 beds on Dalby Ward flexibly to meet the anticipated extra demand on beds between January and March 2019. This is in line with the outline business case submitted to the Trust's Investment Decision Group in January 2018 for additional winter capacity, including the internal and system wide plans to mitigate the bed capacity gap, and to provide an update on the designation of a flu ward should this be required.

3.2 The detailed paper approved by the Trust Executive in support of the flexible winter ward includes the latest demand and capacity model which demonstrates a bed capacity deficit of 30 beds on average across medicine and senior health between November 2018 and March 2019, increasing to a gap of 40 beds in January and February. Plans have been identified internally to mitigate up to 9 beds capacity. System partners (Central London Community Healthcare NHS Trust, London Boroughs of Merton and Wandsworth) have now identified schemes to provide the equivalent of 32 beds.

If the 32 beds of system capacity is delivered in full from 1 January 2019, this together with internal plans equivalent to 9 beds, would fully mitigate the medicine bed capacity gap in January 2019 and leave a residual gap of 7 beds in February 2019.

The Trust Board is asked to note that the operational plan for opening the additional bed capacity on Dalby Ward is supported by the clinical leadership of the Medicine Division. The summary detail of the plan is as follows:

- 14 senior health beds currently on Rodney Smith ward (28 beds) to move to Dalby ward (22 beds) on 1st January 2018.
- The additional 8 beds on Dalby to remain closed until demand requires that these are opened as additional senior health beds.
- Consultant medical staffing on Dalby would remain as per the existing Senior Health team. No additional Consultant resources are required for the extra 8 beds. 1 additional SHO is required to support 8 beds on Dalby and 6 in Haematology and Oncology. Nursing staff on Rodney would move to support 14 beds on Dalby with additional nursing required when at full capacity.
- This move would release an additional 14 beds on Rodney Smith ward to be opened incrementally according to demand, creating 22 winter beds to be used flexibly in total (14 on Rodney Smith and 8 on Dalby ward).
- Consultant cover for up to 20/28 beds on Rodney Smith will be provided within existing resources.
- 1 SpR and 1 SHO are required for 14 additional beds on Rodney Smith ward.
- Nursing staffing is additional for 14 beds on Rodney Smith as these cannot be covered within existing resources. Acute Medicine has a vacancy rate of 16.4%, this rises to 21.5% including significant absences.

NB: The above assumes the number of flu patients will be less than 2017/18. However, in the event of requiring a ward to cohort flu patients Dalby ward will be used.

St George's University Hospitals NHS
NHS Foundation Trust

Standard Operating Procedure

Operations Centre

Winter 2018.19

V4.0 – Updated October 2018

Contents

Appendices

1.0 Introduction

The purpose of this document is to provide guidance to Trust staff helping to ensure the Trust provides a pro-active response to increasing capacity pressures both within the Emergency Department and in the organisation as a whole. This will ensure there is organisational flow at the beginning and end of the patient's pathway. The objective of this Standard Operating Procedure (SOP) is to ensure there is clarity about how site / beds are managed at St. George's Hospital and provide clarity around roles and responsibilities both within the site management team and divisions.

Operational escalation systems and protocols vary considerably from one local health economy to another. A single national system (Operational Pressures Escalation Levels Framework Version number: 1.0 First published: 31st October 2016 by NHS England) was introduced to bring consistency to local approaches, improve management of system-wide escalation, encourage wider cooperation, and make regional and national oversight more effective and less burdensome. This SOP has been updated to reflect the national guideline. The system-wide escalation levels are available in Appendix 1. St. George's capacity management matrix has been aligned with the OPELs framework.

The standard operating procedures (SOP) have been formulated to ensure patient safety, to support the patient experience and to enhance the patient pathway (emergency & elective). The SOP has been designed so that it can be quickly implemented and the impact of actions taken quickly realised. The actions are expected to ensure that flow is sustained for emergency patients within the Emergency Department by releasing bed capacity to maintain patient flow allowing patients access to the "Right place at the right time" whilst also ensuring patients who are being admitted electively are done so in a timely manner, again into the correct clinical area at the right time.

The purpose of this document is to provide a proactive hospital escalation plan to ensure consistent and appropriate actions are taken, in all Divisions, to optimise the management of patient flow at all times by creating sufficient bed capacity to meet patient demand. This will be achieved by ensuring defined actions are taken in times of escalation.

2.0 Aim

The aim is to ensure maintenance of a high quality, comprehensive service for patients, balancing elective and emergency work to ensure the Trust meets all of its performance targets (4 hour standard, RTT, infection control, mixed-sex etc.).

Divisional Chairs and Directors of Operations are responsible for bed utilisation on a day to day basis for specialties within their Divisions. It is expected that the Divisions will work together, ensuring their staff carry out appropriate actions, enabling all patients to be cared for safely, in a timely manner, ensuring Trust objectives in all areas are successfully achieved.

The decision to close beds as part of an agreed long term strategy remains with the Divisional Director of Operations for the Division. The Head of Operations will be charged with the responsibility of ensuring that patient flow is not compromised during the closure of the beds.

Short term closures of beds during anticipated dips in activity, i.e. Christmas and Easter will form part of the agreed relevant corporate plans. The Site Manager will implement these closures through discussion with the On-Call General Manager and the On-Call Director. Re-opening of these areas will be agreed in the same way.

The Clinical Site Management Team operates with the delegated authority from the Chief Operating Officer (COO) and Chief Nurse in order to utilise the Trust bed stock in order to achieve safe patient placement.

The opening of escalation beds out-of-hours must have been agreed as a plan in core hours with the Divisional representatives. If there is no plan is in place it will be agreed between the HoN (ops), Tactical (Silver) on-Call and Strategic (Gold) on-Call. The HoN (ops) will then take on the accountability for safely staffing such areas until the earliest opportunity for these areas to be handed to the relevant Division. It is

the responsibility of each Division to supply accurate planned activity data for each area including highlighting potential threats to target patients if activity is cancelled.

Decisions to open escalation beds will be taken as early in the day as possible to ensure that the environment is adequately prepared, safely staffed and appropriate patients identified for transfer.

3.0 Workload Forecasts

The Surge Capacity Management Plan defines the Hospital's bed capacity into four categories. Business as usual is defined within OPEL level 0 and 1 status. The surge capacity score is calculated with the matrix in Appendix 1.

The Operational team will confirm at the 08:30 Safety & Flow huddle (terms of Reference, Appendix 3) divisional bed requirements for the next 24 hours. This will be split per specialty to take account of all requirements (elective, emergency, ITU step downs, inter-hospital transfers). Divisions will be expected to manage within their bed stock and to proactively drive discharges to support the creation of the right level of capacity at the right time. Additionally, all divisions are expected to participate in all communications, engaging and working collaboratively with each other and the site management team.

Once an escalation status category has been defined and declared by the Clinical Site Manager, the appropriate staff are in a position to act on that information promptly within a defined timescale that will correct and move the Trust back to a level of capacity which will be sufficient to meet the predicted demand on inpatient beds against agreed bed stock capacity.

Information on corrective actions will be reported via the following Flow Meeting or sooner to the Site Manager on bleep 6007. Further meetings will be confirmed by the Clinical Site Manager as defined by the surge capacity score and attendance by the designated Divisional Managers/Clinicians is mandatory.

4.0 Safety & Flow Huddle (Terms of Reference see Appendix 3)

These meetings provide a forum where the Trusts capacity can be reviewed. These meeting will occur in the Incident Control Centre (room G2.099) (in hours at 08:30hrs, 13:00hrs and 16:00hrs) or by conference call (out of hours at 22:00hrs). The required frequency and attendance may change depending on the pressures being experienced at that time. The Head of Nursing (Operations) or Head of Operations will chair all meetings where status is OPEL level 0/1/2. The Chief Operating Officer or Deputy Chief Operating Officer or the Strategic On-Call (or nominated other) will be responsible for chairing meetings where the OPEL Level 3 surge capacity plan is being followed.

Communication of the Trusts Capacity Status will be communicated via reports emailed, by the CSM, within one hour after the Flow meeting.

If there are unforeseen circumstances, meaning a representative cannot attend, please contact bleep 6007 or email apologies to ClinicalSiteManagementTeam@stgeorges.nhs.uk

Required Staff during Core Hours

OPEL Level 0/1	OPEL Level 2	OPEL Level 3
Head of Nursing – Operations* (Chair) Administrator. Representative from each division. ITU Representative. Tactical on-call (at 4pm only).	Attendance as for level 1 plus: • HoN + Head of Operations (Chair) • Tactical on-call Manager. • DDO (or deputy) from each division. • On Call consultant from	A Clinical Operational Meeting will be held within 30mins of level 3 status being declared. The meeting will follow the Surge Capacity Plan format.

	pressured division. • Transport Manager. • HoN AMU/A&E (or deputy).	

**There will be a pre-meet between the HoN (Ops) with all bed managers 20mins before each Trust Capacity Meeting. The bed managers will then not be expected to attend the Capacity Meeting.*

Required Staff Outside of Core Hours

A daily conference call (Details in appendix 3) will be held at 10:00hrs, 16:00hrs and 22:00hrs on weekend and bank holidays. The format will be as per usual daily format. Depending on pressures being experienced further conference calls can be arranged. It may also be necessary to invite additional members of on call staff (e.g. infection control consultant, transport manager etc.) as needed. If requested to do so it is expected that any on call member of staff will endeavor to do so.

OPEL Level 0/1/2	OPEL Level 3
Strategic On-Call Tactical On-Call – Acute Tactical On-Call - Community Head of Nursing – Operations	The Surge Capacity plan will be followed.

5.0 ROLES AND RESPONSIBILITIES

The actions required at each stage of escalation are detailed in the Trust Surge Capacity Management Plan and provide a framework from which each member of staff can base their actions. There are a number of action cards that detail the response from staff members at particular levels of 'surge' (Appendix 5)

5.1 St. George's Surge Capacity Escalation Status & Actions

Introduction

Maintaining timely patient flow through the site is a key factor in providing care that is safe and of outstanding quality. In order to achieve this even at times of surge and when the system is under pressure, the Trust has agreed to adopt the actions detailed below. These are adopted on a Trust wide basis. In addition, it is expected that all directorates hold their own local plans to maintain optimal capacity even at times of high demand.

	Surge Capacity Status	Actions to be taken	Responsible role	Out-of-hours (2000-0800 Mon-Fri, Weekends and Bank Holidays)
	Score : 13 – 26 = **Surge Capacity – OPEL Level 0** 24:7 Site management team. Report any issues or threats to activity real time via bleep 6007 OOHs, e-mail ClinicalSiteManagementTeam@stgeorges.nhs.uk **Mon-Fri** **Daily SITREPS (meeting) 08:30, 13:00, 16:00,** **(Rm 2.099, GW)** All directorates to be represented,	**BUSINESS AS USUAL – ACTION CARD** • Maintain knowledge of the Trust's bed position for the next 24 hours and the status of the Emergency Department. • CMS (https://nww.pathways.nhs.uk) is updated two hourly. • Communication in and out of Clinical Site Management Team as usual inc. Escalation Meetings • Clinical Site Management Report to be	All GMs Site Manager All GMs Site Manager	**BAU**

	including Estates, Diagnostics, Pharmacy and Facilities as well as divisional bleep holder of the day. **ED Board Huddles 10:00, 12:30, 15:30. 17:00, 19:00 (ED majors NiC desk)** ED Consultant and Nurse in Charge, Site Manager, ED GM/ AGM, ED PFC. **Site call 22:00** Tactical on call, Site Manager, Strategic on Call. Teleconference number 0800 368 0707 **or** 020 8934 7061: CSM Code: 5348937: Others Code: 9415184 **Weekends and BH** **Daily calls at 10:00, 16:00 and 22:00** Tactical on call, Site Manager, Strategic on-Call. Teleconference number as above **TRIGGERS** **(If ≥3 triggers activated)** • Predicted capacity- 20:00 < 95% • < 5 4hr breaches before 10:00 • 10 AMU beds available at 11:00 • 6 NBU beds available at 11:00 • Milestones for DTA patients in ED being met. • < 15 min ambulance offloads • < 1 medical & nursing (combined) shift gaps in each of	circulated by 10:30 hrs and following each escalation meeting. • Outlier's information collated and passed on before 08:00hrs to facilitate timely medical review. • Clinical Ward Rounds to be conducted and patient transport booked to agreed routine schedules (SAFER). • Maintain flow for GP referrals direct to the Rapid Assessment Area/AAA and the RATs process. • Ensure timely assessment and treatment of patients throughout the ED pathway via ED Escalation Policy. • Hospitals expecting patients to be repatriated to them to be contacted before midday ad conversation documented on repatriation website (https://nww.ihtl.nhs.uk/stg). • Escalation of concerns as per repatriation SOP. • A weekly SITREP attendance rota should be in place for all specialties. • Consultant, GM & NIC attendance at daily 08:30 SITREP • Divisional bleep held by a member of each Division who is responsible (on a rotational basis) for coordinating local site response and performance. • Staffing rotas and gaps should be identified daily and going forward for the next 14 days, with escalation in the event of gaps.	Site Manager All specialties – consultant in charge. Acute Med Matron ED Consultant in Charge Site Manager Ward matrons Site Manager All specialties DDOs All GMs All HoNs	

	ED, AMU, NBU respectively **External reporting** Head of Operations report to CSU Surge-hub 10:15 teleconference Mon-Fri.	• An outlier safety escalation plan should be in place for all specialties. • Consultant of the week model is in place. • Daily review of all patients by a senior clinician (Consultant or SpR) • Safety brief OOHs to be attended by all lead clinicians for each specialty (Consultant or SpR). • 16:00 SITREP on a Friday to be attended by <u>all</u> on call Consultants for the following weekend, to review current site position, escalate issues and agree actions for the forthcoming weekend. **Operational Standards** • Consultant board rounds must take place by 10am every day • Any internal or external delays are identified and escalated to site team immediately. • Medical ward admissions to be coordinated from AMU. Specialties have 30 mins following referral to attend and review patients and accept them from AMU. If the specialty does not attend within 30 mins, the lead consultant on AMU has admitting rights to specialist medical wards and can admit the patient directly to the ward without specialist review. Site management team oversees the safe transfer of patients. • Medically fit discharge dates set within 12 hours of admission.	All specialties All specialties CDs to ensure attendance All specialties All specialties Matrons AMU consultant in charge All admitting specialties. All ward matrons	

		• Bed clear protocol in place (30 minutes). • IP bleed times by 10am and results by midday. • The directorate has a plan in place to discharge all patients via Departure Lounge. • Transport is booked for 10am a day prior to discharge. • EDLs in pharmacy the day before discharge. • Staff are aware of and trained in admission avoidance (including ambulatory care, on-site GPs, early discharge teams). • All potential dual specialty breaches in ED (where two specialties cannot agree which a patient sits with) to be escalated to Divisional Chair/ Medical Director within 30 mins of issue being identified for immediate plan and resolution.	All ward matrons All ward matrons All ward matrons Discharging clinician HoNs for all specialties ED consultant in charge	
	Score: 27 **– 39 =** **Surge Capacity – OPEL level 1** **TRIGGERS:** **(If ≥3 triggers activated)** • > 5 4hr breaches before 10:00hrs	**COMMENCE ALERT ACTIONCARD** As for OPEL Level 0 Surge Capacity and in addition: • Emphasis on early decision making medical and nursing review of patients from all 4 divisions to facilitate all possible discharges on a timely basis and appropriate access of Community Services.	Heads of Nursing for all Directorates	**BAU**

	• > 30 patients registering within an hour for 2 successive hours. • < 3 cubicles available in EITHER Majors or Resus. • < 2 available beds in CDU • 1-3 (3 max) medical & nursing (combined) shift gaps in any of ED, AMU, NBU respectively. • 3 LAS crews waiting > 15 mins to offload patients. • 1 unplaced DTA within ED over 1 hour. • 60 minute wait for nursing assessment. **Capacity** Predicted Occupancy at 18:30 ≥ than 96% **Flow** • < 10 AMU Beds at 11:00. • < 6 SAU trolleys at 11:00. • < 3 beds available for any one specialty. **Patient wait time 12 – 24 hours for diagnostics**	• Staff to highlight and escalate system delays for resolution to HoN CSM team and identify investigations and diagnostics which if expedited will lead to discharge on a timely basis and expedite these actions. • Consultant in Charge of ED to review seniority of skill mix at assessment, to ensure all opportunities to safely stream patients away from the ED is taken. • Immediately escalate all delays and patient repatriations to Head of Operations level. • Focus on pharmacy TTOs, patient transport, domestic and portering services to ensure priority is given to patient transfer and discharge, and the relative priority of requests after agreeing priority with HoN CSM team. • Book all patient transport "confirmed, ready" • Emergency Department Consultant in Charge to contact relevant specialty on call consultant to escalate patients for review and request direct in-reach to ED where appropriate. • Divisional Silver bleep holder (CD/HoN/GM) leads divisional response and ensures attendance at all site escalation meetings. • Divisional bleep holders to contact on call admitting consultants/ registrars to request review for any possible patients in ED. • Divisional bleep holders to check all elective lists for day case procedures & pre op	All Matrons ED Consultant in Charge All Matrons Ward Managers / Matrons / Transport and Facilities GM Transport and Facilities GM ED Consultant in Charge Divisional silver bleep holders Divisional bleep holders Divisional bleep holders	

		booked bed nights & utilise Departure lounge.		
		• Directorate Consultant on call/ in charge to review DTOCs / NDTOCs (DTOC Escalation plan) re transferring patients into the community – with a view to lowering discharge thresholds where appropriate.	Consultant on call/ in charge.	
		• Discharge team to complete a discharge round of all areas.	Discharge manager	
		• Identify any patients that can transfer to their local DGH who do not require tertiary care.	Discharge manager / Clinicians	
		• Facilities standby to provide additional resources i.e. porters/transport/housekeeping.	GM Estates and Facilities	
		• Facilities standby to provide all transport booking times for next 48 hours.	All GMs	
		• All above actions to be reported as in-progress or completed at all escalation meetings.	Site Manager/ Head of Ops	
		Operational Standards		
		• All Divisional bleep holders (CD/HoN/GM) to be notified of status, and instructed to enact divisional escalation plans.	Site Manager/ Head of Ops	
		• Activate Trust wide plans if required i.e. Consultant decision to admit and/or restricted admissions for tertiary referrals.	Site Manager Head of Ops	
		• Activate discharge and escalation plans to create capacity.	Site Manager	
		• Site Team to increase availability of bank	Site Manager	

		staff. • Strategic on-call to approve all agency requests where addressing immediate capacity pressures (informed by site team).	Strategic on-call	
	Score: **40– 52 =** **Surge Capacity – OPEL Level 2** **TRIGGERS:** **(If ≥3 triggers activated)** • > 10 4hr breaches before 10:00 • > 30 patients registering within an hour for 3 successive hours, or > 35 patients per hour for 2 successive hours • LAS crews waiting > 30mins to hand-over patients. • 0 cubicles available in EITHER Majors or Resus • Turnaround time for plain X-rays or pathology > 1.5 hours. • 0 available beds or chairs in CDU and 0 planned discharges. • 3-6 (6 max) medical & nursing (combined) shift gaps in any of ED, AMU, NBU respectively. • 5 or more unplaced DTAs waiting for >2 hrs within ED (2 or more in surgery / 3 or more in medicine). • > 90 minute wait for nursing assessment.	**COMMENCE ALERT ACTIONCARD** As for OPEL Level 1 escalation, and in addition: • Notify, via switchboard, Capacity Escalation List to ensure consideration of professional issues, via text alert / pagers and email (includes CDs, HoNs, Matrons, Ex. team). • Instigate additional Surge Capacity meetings as assessed appropriate. • Required senior nursing support for all wards from DDNGs and HoNs • Request (via surge hub) all actions from system partners is activated and delivered. • Ensure all patients are reviewed and if necessary by 2nd ward round, by Snr. medical staff. • Consider re-distribution of clinical and medical staff if appropriate, utilising senior medical leadership as required. Consider cancellation of study leave.	Site Manager Site Manager DDNGs Head of Operations Consultants in charge Medical Director	**Out-of-hours** **(20:00hrs-08:00hrs Mon-Fri, Weekends and Bank Holidays)** **Strategic on-call Tactical on-call** **Bronze (on site) Head of Nursing Ops.** • Alert (by 18:00hrs) specific clinical teams (on-call Consultants) that they may be required to attend on-site out-of-hours. • At 22:00hrs teleconference a decision will be made between Tactical & Strategic on-call whether to attend site and establish a command and control structure.

