St George's University Hospitals NHS
NHS Foundation Trust

Public Board Papers

20 December 2018

Trust Board Meeting
Part 1 - Public

Date and Time: **Thursday, 20 December 2018: 10:00 – 13:30**

Venue: **Boardroom H2.6, 2nd Floor, Hunter Wing, St Georges University**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the St George's 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 29 November 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
10:55	**2.2**	**Integrated Quality & Performance Report**	**James Friend** Director of Delivery, Efficiency & Transformation	Inform	Report
11:05	**2.3**	**Elective Care Recovery Programme**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
11:20	**2.4**	**Quality Improvement Academy Update**	**James Friend** Director of Delivery, Efficiency & Transformation	Update	Report
11.35	**2.5**	**Cardiac Surgery Report**	**Richard Jennings** Chief Medical Officer	Update	Report
11.45	**2.6**	**Water Safety Report**	**Kevin Howell** Director of Estates	Update	Report
FINANCE					
11.55	**3.1**	**Finance and Investment Committee Report**	**Ann Beasley** Committee Chair	Assure	Report
12.05	**3.2**	**Month 8 Finance Report**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
WORKFORCE					
12.15	**4.1**	**Workforce and Education Committee Report**	**Harbhajan Brar** Director of HR & Organisational Development	Assure	Report
STRATEGY					
12.25	**5.1**	**Clinical Strategy Highlight Report**	**Suzanne Marsello** Director of Strategy	Update	Report
GOVERNANCE					
12:35	**6.1**	**GDPR Implementation Update**	**Andrew Grimshaw** Chief Finance Officer	Assure	Report

ESTATES					
12:40	**7.1**	**Patient Led Assessment of the Care Environment (PLACE) 2018**	**Kevin Howell** Director of Estates	Update	Report
CLOSING ADMINISTRATION					
12:50	**8.1**	**Questions from the public**	-	-	Oral
	8.2	**Any new risks or issues identified**	**All**	-	-
	8.3	**Any Other Business**	**All**	-	-
	8.4	**Reflection on meeting**	**All**	-	Oral
13:00	**PATIENT/ STAFF STORY**				
A patient who brought a complaint about abusive patients on her ward will attend and will be joined by Vicky Morrison, Cardiothoracic Director and Martin Haynes, Head of PMO.					
13:15	**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: 31 January 2019, 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	22.02.18	29.03.18	26.04.18	31.05.18	28.06.18	26.07.18	30.08.18	27.09.18	25.10.18
29.11.18	20.11.18	20.12.18	31.01.19	28.02.19	28.03.19				

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Sir Norman Williams	Non-Executive Director/Senior Independent Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse & Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Richard Jennings	Chief Medical Officer	CMO
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 Murphy	Interim Head of Corporate Governance	HCG
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 29 November 2018, 10.00 – 13.00, Barnes and Sheen Rooms, 2nd Floor, Queen Mary's Hospital

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	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 Rhodes	Acting Medical Director	MD
IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
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
Tom Shearer	Director of Financial Performance	DFP
Jenni Doman	Assistant Director, Facilities	ADF
Sally Herne	NHSI Improvement Director	NHSI
APOLOGIES		
Andrew Grimshaw	Chief Financial Officer	CFO
Kevin Howell	Director of Estates & Facilities	DEF
Jenny Higham	Non-Executive Director	NED
SECRETARIAT		
Jill Jaratina	Interim Deputy Trust Secretary (Minutes)	IDTS

Feedback from Board Walkabout

Members of the Board gave feedback on the departments visited, which included Gwynne Holford Ward, Wolfson Rehab Unit, Bryson Whyte Rehab Unit, Mary Seacole ward, Day Case and Endoscopy, Dermatology, Outpatient Physiotherapy, Rehab and Bader Gym, Gait Lab/Wheelchair Service, Special Seating and Douglas Bader Rehabilitation Centre.

Providing feedback on Gwynne Holford Ward and Wolfson Rehabilitation Unit, the ADF commented that Gwynne ward was clean, well presented and the team on the ward were very positive. Patients on the ward provided positive feedback about the care they were receiving. The average length of stay for a patient was 79 days. The Wolfson Rehab Unit, which is one of a few vocational rehab centres

nationally, was very highly regarded and a team had recently visited from Vietnam to see the unit.

The DCA provided feedback on Bryson Whyte Rehab Unit and Mary Seacole Ward. The former was similar to s day hospital, with patients generally over 65 years of age. Patients could self-refer as well as be referred by their GP. Staff highlighted that issues relating to estates were not dealt with as speedily as expected. It was observed that the rehabilitation equipment had, "I am clean stickers". Staff on Mary Seacole Ward commented that the profile of the inpatients in the last two years had changed, with greater numbers of frail patients. The average length of stay was 25 to 30 days. Staff commended the good relationship between the ward and the rehabilitation unit. Louise Patterson, Team Leader BWRU commented that staff were looking forward to using iClip next year.

The COO provided feedback on the Day Case and Endoscopy Unit and Dermatology. The Endoscopy Unit Team Leader had expressed concerns about the utilisation of the three sites. The COO advised the Board that he would discuss these concerns with the General Manager for Endoscopy. The group had also spent time in the Dermatology Unit which looked after patients with conditions such as psoriasis. The Diabetes Nurse Specialist was of the impression that teams were not working as well they could and recommended greater integration with the Tooting site. The CEO asked the COO to further consider integration as this had been raised in the past.

The DFP provided feedback on the visits to Outpatient Physiotherapy and Rehab and the Bader Gym. It was noted that the unit had received 98% positive patient feedback. It was observed that the unit was less busy and more calm than the St Georges' unit and patients experienced a shorter wait. It was reported that the service had two contracts for back and neck patients and staff expressed their frustration at using both paper and digital notes. It was reported that Lisa Duncan, Team Leader-Bader Gym, had started a working group for amputees which met on a Saturday. The Board Chairman commented on this commendable initiative and asked that it be recognised.

The CN provided feedback on the visits to Gait Lab/Wheelchair service and Special Seating where staff showed her around the service and explained that the service provides mobility equipment and seating for postural management for adults and children with medium and complex postural needs. Patient referrals were received through general practitioners and consultants across the country. Staff had highlighted the issues with space and that they could only see one patient at a time. The CN commented on the large number of cameras and the advanced technology used in the unit.

The Head of Service for Special Seating advised that the service had a significant waiting list but this was gradually reducing as new staff had been recruited. The service had 11,000 registered users and at least 1000 patients are managed at any one time. The unit provided varying assessments for different types of wheelchairs. In the workshop, the CN observed a staff member assembling a wheelchair. The risk assessment process was described to the CN and it was explained that patients could be offered a voucher on request if they wanted top of the range wheelchairs.

Ann Beasley fed back on the visit to the Douglas Bader Rehabilitation Centre which supports 10 inpatients and 8 outpatients. The Team Leader had discussed succession planning for the Clinical Nurse Lead role and the bespoke technology used in the unit. Ann Beasley highlighted an issue with the dress code but, overall, staff were enthusiastic and the impact on patients was visible.

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed Richard Jennings, Chief Medical Officer, who was commencing his role on 3 December 2018. It was noted that Tom Shearer, Director of Financial Performance (DFP) was deputising for the Chief Finance Officer and Jenni Doman was deputising for the Director of Estates and Facilities. Apologies were noted as above. It was noted that Stephen Collier would be leaving the meeting before the scheduled finishing time.
Declarations of Interest	
1.2	It was noted that Jenni Doman, who was deputising for the Director of Estates and Facilities, is a Staff Governor. No other declarations of interest were made.
Minutes of Meeting held on 25 October 2018	
1.3	The minutes of the meeting held on 25 October 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.
CEO's Update	
1.5	The CEO commenced her report by drawing attention to the timeliness of the meeting papers and reminded the Executive team of the requirement to submit Board and Committee papers within the deadline to enable timely circulation. She advised the meeting that the Corporate Governance team had left work at 20.30hrs one Friday as meeting papers had not been received in time for circulation and emphasised the further action in future of naming those who did provide reports in accordance with the set timescale. The following updates were provided: • Mr Livesey, a well-respected cardiac surgeon from Southampton had been appointed to lead the cardiac surgery unit and would be joining the Trust on 3 December 2018, initially on a full-time basis. Staff had fed back that the culture in the department was improving and staff were more positive about the future of the service. • The CEO, Board Chairman and Sarah Wilton had attended a celebration of partnership with McMillan Cancer Support. The CEO reported that waiting times for cancer patients attending the Emergency department had reduced from 3-4 hours to being seen straight away. The CEO had also attended an event as part of the New Beginnings project and the team had asked the Chair if they could present a paper to the Board. • The rollout for iCLIP was due for completion at the end of November 2018 and this had proved to be a positive way forward. • The Trust had made a decision to financially support settlement applications for the 1200 EU staff members employed by the Trust. • It was noted that there had been a decrease in the number of cancelled operations from 23% to 15%. The number of patients eligible for but not having pre-operative assessments had dropped from 29.9% to 3%. The Trust was working towards reducing the number to zero.

	• The Trust had won a Health Service Journal award in the Acute Sector Innovation category for a RAPID prostate pathway established between St George's Trust, the Royal Marsden Hospital, Imperial College Hospital, and Epsom and St Helier Hospitals. • The Trust's vacancy rate had reduced to below 10% for the first time in October 2018. The Board noted the report.
QUALITY & PERFORMANCE	
2.1	**Quality and Safety Committee Report**
	Sir Norman Williams, Chair of the Quality and Safety Committee, presented a summary of the discussions of the meeting held on 22 November 2018. The Committee noted the gradual improvements in hospital acquired pressure ulcers and outpatient first attendances. Deterioration in some areas was noted. The QID had assured the Committee that further assurances for the completed CQC actions would be presented at the next Committee meeting in December. The Committee was concerned to hear that two serious incidents (never events) had been declared 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 were being investigated under the Trust's Serious Incident investigation processes. The outcomes of the investigations would be reviewed by the Committee to ensure that the appropriate learning takes place. The Committee was also alerted to a further incident that had happened involving a prescribing error in which the regularity of the administration of heparin was changed. Sarah Wilton had also expressed concerns over weekend mortality. The Committee was aware that weekend mortality was a national issue but they were keen for the Trust to conduct a weekend mortality analysis. The CEO had expressed concerns over the increase in the number of falls. The Committee asked for a falls analysis to be carried out for presentation at the next Quality and Safety meeting in December 2018. The Committee had discussed the ward accreditation scheme and expressed their disappointment at the Outpatients department rated as "requires improvement". Ann Beasley commented that when analysing the outpatients data in the report, her impression was that everything was getting worse. The CEO explained that the Outpatients Department had low expectations in the past and the accreditation scheme facilitated a baseline. The CN added that minor issues such as storage of patient notes and compliance with below the elbow policy would be resolved. A detailed analysis of the 19 areas that had been rated as requiring improvement would be carried out. The MD urged the Committee to consider the findings of the 2016 CQC inspection. The CEO commented that the organisation had made progress in managing quality and finance but embedding improvement remained a challenge. It was essential that staff demonstrated the Trust's values and this needed to start with the Board. To date, the Trust had taken a number of small steps forward but now needed more substantial change. The Chairman observed that these cultural issues needed regular attention by the Board. The MD reported that mortality remained lower than expected compared with the national rates. Mortality was reported on a rolling average in the past and this had changed to monthly reporting. The Committee noted the peak in mortality in February 2018 and acknowledged a similar national position. The MD advised the Board that the Trust was within the upper quartile for mortality and this position could be maintained without additional finance. A paper providing

	assurance on the seven day week service would be presented to the Workforce and Education Committee and the Board. The Board noted the report.
2.2	**Integrated Quality & Performance Report**
	The DDET commented that there continued to be challenges in theatres and achieving discharges before 11.00 am. Emergency Department performance in November had further deteriorated and staff attributed this position to iClip which had recently been rolled out across the Tooting site. It was noted that the IT department was setting up a programme to capture issues caused by iClip in order to resolve them quickly and this would also be the focus of the transformation team in the next two to three months. The COO expressed concern to the Board about the cancelled operations and brought the Board's attention to the error in reporting the 52 week cancellations. The Board was assured that the error would be rectified in the next report. The Trust had delivered six of the seven cancer standards in September, continued to achieve the 14 day standard, and was returning to compliance against all breast symptomatic standards. It was noted that the Emergency Department performance would be presented as part of the winter plan. Stephen Collier commented that the Trust was almost achieving the monthly activity and sought assurance that the gap would be closed. The Chairman agreed that results reflected in the report were commendable and staff should be thanked for their effort. The CEO commented that a lot of patients with cancer are diagnosed in the Emergency department which prompted questions about whether the Trust could measure this. The CN remarked that the falls underlying trend had risen and a falls analysis would be presented to the next Quality and Safety Commission. **Action TB.29.11.18/01: CN to present falls analysis report to the Quality and Safety Committee in December 2018**. She also noted that a patient experience report would be presented to the Board in January 2019. The MD commented that the Trust had not experienced any never events for five months but two such events had been declared that month which was of concern particularly as one incident was a replication of a never event that had occurred in Croydon six months ago from which learning should have been embedded. In relation to workforce, the Board noted the decline in the vacancy rate and urged the Executive to sustain this position. The Chairman commented again on the need to improve the compliance rate for non-medical appraisals. The DHROD advised that the Trust would be introducing an electronic system in the near future which would help to achieve the 90% target but real progress was dependent on implementing this system. The Board noted the report.
2.3	**Winter Plan**
	The COO presented the Winter Plan and advised the Board that the 2018/19 plan followed the 2017/18 format. The Board was asked to note the change in the reporting to the nationally-used OPEL framework categories. The Trust had not met the patient flow and bed occupancy target for October and ED performance had deteriorated significantly. System partners (Central London Community Healthcare NHS Trust, London Boroughs of Merton and Wandsworth) had now identified schemes to provide the equivalent of 32 beds. Sarah Wilton expressed concern about costs and that the service provided by the private sector would not equate with the care

	provided at the Trust, noting that patients had had negative experiences in the past. The COO commented that the Trust Executive Committee had discussed the opening of a winter ward (Dalby). He advised that a checklist for opening the ward would be completed for December 2018. The DDET explained that partner organisations had a commitment to help the Trust close the gaps. The Trust had requested a clear matrix from them and the CCG was leading on obtaining the matrices from the London Boroughs. The DDET advised that the Trust did not have to pay for this service. The COO asked the Board to note that the operational plan for opening the additional bed capacity on Dalby Ward was supported by the clinical leadership of the Medicine and Cardiovascular Division. Triggers to inform the decision to open the additional capacity were being developed with support from the Emergency Care Improvement programme. The CEO informed the Board that she had received notification of closures of residential and nursing homes in South West London so gaps in social care were likely. The Chairman asked that this issue be further explored at the planned Health Strategic event. The Board members agreed the recommendations set out in the paper.
2.4	**Elective Care Recovery Programme Update**
	The COO summarised the report and highlighted particular points for the Board to note. The Training Strategy had been agreed in October 2018 and sessions were planned up to 3 December 2018. The Trust continued to aim to return to national reporting in Q4 2018/19. The final assessment outcome for phases 1 and 2 would be presented to the Board in January 2019. **Action TB.29.11.28/02: COO to include update on training in ECRP paper to the December Board.** The Board noted the report.
2.5	**Cardiac Surgery Report**
	The MD reported Mr Livesey's appointment had been communicated to the cardiac surgeons and the wider unit earlier in the week. NHS Improvement required an independent review of deaths over the past five years and this was about to start. Lessons would be shared with the Board once the review was completed. The Board noted the report.
FINANCE	
3.1	**Finance and Investment Committee Report**
	Ann Beasley, Chair of the Finance and Investment Committee, updated the Board on the discussions at the meeting held on 22 November 2018. The Board was informed that the Trust continued to wait for a response regarding capital expenditure from NHSI. The Committee had discussed underperformance and how the Trust could drive costs down. Planning for 2019/20 was discussed at length as well as proposed significant changes. The South West London Pathology- LIMS Business case was discussed and recommended to the Board. Tim Wright recommended that the IT department should have a timeline of progress for iClip. The Chairman agreed with this suggestion and said that the ICT strategy needed to be discussed. **Action TB.29.11.18: ICT strategy to be added to Board workshop forward planner.** The Board noted the report.
3.2	**Month 7 Finance Report**
	The DFP presented the report and the Board noted that the Trust had not met its financial

	target for Q2 and the issues had been discussed at the Finance and Investment Committee meeting in November 2018. The pre-PSF deficit of £33.3m at the end of October was mainly driven by material issues such as cardiac lost income arising from lower than planned levels of activity and medical pay. The Board noted the Trust's financial performance as set out in the report.
STRATEGY	
4.2	**Trust Strategy Highlight Report**
	The DS presented the progress report on the Trust's five-year clinical strategy. It was noted that for workstream 3 (alignment, deliverability and prioritization), and initial impact modeling were behind schedule, but a recovery plan was in place. In relation to workstream 4 (communication and stakeholder engagement), eight engagement events had been completed, two of which were public events in Merton and Wandsworth in November 2018. A further public event had been arranged in December at St George's. Tim Wright requested further information about the cross cutting issues. The DS advised that information would be provided at the Board seminar in December 2018. The Board noted the report.
GOVERNANCE	
5.1	**GDPR Progress Report**
	Taking the report as read, the DFP outlined the progress on the project to implement the provisions of Data Protection Act 2018, which included the provisions of the GDPR. In regards to contracts, the Trust had recently commenced a joint approach across SWL and progress would be monitored by the Information Governance Group. The Board noted the report.
CLOSING ADMINSTRATION	
6.1	**Questions from the Public**
	A member of the public asked a question which had also been submitted in writing, namely the cost of each of the Bewick and Hollywood reviews into the cardiac surgery unit and the cost of the mediation in December 2017, including any associated costs, such as providing cover whilst the surgeons were off site and lost revenue from cancelled surgeries. The DFP responded that the Bewick review had cost £47,410.14 (including VAT), the Hollywood review £38,361.45 and the December 2017 mediation £26,180.05. As the mediation was planned well ahead of time, arrangement had been put in place to ensure there was no loss of income over the two days on which the mediation was conducted. The COO further explained that, as St George's is a trauma centre, the Trust continued to provide a full emergency service at all times.
6.2	**Any new risks or issues**
	No new risks or issues were identified.
6.3	**Any Other Business**
	The Board Chairman thanked the MD for his work in the role of Acting Medical Director for more than two years and commented that he had served the Trust ably and with great loyalty in some very difficult circumstances for which the Board was extremely grateful. She moved a formal vote of thanks which was seconded by Ann Beasley, who also commended the way the AMD had handled difficult situations. The Board unanimously endorsed the vote of thanks.

6.4	**Reflection on meeting**
	The CN commented that the Queen Mary meeting venue was better and quieter than St George's, that the meeting was good, and all the issues that should be discussed had been discussed. Ann Beasley commented that there was a real sense of progress and the right discussions were conducted. The DDET suggested that the public should be informed about other items presented to Committees that are not presented to the Board for the purpose of public accountability. The Chairman agreed with the DDET and commented that she sought to highlight the issues for public accountability for each agenda item.
	Patient Story
	The Chairman welcomed Hannah Lyons and baby Charlie Lyons and asked her to talk through her experience. Hannah explained that she was admitted after a car crash in June 2018 in which she was seriously injured. She received wonderful care in ICU, however she experienced a series of incidents that reflected lack of thought for breastfeeding mothers outside of the maternity unit. Hannah pointed out that the initial problem was communication as staff were not able tell her husband her correct location. When Hannah's husband was directed to the Emergency Department, he was told that he could not see his wife. At this point baby was hungry and the baby was given formula milk despite recommendations babies were best breast feed the baby for six months and Hannah would have been able to breast feed. When Hannah was transferred to ICU, no-one could tell if the baby was allowed into ICU. When Hannah received a call to inform her of the transfer to a general ward, she was informed that could not take Charlie to the ward as the risk to other patients would be too great. A side room was eventually found. There was also confusion over policies and Hannah expressed concern that staff appeared not to understand them. A porter who transferred Hannah to the ward had been trained about dignity and respect and insisted that she was appropriately covered. A CT scan was performed and staff later advised Hannah not to breastfeed after the scan but she had already breastfed at this point. A phlebotomist who had attended to Hannah to take bloods left without saying anything when he realised that she was breastfeeding. The Chairman acknowledged that staff had not fully appreciated Hannah's situation and the Trust's policies appeared inadequate. In response, Hannah stated that she was now a representative on the Infant Feeding Group and she had attended a meeting. Sarah Duncan, Patient Experience Manager, advised that a new policy to give guidance to staff on breastfeeding mothers who attend St George's hospital had been developed and there would be a launch of the policy which it also be communicated via a newsletter. Sir Norman Williams, NED asked if the policy had considered the side effects of drugs on breastfeeding mothers as some drugs can be passed on to the child. Sarah Duncan confirmed that this had been considered. The DS asked if staff on the ward had offered any help and if Hannah had managed to access the patient advocacy service. The CN added that staff could have sought advice from the corporate nursing team about how individual care could be provided. The CN commented that the Trust required more than a policy to prevent more occurrences. Hannah responded that she was not sure at what point she realised there was a patient advocacy service. The Board Chairman thanked Hannah for sharing her story, apologised again on behalf of the Trust for the experience she had received as a patient and reiterated that the policy on its own would not be sufficient to prevent such occurrences.

Date of next meeting: Thursday 20 December 2018 at 10:00 at St George's Hospital

Trust Board Action Log Part 1 - December 2018

Action Ref	Theme		Due	Lead	Commentary	Status
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	Considered by the QSC at its meeting on 13 December 2018	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	Discussed at TEC on 5 December 2018	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 and 13 December 2018. Scores to be brought back to Board as part of Q3 update in January	PROPOSE FOR CLOSURE
TB. 25.10.18/5	**Board Assurance Framework**	Workforce & Education Committee to review Strategic risk 8 at meeting in December	20.12.2018	DHROD	Considered by the WEC at its meeting on 6 December 2018. Scores to be brought back to Board as part of Q3 BAF update in January	PROPOSE FOR CLOSURE
TB. 29.11.18/1	**IQPR**	CN to present a falls analysis report to Quality and Safety Committee	13.12.2018	CN	Considered by QSC at its meeting on 13 December 2018	PROPOSE FOR CLOSURE
TB.29.11.18/2	**Elective Care Recovery Programme**	COO to include update on training in ECRP paper to the December Board	20.12.18	COO	On agenda	PROPOSE FOR CLOSURE
TB.29.11.18/3	**ICT**	ICT strategy to be added to Board workshop forward planner	31.12.18	CFO/DCA	Added to forward planner. Date TBC as part of 2019/20 programme of Board workshops.	PROPOSE FOR CLOSURE

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	20 December 2018	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

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

I want to begin my report this month by talking about the world outside St George's.

NHS Improvement and NHS England announced this week the appointment of seven new regional directors. Both NHSI and NHSE are to work in a more integrated way, and the formation of a new central NHS Executive Group is evidence of this happening in practice.

Our relationship with the regulators is so important, and I am delighted that Sir David Sloman, currently Chief Executive of the Royal Free, is to become regional director for London. It is also noteworthy that Ann Radmore, Chief Executive of neighbouring Trust Kingston, is also taking on a regional role in the east of England.

Sir David's appointment in particular will be important for us as we continue on our improvement journey – but also as additional Government funding becomes available, and the NHS 10 year plan becomes a reality.

More locally, there continues to be significant interest in the south west London healthcare economy, including re-development plans put forward by Epsom and St Helier.

Any changes to the current configuration of services at Epsom and St Helier are likely to impact on St George's, and it is important these are factored into any future proposals.

Of course, we are developing our own clinical strategy for 2019-24, and we will need to ensure any sector changes at a local or national level are factored into and reflected in our plans.

Cardiac surgery at St George's:

Last month, 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.

Since the last Trust Board meeting, I am pleased that Steven Livesey has now taken up his leadership role within the service – and, separately, the CQC has published its inspection report for cardiac surgery at St George's, following their visit in August and September.

I am pleased to say that our cardiac surgery service is safe, but it is clear from the CQC's report that major, major improvements are still needed – and we shouldn't understate the scale of the task ahead.

We have known for some time that improvements are needed, as is a culture change within the service. Improvements are being made – but some things can't be changed overnight, and this is a point I made clear in a communication to staff and a media interview last week.

Despite this, I do believe real progress has and is being made, and the cardiac surgery service at the Trust is now very different to the one the CQC inspected in the summer.

Real, concrete steps have been taken to modernise the service – for example, all cardiac surgery cases are now reviewed by a multi-disciplinary team.

As important, feedback from cardiac surgery teams is more positive, and the staff I speak to feel more confident about their own futures, and that of the service.

This is positive, and both the Trust Board and I remain committed to cardiac surgery at St George's, and see it as a key part of the organisation's future.

The challenges we've faced in recent months are a direct result of our attempt to deliver changes in the service we all know are needed; for the benefit of patients and staff.

As a result, my strong view remains that we need to continue delivering improvements in cardiac surgery; and this will enable us, over time, to restore a full service for patients, and the communities we serve.

Our performance:

Operational performance remains a key focus for the organisation, particularly as we head into winter.

We need to see improved performance in terms of emergency care, with only 85% of patients seen, admitted or discharged from the Emergency Department at St George's in November.

We are not alone in this regard. Indeed, a glance across London and the rest of the country shows that the performance challenges in emergency care are widespread.

Of course, we can't control the number of patients wanting to access our services, but we can still improve some aspects of patient flow better internal systems and processes.