	• Risk of 12-hour trolley wait (one DTA waiting ≥8hrs with no definite plan) Capacity Occupancy ≥ than 98% Flow • < 3 AMU Beds at 11:00. • < 2 SAU trolleys at 11:00. • < 2 bed available for any one specialty Patients wait time more than 24 hours	• Review all elective lists. Consider capacity projection for EL workload. • Agree with LAS the need for an ALO to be based in ED • Ensure the use all safe escalation areas in St. George's Hospital. • Ensure Escalation Process for all DTOC & non-DTOC patients is being utilised. Accelerate patients suitable for Discharge to Assess. • Scheduled maintenance (estates) to be reviewed – consider rescheduling. • Review and prioritise planned and elective admissions for the next two days including Critical Care pressures. • Divisional Silver bleep holder to ensure that directorate teams (CD/GM/HoN) activate local directorate Red continuity plans. • All referred specialties to attend ED to assess referred patients in dept. within 15 mins of referral. • Divisional bleep holders to cancel all non-urgent meetings and activate local directorate continuity plans to include; 1) ward support team 2) local response management team. • Review all patients with a LoS >7 days.	Divisional Directors of Ops Site Manager Site Manager Site Manager GM – Estates and Facilities Divisional Directors of Ops Divisional Silver bleep holder Consultants in charge Divisional Silver bleep holders	• Weekend days and Bank Holiday days Tactical on-call to attend site and decide whether there is a need to establish a command and control structure, ask Strategic on call to attend site if needed. • On-call Consultants requested to attend site and carry out 2nd ward round / support teams. • HoN, Ops. to confirm if an escalation area can be opened and staffed safely for at least 24hrs.

		• There must be 2 consultant board rounds a day before 9AM and 2PM respectively. • Reassess and prioritise all elective activity into clinical urgency/complex planning/near breach date. • Standby to cancel all study leave to staff beds across sites. • Ensure all outlier escalation plans are activated.	Consultants in charge GMs Medical Director and Directors of Nursing. All specialties	
	TRIGGERS: **(If ≥3 triggers activated)** **OPEL Level 3** • > 35 patients registering per hour for a period of 3 hours consecutively. • ≥120 patients in ED • One ambulance waiting ≥45minutes to handover. • No cubicles available in EITHER Majors or Resus. • 2 hour turnaround time for plain X-rays or pathology. • 0 available beds or chairs in CDU and no planned discharges. • >7 medical & nursing (combined) shift gaps in any of ED, AMU, NBU respectively. • 10 or more unplaced DTAs within ED • 1 unplaced patient awaiting admission @8hrs without definite plan / ward. • 120 minute wait for nursing assessment.	**COMMENCE ALERT ACTIONCARD** As for Surge Capacity OPEL Level 2 and in addition: • Alert communications (Via Text / Email) & Communications managers to consider any communication requirements. • Chief Operating Officer or Strategic on-call to escalate to SWL1 On-Call (pager SWL1) immediately on declaring Level 3. • Contact CSU & CCG to request that all OPEL escalation actions are completed at Level 3. • Consider cancellation of all electives except cancer and urgent patients. Inform theatres not to call new cases until approved by CSM team.	COO (or delegate) COO (or delegate) Head of Ops Divisional Directors of Ops	**At any time** • Tactical and Strategic on-call attend site and establish a command and control structure • Tactical and Strategic decide with Head of Nursing which clinical teams are required to attend on-site. • On Call specialty Consultants to review the suitability of specialty patients in ED waiting beds for admission avoidance

	Capacity Occupancy ≥ than 98% **Flow** 0 AMU beds 0 SAU trolleys	• Instigate prompt senior medical and nursing review of all patients and consider lowering of the threshold for discharge where possible. • Review 36 hours staffing and cancel study leave and non-urgent meetings where appropriate (DDNGs to support decision). • Full implementation of Full Capacity Protocol • Strategic on-call considers declaring formal corporate Business Continuity.	Medical Director/ Chief Nurse Medical Director/ Chief Nurse COO (or delegate) Approved by Executive / Strategic on-call Strategic on-call	pathways.

More information

- These escalation cards are the agreed actions to be taken by the Trust in order to maintain patient safety and quality of care at times of system pressure.
- The document is managed and its actions maintained by the Site Head of Operations, Brendan McDermott – Brendan.mcdermott@stgeorges.nhs.uk
- Publication date: November 2017
- Reviewed date: October 2018

5.2 Notification of Escalation Following Trust Capacity Meetings

- The Internal Escalation Status will be determined and communicated by the CSM following each Trust Flow Meeting as well as any time the CSM determines that that the situation is deviating from expected.
- The Internal Trust Escalation Status (i.e. OPEL Level 0/1/2/3) will be displayed in the Operations Centre. This will be kept up to date by the Operations Centre Staff.
- The Trust Status Update Report will be completed by the HoN/CSM and e-mailed via the Clinical Site Management Team (ClinicalSiteManagementTeam@stgeorges.nhs.uk) email account. This will occur within one hour of the Trust Capacity Meeting completing and follow the template in Appendix 5.
- The following groups will receive the Status report:
    - Executive Directors
    - Clinical Directors
    - Divisional Directors of Operations
    - Divisional Directors of Nursing
    - Heads of Nursing and Matrons
    - General Managers

      It is expected that this is cascaded by line managers to any other interested party within the organisation.
    - Where the overall Trust Status is deemed to be OPEL Level 2 or 3 a text message will be sent to the above staff detailing this and the timing of the next meeting. (Appendix 6)

6.0 External Reporting Arrangements

The HoN/CSM will ensure the following reporting:

- CMS is updated by the Site Management Team every two hours and is viewable by LAS and the CSU. The reports are due:
    - ED - 2 hourly, 24/7,
    - Beds - 4 hourly, 8am to 10pm

  CMS status will be reported on the Trust Capacity Updates as per RAGB rating.
- Winter Daily SITREP (by 11am Mon – Fri) (via NHSI website)
- Daily ECIP Return (by 4pm Mon – Fri) (via UNIFY)

7.0 Elective Activity

The Trust has a number of strands in the elective workload planning:

- The 18 week activity plan does not allow for a reduction in elective activity in winter. The approach is therefore to increase capacity, using other NHS providers and the private sector.
- Appropriate work is transferred to the day surgery unit.
- Gynaecology, surgery and Paediatrics agree to utilise beds more flexibly across their areas.
- A weekly theatre planning meeting ensures lists are fully utilised and free lists are handed back to be used by other specialties 4 weeks before the date of the list.
- The heaviest elective days are Monday, Tuesday and Thursday. Cavell Ward is a five day per week short stay surgical ward.
- At times where it is considered prudent to rationalise elective work due to the emergency demands on the Trust there is a procedure to follow. Once complete a copy of the proforma for reviewing elective activity must be submitted to the Operations Centre.

7.1 Formal Reviewing of Elective Activity

During times of OPEL Level 3 status or extreme operational difficulty/capacity challenges decisions will need to be taken to cancel scheduled elective activity for a period of time to enable the site and its services to resolve a significant deficit of available bed capacity. However, no patient should wait more than 52 weeks for an elective procedure.

It is important that such decisions are considered carefully taking into account the needs of all patients and the trust's requirements. Such decisions must be taken by appropriate senior clinicians.

The process must be open, transparent and fair. Decisions made must result in actions taken.

The proforma in appendix 7 is to be used on occasions where, due to operational pressures, planned elective work is to be cancelled.

8.0 Escalation Plans

8.1 Emergency Department (ED)

There are a number of underlying principles for this plan. These are:

- To reduce crowding in the ED. This is the main aim and on a practical level, this means preventing situations when we have 9 or more patients in Resus. It also means that we maintain the capacity to offload and take handover of ambulance patients at all times.

- To simplify processes so that all patients are triaged, assessed in priority order and a decision is made regarding their plan.

- To have clear escalation processes in the department when we have surges in demand. Surges will happen. We need to have processes in the ED to be able to deal with them.

For further information on Crowding and its impact, please click on the link below:
https://www.magonlinelibrary.com/doi/full/10.12968/hmed.2018.79.9.500

Streaming
For walk in adult patients, they will be seen by the streaming nurse first.

- The streaming assessment will last for 2 minutes.
- Every patient will be assigned a Manchester Triage Score (MTS)
- The patient will be streamed to one of the following:
    - Resus
    - Assessment
    - UCC
    - Navigate

It is essential the every patient is given a Manchester Triage Score so that staff in each area are able to prioritise patients on their screen 'at a glance'

Initial Assessment
Patients on the Assessment screen will be seen in priority order and key interventions will take place such as ECG, analgesia, bloods and identification of possible sepsis, major trauma or high risk mental health.

The biggest change planned for winter is that from 28th November 2018, there will be no RAT doctor in Assessment. Hence no patient should remain on this screen after initial assessment.

Any patient who would have previously stayed on the Assessment screen will now be moved to the UCC screen to be seen in this area

Please note: All patients previously allocated to Majors WR will continue to be seen in this area.

Urgent Care Centre (UCC)

The numbers of patients being seen in UCC will increase. Therefore from 28th November 2018, more medical staff (including senior medical staff) will be allocated to this area. Care in UCC will follow the following principles:

- Patients will be seen in priority order
- No staff in UCC will be expected to see patients outside their scope of practice
- Any patient who is of concern, must be escalated either for a more senior member of staff to see or to be transferred to Majors or Resus to be seen

We will provide further detail on how UCC will be configured over the next few weeks

Majors

Our aim is to retain capacity in Majors at all times so that:

- Patients can always step down from Resus
- Ambulances can always offload
- Patients can always escalate up from UCC

Majors RAT will continue to function as normal. However as much as possible, we will aim to have a senior doctor at Majors RAT (particularly at times of peak demand) to ensure these patients are seen promptly.

One change is that all patients at Majors RAT who cannot sit will remain in Majors

An example of how this will change flow is that if a patient with severe back pain cannot sit (either in a chair or wheelchair), they will remain in Majors.

Dealing with surges in Emergency demand

We will have times when there will be surges in demand. Hence it is important that we have a plan to cope with these.

For the most part we would expect patients in the triage categories below to be seen as follows:

- P1 – Red - Immediate
- P2 – Orange - 10 mins
- P3 – Yellow - 1 hour
- P4 – Green - 2 hours
- P5 – Blue – Navigate

At times of peak demand we would expect the following staff to escalate as follows:

Role	When to escalate	Escalates to	How to escalate
Streaming nurse	More than 5 people waiting to be streamed	Nurse in Charge	Bleep
Initial Assessment Nurse	Patients on assessment screen for over 30 minutes	Nurse in Charge	Bleep
UCC Coordinator	Priority 3 patients in UCC waiting 1 hour	Senior Doctor in UCC	In person
Majors Coordinator	Priority 3 patients in Majors waiting 1 hour	Senior Doctor in Majors	In person
Resus Coordinator or Trauma Team Leader bleep holder	Number of priority calls exceeding available trolley space	Nurse in Charge Consultant in Charge	Bleep /Intercom /Phone

ED will provide further guidance to senior staff on their actions at times of high demand

ED is also working separately on plans to:

- Improve flow to x-ray and CT
- Improve turnaround times for blood tests
- Improve adherence to the Trust Interprofessional Standards
- Simplify condition specific pathways
- Improve layout and simplify signage for clinical areas
- Attempt to improve IT and Printing we appreciate also that these changes are planned soon after another big change (the iCLIP roll out). However this provides us with a real opportunity to see how we can streamline our process so that they are simple, clear and robust.

8.1 ED Redirect or Closure

NHS England (with the support of NHS Improvement) implemented the immediate suspension of all hospital redirects (with the exception of those requested for major infrastructure failure) from January 2017. This includes both resus / blue light redirections normally requested via the LAS, and capacity related redirections normally requested via NHS01.

NHS England London
ED Capacity Manage

8.2 Demand and Capacity

St. Georges has a well-developed SOP for the management of demand and capacity, including surges in demand on a day to day basis as outlined above (section 5.1)

Adobe Acrobat
Document

Escalation action
cards & out-of-hours

8.3 Delayed Transfers of Care (DTOCs)

The Trust is continuing to work with local Social Care colleagues to progress the 'Discharge to Assess' model.

ESCALATION
PROCESS FOR MANA

8.4 Repatriations:

St. Georges has an agreed protocol for all hospitals in South West London that patients referred will be repatriated to their local hospital within 48 hrs. For Stroke mimic patients this is 24hrs. The escalation process has been updated and clearly outlines roles and responsibilities at days 1, 2 and 3.

This was further updated in 2017 for local hospital, outlining their agreed responsibilities on a daily basis.

This plan is included below.

SOUTH WEST
LONDON REPATRIAT

8.5 Critical Care

Critical Care
Escalation 2018.pdf

9.0 Escalation Areas

It is recognised that there is a lack of suitable escalation beds that can be opened / utilised at short notice.

At times where Trust Surge Capacity Status is OPEL Level 0 or 1 there should be no escalation areas in use, unless as part of the Divisional Director of Operations plan for activity.

At times where the Trust Surge Capacity Status is OPEL Level 2, it may require the use of escalation areas in order to ensure patient safety as well as experience is kept at the level expected.

The process to open escalation areas is detailed in the Surge Capacity Management Plan:

Objective – The overriding principle is that patient safety will not be compromised.

The Trust is required to achieve the following:

1. ED quality indicators including the 4 hour standard.
2. 18 weeks access target for elective patients.
3. Cancer access targets.
4. Eliminate mixed-sex accommodation breaches.
5. Manage infection control issues / outbreaks safely

Systems	Bed capacity gap in one division only Bed capacity gap in more than one division At least 6 patients in the ED requiring beds – no beds available – across all specialties All elective & emergency patients placed but ≥ 4 patients waiting at other hospitals to come in (clinically need to be at St. Georges)
ED Consultant	Need to inform CSM – 24/7
Clinical Site team	CSM discusses with DDO / DDNG (Flow meetings) – in hours. CSM/HoN discusses with Tactical on-call out of hours.
Systems	**At Surge Capacity Management – OPEL Level 2** • Ensure that all actions at Surge OPEL Level 1 and Surge OPEL level 2 have been implemented • Ensure that any funded beds identified for outlying have been utilised by the specialty experiencing greatest pressure. • Escalation areas will be opened in the following order following agreement with Clinicians and managers: Inform all clinicians of operational status. The order may change in consultation with staff. a. Neuro day Unit – Max. 4 patients – neuro or surgical patients b. AAA – to be used in consultation with the Medical Management Team, for appropriate medical patients, ensuring balancing future anticipated ambulatory requirement. c. Endoscopy – Max 4 patients. – Level 1, EDD<24 hrs, minimal care needs, non- confused and mobile. d. Corporate Business Continuity Plan activation

Tactical on-call **(out of hours) – Decision maker**	Head of Operations or HoN/CSM team to discuss with Tactical on-call re.decision → Will advise CSM if a decision to override ring fencing is permitted and how for how long and number of patients.
Strategic on-call	Discussed by Tactical on-

Escalation areas detailed previously are all subject to risk assessments, carried out on an annual basis. Copies of which are held in the Operations Centre.

Additional to this a checklist (Appendix 8) detailing actions taken to open an escalation area safely must be completed and submitted to the Operations Centre prior to an escalation area being used. This is to be completed by an appropriate nurse from within the Division utilising the area. A copy of this is to be kept in the Operations Centre (location to be determined).

Identification of Suitable Patients for Escalation Areas

The overriding principle in the identification of patients for escalation areas is that the patients care needs must be able to be safely met in the area they are being placed.

The CSM must ensure that the appropriate medical and nursing input from the different areas has been sought (as per checklist) in order to authorise patients to be outlied.

It is universally accepted that patients who fulfil the following criteria are never suitable for outlying:

- Medically or psychiatrically unstable
- Dementia or confusion of unknown cause
- Learning disabilities
- A requirement for infusion of blood products or chemotherapy

If escalation areas are expected to be opened this should be done by 8pm at the latest.

10.0 Community Services Escalation Response to Surge Pressure Management

Community Services Division provides St. George's Hospital with a number of key community based and non-acute services.

The key ones which link to St. George's Hospital capacity are reflected in the pressure surge matrix (Appendix 9). The corresponding responses by those services are below:

Please note that all services with numbers are not expected to close with increased capacity – up to Pressure Score 4 Red is normally expected to be managed within existing resources. Work around supporting winter capacity will ensure safe coverage and therefore to avoid Levels 4 and 5 Red and Black currently being developed led by AD)

Daily capacity plans to be submitted to the Operations Centre by 08:30hrs.

All services have local Business continuity plans which are available on the intranet.

11.0 Staffing

The Safe Staffing Levels Policy relates to all services within the Trust in relation to nursing and midwifery.