On a more positive note, only 18 patients were waiting longer than 6 weeks for a diagnostic test at the end of October – and we met all seven cancer targets during the same month.

Our winter plan has been shared with staff, and I am confident that the additional capacity we are creating on Dalby ward at St George's will help us manage demand – as will a concerted effort to improve our Emergency Department, inpatient and discharge processes.

In light of the above, the coming weeks and months are likely to be challenging for staff, and we need to provide them with all the support they need, both in terms of practical and emotional support.

Our people:

The deadline has now closed for the NHS staff survey, and we matched last year's completion rate of 51.5%, with 51.6% of staff filling it out this year.

We didn't reach our target of 60% of staff completing the survey, but performed well above the average for acute Trusts which is 44.3%.

The results of the survey will be shared with us next year, and our focus will then turn to the most important task of listening to what staff have told us, what is working well, and where we need to improve.

We recently launched our new diversity and inclusion strategy, which as we know is an area we need to improve on – as highlighted by previous staff surveys.

This is something that we all need to own and show we are real and serious about – and that includes myself, every member of the executive team, and staff across the Trust.

There are a range of concrete steps we will be taking – including new D&I champions, plus performance objectives for managers linked to bullying and harassment – but we need the whole of the organisation to embrace this, not least because it is the right thing to do.

Our financial position:

I am naturally concerned about the Trust's financial position, and it is clear we have not made as much progress in reducing the deficit as we had planned.

There are a number of reasons for this, some of which could not have been anticipated– for example, the loss of income resulting from changes we had to introduce to referral pathways in cardiac surgery earlier this year.

That said, we are not seeing enough progress in areas that are very clearly within our gift to solve or address – including overspends in medical staffing, and elective activity, which continues to be under trajectory, despite a concerted effort to treat more patients.

We will need to look again at the areas that continue to overspend, and take more decisive action to bring costs down as we approach the end of the year.

We are launching a new five year clinical strategy in April 2019 – and I want us to be in a position where we can start to look at where we might invest resources, rather than continually focussing our efforts and energies on reducing the deficit. We are a long way off from this at present.

Other business:

I can confirm that there have been no uses of the Trust seal since the last Trust Board meeting.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	20 December 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 the13 December 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Quality and Safety Committee Report – December 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 the Chair noted it appeared stable, showing no significant deterioration in performance but also no significant improvement. There is a continuing challenge with meeting the 'antibiotics within 1hr' standard when sepsis is identified in the Emergency Department. Complaint response times have fallen significantly below the trajectory; the Director of Quality Governance gave a commitment that the Committee will see the targets achieved by March 2019.

2 Action Plan in Response to the CQC Inspection Update
The Committee heard from the Trust's Quality Improvement Director that of the 82 actions in the plan 8 are amber and will not be delivered by the end of the financial year; these will go forward into the revised and updated Quality Improvement Plan. The Committee was assured that there was good reason for them to be outstanding as they were on-going actions that would continue to be delivered over a period of time.

3 South West London Pathology Quality Report (SWLP)
A never event was highlighted involving a blood typing error, a similar incident happened eleven months ago, in both cases the patient did not come to harm. The recent incident is being investigated and will report shortly. Immediate action was taken as the controls put in place after the first incident had not been effective. The key action is standardisation of the blood typing process across all sites where SWLP provides this service; the Committee was assured that this is now implemented across all sites.

4 Integrated Quality & Performance Report
The Committee was concerned to hear of the increase in falls. The incidence of category 2 pressure ulcers has increased since the previous Committee meeting. C. Diff was noted to be above target.

5 Elective Care Recovery Programme (ECRP)Update
The Committee heard from the Chief Operating Officer that the ECRP will form a separate report to the Board however the Committee was content with progress.

6 Cardiac Surgery Update
The Committee noted the in-depth report and improvements which will be reported to Board. The cardiac surgery service is now accepting cases with a EuroSCORE of 5 or less, that is more complex patients. Concern remained with regard to behavioural and cultural issues, the arrival of the new clinical director was welcomed. The Dendrite system to monitor outcomes is now operational and will improve reporting on cardiac surgery outcomes.

7 Patient Safety & Quality Group Report
The Committee noted there had been no clinical harm identified to date from the cohort of patients being contacted by their GP practice. There had been no change in ward accreditation. The Committee was given assurance that the 17 outstanding actions arising from SIs in the Children, Womens, Diagnostics, Theatres, Critical Care and

Community Services Division all had robust reasons for being delayed with many being on-going actions which were being monitored.

8 Water Safety Report

The Committee heard that there continued to be problems with water quality however the report provided to the Committee would be taken to Pt. 1 Board in December with a separate paper to Pt. 2 Board in December.

9 Falls

The Committee heard that falls had increased in October but there were positive reports that the incidence of fractured head of femur as the result of a fall in the hospital had reduced from 14 in 2017/18 to 2 in the first two quarters of 2018/19.

10 Friends and Family Reporting

The Committee was informed that performance was in line with other Trusts with regard to inpatients and that it was anticipated that outpatients would improve with the text message system which is about to be launched and the link on the Trust website which went live this week**.**

11 Audits

The Committee received a report on learning from clinical audits however it asked for a paper setting out the clinical audit system and how it is reported through the Trust to provide assurance that the audit cycle is completed and learning is embedded.

Sir Norman Williams
Committee Chair

13 December 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	20 December 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 about Quality and Performance for the year to Month 8.		
Executive Summary:	This report consolidates the latest management information and improvement actions across our quality, patient access, performance and workforce objectives. The shorter reporting timescales this month mean that Balanced Scorecard Activity and Productivity metrics have not yet been finalised. 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: 13/12/18** **Date: 13/12/18**	
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 – 20 December 2018
Reporting period – November 2018

Outstanding care, every time

Executive Summary – November 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.

Our Patients

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

Our Processes

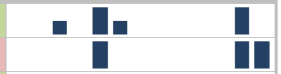
- Performance against the Four Hour Operating Standard in November was 85.5%, which was below the monthly improvement trajectory of 93%. The improvement trajectory requires the delivery of 90% performance in December 2018 and relies upon continued improvement in the experience for patients not requiring admission.
- The Trust achieved all of the seven national mandated cancer standards in the month of October, continuing to achieve 14 day standard and the 62 day standard.
- Focus remains on reducing on the day non clinical cancellations and ensuring that all patients are rebooked within 28 days, in November 96.3% of our cancelled patients were re-booked within 28 days.

Our People

- The Trust Vacancy rate threshold has been achieved in the month of November reporting 8.9% against a target of 10%
- Staff sickness remains above the trust target of 3% for the month of November
- Non-medical appraisal rates have remained in line with previous months. Performance in November was 71.8% against the 90% target.

NB Due to the earlier reporting times for Month 8 Balanced Scorecard, Finance, Activity and Productivity information is not yet available in final form and will be reported through the next Board cycle

Patient Safety

Indicator Description	Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Trend (12 months)
Number of Never Events in Month	0	0	0	1	0	2	1	0	0	0	0	0	2	0	
Number of SIs where Medication is a significant factor	0	0	0	0	0	1	0	0	0	0	0	0	1	1	
Number of Serious Incidents	8 / mth	6	2	1	4	5	4	6	3	4	2	4	5	6	
Serious Incidents - per 1000 bed days	N/A	0.24	0.08	0.04	0.18	0.19	0.17	0.26	0.13	0.17	0.09	0.18	0.20	0.26	
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.0%	95.1%	94.9%	94.8%	94.3%	93.1%	95.3%	96.5%	94.9%	95.7%	96.3%	95.1%	95.0%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.1%	98.5%	98.9%	97.9%	98.5%	97.8%	98.0%	98.7%	98.5%	98.2%	99.0%	98.3%	97.7%	
Percentage of patients who have a VTE risk assessment	95%	96.4%	96.0%	95.4%	96.3%	96.0%	95.9%	95.8%	96.0%	96.9%	96.4%	96.2%	96.0%		
Number of Patient Falls	N/A	157	127	189	140	157	138	117	155	143	136	141	181	173	
Falls (Moderate and Above Severity)	N/A	1	3	1	2	2	3	1	1	1	1	0	1	3	
Number of patient falls- per 1000 bed days	N/A	6.23	5.17	7.49	6.15	6.05	5.77	5.01	6.70	6.11	5.91	6.26	7.40	7.50	
Acquired Category 2 Pressure Ulcers	N/A	16	13	16	13	12	2	6	10	20	15	9	12	25	
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.64	0.53	0.63	0.57	0.46	0.08	0.26	0.43	0.85	0.65	0.40	0.49	1.08	
Avoidable Category 3 & 4 Pressure Ulcers	0	0	0	0	0	0	5	0	2	2	3	2	0	0	
Avoidable Category 3 & 4 Pressure Ulcers per 1000 bed days	0	0.00	0.00	0.00	0.00	0.00	0.21	0.00	0.09	0.09	0.13	0.09	0.00	0.00	
Acquired Category 3 Pressure Ulcers		15	6	9	6	6	11	4	6	5	3	2	1	3	
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Briefing

- Six Serious Incidents (SIs) were reported in November, with a total of 34 SIs year to date.
- The number of falls reported in November was 173, of the falls reported three patients sustained moderate harm.
- All grade 3 and 4 pressure ulcers that are acquired at the Trust have had a rapid response review completed. These are reviewed by a panel chaired by the Chief Nurse to establish their avoidability. In November 3 patients acquired a grade 3 or grade 4 pressure ulcer.

- 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. The programme will be rolling out to other wards.

Infection Control

Indicator Description	Threshold	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	YTD Actual	YTD Theshold	Trend (12 months)
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	
Cdiff Incidences (in month)	30	0	0	0	1	2	6	1	3	3	2	2	3	2	22	20	
MSSA	25	2	3	0	3	1	2	2	1	1	2	1	4	2	15	17	
E-Coli	60	2	5	5	5	5	1	9	6	4	3	4	2	4	33	40	

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 November the Trust reported two cases, totalling 22 cases year to date.
- The Trust annual threshold for E coli is 60 for 2018-19 and year to date the Trust has reported 33 cases, 4 of which occurred in November.
- 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 2 incidents in the month of November 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

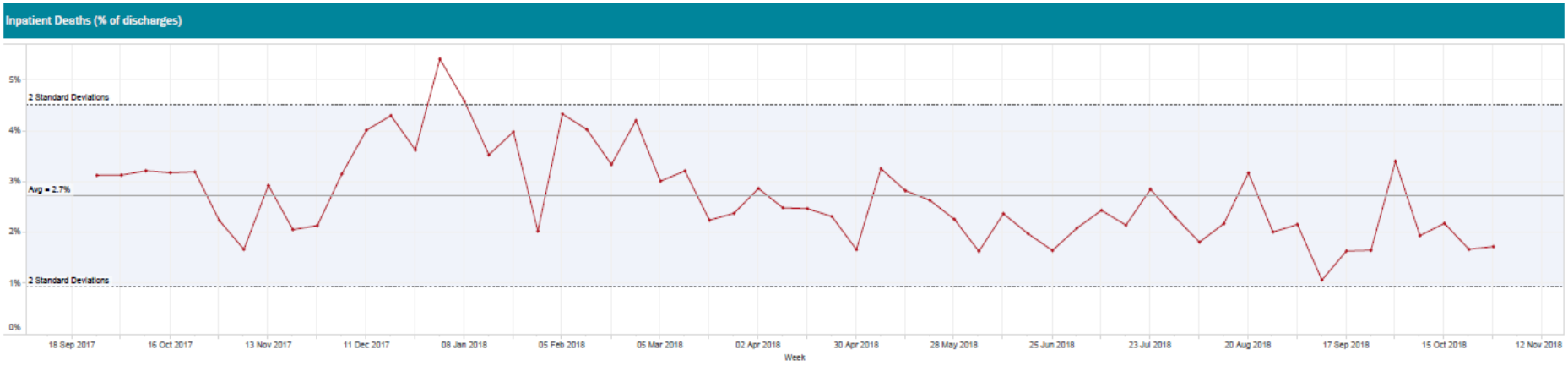
Indicator Description	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Sep-17 to Jul 2018	Trend
Hospital Standardised Mortality Ratio (HSMR)	78.9	86.1	90.1	72.6	97.3	93.8	106.3	94.9	86.7	79.5	69.8	80.3	86.8	
Hospital Standardised Mortality Ratio Weekend Emergency	89.5	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%	8.33%	8.24%	8.08%	

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



Maternity

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	Nov '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	14	
% 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%	27.5%	
% 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%	12.1%	
Number of hours in the month that Carmen Suite closed	%	0														No closures	
% 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%	3.6%	
% 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%	2.6%	
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	9	
Supernumerary Midwife in Labour Ward	%	>95%													95.16%	98.30%	
Number of babies born with Hypoxic Ischaemic Encephalopathy (/1000 babies)	Number	<2/1000	1	1	0	1	0	0	0	2	2	0	0	0	2	1	
Number of babies still born at term (37 weeks+)	Number	<3	0	0	1	1	1	0	0	1	1	1	0	0	0	0	
Number of babies still born at term (28 to 36 weeks and 6 days)	Number	<3	0	0	1	1	1	0	2	2	0	1	0	1	0	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	0	
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	0	
% 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%	75.6%	81.8%	

Briefing

- In November births were on target, with a total of 406 babies born. The overall caesarean section rate increased slightly, but was still within expected parameters.
- The Labour Ward co-ordinator was supernumerary on all except one occasion across the 60 shifts in the month. This figure, along with the number of times the Carmen Birth Centre is closed is being recorded electronically from 3rd December.
- The number of women booked by 12 weeks and 6 days of pregnancy remains under target. Verification is being sought to determine whether this will remain a national Key Performance Indicator whilst work continues with the antenatal team to try and ensure that every woman referred in time is seen within "12+6". As more teams move towards a continuity of carer model it is hoped that this performance will improve.
- The neonatal death and still birth figures are being reconfirmed for data quality as these seem low in month compared to previous months.

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

Patient Voice

Indicator Description	Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Trend
Emergency Department FFT - % positive responses	90%	84.1%	86.5%	82.2%	81.0%	81.4%	84.0%	85.0%	85.5%	83.7%	84.6%	83.5%	84.2%	83.7%	
Inpatient FFT - % positive responses	95%	95.7%	95.6%	94.7%	96.0%	96.3%	97.2%	97.3%	97.1%	96.7%	96.6%	96.3%	97.0%	96.7%	
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%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%		
Maternity FFT - Postnatal Ward - % positive responses	90%	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%	91.6%		100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%			
Community FFT - % positive responses	90%	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%	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		
Complaints Received		77	68	90	80	94	96	85	79	120	96	93	90	88	
PALS Received		305	262	290	236	259	264	317	292	337	294	335	416	353	

Briefing

- ED Friends and Family Test (FFT) – The score has seen a slight decrease in November reporting 83.7% in the recommended rate.
- Inpatient Friends and Family Test (FFT) continues to be above threshold reporting 96.7% in November providing reasonable assurance on the quality of patient experience
- Maternity, Community and Outpatient FFT remain above local threshold with work continuing to improve the number of patients responding, November data yet to be reported
- 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 October to 60% and has not met the trajectory. For 40 day complaints received in September 47% were responded to within the timescale. There was one 60 day complaint received in August 2018, which met the response deadline 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

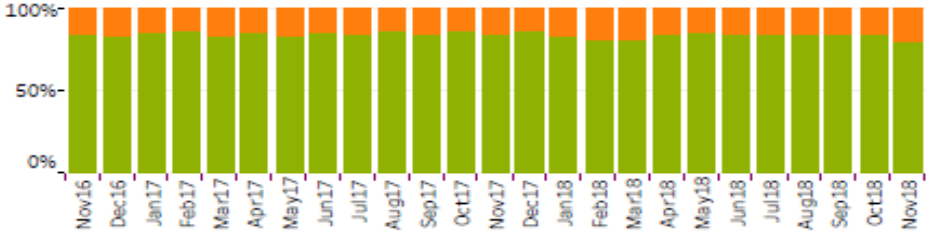
--- Target ∉ MetricMeasure Percentage Neutral

A&E Friends & Family Response Rate

Target: 20% Oct 18: 12.80% Nov 18: 11.20% Movement: ▼-1.60%

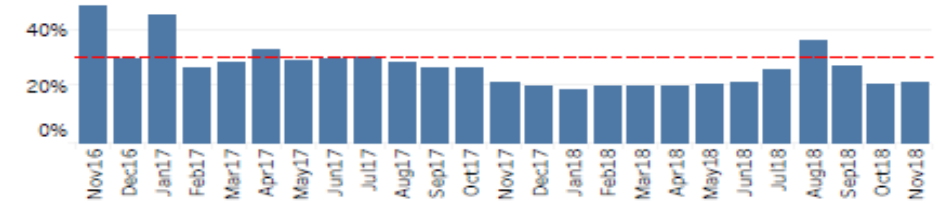
A&E Friends & Family Recommend Rate

The expected target is 90%



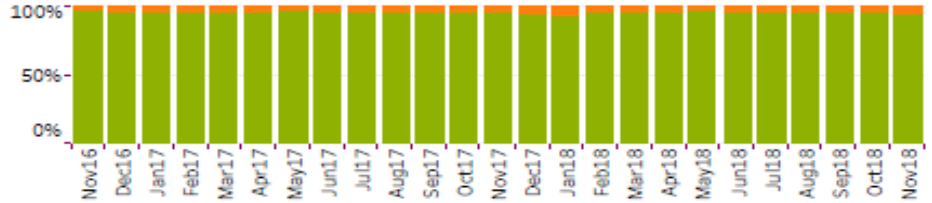
IP Friends & Family Response Rate

Target: 30% Oct 18: 20.60% Nov 18: 21.00% Movement: ▲0.40%



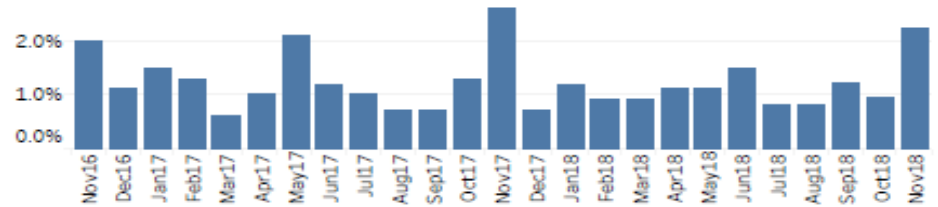
IP Friends & Family Recommend Rate

The expected target is 95%



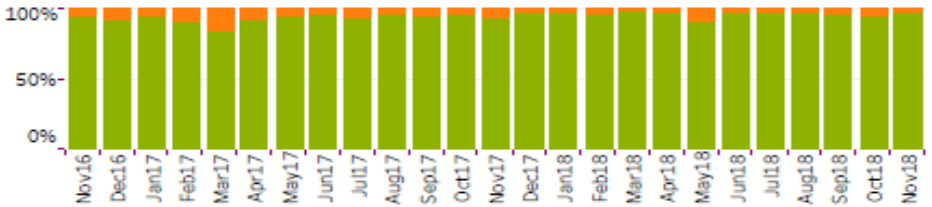
OP Friends & Family Response Rate

Target: 20% Oct 18: 0.90% Nov 18: 2.20% Movement: ▲1.30%



OP Friends & Family Recommend Rate

The expected target is 90%



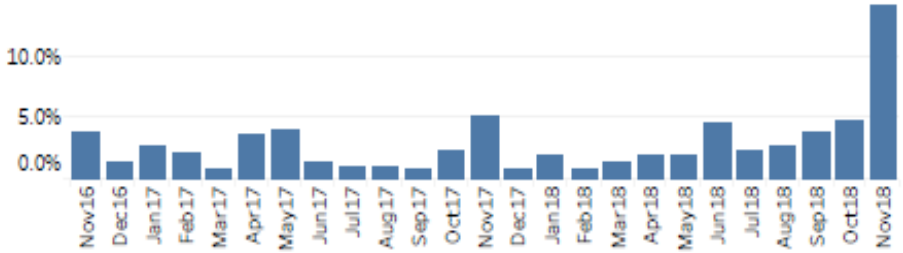
Patient Voice

CARING – Friends and Family 2

--- Target ∉ MetricMeasure Percentage Neutral

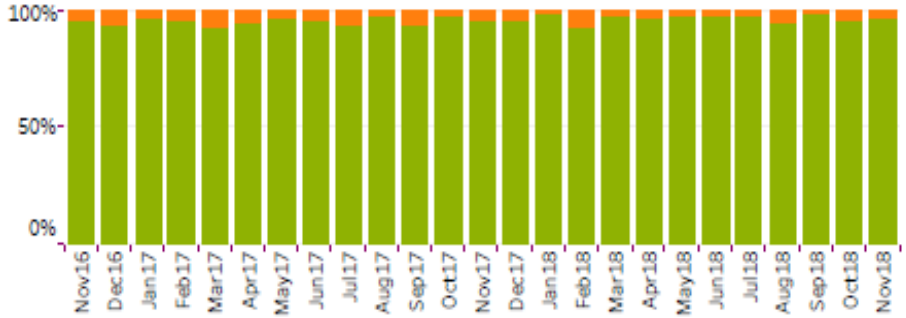
Community Friends & Family Response Rate

Target: 20% Oct 18: 4.70% Nov 18: 14.10% Movement: ▲9.40%



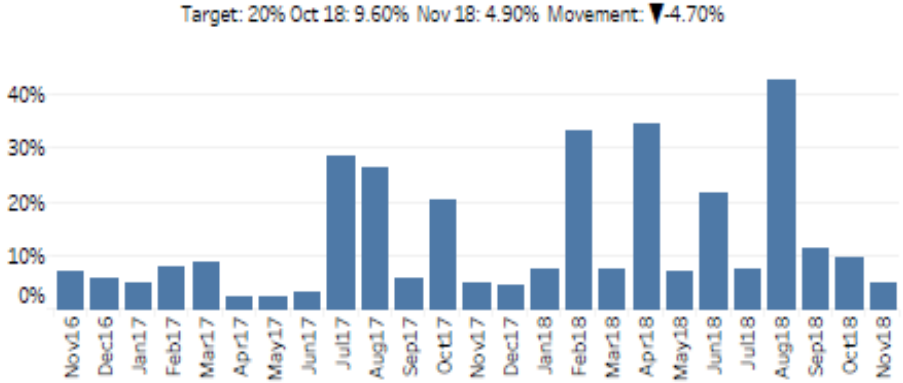
Community Friends & Family Recommend Rate

The expected target is 90%



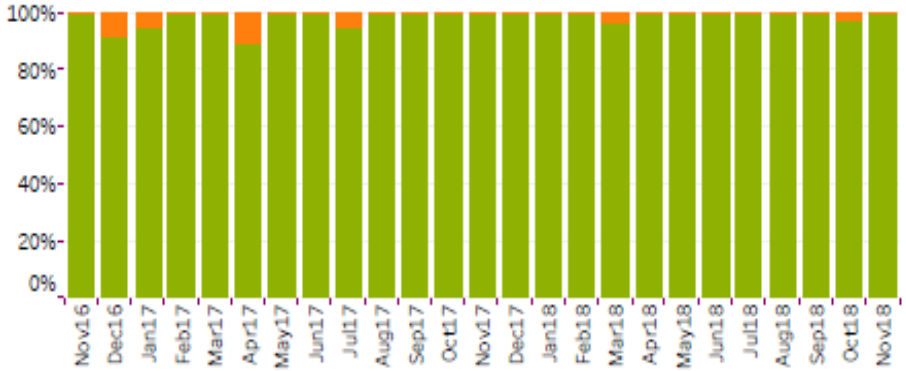
Maternity (Birth) Friends & Family Response Rate

Target: 20% Oct 18: 9.60% Nov 18: 4.90% Movement: ▼-4.70%

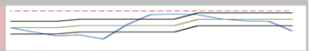


Maternity (Birth) Friends & Family Recommend Rate

The expected target is 90%



Emergency Flow

Indicator Description	Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Trend
4 Hour Operating Standard	95%	87.2%	85.0%	83.0%	83.5%	81.6%	88.4%	93.3%	93.6%	93.3%	91.1%	90.3%	90.1%	85.5%	
Patients Waiting in ED for over 12 hours following DTA	0	1	0	0	0	2	1	1	0	1	0	1	0	1	
Time to Treatment (number of patients seen within 60 minutes)	60%	54.2%	54.1%	51.7%	52.2%	52.6%	61.5%	63.5%	65.5%	63.7%	70.3%	64.1%	69.5%	68.2%	
Admitted patients with a length of stay 7 Days or Greater		362	376	373	337	343	355	308	324	315	316	301	325	326	
Ambulance Turnaround - % under 15 minutes	100%	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%	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	82	112	180	135	105	92	65	72	75	85	109	111		
Ambulance Turnaround - % under 30 minutes	100%	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%	91.7%	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	2	3	3	10	1	0	0	0	2	3	0		

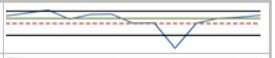
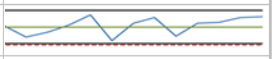
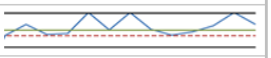
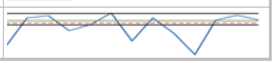
Briefing

- Performance against the Four Hour Operating Standard in November was 85.5%, which was below the monthly improvement trajectory of 93%. The improvement trajectory requires the delivery of 90% performance in December 2018 and relies upon continued improvement in the experience for patients not requiring admission.
- Urgent and Emergency Care attendances in November were 1% higher than in the same month in 2017. There was 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 and the ED clinical leadership team have implemented a revised operational model to ensure that patients are getting to the most appropriate environment for their assessment, for their treatment and for their care.
- The number of patients admitted via the Emergency Department increased by 7% compared to November 2017 (11 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 November saw a decline compared to the previous month reporting 61.52%.
- 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.