This policy is a guide for managers and nursing staff on safe nursing and Midwifery staffing levels for in-patient bed based services, out-patient services and community services. It outlines a staged approach to escalation procedures should staffing levels cause concern.

The Trust has a duty to ensure staffing levels are sufficient to maintain safety and provide quality care. Patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. This right is enshrined within the National Health Service (NHS) Constitution, and the NHS Act 1999 makes explicit the board's corporate accountability for quality.

The overarching aim is to work towards having the right staff with the right skills in the right place at the right time with the right leadership.

At least once every six months, Trust boards will monitor staffing capacity and capability. There will be monthly board reporting and reporting externally to a public facing website. Wards now display the funded and actual numbers of qualified and unqualified staff on duty for every shift. The Director of Nursing is responsible for each shift being safely staffed.

This guideline does not override the need and importance of using professional judgement to make decisions appropriate to the circumstances. There is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. Each ward has to determine its nursing staff requirements to ensure safe patient care. The emphasis should be on safe patient care not the number of available staff:

- Staffing numbers and skill mix is not as expected and minor adjustments are made to bring staffing to a reasonable level given workload and acuity
- Staffing numbers and skill mix are as expected, but given workload and acuity additional staff are required

Agreed Staffing Levels for wards and departments 2017
(updated October 2018)

Division	Ward	No of beds	Days	Nights	Weekends
Surgery and Neurosciences	Brodie neurosurgery	30	6RN 3HCA	5 RN 2HCA	6 RN 3HCA
	Cavell	28	5RN 2 HCA	3RN 2HCA	5 RN, 2HCA
	Florence Nightingale	22	6 RN, 3 HCA	4 RN	6RN 3HCA
	Gray	32	7RN 3HCA	4 RN 2 HCA	7 RN 3 HCA
	Gunning	28	6RN 4HCA	3RN 4HCA	6RN 4HCA
	Gwynne Holford	36	5RN 5HCA	3RN 3HCA	5RN 5HCA
	Holdsworth	26	6 RN 3 HCA	3 RN, 3 HCA	6 RN 3 HCA
	Kent	31	7 RN 6HCA	5RN 5HCA	6RN, 6 HCA
	Keate	21	5 RN 2 HCA (4+1 on late)	3 RN 1 HCA	5 RN 2 HCA (4+1 on late)
	McKissock	21	5RN 3HCA	3 RN 2HCA	5RN 3HCA
	Nye Bevan Unit Surgical Assessment Unit)	8 beds, 8 trollies, 15 chairs, 2 clinics	4RN 2HCA Additional RN on twilight	4RN 1HCA	4RN 2HCA Additional RN on twilight
	Vernon	31	6 RN 2 HCA	4 RN, 1 HCA	6 RN 2 HCA
	William Drummond	20	9 RN, 2 HCA	9 RN 2 HCA	9 RN, 2 HCA (8RN 2HCA on Sunday)
	Thomas Young	26	6RN 4HCA	5 RN 3HCA	6RN 4HCA
Medicine & Cardiothoracic	Allingham	28	6 RN, 4 HCA	4 RN, 3 HCA	6RN, 4 HCA
	Amyand	32	7 RN, 4 HCA	5 RN, 3 HCA	7RN, 4 HCA
	Benjamin Weir	32	7RN 3HCA	6RN 1HCA	7RN 3HCA Reduce RN to 5 on sat and sun night
	Belgrave	24/ 28 (when 4 beds occupied by CCU return to Belgrave, day RN will increase to 6)	5 RN 3 HCA	4 RN 2 HCA	5 RN 3 HCA
	Caroline	24	5 RN 2 HCA (1RN on Friday for Bronchoscopy)	4 RN	5 RN 2HCA sat 4RN 2HCA sun
	Cardiothoracic Intensive Care Unit	21 (18 Sat night and Sun)	22RN	21RN 1HCA No HCA on nights Thur-sun.	19 RN sat day 18 sat night and Sunday day and night
	CCU	11	6RN	7 RN	7 RN
	Champneys	19	5 RN, 2 HCA	3 RN, 1 HCA	5 RN, 1 HCA
	Cheselden	22	5RN 2HCA Wed and Fri –	3RN 1HCA	4RN 2HCA

Children and Women's			1 early RN		
	Gordon Smith	19	5RN, 2 HCA	3 RN 1HCA	5RN 2HCA
	Heart Failure Unit	11	3RN 1HCA	3RN	3RN 1HCA
	Heberden	24	5RN 6HCA	3RN 3HCA	5RN 6HCA
	James Hope	9 trolleys 7 beds	6RN (5 LD and 1 early) 1 HCA	2RN Mon-Fri	
	Marnham	28	7 RN, 3 HCA	5 RN, 2 HCA	7 RN, 3 HCA
	McEntee	18	4 RN 2HCA	3RN 1HCA	4RN 2HCA
	Richmond AMU	51	12RN 8HCA	12RN 7HCA	12RN 8HCA
	Rodney Smith	28	5 RN 4 HCA	4 RN, 3 HCA	5 RN, 4 HCA
	Ruth Myles	13	5RN (4 LD & 1 Early) 1HCA	3RN	4RN 1HCA
	Trevor Howell	19	5RN 2HCA	3RN 2HCA	5RN 2HCA
	Carmen - Antenatal Ward	12	2 RM 1 MCA/HCA works across antenatal and birth centre	2 RM 1 MCA/HCA	2 RM 1 MCA/HCA
	Champneys	18	3 RN & 1HCA (Mon, Wed & Fri) 3 RN (Tues, Thurs)	2 RN, 1 HCA	3 RN, 1 HCA (sat) 2RN 1 HCA (sun)
	Delivery rooms, HDU,x2, triage	19	10RM, 2 HCA 1 RGN for HDU (mon-fri)	10RM, 2 HCA 1 B7 to carry unit bleep	10RM, 2 HCA 1 B7 to carry unit bleep
	Freddie Hewitt	17	6 RN 1 HCA	5 RN	6 RN 1 HCA
	Gwillim (postnatal)	32 beds 32 cots	7 RM early 6 RM late 1 RN LD 2 HCA LD 1 MSW	4 RM 2 HCA 1 MSW If more than 12 TC babies an extra midwife is required	5 RM LD 1 RN LD 2 HCA LD 1MSW LD
	General Intensive Care	21 (18 Sat night and Sun)	20RN 1HCA	20RN 1HCA on Fri and Sat night	20RN during sat day 17 RN during sat night and all day Sunday
	Jungle	15 (Generally 30-45patients per day)	3 RN on LD 2 Early mon-fri Mon Wed and Friday 1 extra early to cover MRI in AMW Opened 7.00-20.00	Closed	Closed I RN for 3 hours for pre admission session
	Nicholls/Ocean	19	7RN 1HCA	5 RN	6 RN, 1 HCA
	Neuro Intensive Care Unit	17(mon –sat) 14 (Saturday night and all day and night	15 RN 2 HCA	15 RN 2HCA	Nights reduced to 13RN and 1HCA Saturday and Sunday and 13 RN and 1 HCA

		Sunday)			day Sunday
	Neonatal Unit	24 (12 ICU/12HDU)	19 RN	19 RN	19 RN
	Special Care Baby Unit	16	6RN + 1 Nursery Nurse	6RN + 1 Nursery Nurse	6RN + 1 Nursery Nurse
	Paediatric Intensive Care Unit	6 ITU 6 HDU	11RN 1HCA	11RN 1HCA	11RN 1HCA
	Pinckney	15	6 RN 1HCA	5 RN	6 RN 1HCA
	Mary Seacole Ward A	21	4 RN, 3 HCA	2 RN, 3 HCA	3 RN, 3 HCA
	Mary Seacole Ward B	21	4 RN, 3 HCA	2 RN, 3 HCA	3 RN, 3 HCA

Theatres safe staffing levels
Minimum levels per theatre session:
Local Anaesthetic lists: 2 qualified scrub practitioners
General Anaesthetic cases: 2 qualified surgical scrub practitioners, 1 HCA, 1 Anaesthetic Practitioner
Complex kit / high turnover lists [minimum 8 cases/session]: 3 qualified, 1 HCA, 1 Anaesthetic Practitioner
When two scrub teams required 4 qualified, 1 HCA, 1 Anaesthetic Practitioner


Safe Nursing Staff Escalation Policy V9.p

12.0 Winter Plan – Staff Awareness Programme

12.1 Winter and Cold Weather preparation

As part of its Winter Plan, the Trust will check the resilience of their estate and equipment, especially medical and IT systems, to ensure that where necessary they can be maintained at working temperatures and there is no risk of system failure. This is important to ensure that a safe environment is maintained for patients, visitors and staff. The Trust will discharge this duty by;

1. Undertaking a programme of regular testing of emergency standby generators and associated essential electrical distribution services, to ensure that all essential systems will operate correctly in the event of a mains power failure.

2. Implementing a planned preventive maintenance (PPM) programme on all business critical ventilation, air conditioning, heating and cooling plant and ensuring that all such plant and equipment is inspected and maintained.

3. Ensuring that the building services engineering infrastructure of Trust buildings is not put at risk by the uncontrolled and/or unplanned introduction and use of both temporary air conditioning and air heating units and permanent air conditioning or heating systems/plant.

4. Ensuring that techniques employed to provide heat and warmth are those that are as environmentally friendly as reasonably practicable and generate least revenue cost to the Trust.

5. Ensuring that those responsible for procuring IT, diagnostic, medical and other electronic equipment consider the building services implications at an early stage and consult with the appropriate department within the Estates and Facilities Directorate.

6. Ensuring that the Trust operates a fair and consistent process in assessing requests for the installation of equipment and services for maintaining temperatures across the Estate by using a formal standardised option appraisal process.

7. Effectively managing staff, patient and visitor expectations of controlling winter time temperatures within its buildings.

8. In conjunction with Medical and Nursing staff, identify those patients and areas of the Estate that are most at risk from extended periods of cold weather. These may include those with;

    - Older people, especially those over 75 years of age and "frail" older people.
    - Wards with babies and young children under 5 years of age.
    - Older people, living on their own

    - People with:
    - Long-term chronic conditions such as TIA, asthma, chronic obstructive pulmonary disease or diabetes
    - Mental ill-health that reduces individual's ability to self-care (including dementia)
    - learning difficulties
    - a history of falls or at having been assessed as being at risk of falling
    - Cardiovascular and Cerebrovascular conditions. (Patients with these conditions are generally treated in Atkinson Morley which has extensive ventilation and comfort cooling/heating throughout the majority of the building).
    - Arthritis
    - Peripheral vascular conditions.
    - Obstetric/Delivery Suite
    - Malnutrition
      (source: adapted from PHE Cold Weather Plan 2015)

9. In conjunction with Community Services staff, maintain a list of vulnerable patients from across the Community Services division. Across Community Nursing, Intermediate Care and Children and Families there will be 20 separate lists. These may include those patients:

    - Living on their own
    - Living with a partner who is confused or frail suffering from a terminal illness
    - Suffering from a long-term chronic condition

A template for community teams to complete this information in is in Appendix 3. From these, the Winter Co-ordinators should be able to provide a summary of the information if requested on the form in appendix 2.

12.2 Winter and Cold Weather Staff Awareness

It is essential that everyone is aware and reminded that the effects of sustained cold weather are not confined to the Trust (workplace) and that people will suffer from the effects at home and in all aspects of their normal daily routines.

The Workplace (Health, Safety and Welfare) Regulations 1992 lay down particular requirements for most aspects of the working environment. This includes guidance for working temperatures (see appendix 1).

The Trust will therefore also implement a 'Winter Plan - Staff Awareness Programme' issuing simple guidance and advice aimed at promoting no cost/low cost measures to minimise the impact of the cold weather. This will be issued in October each year, prior to the start of the official 'NHS Winter Watch' period (1st November to 31st March) and will include the following information.

This plan is applicable to all employees of St George's University Hospitals NHS FT, full time, part time, permanent, fixed term staff and contractors; the plan is also applicable to Staff Bank and volunteers.

1. Plan ahead – be aware of the local weather forecast and know if cold weather is on its way.

2. If severe cold weather is likely to be safety critical, i.e. have an adverse effect on staff work activity that could have serious effects if it went wrong, or staff health, carry out a risk assessment. If the precautions identified by the assessment cannot be implemented in a reasonable time, then an entry needs to be placed on the divisional risk register.

3. Plan your day in a way that allows you to stay out of the cold as much as possible i.e. consider flexible working within the constraints of the service.

4. Trust staff (particularly gardeners and others working outdoors) must ensure they are clothed appropriately, wearing warm clothes and appropriate footwear for the conditions. Any short term changes to the wearing of staff uniform should be agreed with line managers and in accordance with the Trust's Dress Code Policy.

5. If the fire alarm sounds, fire doors must be closed. Windows should be closed and air conditioning switched off; however this must not delay efficient and speedy evacuation.

6. Ensure ventilation and heating systems currently in place are working effectively and report any defects as soon as possible the relevant Estates maintenance helpdesk for your location. Ensure that you record the job reference number when issued.

7. Managers must assess all the risks and if necessary find alternative temporary accommodation for staff or change their rosters or work patterns so that staff are rotated or come into work when the ambient temperature is more tolerable.

8. If temporary heating by portable heaters is required then these must be accessed via Trust Estates helpdesk. No unauthorised portable devices can be used.

9. If staff are required to work in unreasonably cold temperatures (as identified by risk assessment) then the department must provide warm clothing where required. This may be in the form of jackets/ overcoats, gloves, body warmers or any form of warm clothing which may be required.

10. The risk assessment process must take into consideration any known health problems of staff and make reasonable changes to their work activity during exceptional cold weather. This principle also applies to pregnant or nursing mothers. Health Surveillance by the Occupational Health department may be required in exceptional circumstances.

11. Staff must complete a DATIX incident report if they or any other patient or person is adversely affected by the cold.

12. Managers must also consider that staff may have dependents or relatives at home that may be adversely affected by the cold.

13. Be aware of the requirements of the Trust's First Aid Policy and be familiar with the method of obtaining the Resuscitation Team:
    - at St. George's Hospital, Ext 2222,
    - At Queen Mary's Hospital, Ext 2222
    - At HMP Wandsworth, "Hotel 3" on the radio system.
    - In the Community external number (9)999.

See Appendix 10 for Cold weather alerts and associated actions.

Appendix 1.

Overview of the national framework

To enable local A&E Delivery Boards to align their escalation protocols to a standardised process, the national framework has been built on work already done across the four regions.

The levels mirror systems already in use around the country, and aligns with the national Resource Escalation Action Plan2 (REAP) used by Ambulance trusts.

Operational Pressures Escalation Levels

OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms.
OPEL 4	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Operational pressure Escalation Levels (OPEL)

OPEL Zero	Low levels of pressure across A&E Delivery Board area, relevant actions taken in response if deemed necessary, **no support required**
OPEL One	Moderate pressure across A&E Delivery Board area, performance deterioration, escalation actions taken in response, **support required**
OPEL Two	Severe pressure across A&E Delivery Board area, significant deterioration in performance and quality, majority of escalation actions available are taken in response**, increased support required**
OPEL Three	Extreme pressure across A&E Delivery Board area, risk of service failure, all available escalation actions taken and potentially exhausted**, extensive support and intervention required**

These map back to the traditional RAG rated escalation triggers used in SWL in winter 15/16.

ESCALATION TRIGGERS - SWL

Escalation Level	Acute Trusts	Community Care	Social Care	Primary Care	Other Issues
OPEL Zero	•Demand for services above the established 'normal' level but capacity available to meet expected demand • Good patient flow through ED and other access points • Anticipated pressure on maintaining ED 4 hour target	• Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	• Social services able to facilitate placements, care packages and discharges from acute care and other hospital and community based settings	• Out of Hours (OOH) service demand within expected levels • GP attendances within expected levels with appointment availability sufficient to meet demand	•NHS 111 call volume within expected levels
OPEL One	• Anticipated pressure in facilitating ambulance handovers within 15 minutes • Discharges below expected norm • Slow patient flow through ED • Infection control issues emerging • Lack of beds across the Trust • Predicted discharges < expected admissions	• Patients in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds • Infection control issues emerging	• Patients in community and / or acute settings waiting for social services capacity • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions)	• GP attendances higher than expected levels • OOH service demand is above expected levels • Some unexpected reduced staffing numbers (due to e.g. sickness, weather conditions)	• Rising NHS 111 call volume above normal levels • Surveillance information suggests an increase in demand • Weather warnings suggest a significant increase in demand

	• ED patients with DTAs and no plan • Capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO)				
OPEL Two	• Actions at level 2 failed to deliver capacity • Significant failure of ED 4 hour target • Significant ambulance handover delays • Patients awaiting handover from ambulance service within 15 minutes significantly compromised • Patient flow significantly compromised • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow • Serious capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including ECMO)	• Community capacity full • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50%(due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Pressure on OOH/GP services resulting in pressure on acute sector • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Surveillance information suggests an significant increase in demand • NHS111 call volume significantly raised with normal or increased acuity of referrals • Weather conditions resulting in significant pressure on services • Infection control issues resulting in significant pressure on services

OPEL Three	• Actions at level 3 failed to deliver capacity • No capacity across the Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 30 minutes • ED patients with DTAs >8 hrs. • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds (possibly including	• No capacity in community services • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	• Social services unable to facilitate care packages, discharges etc. • Significant unexpected reduced staffing numbers to under 50%(due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow	• Acute trust unable to admit GP referrals • Inability to see all OOH/GP urgent patients • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety	

Mitigating Actions at each trigger level

Escalation Level	Whole System	Acute Trusts	Commissioner	Community Care	Social Care	Primary Care	Mental Health
OPEL Zero	**Business as usual – actions determined locally in response to operational pressures, which should be in line with expectations at this level**						
OPEL One	•Undertake information gathering and whole system monitoring as necessary to enable timely de-escalation or further escalation as appropriate	•Undertake additional ward rounds to maximise rapid discharge of patients • Clinicians to prioritise discharges and accept outliers from any ward as appropriate •Implement measures in line with trust Ambulance Service Handover Plan • Ensure patient navigation in ED is underway if not already in place • Notify CCG on-call Director to ensure that appropriate operational actions are taken to maximise use of nurse led wards and nurse led discharges	• Expedite additional available capacity in primary care, out of hours, independent sector and community capacity • Co-ordinate the redirection of patients towards alternative care pathways as appropriate •Co-ordinate communication of escalation across the local health economy (including independent sector, social care and mental health providers)	• Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. • Maximise use of reablement/ intermediate care beds •Task community hospitals to bring forward discharges to allow transfers in as appropriate. • Community hospitals to liaise with Social and Healthcare providers to expedite discharge from community hospitals.	• Expedite care packages and nursing / Elderly Mentally Infirm (EMI) / care home placements • Ensure all patients waiting within another service are provided with appropriate service • Where possible, increase support and/or communication to patients at home to prevent admission. Maximise use of reablement/ intermediate care beds	• Community matrons to support district nurses/hospital at home in supporting higher acuity patients in the community • In reach activity to ED departments to be maximised • Alert GPs to escalation and request alternatives to ED referral be made where feasible	• Expedite rapid assessment for patients waiting within another service • Where possible, increase support and/or communication to patients at home to prevent admission