Actions

- Allocation of a Senior Clinician to each area within the ED to provide senior leadership and decision making in line with ED winter plan
- Review and re-allocation of nurses within existing establishment during daytime hours to support triage in Children's ED
- Dedicated ED porter to work with diagnostic imaging to be delivered within existing establishment
- Advanced Nurse Practitioner for Children's respiratory medicine to attend at ED daily
- Senior Clinical and Nursing time to be released to provide clinical challenge as part of daily Board Rounds

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	Oct-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%	96.3%	1,258	
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%	97.1%	238	
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%	99.1%	215	
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%	97%	32	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	137	
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%	87.8%	65.5	
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%	91.8%	24.5	

Briefing

- The Trust met all of the seven Cancer standards in the month of October, achieving both the 14 day standard and 62 day standard.
- Performance against 62 day standard was reported at 87.8% overall, reporting a total of eight patients treated passed the 62 day target.

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%
Jun-18	85%	89.2%	93.1%
Jul-18	85%	85.7%	89.4%
Aug-18	85%	85.7%	89.1%
Sep-18	85%	80.6%	85.0%
Oct-18	85%	87.8%	92.5%

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	Oct-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%	-	100.0%	1
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%	99.4%	156
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%	50.0%	2
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%	87.8%	147
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%	96.2%	26
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%	99.8%	168
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%	98.1%	216
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%	100.0%	46
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%	96.6%	295
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%	98.8%	81
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%	92.4%	120

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	Oct-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%	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%	90.0%	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%	100.0%	5.5
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%	100.0%	5.5
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%	88.9%	4.5
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%	50.0%	4
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%	92.3%	6.5
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%	54.5%	5.5
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%	88.9%	18.5
Other	85%	-	-	-	-	-	-	-	-	-	-	-	100.0%	-	100.0%	2

Diagnostics

Indicator Description	Threshold	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Trend
6 Week Diagnostic Performance	1%	1.9%	0.1%	0.1%	0.0%	0.2%	0.2%	0.2%	0.3%	0.3%	0.2%	0.4%	0.2%	0.5%	
6 Week Diagnostic Breaches	N/A	143	6	10	3	17	15	14	25	24	15	30	18	35	
6 Week Diagnostic Waiting List Size	N/A	7,534	6,440	6,884	7,232	7,075	7,956	7,735	7,809	7,236	6,946	7,617	7,593	7,322	

Indicator Description	Threshold	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Trend
MRI	1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.4%	0.0%	0.3%	0.1%	0.2%	0.1%	
CT	1%	0.1%	0.0%	0.1%	0.0%	0.3%	0.1%	0.0%	0.3%	0.0%	0.0%	0.0%	0.2%	0.1%	
Non Obstetric Ultrasound	1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.1%	0.6%	0.0%	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%	0.7%	0.0%	0.0%	0.0%	
Audiology Assessments	1%	17.4%	0.0%	0.0%	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Echocardiography	1%	0.8%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Electrophysiology	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%	
Peripheral Neurophysiology	1%	0.0%	0.3%	0.9%	0.0%	0.4%	0.2%	0.0%	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%	7.7%	
Urodynamics	1%	6.7%	0.0%	0.0%	0.0%	9.1%	5.0%	23.9%	6.3%	26.5%	0.0%	13.9%	14.6%	10.2%	
Colonoscopy	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%	3.0%	
Flexi Sigmoidoscopy	1%	0.6%	0.0%	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Cystoscopy	1%	1.8%	1.5%	2.8%	0.7%	0.0%	1.0%	0.8%	3.0%	1.8%	4.4%	2.6%	3.0%	4.4%	
Gastroscopy	1%	0.8%	0.4%	0.0%	0.0%	1.8%	1.0%	0.0%	0.0%	1.8%	0.0%	0.3%	0.0%	0.0%	

Briefing

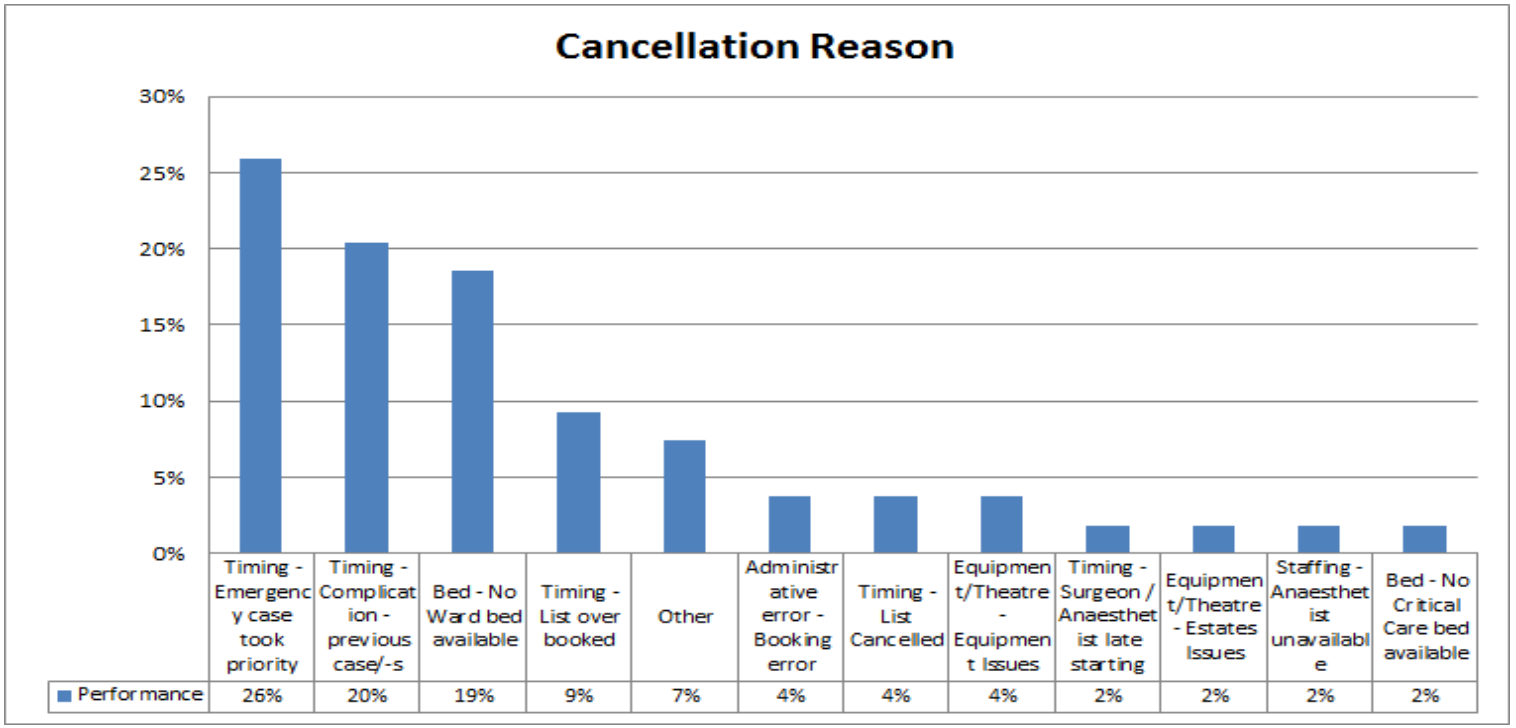
- The Trust has continued to achieve performance in November reporting a total of thirty-five patients waiting longer than 6 weeks, 0.5% of the total waiting list.
- Compliance has not been achieved within Urodynamics, Colonoscopy, Sigmoidoscopy or Sleep studies
- Performance and action plans continue to be monitored through the weekly performance meetings.

On the Day Cancellations for Non-Clinical Reasons

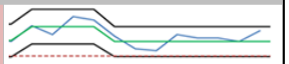
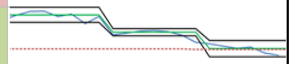
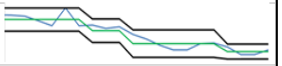
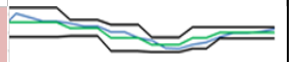
Indicator Description	Target	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Trend
Number of on the Day Cancellations		86	100	94	55	86	64	87	42	54	44	55	52	53	
Number of on the Day cancellations re-booked within 28 Days		76	67	76	48	76	60	80	33	51	39	48	50	52	
% of Patients re-booked within 28 Days	100%	88.4%	67.0%	80.9%	87.3%	88.4%	93.8%	92.0%	78.6%	94.4%	88.6%	87.3%	96.2%	98.1%	

Briefing

- In November 98.1% of our on the day cancelled patients were-rebooked within 28 days.
- Of the 53 cancellations reported, 46% were due to timing issues including lists being overbooked and complication with previous case.



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	Nov-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%	4.1%	
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%	8.9%	
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%	16.9%	
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	9,169	9,171	
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%	71.8%	
% 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%	89%	
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	0	

Briefing

- The Trust Vacancy rate has been achieved in the month of November reporting 8.9% against a target of 10%
- The Trust sickness level has remained above target of 3% reporting 4.1% in the month of November.
- Mandatory and Statutory Training figures for November were recorded at 89%. 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 November with a performance of 71.8% against the 90% target.
- Percentage of Staff vaccinated against seasonal Influenza is 75% as at the 12th December 2018.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	20 December 2018	**Agenda No**	**2.3**
Report Title:	**Elective Care update**		
Lead Director/ Manager:	Ellis Pullinger Chief Operating Officer		
Report Author:	Matthew Davenport, Deputy Director Elective Care		
Presented for:	Update		
Executive Summary:	This is the monthly update on Elective Care to the public Trust Board. The Trust continues to internally shadow report on its referral to treatment (18 week) waiting time performance. October 2018 represents the second month of shadow reporting (November is yet to be closed). Although the Trust is not in a position to report its current referral to treatment time waiting times in public, the Trust is able to confirm that it continues to see a reduction in its overall waiting list size and is on trajectory for its internal improvement target for patients waiting no less than 18 weeks for treatment. This paper provides an update on three issues: • Validation of the Trust's current waiting lists for data accuracy • Return to national Reporting as a Trust on RTT waiting times. • Training Trust staff on Referral to Treatment Principles		
Recommendation:	The Trust Board is asked to receive this report		
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:	The RTT standard is a statutory target for an NHS Trust		
Legal/Regulatory:	Referral to treatment standard is a regulatory target		
Resources:	Elective Care programme		
Previously Considered by:	Monthly update received by the Trust Executive Committee and Quality and Safety sub- Committee	**Date:**	December 2018
Equality Impact Assessment:	N/A		
Appendices:			

St George's University Hospitals NHS
NHS Foundation Trust

Elective Care Recovery Programme Update

20th December 2018

Introduction
The Trust continues to internally shadow report on its referral to treatment (18 week) waiting time performance. October 2018 represents the second month of shadow reporting (November is yet to be closed). Although the Trust is not in a position to report its current referral to treatment time waiting times in public, the Trust is able to confirm that it continues to see a reduction in its overall waiting list size and is on trajectory for its internal improvement target for patients waiting no less than 18 weeks for treatment

1. **Validation of the Trust's current waiting lists for data accuracy**

   Additional staff have been working through the Trust waiting lists and addressing specific data quality metrics to ensure that all patients are being tracked correctly through their care at the Hospital.

2. **Training Trust staff on Referral to Treatment Principles**

   Please see the table of staff trained to date and on which course:

	Attended	Booked	Total
RTT Awareness Sessions - Introduction to RTT	376	119	495
RTT Awareness Sessions - Central Booking Service	43		43
RTT Awareness Sessions - Outpatient Care	188	59	247
RTT Awareness Sessions - Admitted Booking/Scheduling	88	12	100
RTT Awareness Sessions - Inpatient Care	73	28	101
RTT Awareness Sessions - Clinicians	35	10	45
RTT Awareness Sessions - Operational Managers	55	17	72
Grand Total	**858**	**245**	**1103**

- Following the Launch of the Trust RTT Training strategy in October 2018, 858 members of staff have been trained on the principles of RTT related to their job role. There are an additional 245 members of staff booked for training by the end of December 2018. On this trajectory the Trust will have trained 1,103 members of staff against a target of 1,000. Training capacity has been made available throughout Q.4 2018/19. This includes sessions for the Trust's clinical staff to be trained
- Training is to be provided for all new staff joining the Trust from October 2018.
- Targeted training is also being provided to staff where required and based on themes identified through audit and data quality reviews.

3. **Return to national Reporting as a Trust on RTT waiting times**

   As part of the Trust's governance process to make a decision on whether it is ready to return to national reporting of its RTT waiting times an external assessment started on the 15th November. This assessment is being undertaken by an external organisation who are experts

in RTT management and processes. They have been commissioned by the Trust and Wandsworth and Merton CCG to provide this comprehensive assessment. Their work is spread across two phases with the first phase on data quality to be presented to the December private Trust Board for consideration. The second phase will assess the Trust's operational management and the sustainability of its processes to safely and accurately report its RTT waiting times.