OPEL Two	•All actions above done or considered •Utilise all actions from local escalation plans • CEOs / Lead Directors have been involved in discussion and agree with escalation to Level 3 if needed	• ED consultant to be present in ED department 24/7, where possible • Contact on-take and ED on-call Consultants to offer support to staff and to ensure emergency patients are assessed rapidly • Enact process of cancelling day cases and staffing day beds overnight if appropriate. • Open additional beds on specific wards, where staffing allows. • ED to open an overflow area for emergency referrals, where staffing allows. • Notify CCG on-call Director so that appropriate operational actions can be taken to relieve the pressure. • Alert Social Services on-call managers to expedite care packages	• Local regional office notified of alert status and involved in discussions • CCG to co-ordinate communication and coordinate escalation response across the whole system including chairing the daily teleconferences • Notify CCG on-call Director who ensures appropriate operational actions are taken to relieve the pressure • Notify local DoS Lead and ensure NHS111 Provider is informed. • Cascade current system-wide status to GPs and OOH providers and advise to recommend alternative care pathways.	• Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible • Community providers to expand capacity wherever possible through additional staffing and services, including primary care	• Social Services on-call managers to expedite care packages • Increase domiciliary support to service users at home in order to prevent admission. •Ensure close communication with Acute Trust, including on site presence where possible	• OOH services to recommend alternative care pathways • In hours GP services to recommend alternative care pathways • Review staffing level of GP OOH service	• To review all discharges currently referred and assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities wherever possible • Increase support to service users at home in order to prevent admission

OPEL Three	• Contribute to system-wide Communications to update regularly on status of organisations (as per local communications plans) Provide mutual aid of staff and services across the local health economy • Stand-down of level 4 once review suggests pressure is alleviating • **Post escalation:** Contribute to the Root Cause Analysis and lessons learnt process through the SI investigation	• All actions from previous levels stood up • ED consultant to be present in ED department 24/7, where possible • Contact on-take and ED on-call Consultants to offer support to staff and to ensure emergency patients are assessed rapidly • Surgical consultants to be present on wards in theatre and in ED department 24/7, where possible • Executive director to provide support to site 24/7, where possible • **An Acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG to request authorisation to explore a divert to neighbouring**	• Local regional office notified of alert status and involved in decisions around support from beyond local boundaries • The CCGs will act as the hub of communication for all parties involved • **Post escalation:** Complete Root Cause Analysis and lessons learnt process in accordance with SI process	• Ensure all actions from previous stages enacted and all other options explored and utilised • Ensure all possible capacity has been freed and redeployed to ease systems pressures	• Senior Management team and cabinet member involved in decision making regarding use of additional resources from out of county if necessary • Hospital service manager, linking closely with Deputy Director Adult Social Care, & teams will prioritise quick wins to achieve maximum flow, including supporting ED re prevention of admission & turn around. Identification via board rounds and links with • Discharge team & therapists. Hospital Service Manager/Deputy Director to monitor escalation status, taking part in	• Ensure all actions from previous stages enacted and all other options explored and utilised • Ensure all possible actions are being taken on-going to alleviate system pressures	• Ensure all actions from previous stages enacted and all other options explored and utilised • Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible

		trusts whether these are in or out of the region002E			teleconferences as required.		

Appendix 2 - Capacity Management Score Matrix

Acute Services

	M&C			CWTD			SNCT		
Surge Capacity Score	**ED Escalation Policy** (colour coding still to be reviewed)	**Medicine (beds)**	**Cardiac (beds & electives)**	**Adult ICU**	**Paeds (inc. PICU)**	**Gynae (beds)**	**Neuro**	**Surgery (beds)**	**Surge Capacity Score**
1	Green	BAU	BAU	CRITCON 0	BAU	BAU	+2	-5	**1**
2	Yellow	1 in, 1 out DTA wait >1hr	0 IHT delays 2 CCU beds	CRITCON 1	1 in, 1 out DTA wait <1hr	1 in, 1 out Discharges later	-1	-10	**2**
3	Amber	0 beds now Discharges later DTA wait >2hrs	Elective and IHT work placed No other capacity 2 CCU beds	CRITCON 2	0 beds now Discharges later DTA wait >2hrs	-3 Discharges later	-4	-20	**3**
4	Red	0 beds now Discharges later DTA wait >4hrs	<3 IHT delay 0 beds now Discharges later 1 CCU bed	CRITCON 3	0 beds now Discharges later DTA wait >4hrs	-4 Discharges later	-8	-30	**4**
5	Black	0 beds now No discharges later DTA wait >4hrs	>4 IHT delay 0 beds now or later 0 CCU beds	CRITCON 4	0 beds bow No discharges later DTA wait >4hrs	-4 No discharges	-12	-50	**4**
Surge Capacity Score	**ED Escalation Policy**	**Medicine (beds)**	**Cardiac (beds & electives)**	**Adult ICU**	**Paeds (inc. PICU)**	**Gynae (beds)**	**Neuro**	**Surgery (beds)**	**Surge Capacity Score**
	M&C			**CWTD**			**SNCT**		

Surge Capacity Score	**MIU @ QMH**	**Surge Capacity Score**
1	2 ENP 8 until 8	**1**
2	1 ENP 8 until 8 1 ENP part shift	**2**
3	1 ENP 8 until 8	**3**
4	1 ENP part shift	**4**
5	No Staff	**5**
Surge Capacity Score	**MIU @ QMH**	**Surge Capacity Score**

Appendix 3

Safety and Flow Huddle Terms of Reference

20160309_flow and safety huddles_v2_G

Appendix 4

Conference Call

Out of hours the conference call will be held at midday. Further calls can be arranged using these details.

Telephone number – 0800 368 0707 **or** 020 8934 7061:

Others Code: 9415184

Level 1	• Ensure all patients are assigned to a physician within 1 hour of arrival. • Review staffing for next 24 hours. • Board round review of all patients in ED • No fixed commitments whilst on shop floor • Reallocate medical staff to area of demand and review skill mix • Ensure investigations are 'front loaded to help reduce delays in decisions later

Level 2	**Ensure all Level 1 actions are initiated, then ensure the following:** • Re-assess all clinical areas with ED matron (or NiC if OOH). • Request specialist teams to assist in ED. • Ensure board rounds are completed two hourly. • Request all available ED consultants and other ED staff to be present on shop floor where this would be helpful. • Consider cancelling all study/SPA/training time to support ED. • Ensure clinical decisions are made with 120 minutes, escalating any concerns.

Level 3	**Ensure all Level 2 actions are initiated, then ensure the following:** • All clinical staff to undertake clinical duties. • All study/SPA/training time to be cancelled (if not already done so) to support ED. • Where delays in offloading patients from ambulances is occurring to ensure these patients are still assessed. • Request all available ED consultants and other ED staff to be present on shop floor where this would be helpful. • Liaise with the NiC and Site Team regarding the possibility of cohorting patients in an alternative area to create capacity in Majors. • Ensure clinical decisions are made with 120 minutes, escalating any concerns

Aim / Objective

- Maintain knowledge of the Divisions bed position for the next 24 hours and the status of the Emergency Department.
- Be the single point of contact for matters of escalation, unresolved by Site Management.
- Escalation to Divisional; Silver should only occur when Capacity and Patient Flow issues have already been escalated by normal means and have been unsuccessful

Level 1

Business as usual and in addition *:*

- **If Required** - support the bed managers/ HON for Site with any internal escalation.
- Be given assurance locally that all Senior Reviews are undertaken early in the day, and any diagnostic procedure which is discharge dependent escalated to the appropriate person.
- Act as point of contact for service managers and matrons for escalation on flow issues. Escalate any unresolved issues as necessary.
- Provide support and give advice to ward staff, or liaise with matrons for specific areas of concern.
- Attend all Assurance meetings in the ICC (G2.099), and give assurance regarding capacity plans for Division, particularly to cover the out-of-hours periods.
- If necessary develop a recovery plan in conjunction with the Bed Manager/Service Manager using bed management tools to inform.

Ensure all OPEL Level 2 actions are initiated, then ensure the following:

These actions to be completed in association with relevant bed manager and Head of Nursing for Site:

- Request Clinical Director/ Chief Pharmacists to nominate a doctor / pharmacist to go to patient departure lounge to write TTOs if required. This will enable patients to be discharged to the departure lounge without TTOS written.
- Ensure urgent only GP referrals are being accepted by registrar or consultant. Ensure correct locality patients are accepted.
- Be reassured and give assurance that all outliers have been reviewed. This information remains the responsibility of the Site HON/ Bed manager and will be circulated by 7am each day.
- Be given assurance that all board rounds are completed.
- Ensure appropriate medical cover is available for all divisional services.
- HON for site to create a transfer team to enable rapid movement of patients between ED/AMU/Wards. Support if required.
- If a decision to cancel surgery has been made, consider within the Division the impact of the cancellation of some non-urgent elective patients and ensure all cancelled patients are rescheduled with a new date.
- If necessary implement the role of the Ward Liaison Officer (WLO) who will prioritise, coordinate and escalate all outstanding discharge dependent tests or investigations. **This role may already be the role of the ward receptionists**

Level 3	**Ensure all OPEL Level 3 actions are initiated, then ensure the following:** • Gold command & Control will initiated: Actions directed by Gold Command: • Each Division to nominate a Management & Clinical Silver (Tactical). • Ensure all actions within the Full Capacity Protocol are initiated. Initiate local divisional plans for staff to provide clear priorities in relation to patient flow. • GMs/DGM ensures that Consultant SPA's is converted to DCC where possible and that staff are redeployed to Clinical duties. • HON to ensure that nursing study days are cancelled and staff redeployed to clinical duties. • Enact plans surrounding balancing emergency and elective workload – in conjunction with the Director responsible that day. • Strategic / Tactical On-call to be onsite until Command & Control has been stepped-down.

Level 1	• Business as usual. That is reviews all inpatients awaiting assessment and undergoing planned interventions. • Prioritise patients who can be discharges that day. • Attend MDT meetings and board rounds to highlight potential discharges. • Work with discharge coordinators to identify patients for rehabilitation and those suitable for community beds (such as Nightingale House, QMH or Ronald Gibson House) or community referral.

Level 2	**Ensure all OPEL Level 2 actions are initiated, then ensure the following:** • Communicate with fellow team members to ensure they are aware of current Trust status. • Check all potential and actual discharges to escalate once discharged from therapy. • Review staffing for next 24 hours. • Consider cancelling all study/training time to support Wards. • Ensure attendance at ward board rounds. • Liaise with own wards to try to expedite earlier discharge with inside or outside resource. • Teams to share caseloads to focus on the urgent discharge and priority cases.

Level 3	**Ensure all OPEL Level 3 actions are initiated, then ensure the following:** • Support nursing staff to identify alternative forms of transport (private ambulance, taxi) to discharge patients • Head of therapies to attend escalation meetings throughout day. • Ensure all study/training is cancelled where possible to support Wards.

Level 1	• Ensuring an accurate bed state is maintained at all times. • Ensure that an accurate record of all potential and actual discharges is maintained for all areas, escalating any known unresolvable delays to Matron for the area. • Supporting ward staff in identifying all those patients who can move to Departure Lounge and do so in a timely manner. • Attend any planned board rounds or other directorate meetings as required. • Ensure beds vacated are turned around in a timely manner (<30 mines). • Escalate any absence of ward rounds/delays to Site Manager. • Maintain an overview of ED, escalating any unresolvable delays to the Site Manager. • Coordinate (with Divisional Representative) review of elective activity. • Ensure all hospitals have been contacted with regards repatriations. • If required request portering supervisor to mobilise additional support for patient transfers. • Ensure Trust capacity spreadsheet is updated prior to every escalation meeting.
Level 2	**Ensure all Level 1 actions are initiated, then ensure the following:** • Communicate with fellow team members to ensure they are aware of current Trust status. • Ensure all actual/potential escalation areas have patients identified for them. • Check all potential and actual discharges, escalating any unresolvable issues to Matron and Site Manager. • Ensure attendance at ward board rounds. • Coordinate (with Divisional Representative) review of elective activity – with a view to likely cancelations.
Level 3	**Ensure all Level 2 actions are initiated, then ensure the following:** • Ensure continuous validation of available beds. • Ensure escalation of difficulties being experienced with patient flow. • Ensure escalation of any detriment to patient care to appropriate senior staff.

Appendix 5 Action Card – Head of Nursing for Operations

Level 1	• Escalate to Divisional representatives • Maintain patient safety as priority. • Chair meetings to review status of all inpatient areas (escalation meetings) • Initiate additional resources as required such as portering and additional nursing cover. • Liaise with community managers to ensure maximum discharges and use of community beds. • Support the areas most under pressure to provide a visible presence. • Escalate potential breach situation to Divisional Teams/General Manager on call if cannot be resolved in timely manner. • Agree contingency actions aimed at reducing escalation level – consider the possibility of opening additional beds • Ensure these actions are completed in each Division • Ensuring appropriate reporting is completed in a timely manner (both internal and externally to Trust).
Level 2	**Ensure all Level 1actions are initiated, then ensure the following:** • Liaise directly with General Managers, DDOs, COO as well as on call Director and General Manager with regards Trust escalation status. • Initiate additional escalation meetings if deemed necessary after discussions with above. • Ensure bed managers have accurate and timely information so as to guide decision making. • Be clear as to where block to flow are and escalate to appropriate staff to assist in relieving these. Escalating when such actions have not been successful. • Liaise with LAS (DDO) as required.
Level 3	**Ensure all Level 2 actions are initiated, then ensure the following:** • Consider need to call in additional Site Team support. • Provide data and attend escalation meetings. • Agree and implement contingency actions aimed at reducing escalation level. • To be guided by Director (or deputy). • Ensure on-going appropriate reporting.

Appendix 6 – Trust Capacity Update

Text Messages (Morning, Daytime Surge, Morning Meeting Alert)

Yesterday
-
ED Attendance:
Breaches (unvalidated):
Breaches (Since Midnight):
DTAs awaiting bed:
First 12hr breach:
Issues:

Medicine
Emergency Admits:
Elective Admits:
Discharges:
-
Surgery
Emergency Admits:
Elective Admits:
Discharges:
-
Cardiac
Emergency Admits:
Elective Admits:
Discharges:
-
Paediatrics
Emergency Admits:
Elective Admits:
Discharges:
-
This Morning
-
Adult ITU
Empty:
Planned Admits:
Planned Discharges:
-
Medicine
Available beds
AMU:
Wards:
Capacity gap this a.m:
-
Surgery
Available beds
Wards:

Capacity gap this a.m:
-
Cardiac
Available beds
Wards:
Capacity Gap this a.m:
-
Neuro
Available beds
Wards:
Capacity gap this a.m:
-
Paediatrics
Available beds
Wards:
Capacity gap this a.m:
-
Community:
-
Unfunded Beds Opened:
-
Infection Control:
-
Staffing Deficits:
-
DTOC
-
NDTOC

Dear All,

Following the_____capacity meeting there remains a significant capacity gap:

Medicine –

Surgery –

Cardiac – Neuro

– - Paeds –

The next escalation meeting is at _____in the Operations Centre to discuss capacity plans for the remainder of the day and overnight.

Dear All,

Following this evenings capacity meeting there remains a significant capacity gap:

Medicine –

Surgery –

Cardiac –

Neuro – -

Paeds –

There will be an escalation meeting at 08:30 tomorrow in the Operation Centre to discuss capacity plans for the day

Please ensure representation.

Review of Elective Work
(as per Surge Capacity Management Plan)

Membership

Medical Director/ Chief Nurse and Chief Operating Officer (Chair)	
Divisional Chair Medicine	
Divisional Chair Surgery	
Divisional Chair Women's and Children's	
Head of Operations / representation	
Clinical Director/ED consultant rep	

Information to be available for this meeting (collated and presented by Head of Operations)

The following information will be available to the group - demand and capacity for that day and the next 24 hours:

Predicted Medical Admissions		Actual:		
Predicted Surgery Admissions		Actual:		
Predicted Paediatric Admissions		Actual:		
Escalation beds currently utilised	Med: Cardiac:	Surgery: Gynae:		
Electives planned: Endoscopy lists planned:	Medical: Cardiac:	Surgical: Gynae:	Neuro: Stroke:	
Non-Clinical Hospital Cancellations	Medical: Cardiac:	Surgical: Gynae:	Neuro: Stroke:	
Inter-hospital transfers in:	Medical: Cardiac:	Surgical:	Neuro: Stroke	
Repatriations:	Medical: Cardiac:	Surgical: Stroke:	Neuro:	
Discharges:	Medical: Snr. Health: Cardiac:	Surgical: Gynae:	Paeds: Neuro:	
Critical care beds available	Gen.	H'worth.	Neuro.	Cardiac
Critical care transfers out	Gen.	H'worth.	Neuro.	Cardiac
Critical care transfers in	Gen.	H'worth.	Neuro.	Cardiac
Medical Outliers in surgery:				
Surgical Outliers on Medical Wards:				
Champneys Outliers:				

Current Emergency Activity Situation

ED Attendance:		
Emergency Access Breaches:		
ED 4 Hour Target (%)	ED: %	Total: % YTD %

Options

Transfer elective activity off-site i.e. Parkside (see Surgery Private Sector Proforma)

Patient & Specialty	Consequence	Other services impacted

Cancel elective patients

Patient & Specialty	Consequence	Other services impacted

Cancel out patient activity

Patient & Specialty	Consequence	Other services impacted

Decisions

Summary of Decisions

Appendix 8

Actions Required to Open an Escalation Area Safely

	Actions Required to open an Escalation Area safely:	Person responsible	Comments	Completed
Nursing Staff	1. A response Nurse will be used when available. 2. A bank Nurse will be employed but replaced with a permanent member of staff from within the division.	Site Manager & Matron		
Medical staff	Clearly outline the Medical / Surgical team responsible for the patients placed in escalations beds.	Head of Nursing		
Therapy staff	1. Physio 2. OT Clinical Site Manager to inform Ops Manager, In-patient Therapies	Ops Manager, In-patient Therapies		
Patients	**Medicine:** The AMU consultant will identify patients on the AMU who are suitable for transfer. Patients will be identified who are medically fit or with an expected date of discharge (DTOC list) **Surgery:** Matrons will identify patients. **Neuro:** Registrar will identify patients.	Head of Nursing		
Setting up the Ward	Clean / domestic staff informed (MITIE) Check beds table's lockers and chairs are in place.	Head of Nursing		

	Actions Required to open an Escalation Area safely:	Person responsible	Comments	Completed
	Check oxygen and suction. Check with infection control			
IT	Helpdesk (X3456) or IT on-call (SG3456) are informed of ward beds opening and will make any iClip changes Notify network engineers. PACS	Site Manager		
Telecoms	Inform switchboard & ensure telephones are working. The phones have answer machine messages on them so these need to be erased and phones to ring as usual.	Site Manager		
Communication	Information updated at escalation meetings & electronic updates / reports. General communication within adjoining ward that escalations beds are open GM on call and Director on call informed	GM Site Services		
Facilities: **Cleaning**	Cleaning. Ensure regular service is instated if needed. Ensure clean curtains are hung Check shower curtains.	Head of Nursing		

	Actions Required to open an Escalation Area safely:	Person responsible	Comments	Completed
Catering **Linen** **Patient line**				
Estates	Ensure nurse call alarm system is working. Check macerator is working. Ensure the Detectors on the ward continued to be tested.	Head of Nursing		
Security/Fire	Inform security officer is aware. Inform Fire Officer and ensure all safety checks are completed - equipment and fire sensors are working. Check Fire escape.	Site Manager		
Stores	Arrange for delivery of stores. Include kitchen stores and stationary as well as medical nursing.	Head of Nursing		
Pharmacy	Inform pharmacy. Check drug fridge.	Head of Nursing		

	Actions Required to open an Escalation Area safely:	Person responsible	Comments	Completed
	Check Pod lockers.			
Other	Check Resus trolley including location.	Head of Nursing		

A copy of this form must be submitted to the ICC prior to use of escalation area.