The Trust continues to aim to return to national reporting of its RTT waiting time in Q4 2018/19 (i.e. between January and March 2019).

The Trust will receive a final report on whether the conditions have been met in order for it to start reporting its RTT waiting time targets nationally in January 2019.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	20 December 2018	**Agenda No.**	2.4
Report Title:	**Quality Improvement Academy**		
Lead Director	James Friend. Director of Delivery, Efficiency and Transformation		
Report Author:	Martin Haynes. Improvement Methodology Director		
Presented for:	Noting.		
Executive Summary:	The paper provides an end of year overview of the Quality Improvement Academy to inform the Board. As the academy grows its reach and impact across the Trust, its work built around three themes: 1. building momentum and learning in real time 2. building internal capability 3. creating the infrastructure A key focus has been to build awareness of the academy's role and encourage teams to make even the smallest improvement opportunities and share successes with one another. This Trust wide engagement approach is creating growing demand for QIA support, in addition to the higher profile improvement activities including, cardiac surgery, high performing teams, statistical process control-based reporting and pathfinder projects As the team approaches its sophomore year, this paper highlights some of the key success, lessons learned and ambition for the year ahead. The team also wishes to acknowledge support from executive and non-executive colleagues in supporting the work of the Quality Improvement Academy		
Recommendations:	The Board is asked to: • note the intentions and progress of the Academy to date. • continue to support the short and long term aims of the Academy. • continue to support the creation of conditions to do the work of improvement • acknowledge the challenges this way of working brings and the sustained efforts needed to embed it in the organisation.		

Supports			
Trust Strategic Objectives:	Right Care, Right place, Right Time Balance the Books, Invest in the Future Build a Better St George's Champion Team St George's Develop Tomorrow's Treatments Today		
CQC Themes:	Safe and Effective - Well Led		
Single Oversight Framework Theme:	Quality of Care (safe, effective, caring, responsive) Finance and Use of Resources		
Implications			
Risk:	N/A		
Legal / Regulatory:	N/A		
Resources:	None requested in this paper.		
Previously considered	N/A	Date:	N/A
Appendices:	Appendix One – Long list work plan		

1.0 Purpose

The purpose of this paper is to update the Trust Board on the key activities and progress of the Quality Improvement Academy (QIA) during Q3 2018/19

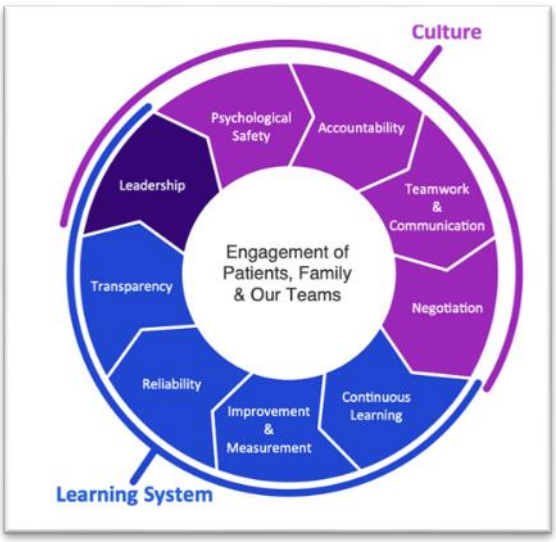
2.0 Creating the cultural conditions for change

This was effectively the second quarter of activity for the QIA and one designed to increase awareness and engagement with individuals and teams across the Trust. The team continued to support the initial pathfinder project teams, grow its own capabilities and encourage teams to engage/reawaken quality improvement as part of their daily work activities.

The typical model for an organisation wishing to embed improvement into every-day life is to start with a traditional tools and techniques-based approach: training a core group of experts who in turn lead and train other staff to undertake quality improvement projects. It is how St George's took its first steps and is a proven methodology where an organisation has in place the right cultural conditions for change.

The importance of having a strong and secure foundation for quality improvement cannot be overstated and the Board will recognise that the troubled history of St George's still casts a shadow for many of our colleagues. Thankfully the situation improves weekly, but to ensure the greatest chances of success and sustainability, our QI approach has been adapted and now leads heavily on the cultural and leadership elements of change followed by the technical tools.

The Safe, Reliable, Effective Care Framework (culture, learning system and leadership) which underpins how we do work at St George's.

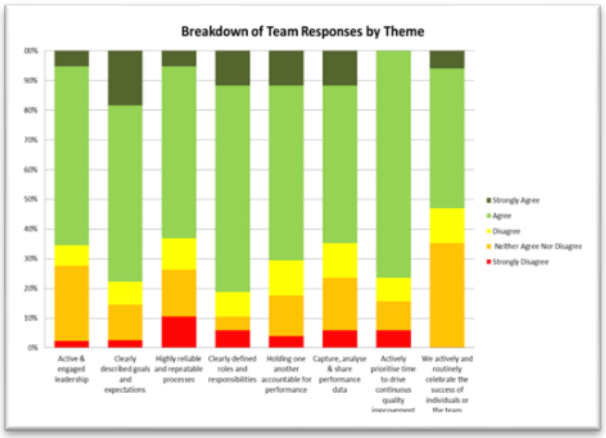


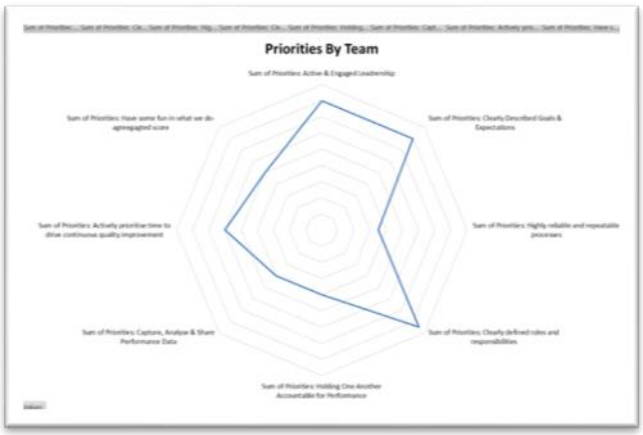
3.0 Q3 Key Activities

This quarter saw the launch of three team-orientated improvement projects including:

- **Cardiac Surgery Appreciative Inquiry**: Given the well-publicised challenges, our approach is about engaging teams in self-determined change and building the tools and social conditions to enable continuous improvement. The work includes developing a learning system on the CTICU.
- **Brodie Ward**: The Ward Accreditation process highlighted a number of team working issues sought help from the QIA team. We are working with GAPS (simulation team) on an education-based improvement project which is creating a number of discrete learning packages for staff members to complete. The work picks key objectives such as performance on the Early Warning Score (EWS) and builds the concept of a learning system, learning boards and huddles.
- **Patient Flow (Amyand, Cavell & Gray Wards)**: As part of the Unplanned and Admitted Patient Care Programme the team has commenced implementation of the **High Performing Teams** (HPT) framework to help improve patient flow). Team members each complete a questionnaire and the combined results help identify areas of concern and improvement priorities.

High Performing Teams Framework & Questionnaire Outputs



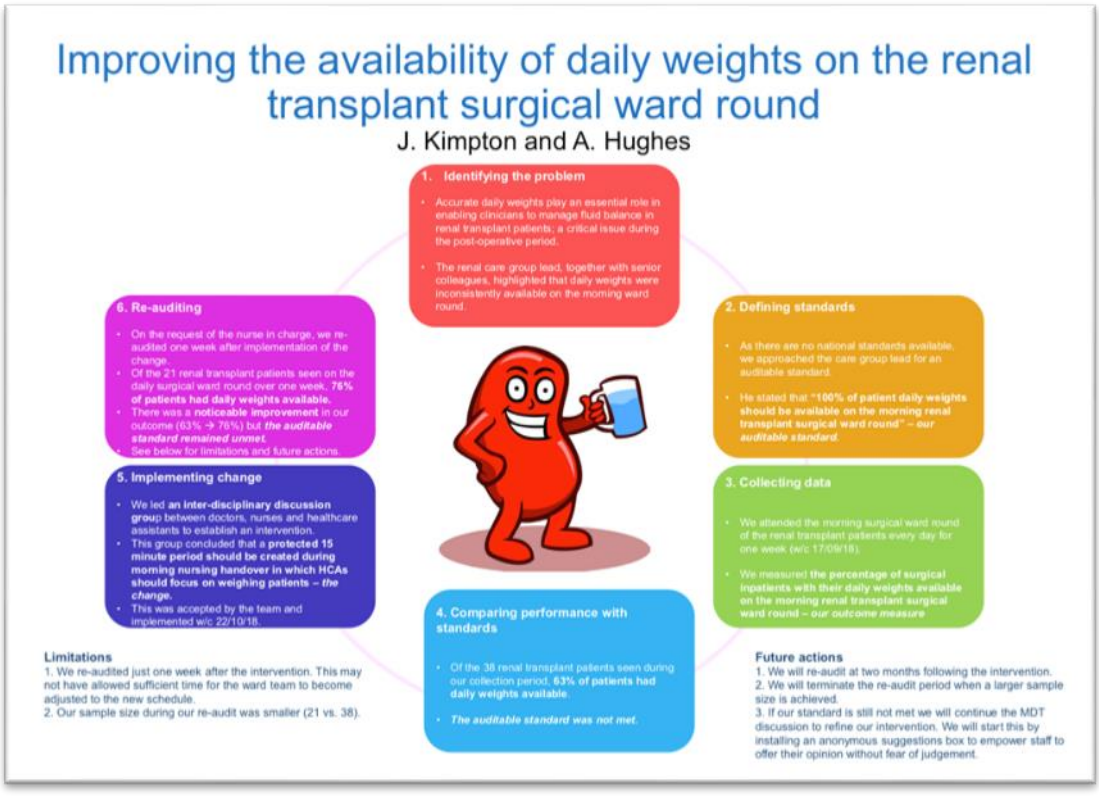


Each of these projects is in the early stages of implementation and will provide a progress update in our next quarterly board report. The team will also monitor responses and outcomes from each project to help inform our overall improvement methodology. The work includes using SCORE as a cultural survey and progress monitoring tool to help focus the work.

The highest profile events of the quarter the Quality Improvement Week and Quality Audit Half Day, both of which attracted a high number of visitors and staff participation

- **Quality Improvement Week**: The 3 ½ days included a range of improvement-based market stalls and a series of TED Talks and QI based interactive workshops. It was a great opportunity for staff to hear about many of the innovative QI projects currently underway and learn more about the QIA and its role in the Trust. We have already set dates for 2019 and are exploring options for a summer improvement event (potentially June 19)
- **Clinical Audit Half Day:** This was a chance for staff to learn how the Trust is successfully using audit to improve performance across the Trust, including a showcase of 60 posters outlining the improvement work of our clinical teams. Dr Hamilton also presented the basis of the culture change work being undertaken to broaden the understanding of why this is so crucial for the Trust.
- Plans for 2019 will combine both the Quality Improvement Week and Clinical Audit activities into a single event during the week 2nd- 6th December

Winner of this year's clinical audit poster competition



Capability development has also been a key feature of the team's work including delivery of QI training workshops to Trust staff and enhanced QI development workshops for our senior QIA leads (lead by our strategic partners IHI)

- Executive Patient Safety Course (Boston, Sep 18): 5-day course designed for senior leaders of QI attended by Martin Haynes, Dr Mark Hamilton & Elizabeth Palmer. This led to the adaption of the culture, learning and leadership framework being adopted as the basis of work done by the Trust.
- Improvement Coach Course (London, Nov 18): 3-day course for senior QI coaches/leaders attended by Alison Benincasa, Deborah Dawson & Bernie Kennedy. These Improvement coaches will work hand in hand with our improvement advisors to propagate improvement knowledge and coaching in the organisation.
- The Trust has also secured 8 places on the Flow Coaching Academy programme (FCA) which provides a 12 month action learning programme to train frontline staff with coaching skills and improvement science to coach improvement with pathway teams in a Big Room setting. Coaches come as pairs, one clinical from within the pathway, one external to provide balance and perspective. The course covers team coaching skills, a Flow Roadmap to guide improvement, data skills as well as the psychology of improvement and behaviour change concepts.