Appendix 9 - Community Services Division Escalation Response Matrix to Surge Pressure Management

	OPEL Level 0	OPEL Level 1	OPEL Level 2	OPEL Level 3
Intermediate Care ADMIN.	• Inform care coordinators and IC team leaders • Email OP MT and PA's and escalation rota members	• Inform care coordinators and IC team leaders • Email OP MT and PA's and escalation rota members	• Inform care coordinators and IC team leaders • Email OP MT and PA's and escalation rota members	Inform care coordinators and IC team leaders Email OP MT and PA's and escalation rota members
Intermediate Care BLEEP HOLDER/ MANAGER ON CALL	Identify any delayed discharges from dom and bed based service and escalate	Business as usual capacity can be covered within existing establishments. Review caseloads, increase staffing and reallocate resources to cover high areas of activity	As Level 1 + • Staff up domiciliary service as required • Ensure RG beds in use • Identify any delayed discharges from domiciliary and bed based service and escalate/expedite	As Level 2
Minor Injuries Unit	Business As us**ual**	Reduce service at time and advise patients of waits / alternatives	• Close service at times and advise of redirection to other services •	Close service until staffing is available

	OPEL Level 0	OPEL Level 1	OPEL level 2	OPEL level 3
QMH Mary Seacole Ward (MATRON /NIC)	Identify any delayed discharges and report to head of nursing	As Level 1	As Level 2 + • Identify any discharges that can be accelerated with Bryson Whyte, Intermediate care, ESD, CNRT and/or outpatient follow up and plan discharge • identify any delays awaiting NHS funded long term care and liaise with commissioners re interim placement • accelerate assessment for patients waiting for assessment if any neuro beds empty	As Level 3
Primary Care Therapy Team	Step down escalation when Level 0 for 48 hours	As Level 1	Support ICS if required	As Level 3

Appendix 10

Cold Weather Alert levels

Level 0	**Year-round planning** *All year*
Level 1	**Winter preparedness and action programme** *1 November to 31 March*
Level 2	**Severe winter weather is forecast – Alert and readiness** *Mean temperature of 2°C and/or widespread ice and heavy snow are predicted within 48 hours, with 60% confidence*
Level 3	**Response to severe winter weather – Severe weather action** *Severe winter weather is now occurring: mean temperature of 2°C or less and/or widespread ice and heavy snow.*
Level 4	**Major incident – Emergency response** *Central Government will declare a Level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health*

Summary cold weather actions for health and social care organisations and professionals, communities and individuals

	Level 0	Level 1	Level 2	Level 3	Level 4
	Year-round planning *All Year*	**Winter preparedness and action** *1 November to 31March*	**Severe winter weather forecast – Alert and readiness** *Mean temperatures of 2°C and/or widespread ice and heavy snow predicted with 60% confidence*	**Severe weather action** *Mean temperatures of 2°C and/or widespread ice and heavy snow*	**Major incident – Emergency response**
Commissioners of health and social care	1) Take strategic approach to reduction of EWDs and fuel poverty. 2) Ensure winter plans reduce health inequalities. 3) Work with partners and staff on risk reduction awareness (e.g. flu vaccinations, signposting for winter warmth initiatives).	1) Communicate alerts and messages to staff/public/media. 2) Ensure partners are aware of alert system and actions. 3) Identify which organisations are most vulnerable to cold weather and agree winter surge plans.	1) Continue level 1 actions. 2) Ensure partners can access advice and make best use of available capacity. 3) Activate business continuity arrangements as required.	1) Continue level 2 actions. 2) Ensure key partners are taking appropriate action. 3) Work with partners to ensure access to critical services.	Level 4 alerts issued at national level in light of cross-government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office. All level 3 responsibilities to be maintained unless advised to the contrary.
Provider organisations	1) Ensure organisation can identify and support most vulnerable. 2) Plan for joined up support with partner organisations. 3) Work with partners and staff on risk reduction awareness (e.g. flu vaccinations, signposting for winter warmth initiatives).	1) Ensure cold weather alerts are going to right staff and actions agreed and implemented. 2) Ensure staff in all settings are considering room temperature. 3) Ensure data sharing and referral arrangements in place.	1) Continue level 1 actions. 2) Ensure carers receiving support and advice. 3) Activate business continuity arrangements as required; plan for surge in demand.	1) Continue level 2. 2) Implement emergency and business continuity plans; expect surge in demand in near future. 3) Implement local plans to ensure vulnerable people contacted.	
Frontline staff – care facilities and community	1) Use patient contact to identify vulnerable people and advise of cold weather actions; be aware of referral mechanisms for winter warmth and data sharing procedures. 2) Ensure awareness of health effects of cold and how to spot symptoms. 3) Encourage colleagues/clients to have flu vaccinations.	1) Identify vulnerable clients on caseload; ensure care plans incorporate cold risk reduction. 2) Check room temperatures and ensure referral as appropriate. 3) Signpost clients to other services using 'Keep Warm Keep Well' booklet.	1) Continue level 1 actions. 2) Consider prioritising those most vulnerable and provide advice as appropriate. 3) Check room temperatures and ensure urgent referral as appropriate.	1) Continue level 2 actions. 2) Implement emergency and business continuity plans; expect surge in demand in near future. 3) Prioritise those most vulnerable.	
GPs and their staff	1) Be aware of emergency planning measures relevant to general practice. 2) Ensure staff aware of local services to improve warmth in the home including the identification of vulnerable individuals. 3) Signpost appropriate patients to other services when they present for other reasons.	1) Consider using a cold weather scenario as a table top exercise to test business continuity arrangements. 2) Be aware of systems to refer patients to appropriate services from other agencies. 3) When making home visits, be aware of the room temperature.	1) Continue level 1 actions. 2) Take advantage of clinical contacts to reinforce public health messages about cold weather and cold homes on health. 3) When prioritising visits, consider vulnerability to cold as a factor in decision making.	1) Continue level 2 actions. 2) Expect surge in demand near future. 3) Ensure staff aware of cold weather risks and can advise appropriately.	

Summary cold weather actions for health and social care organisations and professionals, communities and individuals (cont.)

	Level 0	Level 1	Level 2	Level 3	Level 4
Community and voluntary sector	1) Engage with local statutory partners to agree how VCS can contribute to local community resilience arrangements. 2) Develop a community emergency plan to identify and support vulnerable neighbours. 3) Agree arrangements with other community groups to maximise service for and contact with vulnerable people.	1) Test community emergency plans to ensure that roles, responsibilities and actions are clear. 2) Set up rotas of volunteers to keep the community safe in cold weather and check on vulnerable people. 3) Actively engage with vulnerable people and support them to seek help.	1) Activate the community emergency plan. 2) Activate the business continuity plan. 3) Continue to actively engage vulnerable people known to be at risk and check on welfare regularly.	1) Continue level 2 actions. 2) Ensure volunteers are appropriately supported. 3) Contact vulnerable people to ensure they are safe and well and support them to seek help if necessary.	Level 4 alerts issued at national level in light of cross-government assessment of the weather conditions, coordinated by the Civil Contingencies Secretariat (CCS) based in the Cabinet Office. All level 3 responsibilities to be maintained unless advised to the contrary.
National level	1) CO will lead on co-ordinating cross government work; individual government departments will work with partners on winter preparations. 2) DH, PHE and NHS England will look to improve the CWP and the monitoring and analysis of winter-related illness and deaths. 3) PHE and NHS England will issue general advice to the public and professionals and work closely with other government departments and other national organisations that produce winter warmth advice.	1) Cold Weather Alerts will be sent by the Met Office to the agreed list of organisations and Category 1 responders. 2) PHE and NHS England will make advice available to the public and professionals. 3) NHS England will continue to hold health services to account for action and PHE will routinely monitor syndromic, influenza, norovirus and mortality surveillance data.	1) Continue level 1 actions. 2) DH will ensure that other government departments, particularly DCLG RED, are aware of the change in alert level and brief ministers as appropriate. 3) Government departments should cascade the information through their own partner networks and frontline communication systems.	1) Continue level 2 actions. 2) NHS England will muster mutual aid when requested by local services. 3) Met Office will continue to monitor and forecast temperatures in each area, including the probability of other regions exceeding the level 3 threshold.	
Individuals	1) Seek good advice about improving the energy efficiency of your home and staying warm in winter; have all gas, solid fuel and oil burning appliances serviced by an appropriately registered engineer. 2) Check your entitlements and benefits; seek income maximisation advice and other services. 3) Get a flu jab if you are in a risk group (September/October).	1) If you are receiving social care or health services ask your GP, key worker or other contact about staying healthy in winter and services available to you. 2) Check room temperatures – especially those rooms where disabled or vulnerable people spend most of their time 3) Look out for vulnerable neighbours and help them prepare for winter.	1) Continue to have regular contact with vulnerable people and neighbours you know to be at risk in cold weather. 2) Stay tuned into the weather forecast and ensure you are stocked with food and medications in advance. 3) Take the weather into account when planning your activity over the following days.	1) Continue level 2 actions. 2) Dress warmly; take warm food drinks regularly; keep active. If you have to go out, take appropriate precautions. 3) Check on those you know are at risk.	Follow key public health and weather alert messages as broadcast on the media.

Frontline staff – health and social care, voluntary and community sector (including care homes)

Level 0	Level 1	Level 2	Level 3	Level 4
Year-round planning *All year*	**Winter preparedness and action** *1 November to 31March*	**Severe winter weather is forecast - Alert and readiness** *Mean temperatures of 2°C and/or widespread ice and heavy snow is predicted with 60% confidence*	**Severe weather action** *Mean temperatures of 2°C and/or widespread ice and heavy snow*	**Major incident – Emergency response**
Work within your organisation and with partner organisations to ensure that systems are developed to support the identification and sharing of information between agencies of people who may be vulnerable to cold weather. Systematically work to improve the resilience of vulnerable people to severe cold. Ensure that all staff have been made aware of the cold weather plan and the dangers of cold weather to health and know how to spot signs and symptoms. Use clinic attendances and home visits as opportunities to identify vulnerable people and discuss winter preparedness. Work with at-risk individuals, their families and carers to ensure that they are aware of the dangers of cold weather and cold housing and how access support; ensure that there are clear arrangements for 'signposting' to other services (e.g. home insulation schemes; benefits entitlements) when identified in "clinical" situations. Work with partners to ensure that vulnerable patients/clients have access to fuel supplies. Link to energy supplier priority service registers as required. Ensure that clients and colleagues are aware of and taken advantage of flu and other vaccination programmes.	Identify those at risk on your caseload and make necessary changes to care plans for high-risk groups. For those with multiple agency inputs, ensure that the key worker is clearly identified and care plans consider measures to reduce risk from cold weather. Check client's room temperature if visiting. Ensure that they have at least one room which meets recommended room temperatures. Remind clients of the actions they can take to protect themselves from the effects of severe cold; including warm clothing, warm food and drinks; keeping active as much as they are able within the context of their care plan. Continue to "signpost" those at risk clients/ patients to other services (e.g. home insulation schemes; benefits entitlements) when identified in "clinical" situations; use the Keep Warm Keep Well booklet for up-to-date patient information and advice. Use resources available to you for raising awareness of the health risks associated with winter weather and cold housing (for example, pharmacists have a key role in reminding people to have sufficient medicine and help with preventive medicines managements). Encourage clients and colleagues to be vaccinated against flu, if not already.	As appropriate, contact those most at risk and implement care plans. Continue to check client's room temperature if visiting to ensure that clients are warm. Ensure that they have at least one room which meets recommended room temperatures. Ensure urgent signposting for those at risk (e.g. in cold housing) to appropriate services. Continue to remind clients of the actions they can take to protect themselves from the effects of severe cold. Consider how forecast weather conditions may impact on your work – and make appropriate arrangements. Make sure you and your teams are prepared for an influx of weather-related injuries and illnesses.	As appropriate, contact those at risk (visit, phone call) daily. Ensure staff can help and advise clients. Other actions as per level 2. Maintain business continuity.	*Central government will declare a level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health.* Continue actions as per level 3 unless advised to the contrary.

Provider organisations – health and social care (community services, hospitals, care homes, prisons

Level 0	Level 1	Level 2	Level 3	Level 4
Year-round planning *All year*	**Winter preparedness and action** *1 November to 31March*	**Severe winter weather is forecast - Alert and readiness** *Mean temperatures of 2°C and/or widespread ice and heavy snow is predicted with 60% confidence*	**Severe weather action** *Mean temperatures of 2°C and/or widespread ice and heavy snow*	**Major incident – Emergency response**
Ensure that you are engaged with local EPRR and other strategic arrangements. Ensure that your organisation can identify those most vulnerable to cold weather and draw up plans for joined-up support with partner organisations. Agree data-sharing arrangements within information governance principles. Assess the longer-term implications of climate change; reduction in carbon emissions; and sustainability for longer-term business continuity. Consider how to best mobilise and engage voluntary and community sector organisations and support the development and implementation of community emergency plans. Make sure that staff have identified all those vulnerable to cold weather and that arrangements are in place to support and protect them appropriately. Work with staff on risk reduction awareness, information and education. Encourage staff to be vaccinated against flu before winter starts. Ensure that the business continuity plan includes severe winter weather. Plan for a winter surge in demand for services. Consider carers needs and support they can continue to give. Work with environmental health officers on HHSRS hazard identification.	Ensure that CW alerts are going to the right staff and appropriate actions are agreed and able to be implemented, especially to protect vulnerable clients. Make sure that staff have identified all those vulnerable to cold weather and that arrangements are in place to support them appropriately. Ensure staff are undertaking appropriate home checks when visiting clients, e.g. room temperature; medications and food supplies. Hospitals and care, residential and nursing homes: ensure that rooms, particularly living rooms and bedrooms are kept warm and that staff are taking appropriate action to protect residents from cold weather. Work with partner agencies to co-ordinate cold weather plans; ensure data sharing and referral arrangements are in place. Continue to work with staff on risk reduction awareness, information and education. Encourage staff to be vaccinated against flu, if not already. Work with local authority teams to identify accident hotspots on pavements or roads, advise on gritting priorities to prevent accidents, and ensure access by utilities and other essential services. Ensure staff aware of the business continuity plan for winter weather; plan for a winter surge in demand. Ensure carers are receiving advice and support.	Communicate alerts to staff and ensure that locally agreed CWP actions take place, especially those to protect vulnerable patients/ clients. Continue to ensure local actions for the vulnerable arranging daily ensuring staff are undertaking appropriate home checks when visiting clients, ensure carers are receiving medications and food supplies appropriate advice and support. Hospitals and care, residential and nursing homes: continue to ensure that rooms, particularly living rooms and bedrooms are kept warm Activate	Communicate alerts to staff and ensure that locally agreed actions take place, esp. those to protect vulnerable patients/clients. Implement local plans for contacting the vulnerable. Consider daily visits/ phone calls for high-risk individuals living on their own who have no regular contacts. Ensure carers are receiving appropriate advice and support. Implement plans to deal with surge in demand. Implement business continuity arrangements.	*Central government will declare a level 4 alert in the event of severe or prolonged cold weather affecting sectors other than health.* All level 3 responsibilities must be maintained during a level 4 incident. Implementation of national emergency response arrangements by central government. Continue to implement business continuity arrangements.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 November 2018	**Agenda No**	**2.4**
Report Title:	**Elective Care Recovery Programme 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 Trust continues to internally shadow report on RTT performance. October representing the second month of shadow reporting ahead of a planned return to national reporting RTT in quarter 4 (Q4) 2018/19. This currently only applies to the Tooting site with a future return to reporting decision required for the Queen Mary's Site subject to a successful deployment of Cerner in 2019. A review of migration plans for QMH is underway. This paper looks at the progress made in - Performance – continued reduction in overall PTL size, Reduced long waiting patients, improvements in data quality metrics. - Validation – additional validation resource has been working through the Trust PTLs and specific data quality metrics as outlined in the August Board as part of the Elective Care update. - Training – A training strategy was agreed in October. All training sessions are role specific and available for all appropriate staff. Sessions are currently planned up to 31st December 2018 with plans to extend into Q4. The Trust continues to aim for a return to national reporting in Q4 2018/19. An external assessment started 15th November reviewing the Trusts readiness to return to report. Phase one - review of the Trusts data quality will be available for review in December Trust Board. Phase two – operational management and sustainability will be completed mid-December. A report on phase two will not be available for December Trust Board. January Trust Board will have the final assessment outcome for both phase one and two.		
Recommendation:	The Trust Board is asked to receive this report and note the aim to return to report in Q4 2018/19.		
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:	As set out in Appendix 1		
Legal/Regulatory:	Referral to treatment standard is a regulatory target		
Resources:	Elective Care programme		
Previously	Trust Executive Committee	Date:	21/11/18

Considered by:	Quality and Safety Committee Finance and Investment Committee		22/11/18 22/11/18
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1 – Recommendations from the Bewick Report		

Elective Care Recovery Programme Update

Trust Board (Part 1)

29th November 2018

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

- The Trusts PTL is refreshed daily and available to all staff online. This includes length of wait at patient level and performance of admitted, non-admitted specialty and site view. Continued focus is on the longer waiting patients. As reported at the September and October Trust Board the total incomplete PTL size is ahead of trajectory as was performance against recovery plan.
- There has been a continued and sustained reduction in the number of patients waiting over 18 weeks for first definitive treatment.
- The Trust is ahead of trajectory for a number of data quality metrics as agreed with Trust regulators.
- The Trust has seen an increased number of patients being booked for treatment and overall utilisation is increasing in both theatres and outpatients.