We now have a suite of QI improvement training workshops available to all staff:

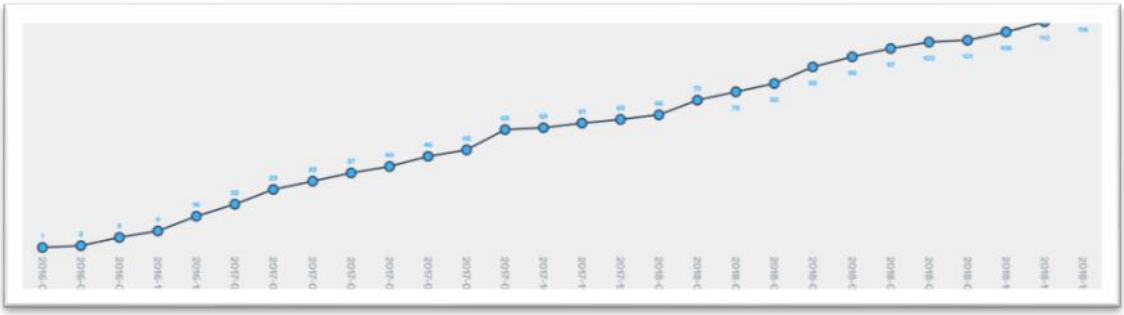
- ½ Day Practical Introduction to Quality Improvement
- 1 Day Making Data Count (SPC charts/time series reporting)
- 1 Day Quality Improvement Workshop
- 2 Day Quality Improvement Workshop (1-day technical, 1-day culture)
- The team has also developed a senior leaders QI workshop designed as part of 'Creating the conditions for change'.

New / Ongoing Activities in the Quarter

- Delivery of one day Quality Improvement workshop to all Ward Managers
- Delivery of SPC & half day training workshops (over 235 people have attended one or other of these workshops)
- Networking and shared learning as part of IHI Alliance
- We continue to work with NHSI colleagues on exploring their culture change programs and the #plotthedots initiative on SPC charts, to maximise the benefit of our relationship and draw on the key tools and skill sets they have to offer. We are talking to Trusts that have used these programs to better understand how they have utilised them to best effect.
- QIA support for staff & public strategy sessions
- After action reviews following recent Electrical System Shutdown and Major Incident on 3rd Nov.

- Continuation of SPC reporting as part of QIP dashboard
- Process mapping and critique of Trust induction process
- Ongoing coaching support for existing QI projects
- Commenced planning process between Quality Improvement and Leadership Academy teams to create integrated improvement offering for all staff and ongoing leadership development.
- Development of learning and support structures for those actively engaged in QI in the Trust-online forums, information meetings and project clinics
- We also continue to promote use of the Life QI application to manage our improvement projects. The following graph shows a very encouraging trend of new users.

Life QI Application – new users



4.0 Lessons learnt

The Trust has shown an important commitment to growing the capability and capacity to do improvement work and to support the culture change needed to embed this in the long term ambitions of the organisation.

The ability for teams to do sustained improvement work has to be balanced against the need to move from current state to future state. Some, but not all teams have struggled to find time capacity to do the work. This has been especially true of the general and middle managers in the organisation. This is not uncommon in developing organisations as they are some of the most heavily pressured posts. It is for this reason however that the academy will invest heavily in this group over the next two quarters.

5.0 Forward View

The following is a summary of the key activities planned for balance of Q3 & Q4 2018/19

- Jacqueline Totterdell CEO, Richard Jennings, CMO and Mark Hamilton, Associate Medical Director to attend IHI Conference at Orlando Health
- Creating Conditions for Change QI workshop for TEC team (4/2/19)
- QIA team development workshop (Jan 19)
- Sign off 2019/20 QIA business plan
- Development of combined QI/Leadership Academy development plan/workshops for divisional and service leadership teams
- Complete end of year assessment against CQC QI framework
- QIA updates to intranet
- Write and publish the QIA annual report
- Support development of a Trust quality and organisation development strategies in partnership with clinical, nursing and corporate teams

6.0 Conclusion

The past quarter has created a growing energy and interest in Quality Improvement, across the Trust and in many ways the real 'pull' from our colleagues is for more effective, multi-disciplinary team working. Both the Quality Improvement Week and Clinical Audit events highlighted some really outstanding improvement projects, but in large part they still remain 'role-based' initiatives.

Moving forward our challenge is to enable active participation, particularly from operational and clinical leaders that creates the time and conditions for improved collaboration across the historical role boundaries; making quality improvement an everyday activity.

Although easier said than done, the good news is we already have a suite of simple, accessible tools to manage the technical aspect of that work. Equally our current work to align the capabilities of our Quality Improvement and Leadership Academies also provides a real opportunity to better equip our key clinical and operational leaders with the skills, confidence and capacity to make QI part of how we work at St George's.

Even in these first few months this transition is challenging deeply held beliefs and current ways of working. For many people it feels counterintuitive to put aside time for quality improvement at precisely the same point we are facing tough operational challenges. Yet it is precisely why we need to face into these challenges now if we are to genuinely bring about the daily improvement that will help us permanently exit financial and quality special measures.

Appendix One – Long list work plan

The following provides a quarterly update on the academy's original work plan and the team is currently working on plans for 2019.

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

Point of Delivery	Description / Task	Q2 Status	Q3 Status	Commentary
Q2 2018	Application for NHSI Funding	2	2	
	Health Foundation Grant (£30k)	2	3	
	Shortlisted for Flow Coaching Academy	3	3	
	IHI site visit 4th & 5th Sep	3	3	
	Evaluation of QIA Exec engagement with IHI Teams	3	3	
	Executive Patient Safety Course Boston 20th-28th Sept	2	3	
	Defined improvement methodology	2	3	
	Formal review of QIP & QIA support requirements	1	2	
	Develop TEC reporting pack	2	2	
	Integrated QIA / QIP Comms Plan (v1)	2	3	
	Established portfolio of projects	2	2	Seeking to consolidate within QI Life as teams commence new projects
	Establish QIA meetings/governance structure	3	3	
	Complete self-assessment against CQC evaluation framework	3	3	
	Education of cancer nurses (n=11, P+3)	3	3	
	Point of care foundation in maternity	2	2	
	Establish relationship with HIN	2	3	
	Complete weekly contact updates in Delivery Board	3	3	
Q3 2018	Confirm areas now using SPC reporting	1	2	Progressing more slowly than originally expected in response to available QIA capacity
	QIA training for CGLs / CDs	1	2	Joint plan with Leadership Academy
	Proactive sharing of project success via comms	2	2	As part of wider comms plan
	HIN Navigator role	2	2	
	Plans for ImproveWell	1	1	Held for 2019
	QIA team development plan	2	2	To be finalised on 29th Jan 19
	HIAE 30th & 31st Oct	2	3	
	Quality Week (Nov 18)	1	3	Dates also confirmed for 2019
	Enhance use of time series data (SPC)	2	2	Ongoing (focus on QIP Dashboard)
	>50% of GM trained in data for Improvement	1	2	Now linked with plan for CGL/CDs
	Ward Manager QI workshop 16/10	2	3	Further workshops book for June 19
	Set up exemplar visits	2	3	CEO & CMO visit to IHI Conference & Orlando Health
	Blog!	1	1	
	Mass QI inoculation for QIP teams	1	2	
	Agree working fit between QIA and Sims team	2	3	Co-collaboration started with Brodie Ward
	Update driver diagram	2	2	
	Publishing & promotion of CJ SPC & MFI workshops	2	3	Courses now on Totara

Point of Delivery	Description / Task	Q2 Status	Q3 Status	Commentary
	Agree stakeholder management plan	1	1	
	Mandate exec / middle mgmt. QIA education	1	2	Now linked to wider CD / CGL development
	Enhance use of SPC in CommCell(s)	2	2	Held pending QIA capacity
	Use of bronze, silver, gold QIA accreditation	2	2	
	Agree QIA 1-6 support model	1	2	
	Formal QIA introduction at Trust induction	2	2	
	Development plans for Deborah & Alison	2	3	
	Formalise learning system (for web & staff use…)	1	1	
	Enhancing cancer nursing	2	2	
	Life QI for reporting (ELFT example)	1	1	
	Joy in work	1	1	Held pending progress on other core QI activities
	Psychological Safety	1	1	Integrated into training / development plans rather than specific project activity
	High performing teams	2	2	Roll out commenced as part of UAPC programme
	Breaking the Rules Week	1	1	Held pending progress on other core QI activities

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	20 December 2018	**Agenda No**	**2.5**
Report Title:	**Cardiac Surgery Update**		
Lead Director	Richard Jennings, Chief Medical Officer		
Report Authors:	Andrew Rhodes, Medical Director (outgoing) Matt Jarratt, General Manager, Cardiac, Vascular and Thoracic Surgery Raj Sharma, Programme Director Cardiac Surgery		
Presented for:	Assurance and discussion		
Executive Summary:	This report provides an update to the Quality and Safety Committee 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 Berwick (July 2018) and the concerns of the CQC. The service has undergone significant governance improvements since the publication of the Bewick review, and since the visit undertaken by the CQC in August and September 2018. These improvements include the introduction and embedding of consultant of the week; the implementation of new software to capture clinical information recorded throughout the patient pathway (Dendrite); and the development of new standard operating procedures for key elements of service governance. The service has in place a new clinical lead (Mr Steve Livesey), who is overseeing further improvements including a return to undertaking intermediate risk cases (Euro II Score <5; an increase from Euro II Score <2). These changes have been overseen by external bodies, including: 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.		
Recommendation:	The Quality and Safety Committee is asked to discuss the assurance provided by this 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:	QSC	**Date**	13/12/2018

CARDIAC SURGERY UPDATE
Trust Board meeting, 20 December 2018

1.0 PURPOSE

1.1 To update the Quality and Safety Committee on progress being made with Cardiac Surgery since the last time the Quality and Safety Committee met in November 2018.

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 2 Standard Deviations) for mortality by NICOR (the National Institute for Cardiovascular Outcomes and Research). The period covered by these alerts was 2014-2017.

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 A number of recent changes have been made to the service. These include: the appointment of Mr Steve Livesey as clinical lead for the service (Mr Livesey started in post on 3 December 2018), the appointment of Mr Justin Nowell as clinical governance lead for the service (thereby returning the service to a cardiac surgeon as governance lead), and the return to undertaking intermediate risk surgical cases (Euro II Score <5; an increase from Euro II Score <2), and the introduction of a new software system for the capturing of clinical information in real time, to enable earlier and fuller analysis of morbidity and mortality information. Raj Sharma continues as programme director for the service.

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.

3.2 A Quality Report from the Care Quality Commission following visits in August and September 2018 was published on 6 December 2018. The Quality Report said that there were no immediate concerns with regard to patient safety and patients were well-prepared for surgery. It also noted that comprehensive risk assessments for patients were being carried out, and that the latest available data showed the mortality rate for the unit had reduced to 2.7%. The key findings, however, were that there was a lack of cohesion and poor working relationships between surgeons; a lack of culture of learning from incidents, mortality and morbidity amongst consultants, that the quality of mortality and morbidity meetings was poor, that there were multiple patient record systems

leading to the risk of information not being accessible or not being handed over properly, and that there was lack of understanding and insight of the performance of the team and the importance and role of national audits. Overall the report identifies significant weaknesses within the service, though it does not identify any significant new areas of concern that were not already known to the trust, and progress has been made in addressing these weaknesses in the weeks since the CQC visited. The report is included in 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. The number of cases to transfer to KHP trusts has reduced since the agreement to return to undertaking intermediate risk cases.

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. In addition, NHS Improvement has commissioned an Independent External Mortality Review Panel which is reviewing the care given to patients who died following elective cardiac surgery during the periods covered by the NICOR alerts; this review began in December 2018. The work of this Review Panel is being supported by the Mortality Monitoring team within St. George's, and all the Trust's morbidity and mortality reviews of cases have been shared with the review panel for consideration.

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 Chief Medical Officer and Chief Nurse. The Trust is confident, as the CQC is, that 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 Mr Steven Livesey started work as clinical lead for cardiac surgery on 3 December 2018. Mr Livesey is an established and respected consultant Cardiac Surgeon from Southampton. He is working with the internal team (initially full time) to provide leadership to the unit (in the role of Care Group Lead, with the title Associate Medical Director), to lead the necessary changes and to improve the safety and risk profile of the service. Mr Livesey holds a clinical contract, and part of his role is to lead clinical mentoring and development for locum consultants.

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).

  All three risks have been in place on the trust risk register since September 2018. They will be reviewed by Mr Livesey in the coming days and updated in response to any identified change.

6.0 COMMITTEE DELIBERATIONS

6.1 Since the last meeting of the Quality and Safety Committee (22 November 2018), the Trust Board considered an update on cardiac surgery at the meeting of 29 November 2018.

6.2 The Board noted improvements made within the service.

7.0 RECOMMENDATION

7.1 The Quality and Safety Committee is asked to discuss and take assurance from this update on progress being made in Cardiac Surgery.

Date: 7 December 2018

APPENDIX 1.

Update against the Recommendations from the Bewick Report.