2) Validation

- October Board reported an initial 5,000 pathway validation shad been commissioned following the decision at August Trust Board to invest in cleaning the PTL. Following the successful completion of this initial phase of validation an additional 15,000 pathway reviews were commissioned. Work began week commencing 19th November 2018 and is due for completion by 31st December 2018. The main focus of this phase of validation will be the incomplete RTT PTL.

3) Training

- A new training implementation strategy was approved in early October 2018.
- Training is to be provided for all new staff joining the organisation from October.
- Training for existing staff will also be provided from October 15th.
- Training is currently being delivered within the existing ICLIP roll out training programme at the Tooting site – The same successful deployment programme will be used to support migration at QMH in 2019.
- Targeted training is also being provided. This follows themes identified through audit and data quality reviews.

Clinical Harm Review Update

This section provides an update on the additional validation being undertaken by GP practices.

- To date the majority of Practices across the South West London Alliance have agreed to participate in reviewing their patients and the Practices have been securely sent their patient information. The current outcome from the reviews was that only 50 patients have been identified as possibly needing further investigation and these patients will be clinically validated by services and out of the 50 patients, 12 needed further review and these patients have all be seen by the services. No clinical harm was identified from the 12 patients. To date the GPs have identified 38 cases that are potentially at risk to clinical harm. The services have reviewed 35 cases and no patients were identified being at risk to any clinical harm.

- 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.)

- To date 3172 cases have been reviewed and no clinical harm identified.

- SGUH have 504 remaining cases to be reviewed and expected to be completed mid-December. No clinical harm has been identified from the reviewed cases.

4) Return to Reporting

The Trust Board took the decision to stop reporting its referral to treatment waiting times in 2016. The Trust has agreed an RTT recovery plan with regulators which include a return to reporting plan. The main focus of the return to reporting plan is assurance of quality of data and continued performance improvements. The Trust continues to aim for a return to national reporting on RTT in quarter 4 2018/19 for the Tooting site only at this stage.

A return to reporting assessment has also commenced which will be reviewing the Trusts Data Quality and sustainability of national reporting. The full outcome of the assessment will be available at January Trust Board 2019.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 November 2018	**Agenda No**	**2.5**
Report Title:	**Cardiac Surgery Update**		
Lead Director	Andrew Rhodes, Medical Director		
Report Author:	Andrew Rhodes, Medical Director		
Presented for:	Update		
Executive Summary:	This report provides an update to the Trust Board on the steps being taken to improve the cardiac surgery service following the NICOR safety alerts and the findings of the independent report by Professor Bewick. An enhanced set of governance arrangements has been put into place since September, so helping to provide us with the space necessary to introduce the improvements required to deliver a high quality and sustainable service for the future. These changes have been overseen by a number of external bodies, that include: an independent scrutiny panel (appointed by NHS Improvement), an ongoing series of Quality Summits (led by NHS England and NHS Improvement), local commissioners, the CQC and the South London Operational Delivery Network. The safety of the service is currently being maintained by this enhanced level of monitoring and Executive oversight. Longer-term plans for how the service should develop for the next 6-9 months are being developed. A new Clinical Lead has been identified who will be starting in December. He will lead the services - and provide oversight for the changes necessary - going forward.		
Recommendation:	The Board is asked to note the update on progress being made in Cardiac Surgery.		
Supports			
Trust Strategic Objective:	• Treat the patient, treat the person • Right care, right place, right time • Champion Team St George's		
CQC Theme:	• Safe, Well Led		
Single Oversight Framework Theme:	• Quality of Care, Leadership and Improvement Capability		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The paper details the Trust's engagement with regulators on this issue.		
Resources:			
Previously Considered by:	Trust Executive Committee Quality and Safety Committee	**Date**	21 Nov 2018 22 Nov 2018
Appendices:	Appendix 1. Progress against Bewick Recommendations.		

CARDIAC SURGERY UPDATE
Trust Board, 29th November 2018

1.0 PURPOSE

1.1 To update the Trust Board on progress being made with Cardiac Surgery since the last time the Board met in October.

2.0 BACKGROUND

2.1 There have been concerns with regards to the safety of the service since May 2017, the point at which the Trust was informed it was a national outlier (at 2SD) for mortality by NICOR (the National Institute for Cardiovascular outcomes and Research).

2.2 The Trust initiated a Steering Group in May 2017 to review and manage a number of changes needed for the service. In July 2018, the Trust received a report from Professor Mike Bewick, who had been commissioned by the Trust to provide an independent external assessment of the issues within the service and assurance about the Trust's plans for improving the service going forwards. This report confirmed previous views of what the problems were and provided a series of recommendations. The Trust Board accepted the report and agreed to implement the recommendations in full.

2.3 Since early September, a number of changes have been made to the service. These included: diverting the most complex cardiac surgery patients to be treated at other London hospitals, removal of training status of the department, employment of two locum consultants, and system working with partners to ensure a high quality and sustainable service for the future.

3.0 EXTERNAL ASSURANCES

3.1 The safety of the service is overseen by an external Quality Summit, convened by NHS England and NHS Improvement, but also attended by the CQC, the GMC, HEE and system partners. In addition, the safety of the service is reviewed in a local Clinical Quality Review Meeting, co-chaired by NHS England and Wandsworth CCG. The Quality Summit has met three times, the most recent occasion being 29 October.

3.2 The Quality summit (29th October) reviewed the progress the Trust had made with implementing the required improvements and asked for a Trust update on the ongoing safety metrics, the learning from incidents, the recruitment processes to ensure adequate medical coverage at both consultant and non-consultant levels and the progress it is making against the Bewick Recommendations (Appendix 1).

3.3 System partners (KCH & GSTH) are working with the Trust to ensure all high-risk cases are transferred and cared for in a timely fashion and to review any moderate / severe incidents that occur to ensure appropriate learning and remedial actions take place.

3.4 An Independent Scrutiny Panel is in place, appointed by NHS Improvement, to advise the Trust on how, and what, to implement following the external reviews that have been received over the last

year. This panel has met face-to face with the Trust on three occasions and independently from the Trust on a number of other occasions. Advice is being received on a number of matters that should help to move the service forward. Further meetings are planned.

3.5 The decision to move the most complex cardiac surgery cases elsewhere was implemented at the beginning of September. At that time, it was viewed that this decision would be required for an initial period. Work is now being done, facilitated by NHS England's Specialized Commissioning team, to develop a longer-term plan and strategy, and the eventual return of complex cases to St George's. The aim of this strategy is to develop a vision for how cardiac surgery and cardiology would be delivered for the population of South London, Kent, Surrey and Sussex.

3.6 The CQC performed an unannounced inspection of Cardiac Surgery in August 2018 and the CQC will publish their inspection report in due course.

4.0 INTERNAL ASSESSMENT

4.1 The safety of the service is closely monitored by the Trust and a daily safety dashboard is considered by the Medical Director and Chief Nurse. The Trust is confident in the safety of the service is currently being maintained, but this is requiring a high level of oversight by a significant number of senior individuals within the Trust.

4.2 An external Clinical Lead for the service (Mr Steven Livesey) has been identified who will start in the Trust in December 2018. Mr Livesey is an established and respected consultant Cardiac Surgeon from Southampton. He will work with the internal team (initially full time) to provide 'independent' assurance of progress, to lead the necessary changes and to improve the safety and risk profile of the service. Mr Livesey will have the title of Associate Medical Director for Cardiac Surgery.

5.0 IMPLICATIONS

Risks

5.1 There are currently three extreme risks on the risk register for this service:

- Losses incurred through reduced income as a result of decreased activity, and direct costs incurred through turnaround programme. (Original risk score 25, current score 20).
- Adverse impact on staff well-being, safety of service and adherence to Trust values on poor behaviours from within cardiac surgery team, anaesthetics, theatre staff and other key groups (Original risk score 20, current score 16).
- Drop off in referrals and significant loss of patient and referrer confidence in the service caused by high media profile of current challenges. This impacts on the longer-term viability of the service (Original risk score 25, current score 16).

6.0 COMMITTEE DELIBERATIONS

6.1 Both the Trust Executive Committee (TEC) (21st November) and the Board's Quality and Safety committee (QSC) (22nd November) considered updates on Cardiac Surgery since the last Board meeting.

6.2 Both Committees reviewed the safety data and risk profiles described in the paper and noted the progress being made to further improve the safety of the service and to implement the recommendations from the Bewick report.

6.3 The chair of the Quality and Safety Committee described how he had attended a Multi-Disciplinary Team meeting of the service and had witnessed credible clinical discussions and decision-making but how there were still improvements to deliver.

6.4 Both the TEC and the QRC recognized that the new Clinical Lead should strengthen the service and make the improvements necessary to bring the most complex work back to the Trust. It was noted that this would have a favourable impact on the morale of the clinical team and also on the year end financial forecasts.

7.0 RECOMMENDATION

7.1 The Trust Board is asked to note the update on progress being made in Cardiac Surgery.

Author: **Professor Andrew Rhodes, Medical Director**
Date: **23rd November 2018**

APPENDIX 1.

Update against the Recommendations from the Bewick Report.

	Recommendation	Update (23/11/18)
1	**The current consultant cardiac surgical team** membership is incompatible and requires **restructuring** with some urgency.	This recommendation remains under consideration with advice being taken from the independent scrutiny panel.
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. We are currently running on 8 WTE, although two of the consultants are junior and are being supported into fully independent practice. One consultant is currently off sick.
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.	Both of these appointments have now commenced.
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	An external clinical lead has been identified and will start in the Trust in December 2018.
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.	A bespoke support package has been created for the two new appointments. Senior mentors have been identified from both internally in the department and also externally from KHP. 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,	Pathway leadership has now been taken over by a consultant cardiologist who is running the daily MDTs and is providing overall leadership into the service. The new external Clinical Lead will also

	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 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	be asked to support this recommendation.
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.	Over the last month there has been a significant reduction in referrals into the SGUH system. This, unless corrected, will have long lasting impacts into the sustainability of the service. Improvements in relationships with system partners are being targeted through both cardiac surgery and cardiology in order to strengthen our referral source and patient pathways.
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 and Dr Renate Wendler are supporting 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	Longer term strategic discussions are taking place with our system partners –GST & KCH- facilitated by NHS England.

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 supporting the culture change aspects of this recommendation.
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.	The Dendrite system will go live on 28th November 2018.
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 (Associate Medical Director) 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 is now in place.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 November 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 22 November 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 – November 2018

1.1 Finance Risks- the Deputy Chief Financial Officer updated the Committee on the latest position on the finance risks. The Committee reflected on some of the functional risks such as 'managing I&E in line with budget' in view of the current financial performance of the Trust. The Committee evaluated that risk scores would need further review and would be brought back next month.

1.2 ICT Risks- the Chief Information Officer updated on ICT risks, showing latest progress on timelines for mitigating all ICT risks. She also noted the emerging risk on the iClip roll-out at the Tooting site and Queen Mary's that will require regular review. The Committee noted the further improvements in understanding on ICT risks, whilst noting that more work is required.

1.3 Estates Risks- the Director of Estates & Facilities updated on Estates risks. He noted that there was potential improvement on some of the risks but evidence was still being gathered before bringing this change to the committee. The review of the Premises Assurance Model (PAM) was postponed to December's meeting owing to a mix up with papers.

1.4 Activity performance- the Director of Delivery, Efficiency & Transformation noted an excellent month on Outpatient, Elective and Daycase activity in October. Whilst there are a high number of working days in October which means it was to some extent expected, the Committee praised the efforts of Four Eyes and especially the new General Manager for Theatres & Anaesthetics. The DDET highlighted that this good performance has continued into November with 1,214 and 1,215 Elective & Daycase procedures completed in the first two weeks, against a target of 1,218 per week.

1.5 Outpatient Transformation- the DDET noted the work being done at a clinical level with commissioning colleagues, as well as work to improve check-in facilities and telephone clinics. The Committee welcomed the improvements being made.

1.6 Emergency Flow - the Chief Operating Officer noted latest performance and action plans in delivery of the 4 hour A&E target. October performance was 90.11%, however November has been more challenged. Overnight performance recorded on the days leading up to the day of the Committee meeting were particularly adverse and required a further review. The Committee noted the actions taken, notably to have senior management support in the department at all times.

1.7 Capital Expenditure - The Interim Director of Financial Operations noted progress on the emergency capital bid and spending undertaken at risk in the capital expenditure programme. The Committee asked for an updated paper on the scenarios of reduced capital funding being granted, which would bring out the risks in Estates and ICT.

1.8 Financial Performance & Forecast- the Deputy CFO noted the continuing deterioration in the financial position with Pre-PSF adverse variance in Month 7 of £5.0m leading to an adverse variance in the year to date position of £11.2m compared to plan. He also noted the expected full year deficit which is in excess of plan, shared with NHS Improvement at the Provider Oversight Meeting this week.

1.9 The Committee explored some of the ways to improve the forecast, including Cardiac Surgery, CIP and Medical Expenditure. The Committee questioned to what extent the forecast position could be improved upon, and asked that the board paper consider more information on improving this position.

1.10 Cash & Associated Issues- The Interim Director of Financial Operations noted that revenue borrowing and receipts were as expected, however capital borrowing shortfalls were being offset by reduced creditor payments. The Committee were encouraged by the further progress on historic debt collection, although the cash position would remain challenged owing to I&E pressures.

1.11 Annual Planning Update – the Director of Financial Planning noted the various developments in external guidance that will inform business planning for 2019/20. In particular, there is a risk around the reduction in Market Forces Factor, although this is expected to be neutral in 2019/20 once offset with other tariff changes. The Committee agreed with the suggestion that budget setting would have to be based on a less traditional process.

1.12 SWLP LIMS business case – the Interim Managing Director- SWLP introduced the business case. The Committee asked for some clarity on the preferred supplier and any financial risk from consortium members leaving before the end of the contract. The Committee recommended the case to be approved by the Trust Board.

1.13 Epsom & St Helier update – the Director of Strategy introduced the paper on Epsom & St Helier. The Committee were concerned at the lack of options explored and agreed that the Trust should feed this back to the IHT Programme (who is coordinating the piece of work).

1.14 IDG update – this update was taken as read.

1.15 SWLP Report – The Deputy CFO noted that SWLP remained on plan to date, with a risk on CIP Delivery.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 22 November 2018 for information and assurance.

Ann Beasley
Finance and Investment Chair,
November 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 November 2018	**Agenda No.**	**3.2**
Report Title:	**Month 07 Finance Report**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Michael Armour & Tom Shearer		
Presented for:	Update		
Executive Summary:	Overall the Trust is reporting a Pre-PSF deficit to date of £33.0m at the end of Month 07 (October), which is £11.2m adverse to plan. Within the position, income is adverse to plan by £6.8m, and expenditure is overspent by £4.4m.		
Recommendation:	The Trust Board notes the trust's financial performance to date in October.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and use of resources		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Finance and Investment Committee	Date	22/11/18
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 7 (October 2018)

Chief Finance Officer

29th November 2018

Executive Summary – Month 7 (October)

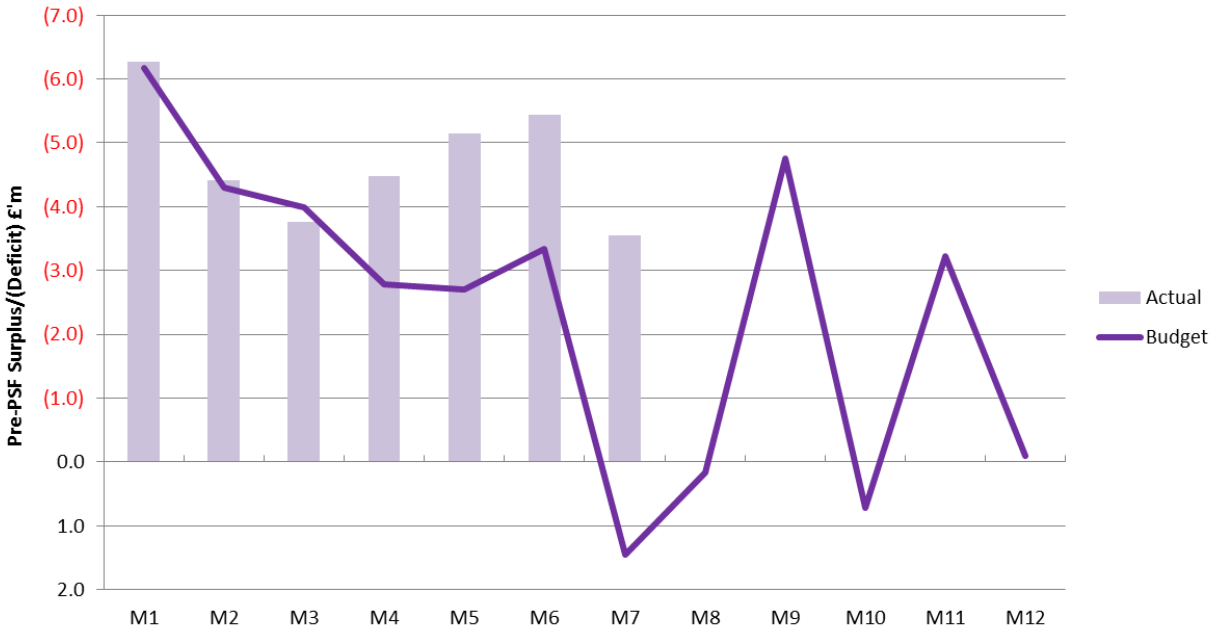
Note: All figures and commentary in this report refer to the revised Trust plan submitted to NHS Improvement on 20th June.

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The trust is reporting a Pre-PSF deficit of £33.0m** at the end of October, which is **£11.2m adverse to plan**. Within the position, income is adverse to plan by £6.8m, and expenditure is overspent by £4.4m. There also remains an element of income estimation in the position which will need to be validated ahead of freeze dates. **M4-7 PSF income of £3.8m** in the plan has **not been achieved** in the Year-to-date position, as the Trust continues to be adverse to the Pre-PSF plan.	£11.2m Adv to plan	£6.2m Adv to plan
Income	Income is reported at £6.8m adverse to plan year to date. Elective is the main area of lower than planned performance; with shortfalls in volume (£9.3m) being offset by pricing gains (£3.6m) in other areas. Non-SLA income is also adverse to plan, with shortfalls in commercial Pharmacy partially offset by underspends in drugs. There is also a shortfall in private & overseas' patients income.	£6.8m Adv to plan	£4.7m Adv to plan
Expenditure	Expenditure is £4.4m adverse to plan year to date in October. This is caused by Non Pay adverse variance of £4.7m (although a large proportion of this is offset in Income as pass-through is over-performing). Pay is on plan and CIP under delivery is causing most of the remaining adverse variance in non-pay.	£4.4m Adv to plan	£1.5m Adv to plan
CIP	The Trust planned to deliver £23.7m of CIPs by the end of October. To date, £21.4m of CIPs have been delivered; which is £2.3m behind plan. Income actions of £6.1m and Expenditure reductions of £15.2m have impacted on the position.	£2.3m Adv to plan	£1.8m Adv to plan
Capital	Capital expenditure of £16.3m has been incurred year to date. This is £0.9m below plan YTD. The position is reported against the internally financed plan of £18.9m. This does not include DH capital loans (to be secured) of £27.873m.	£0.9m Fav to plan	£2.4m Fav to plan
Cash	At the end of Month 7, the Trust's cash balance was £3.5m, which is better than plan by £0.5m. The Trust has borrowed £21.8m YTD which is in line with plan. The Trust secured a loan of £3.2m for November and has requested £12.2m for December. If approved the December drawdown will exceed the cumulative borrowings to M09 that is in the plan by approx £14.9m due to the higher deficit .The borrowings drawn are subject to an interest rate 3.5%.	£0.5m Fav to plan	£0.3m Fav to plan
Use of Resources (UOR)	The Regulators Financial Risk Rating. At the end of October, the Trust's UOR score was 4 as per plan.	Overall score 4	Overall score 4

Contents

1. Month 7 Financial Performance

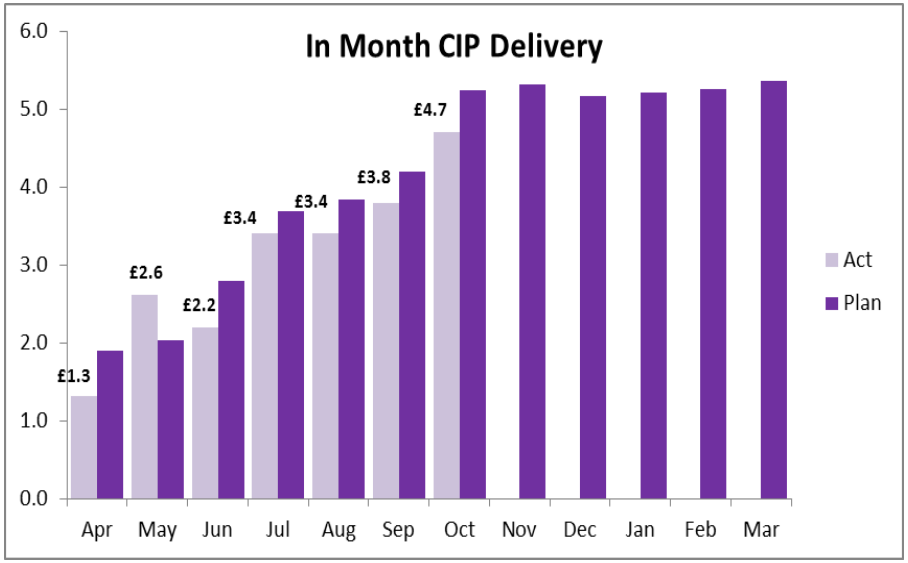
			Full Year Budget (£m)	M7 Budget (£m)	M7 Actual (£m)	M7 Variance (£m)	M7 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF	Income	SLA Income	664.5	57.9	55.9	(2.0)	(3.5%)	385.1	379.1	(6.0)	(1.6%)
		Other Income	157.8	13.5	13.4	(0.1)	(0.8%)	94.0	93.2	(0.8)	(0.8%)
	Income Total		**822.3**	**71.4**	**69.3**	**(2.1)**	**(3.0%)**	**479.1**	**472.3**	**(6.8)**	**(1.4%)**
	Expenditure	Pay	(509.7)	(41.8)	(42.2)	(0.4)	(1.0%)	(300.3)	(300.2)	0.0	0.0%
		Non Pay	(307.6)	(25.3)	(27.8)	(2.5)	(9.9%)	(181.1)	(185.7)	(4.7)	(2.6%)
	Expenditure Total		**(817.3)**	**(67.1)**	**(70.0)**	**(2.9)**	**(4.4%)**	**(481.3)**	**(486.0)**	**(4.6)**	**(1.0%)**
	Post Ebitda		(34.0)	(2.9)	(2.8)	0.1	1.9%	(19.6)	(19.3)	0.3	1.3%
Pre-PSF Total			**(29.0)**	**1.5**	**(3.5)**	**(5.0)**	**(343.4%)**	**(21.8)**	**(33.0)**	**(11.2)**	**(51.3%)**
PSF			12.6	1.3	0.0	(1.3)	(100.0%)	5.7	1.9	(3.8)	(66.6%)
Grand Total			**(16.4)**	**2.7**	**(3.5)**	**(6.3)**	**(230.4%)**	**(16.1)**	**(31.1)**	**(15.0)**	**(92.8%)**

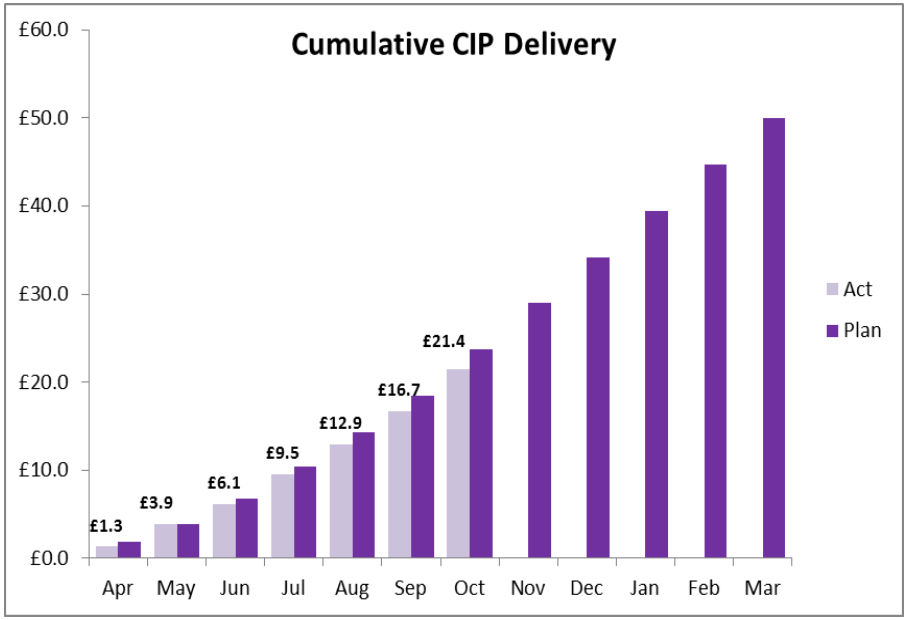


Trust Overview

- Overall the Trust is reporting a Pre-PSF deficit of £33.0m at the end of Month 7, which is £11.2m behind plan.
- **SLA Income** is £6.0m under plan. The main area of note is Elective with a material adverse variance (£5.7m), which is driven by lower than planned volumes of activity (£9.3m) partially offset with increased income per case (£3.6m).
- **Other income** is £0.8m, which is primarily Commercial Pharmacy income shortfall. This is partially offset by reduced Non-Pay expenditure.
- **Pay** is on plan. Non-medical staffing underspends are offset by medical staffing overspends. It should be noted that within staff groups there are areas of over as well as under spending.
- **Non-pay** is £4.7m overspent, with an in-month adverse variance of £2.5m caused partly by Procurement CIP non-delivery. The year to date overspent is mainly owing to increased pass-through costs.
- **PSF Income** is adverse to plan in M7 by £3.8m, as the Trust has not met the pre-PSF control total target of a £21.8m deficit.
- **CIP delivery** of £21.4m is £2.3m behind plan. The Clinical Divisions' shortfalls have been partially offset by Overheads and Central schemes. Delivery to plan is:
  - Pay £0.1m favourable
  - Non-pay £1.1m adverse
  - Income £1.4m adverse

2. Month 7 CIP Performance





CIP Delivery Overview

- At the end of Month 7, the Trust is reporting delivery of £21.4m of savings /additional income through its Cost Improvement Programme.
- This compares to an external plan to have delivered £23.7m of savings/ additional income by Month 7. Overall delivery is adverse of plan by £2.3m.
- The adverse variance to plan is due to under delivery of CIPs across all divisions as follows:
  - CWDTC - £552k
  - MedCard - £794k
  - SCNT - £828k

  primarily due to the under achievement of income and non-pay schemes.

Year End Forecast & Actions

- Based on the forecasting exercise, the Trust identifies £50m CIP forecast delivery which matches the 2018/19 plan, albeit with risks and opportunities.
- Key actions to deliver the CIP forecast include:
  - Delivering the urgent financial recovery action previously agreed at TEC and FIC, the major opportunity being release of £5.4m to the pay CIP by managing to budget and releasing the vacancies where safe to do so
  - Action to mitigate the risk of under-delivery of income, procurement, private patient and estates & facilities CIPs
  - Developing and delivering divisional CIP improvement plans not included in the forecast position
  - Further detailed review of amber, red and pipeline CIP schemes (value c.£18m) to identify if any can be implemented faster, along with an assessment of the resource requirement
  - Delivery of the additional £5m new CIP schemes planned to start in M7-12

3. Balance Sheet as at Month 7

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**377.2**	**389.4**	**379.9**	**9.5**
Stock	**6.4**	5.9	7.4	-1.5
Debtors	**112.3**	105.0	93.9	11.1
Cash	**3.5**	3.0	3.5	-0.5
Creditors				
	-118.4	-117.1	-126.7	9.6
Capital creditors	**-15.4**	-9.6	-5.2	-4.4
PDC div creditor	**0.0**	0.1	-2.0	2.1
Int payable creditor	**-0.7**	-1.5	-1.4	-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**	**-72.7**	**-88.4**	**15.7**
Provisions> 1 year	**-1.0**	-0.7	-0.9	0.2
Borrowings> 1 year	**-241.6**	-268.6	-257.9	-10.7
Long-term liabilities	**-242.6**	**-269.3**	**-258.8**	**-10.5**
Net assets	**64.4**	**47.4**	**32.7**	**14.7**
Taxpayer's equity				
Public Dividend Capital	**133.2**	133.2	133.4	-0.2
Retained Earnings	**-167.9**	-184.8	-199.8	15.0
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**	**47.5**	**32.7**	**14.8**

M01-M7 YTD Balance Sheet movement

- Fixed assets are £9.5m lower than plan due to lower capital spend than plan as capital bids are still being considered by the NHSI.
- Stock increased in month by £0.1m but remains £1.5m higher than plan due mainly to increase in Pharmacy stock. Pharmacy stock should reduce significantly over the next few months as the new robot is now fully operational.
- Overall debtors are £11.1m lower than plan.
- Creditors are £9.6m higher than plan relating mainly to the rescheduling of the payment of NHSPS rental charges and other NHS suppliers.
- Capital creditors ate lower than plan due to lower capital expenditure (no DH capital loans received yet)
- The cash position is £0.5m better than plan. Cash resources are tightly managed at the end of the month to ensure the £3.0m minimum cash balance is not exceeded.
- The Trust has borrowed £21.3m YTD for deficit financing which is in line with the plan. The Trust will drawdown £3.2m for November and has requested £12.2m for December to finance the deficit. This would exceed the borrowing requirement in the YTD plan by £14.9m.
- The Trust had not drawn down any capital loans to date. A capital bid for approx £27.9m was submitted to NHSI at the end of August and is currently being reviewed by NHSI.
- The deficit financing borrowings are subject to an interest rate 3.5%. Also borrowings for new finance leases are lower than plan.

4. Month 7 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	-31.7	-14.8
Depreciation	13.7	13.7	0.0
Interest payable	6.2	6.1	-0.1
PDC dividend	0.5	0.5	0.0
Other non-cash items	-0.1	-0.1	0.0
Operating deficit	**3.4**	**-11.5**	**-14.9**
Change in stock	0.5	-1.0	-1.5
Change in debtors	9.2	18.4	9.2
Change in creditors	-3.4	8.3	11.7
Net change in working capital	**6.3**	**25.7**	**19.4**
Capital spend (excl leases)	-30.2	-26.3	3.9
Interest paid	-5.5	-5.5	0.0
PDC dividend paid	-0.5	1.5	2.0
Other	-0.2	-0.1	0.1
Investing activities	**-36.4**	**-30.4**	**6.0**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	21.2	21.2	0.0
Capital loans	9.9	0.0	-9.9
Loan/finance lease repayments	-4.9	-5.0	-0.1
Cash balance 31.10.18	**3.0**	**3.5**	**0.5**

M01-M7 YTD cash movement

- The cumulative M7 I&E deficit is £31.7m, £14.8m 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 £31.7m, depreciation (£13.7m) does not impact cash. The charges for interest payable (£6.1m) and PDC dividend (£0.5m) 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 £11.5m.
- The operating deficit variance from plan of £14.9m.
- Working capital is better than plan by £19.4m. The favourable variance on debt comprises £9.3m adverse variance on invoiced debt but a £18.5m favourable variance on accrued debt. The £11.7m favourable variance on creditors relates mainly to the timing of payments for the CNST premiums and other NHS bodies.

- The Trust has borrowed £21.2m YTD which is in line with the YTD plan. The Trust drew down £0.75m October and has secured £3.3m in November of £3.2m and requested £12.2m for December. If the December draw down is approved, cumulative working capital borrowings would be £14.9m more than the plan as a result of the higher deficit. The borrowings are subject to an interest rate of 3.5% for the amounts drawn since November 17.

October cash position

- The Trust achieved a cash balance of £3.5m on 31 October 2018, £0.5m 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 rescheduling of payment of rental charges from NHSPS. **The Trust will remain dependent on monthly borrowing from DH given the higher I&E deficit.**

5a. Capital Programme – total, internal and at risk

TOTAL - CAPITAL EXPENDITURE POSITION

Spend category	Internal Budget £000	M07 YTD budget £000	M07 YTD exp £000	M07 YTD var £000
Infrastructure renewal	**5,732**	**5,430**	4,473	*957*
IT	**3,220**	**3,013**	3,979	*-966*
Medical equipment	**1,890**	**1,489**	838	*651*
Major projects	**5,756**	**5,274**	4,780	*494*
Other	**1,108**	**688**	1,008	*-320*
SWLP	**545**	**543**	132	*411*
Urgent £11.8m March 2018 projects	**711**	**709**	1,059	*-350*
Total	**18,963**	**17,148**	16,269	*879*

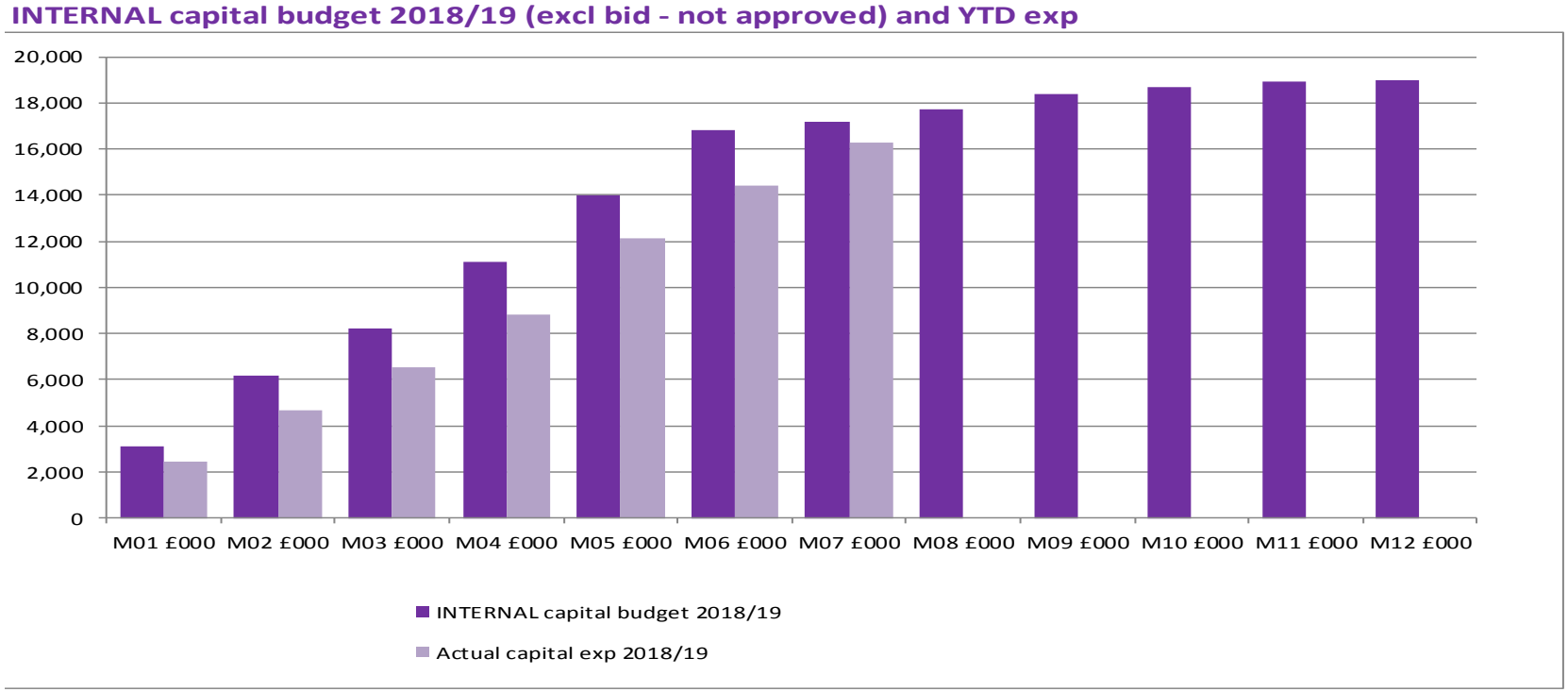
INTERNAL CAPITAL BUDGET only

Spend category	Internal Budget £000	M07 YTD budget £000	M07 YTD exp £000	M07 YTD var £000
Infrastructure renewal	**5,732**	**5,430**	4,325	*1,105*
IT	**3,220**	**3,013**	3,613	*-600*
Medical equipment	**1,890**	**1,489**	838	*651*
Major projects	**5,756**	**5,274**	4,777	*497*
Other	**1,108**	**688**	1,008	*-320*
SWLP	**545**	**543**	132	*411*
Urgent £11.8m March 2018 projects	**711**	**709**	1,059	*-350*
Total	**18,963**	**17,148**	15,752	*1,396*

CAPITAL AT RISK EXPENDITURE only

Spend category			M07 YTD exp £000	M07 YTD var £000
Infrastructure renewal			148	*-148*
IT			366	*-366*
Medical equipment			0	*0*
Major projects			3	*-3*
Other			0	*0*
SWLP			0	*0*
Urgent £11.8m March 2018 projects			0	*0*
Total			517	*-517*

5b. Internal capital budget and expenditure M7



- The Trust's internally funded capital expenditure budget for 2018/19 is £18.9m, an increase of £0.2m on last month due to a one-off PDC capital allocation received from DH for Wi-Fi development.
- The Trust has incurred capital expenditure of £16.3m in the first seven months of the year. This comprises £15.8m against the YTD internal capital budget of £17.1m (an under spend of £1.3m) and £0.5m expenditure incurred 'at risk' on the projects for which the Trust has submitted a bid for capital funding to NHSI.
- The main component of the year to date under spend on internal capital relates to the biggest project – the Lanesborough wing stand-by generators project (Infra Renewal category) which is under spent by £1.2m as at M07. The project is behind schedule but is forecast to come within budget and so the M07 YTD underspend represents a temporary timing difference.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M7 YTD)	Actual (M7 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	4
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 October, 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 (6.60%) minus planned % I&E deficit (3.30%). This value is -3.30% which generates a score of 4.
- 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:	29 November 2018	**Agenda No**	**4.2**
Report Title:	**Trust Strategy Highlight Report**		
Lead Director/ Manager:	Suzanne Marsello, Director of Strategy		
Report Author:	Ralph Michell, Head of Strategy Laura Carberry, Strategy and Partnership Manager		
Presented for:	Update		
Executive Summary:	In March 2018, the Board agreed to commence the development of a 5-year Clinical Service Strategy. This paper updates the Trust Board on the development of the 5-year Clinical Service Strategy (due end March 2019) to date and the deliverables in November, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales.		
Recommendation:	Trust Board is asked to note the progress reported and the identified issues and risks.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	**Safe** **Effective** **Well-Led**		
Single Oversight Framework Theme:	Strategic Change		
Implications			
Risk:	As outlined in paper		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix 1: Clinical Strategy Development Timeline and Workstreams Appendix 2: Issues to be addressed as Clinical Strategy Development progresses		

Trust Strategy: Highlight Report

1.0 Purpose

1.1 This paper updates the Trust Board on the development of the 5-year Clinical Service Strategy (due end March 2019) to date and on the deliverables in November, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales.

2.0 Progress in November 2018:

2.1 All actions committed to are on plan for November 2018, although the Initial Impact Modelling is behind plan largely due to the availability, bandwidth and capacity of both the Divisions and the Strategy Team being limited - there is a plan to recover this as detailed below.

Deliverables/ Milestones for November 2018	Progress	Actions for December 2018	Completion Date/ RAG*
Overall Programme Plan (Workstream 1)	Programme Plan 'live' and ongoing progress on workstreams Project Risk Register refreshed	Delivery ongoing	**On plan**
Development of Options (Workstream 2)	Board Seminar on Strategy for Critical Care, Renal, Thoracic and Women's (13 November)	Completion of deliverables to enable Board Seminar to cover Vascular (18 December 2018)	**On plan**
Alignment, Deliverability and Prioritisation (Workstream 3)	Alignment of the different propositions and assessment of cohesion, conflicts and likely reactions of stakeholders. Criteria definitions developed and a framework for prioritisation (scoring and weighting) of propositions and services finalised following testing. Initial Impact Modelling: Meetings with Specialist Services to quantify their propositions. This work is slightly delayed due to competing priorities for services and strategy team (e.g. Epsom St Helier modelling analysis). A recovery plan has been drawn up which will deliver the outputs to time. The key mitigating action is that the strategy team is developing modelling assumptions and testing them with services, rather than working with services to develop those assumptions collaboratively as per the original plan.	Completion of deliverables to enable and inform Board Seminar covering overall Specialist Services Wash-Up (18 December 2018) including: • Application of framework for prioritisation • Initial Impact Modelling finalised (Steps 3 and 4) to include implications for, and input from, Support Services, Estates and Workforce.	**Initial Impact Modelling is behind plan, but recovery plan in place**
Communication and Stakeholder Engagement (Workstream 4)	Completed Engagement Events x 8: • Public x 2 Wandsworth (23 November) Merton (27 November)	5 Engagement Events planned: • Public x 1 St George's (10 December) • Staff x 3	**On plan**

	• Staff x 5 Women's (19 November) Children's (20 November) Critical Care (26 November) Renal (26 November) Children's and Women's (30 November) • Stakeholders x 1 Outpatients (6 November)	Neurosciences (3 December) Cancer (5 December) Cancer, Neurosciences and Renal (6 December) • Stakeholders x 1 Senior Health (4 December)	
'Into Delivery' Planning (Workstream 5)	Alignment to 2019/20 Business Planning i.e. Y1 of a 5yr Strategy. 2019/20 Business Planning templates including a Delivery/ High-level Implementation Plan to 2023/24 as explicit link to Strategy submissions (30 November).	Alignment and assurance of 2019/20- 2023/24 deliverables 'Challenge and Confirm' with Divisions, Finance and Strategy planned from December 2018 onwards Star Chambers in January 2019 Challenge of Divisional Plans by FIC and TEC end January 2019	**On plan**
Enablers and Interdependencies (Workstream 6)	Initial discussions with Diagnostics, Finance, Information (for Modelling purposes) and Workforce (October) and Clinical Genetics, Pharmacy, Theatres and Anaesthetics and Therapies (November) to agree approach and plan (completed 23 November 2018).	TBC- based on discussions Initial discussions with Estates and IT (November/ December)	**On plan**
Production and Publication of Strategy (Workstream 7)	Review of published Strategies of other Trusts (content, format, priorities, strengths, weaknesses). Agreement with Chair and CEO of desired format and plan to obtain Plain English kite mark for published strategy document.	To begin January	**On plan**

** RAG rating refers to current in-month progress of the workstreams, rather than an assessment of the content covered in its entirety with its related risks.*

A Clinical Strategy Development Timeline is attached (Appendix 1) along with a description of the 7 workstreams.

3.0 Key Milestones for December 2018

- Board Seminar to cover vascular and an overall Specialist Services Wash-Up (18 December)

- Following agreement of 2 Board Seminars in January 2019 and 1 in early February 2019 by Chairman to cover local hospital/ networked services Medical and Surgical Specialties.

4.0 Issues and Risks

Capacity in the Clinical Divisions to engage is the foremost significant risk to the strategy timescales.

No	Area	Description of Issue/ Risk	Mitigation	RAG
1.	Capacity (Clinical Divisions)	Bandwidth and breadth of challenges for Clinical and Managerial colleagues in the divisions and competing day-to-day priorities- finance, operational performance, quality standards- could lead to a lower prioritisation of strategy work leading to a delay in delivering a strategy	Strategy Team to engage and provide support, as far as possible, but clinical expertise and input will continue to be a key input and necessary requirement and resource restraint	
2.	Engagement (Clinical Divisions)	Clinical Strategy Development by end March 2019 is accelerating and Clinical Divisions communication and engagement could lack expediency and impetus leading to a delay in delivering a strategy and/ or difficulties with buy-in and ownership of the strategy	Divisional Engagement Plan agreed with Triumvirates Strategy Team attending Care Groups, Directorate Meetings and DMBs, as far as possible Engagement Events planned for Staff in November/ December 2018.	
3.	Reputational (Engagement Events)	Engagement Events- brief, concise sessions with lead-in limited. This could lead to criticisms of engagement being lip-service only and not authentic as it is rapidly rolled out and rushed.	Dates, invitations to stakeholders and venues to be landed and locked down by 12 October 2018. Communications, Divisions, Strategy and Transformation teams working together on content/ format and delivery of events.	

5.0 Recommendation

Trust Board is asked to:

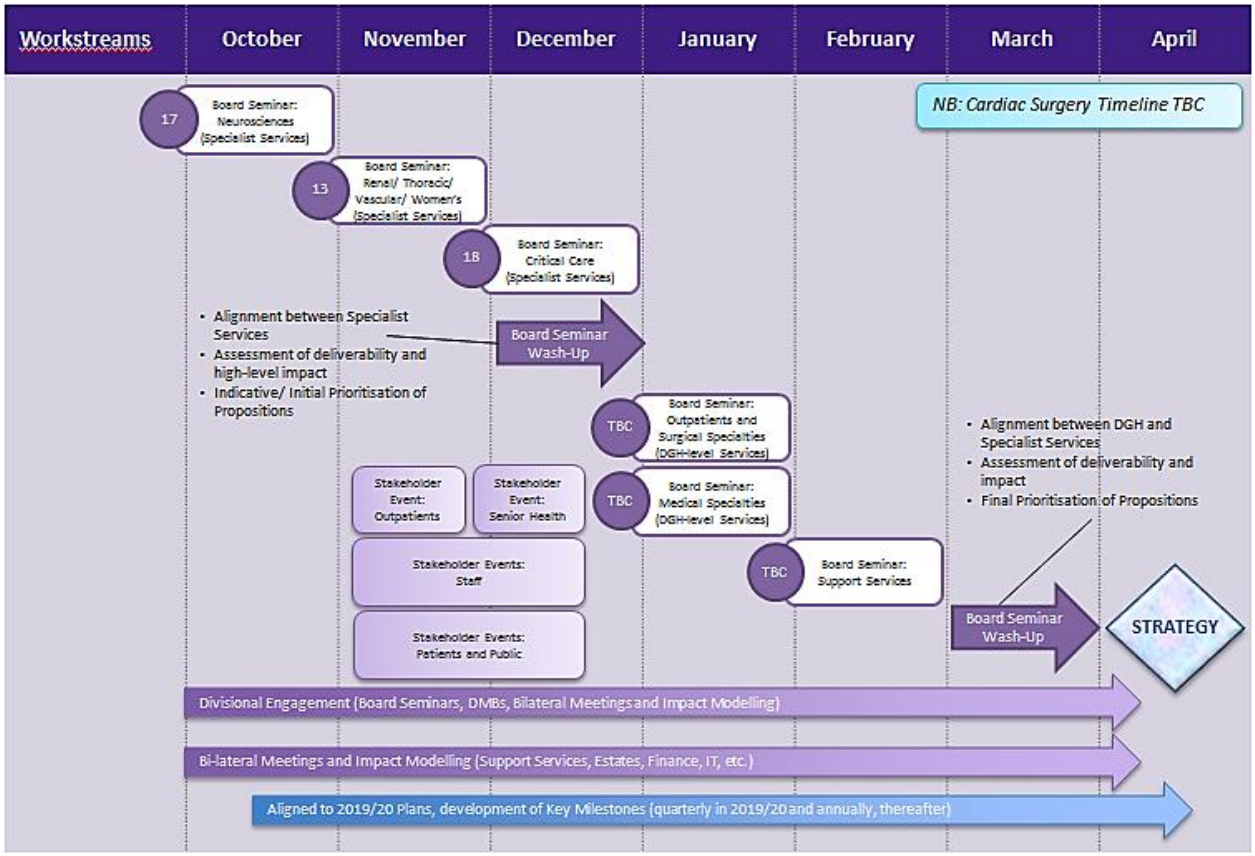
- Note the progress reported and the identified issues and risks.

Author: **Laura Carberry, Strategy and Partnership Manager**

Date: **23rd November 2018**

Appendix 1: Clinical Strategy Development Timeline and Workstreams

Clinical Strategy Development Timeline



Clinical Strategy Workstreams

Workstream	Description
1. Programme Management	Programme plan, risk register, etc.
2. Development of Options	Development of options for board to consider, (e.g. as per work to date for board seminars)
3. Alignment, Deliverability and Prioritisation	Making sure that the board's preferred options align and that any conflicts/issues are visible & managed, enabling the board to prioritise where necessary, and ensuring that what goes into the strategy is realistic & deliverable (with reference to money, estates, workforce, reactions of competitors/commissioners etc.)
4. Communications and Stakeholder Engagement	In developing the strategy and then disseminating once published. Covering a) strategically important stakeholders such as commissioners, regulators and b) staff & public.
5. 'Into delivery' Planning	Development of high-level milestones over the next 5 years for implementing the strategy
6. Enablers and Interdependencies	Alignment with business planning round for 19/20, and strategies for estates, finance (medium term financial plan), IT, workforce, research.
7. Production and Publication of Strategy	Agreeing what it should look like / who it should speak to; drafting/writing it; graphic design; publishing etc.

Appendix 2: Issues to be addressed as Clinical Strategy Development progresses

These are issues that have been identified from early strategy discussions and are recorded to ensure that they are not lost during the development process.

- The clinical strategy needs to be developed taking account of research and education priorities: meeting held with Principal of SGUL; Medical Director is a member of Strategy Project Steering Group. Medical Director to convene meeting re development of Research Strategy.
- Clinical innovation is a core part of the strategy: to be considered with each service as plans developed.
- The external environment analysis should include systems outside of SWL e.g. South London (links to specialised commissioning reviews), Surrey and Sussex: presentation to Board Strategy Seminar in July.
- Working within the SWL system at borough level with primary care, mental health and community provider colleagues within the wider health system is important: this will be picked up as the strategy work for the secondary health/ local hospital services is developed.
- Maximising the relationship with St. George's, University of London is an important partnership: meeting held with Principal of SGUL. Input to Board Seminars and links to Research Strategy.
- Include Kingston University as a key partner regarding training of nurses and other professional groups.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	29 November 2018	**Agenda No.**	5.1
Report Title:	**General Data Protection Regulation: Implementation Update**		
Lead Director/ Manager:	Andrew Grimshaw, CFO & SIRO		
Report Author:	Elizabeth White, CIO		
Presented for:	Update		
Executive Summary:	This paper provides an update on the work for the Trust to become fully compliant with Data Protection Legislation.		
Recommendation:	The Board is asked to note the update.		
Supports			
Trust Strategic Objective:	Build a better St George's.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources.		
Implications			
Risk:	As set out in paper.		
Legal/Regulatory:	The EU General Data Protection Regulation (GDPR) was approved in 2016 and has become directly applicable as law in the UK from 25th May 2018 and the Data Protection Act 2018 (DPA18), fills in the gaps in the GDPR, addressing areas in which flexibility and derogations are permitted		
Resources:	As set out in paper.		
Previously Considered by:	Trust Executive Committee as an update	**Date:**	21st November 2018
Appendices:			

GDPR Implementation Update
Trust Board 29th November 2018

1.0 PURPOSE

The EU General Data Protection Regulation (GDPR) was approved in 2016 and has become directly applicable as law in the UK from 25th May 2018 and the Data Protection Act 2018 (DPA18), fills in the gaps in the GDPR, addressing areas in which flexibility and derogations are permitted. The new Act aims to modernise data protection laws to ensure they are effective in the years to come. This paper outlines progress in the project to implement the provisions of DPA18, and also embed them into Information Governance business as usual.

2.0 Key headlines

Issue	Target date	RAG	Key issue	Action required
Asset Audit	Feb 19	A	Some departments slow or failing to respond.	Lists provided to Executive leads
Training	Mar 19	A	Ensuring staff participate in the updated Info Governance training (online).	Monitoring to take place at IGG with report on divisional progress in future reports to TEC.
Contracts	Mar 19 (tbc)	R	Recently commenced joint approach across SWL. Procurement support engaged.	Progress to be monitored at IGG. Capacity constraints may impact, these remain under review.
Policy review	Mar 19	A	Ensure all trust policies adequately reflect the impact of the move to GDPR (DPA19)	Risk analysis of urgency.
Testing compliance	Ongoing	tbc	Until the above core activities are complete the Trust will largely remain reactive to DPA issues.	Rolling programme of testing, and compliance to be developed and agreed at IGG. Include Trust wide readiness assessment in 2019/20 Internal Audit Programme.

3.0 IMPLEMENTATION UPDATE

Since the last update, the focus of GDPR has been mainly:

3.1 Training

- Information Governance mandatory training has been updated and is under review currently by IGG
- Awareness training under development for DPIA and SOP
- *Access to Records and Subject Rights* slide deck has been created to be published following peer evaluation

- *Information Asset Owner / Administrator* slide deck has been created to be published following peer evaluation
- *How to complete a Data Privacy Impact Assessment* slide deck has been created to be published following peer evaluation
- *Records Keeping / Care Records* slide deck has been created to be published following peer evaluation

3.2 Communication.

- Continue to updating Information Governance intranet pages to capture all elements of Data Protection legalisation
- Prompt live on login on Data Protection Principles
- Bespoke GDPR awareness sessions continue for clinical departments
- Increased engagement with QMH

3.3 Progressing the Information Audit

- The data capture is planned for completion in February 2019, and the subsequent work on identified risk such as the assessment and developing the mitigation plan will extend into spring 2019.
- 19 asset registers were completed in October, and 12 were signed off. 68 out of 109 asset registers have been mapped to date, with 15 new areas identified.
- Delays in completion of asset registers by estates, procurement, communications, cardiology, blood pressure, endoscopy (sign off only) and gastroenterology.

3.4 Contracts and Data Sharing

- Collaboration continuing with Procurement.

4.0 NEXT STEPS

The main areas of focus in the coming month are:

4.1 On-going Identification of lawful basis for processing for creation of bespoke privacy notices
4.2 Completion of IAR training of non-clinical areas
4.3 Progress data mapping for additional 10 clinical areas per month
4.4 Add new IG training to MAST in December
4.5 Identification of priority policies and procedures required under GDPR.
4.6 Conduct further training and awareness sessions
4.7 Audit of current status
4.8 Risk base analysis for contracts