	Recommendation	Update (7/12/18)
1	**The current consultant cardiac surgical team** membership is incompatible and requires **restructuring** with some urgency.	This recommendation remains under consideration.
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.	We now have 8 WTE, although two of the consultants are locum and are being supported into fully independent practice.
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 now started in post (Mr Steve Livesey).
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. An aspect of Mr Livesey's role is to oversee the mentoring of newly appointed surgeons.
7	**Pathway leadership role**. To complement the role of CGL which concentrates on the operational and governance issues of the unit a new role supporting development of a 'total pathway of care' model, encouraging multi-speciality team working across pre-, peri-and post-operative care. We see this as an essential step in promoting more	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. Mr Livesey has also been asked to support this recommendation.

	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	
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 three months 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, and a decision has been taken to return governance leadership of cardiac surgery to a cardiac surgeon (Mr Nowell).
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	Longer term strategic discussions are taking place with our system partners –GST & KCH- facilitated by NHS England.

	meaningful negotiations	
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 went live on 28 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. Following temporary external (to cardiac surgery) governance leadership, a cardiac surgeon has been identified as governance lead going forward, who will work with an Associate Medical Director (Dr Wendler) to develop improved 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.

Meeting Title:	**Trust Board**		
Date:	20 December 2018	**Agenda No.**	**2.6**
Report Title:	**Interim Water Quality & Safety Update - Summary of the current position of the water systems for St George's Hospital, Tooting**		
Lead Director/ Manager:	Kevin Howell, Director of Estates & Facilities		
Report Author:	Rathan Nagendra, Assistant Director of Estates		
Presented for:	Update		
Executive Summary:	This paper identifies the current position with regards to the standard of the water supply for St George's Hospital, Tooting. It identifies the gaps in statutory compliance assurance in line with legislation, however it also identifies the actions being undertaken to achieve safety to patients and other vulnerable visitors or staff in St George's Hospital		
Recommendation:	The Board are asked to: • note this report and the limited assurance that is given. • note the confirmation of continued patient safety from the water supply as given by the hospital professionals and the external assessors.		
Supports			
Trust Strategic Objective:	Build a better St George's Patient Safety		
CQC Theme:	Safety		
Single Oversight Framework Theme:	Quality of care and Operational Performance		
Implications			
Risk:	As outlined in the report		
Legal/Regulatory:	Statutory Compliance		
Resources:			
Previously Considered by:	Water Safety Committee	**Date:**	
Equality Impact Assessment:	N/A		
Appendices:	N/A		

Trust Board – Part 1

20th December 2018

Interim Water Quality & Safety Update - Summary of current position of the water systems for St George's Hospital, Tooting

1.0 PURPOSE

1.1 This paper identifies the current position with regards to the standard of the water supply for St George's Hospital, Tooting. It identifies the gaps in statutory compliance assurance in line with legislation, however it also identifies the actions being undertaken to achieve safety to patients and other vulnerable visitors or staff in St George's Hospital

2.0 BACKGROUND

2.1 In order to address the water risk issues faced by the Trust it is important to breakdown the issues on a building by building basis, identify the key risks and put an action plan in place to tackle these issues.

2.2 Legionella and Pseudomonas are identified through sampling of water outlets across the Trust. It is important the sampling follows a logical methodology (sampled from furthest outlets and by clinical risk to patients).

2.3 It was found that there were scarce pipework drawings available to allow the Trust to complete this. Therefore surveys were required to make these drawings and identify these outlets. This has been completed for St James Wing and Grosvenor Wing. Lanesborough Wing and proposals to cover smaller buildings in the trust are now being considered and due for completion by March 2019.

2.4 It is widely accepted that the predominant issue which is causing this failure in standards of our water supply is the huge imbalance of our water infrastructure caused by a number of years of bad planning and lack of control. The surveys will identify the specific issues and promote an acceptable physical solution, with resilience, as we go forward. The trust will continue to utilise other systems of control such as chlorine injection and chlorine dioxide systems, both of which are functioning now and being monitored. We have also overhauled the borehole water supply and pumps, which will negate the incoming water temperature during the summer period issues that exist for other trusts who use mains water from the local authority.

3.0 UPDATE ON THOSE AREAS AFFECTED

3.1 St James Wing

Historically St James Wing had the highest risk in terms of patient profiles as well as legionella incidents. Following sampling of the outlets it was found that there is potentially systemic contamination of St James Wing with legionella. To mitigate and reduce the immediate risk Point of Use (POU) filters were installed in all compatible water outlets.

It was found that largely the issues centred on the ground and first floor where there have been numerous projects which have increased the clinical space in these areas. This has led to poor flow rates and temperatures in these areas which need to be addressed.

In consultation with the chief microbiologist and the AE, it was agreed that the POU filters would be in place until the flow rate and temperature issues were addressed. The Estates team through an engineering design consultancy have now completed major survey work of St James hot water pipework system and are now working up design proposals in order to address these issues. It was also agreed between the AE and the chief microbiologist that one of the initial proposals to chemically disinfect a whole wing should be held as a last resort proposal due to the risk posed of having chemically dosed water supplies in a live hospital to our patients, visitors and staff. This may need to be reviewed if the alterations to the infrastructure, the redistribution of supplies and other measures do not prove to be fully successful.

Once design work is complete, the plan is to buy the materials and mobilise an internal managed team to carry out the works as this would be the quickest solution. The planned date for completion is April 2019.

As the POU filters are in place it was agreed at the Water Safety Committee through the chief microbiologist that legionella sampling would no longer be required in the short term for St James Wing.

3.2 **Grosvenor Wing**

In a similar vein Grosvenor Wing pipework surveys have been completed, design work is due for completion in December 2019, with emerging construction works due to finish by March 2019. There is little clinical activity in Grosvenor Wing and due to this profile there is a smaller risk of contracting legionnaire's disease. The hot water supply is fed from Hunter Wing which is managed through the University. Due to the poor flow rates and temperature issues in Grosvenor Wing, the University have implied that it is impacting on their areas and have requested these works to be completed as soon as possible. They have also proposed the installation of heat plates to boost the water temperature.

3.3 **Lanesborough Wing**

Historically there have been very little legionella issues in Lanesborough Wing. The profile of patients means that there is a greater risk of Pseudomonas to patients. Increased Pseudomonas risk is largely due to poor clinical and cleaning practices this is regularly checked through Infection Control. We have also implemented a revised cleaning regime and enhanced training of our cleaning partners to combat the issue of pseudomonas.

Surveys are due to start in early January, with design work to be completed by March 2019.

3.4 **Low Use outlets**

The Estates department are responsible for the circulation of hot water in each building however the last part of the pipework (which feeds the taps and showers) water circulation is not possible. Water can become stagnant in these outlets and increase legionella risk if the outlets are used infrequently. Estates are not aware due to the operational changes that can be made within a ward environment where low use outlets exist on each area are. The person in charge of an area, (i.e. a Matron), are responsible for identifying low used outlets.

3.5 As identified in the WSG the responsibility of identifying low used outlets will be through the nursing division. The Deputy Chief Nurse has instigated implementing an electronic system to assist the clinical staff in identifying low used outlets to be passed onto the Estates team to flush (for the time being). This is due for completion by January 2019. The Estates and Facilities team will also ensure that flushing is carried out by our cleaning teams and our nursing teams to fortify the work being done by the Estates water team.

3.5 **Training**

Training is required for the Water Safety Group in order to fully understand and fulfil the requirements of their roles. This is being lead through the Chair and Deputy Chair. There is a pro-forma which is currently being completed by the members of the Water Safety Group. This will allow the AE to make any recommendations regarding training.

3.6 **Estates Team output**

There have been a number of staff departures which has impacted the output and performance of the Water Safety Team. The AE is aware of this, and recognises the difficulties the team faces in keeping up with the workload. New staff have been appointed and further interviews are being carried out. High risk issues and the WSG programme will be adhered to, external resources have been sought.

Regular and frequent telephone conference calls with IPC, Consultant Microbiologist and Estates are taking place in order to ensure that all known risk are being managed as best as possible given the limited manpower resource experience by Estates currently.

3.7 **Partners and other users**

Our partners, such as the University and Moorfields have expressed concern regarding the current situation and the risk to their occupants. Discussions have been had with the relevant AE's and infection control teams and is generally accepted that the use of POU filters negates the immediate risk. In the case of the University, the majority of these areas do not contain people of high risk who are susceptible to legionnaire's disease. The trust are in liaison with the respective engineering departments of our partners and where they wish to put in their own additional controls such as heat exchanger for the University, the trusts estates Department will assist.

4.0 RECOMMENDATIONS

I cannot give the board full assurance that the water systems for St George's Hospital are safe in relation to the relevant legislation in light of the continued positive results received. What can be given is assurance that every action has been taken to ensure the safety of those who are vulnerable and susceptible to infection. We can also give assurance that the action plan and proposed infrastructure works have been discussed and agreed as appropriate by the technical experts, our Approved Engineer and the Infection Control team led by the Chief Microbiologist and DIPCI. The proposals and methodology have been utilised by other trusts with a similar issue and have generally been successful. It is accepted that it is a protracted action plan which is necessary due to the scale and complexity of the water system. The trust will continue to carry out on-going day-to-day maintenance regimes to reduce the risk and monitor the standards through obtaining results carefully.

Kevin Howell
Director of Estates & Facilities
December 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	20 December 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 13 December 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:	Finance and use of resources		
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 – December 2018

1.1 Finance Risks- the Chief Financial Officer (CFO) updated the Committee on the latest position on the finance risks. He noted the increased risk scores in the functional risks which form part of strategic risk 5, following discussions at the previous committee meeting. This has left the overall score unchanged and the committee reflected that some of the functional risks could be weighted in future.

1.2 ICT Risks- the Chief Information Officer updated on ICT risks, showing latest progress on timelines for mitigating all ICT risks. In particular she noted the potential risk score reduction on failed discharge summaries following the implementation of iClip.

1.3 Estates Risks- the Director of Estates & Facilities updated on Estates risks. He noted the new structure of the report, which was welcomed by the committee. He also noted the workshop scheduled for January which would likely lead to changes in risk scores. A new risk on Estates' support to wards on maintenance issues would be assessed by Executive colleagues.

1.4 Premises Assurance Model (PAM) review- the Director of Estates & Facilities updated on the PAM. He noted the assessment provided a baseline for improvements and the committee agreed that any requirements must be considered as part of the 2019/20 business plan.

1.5 Performance- the Director of Delivery, Efficiency & Transformation noted his expectation that Elective and Daycase activity plans would be materially met by the time all activity had been submitted for the month. The Chief Operating Officer (COO) observed the excellent performance in October in all Cancer targets and a year of successfully achieving all diagnostic wait targets. The committee thanked the COO for this result.

1.6 Emergency Flow - the COO noted latest performance and action plans in delivery of the 4 hour A&E target. November performance was 85.49%. He noted the performance management process that involves cross-divisional challenge, and a potential move to publicise service by service performance. The committee noted the continued hard work, with more progress to be made.

1.7 Financial Performance & Forecast- the Deputy CFO noted performance in November was in line with the agreed financial forecast. The Pre-PSF year to date deficit is £36.1m, which is adverse to plan by £14.5m. It was observed that the forecast for the Trust is between a median case of £55.6m deficit and best case of £51.6m.

1.8 The Committee explored some of the ways to improve the forecast, including Medical pay expenditure and medical pay rates. The CFO noted the executive commitment to deliver the best case deficit at year end.

1.9 Capital Expenditure - The Interim Director of Financial Operations noted progress on the emergency capital bid and the capital and cash scenarios that existed should funding be made available from the Department of Health or otherwise. The Committee agreed that without this confirmation of funding, patient safety issues were of such a nature that a letter would be written to the Chair of NHS Improvement explaining the severity of the Trust's current capital situation. The Committee also welcomed the tight management of capital currently in place.

1.10 Cash & Associated Issues- The Interim Director of Financial Operations noted the increased cash from payments (including capital payments), receipts and working capital

borrowing, which was offsetting the lack of capital loan receipt of £14.9m. The Committee noted the working capital loan request agreed with NHS Improvement for £12.2m in December, £5.6m requested for January 2019, and expected request of a further c£10m to cover February and March. This was on the basis of a £52m deficit. The committee thanked the finance team for the strong cash management that has taken place, recognising the importance of this action.

1.11 Annual Planning Update – the Director of Financial Planning noted the date for receiving external guidance for 2019/20 was 21st December. While guidance was absent, the committee had a useful debate on the process for business planning and the learning from last year, which included earlier identification of CIP schemes to support earlier delivery.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 13 December 2018 for information and assurance.

Ann Beasley
Finance and Investment Chair,
December 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	20 December 2018	**Agenda No.**	3.2
Report Title:	**M08 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 £36.1m at the end of Month 08 (November), which is £14.5m adverse to plan. Within the position, income is adverse to plan by £6.6m, and expenditure is overspent by £7.9m.		
Recommendation:	The Trust Board notes the trust's financial performance to date in November.		
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:	The Finance & Investment Committee	Date	13/12/18
Appendices:	N/A		

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 8 (November 2018)

Chief Finance Officer

20th December 2018

Executive Summary – Month 8 (November)

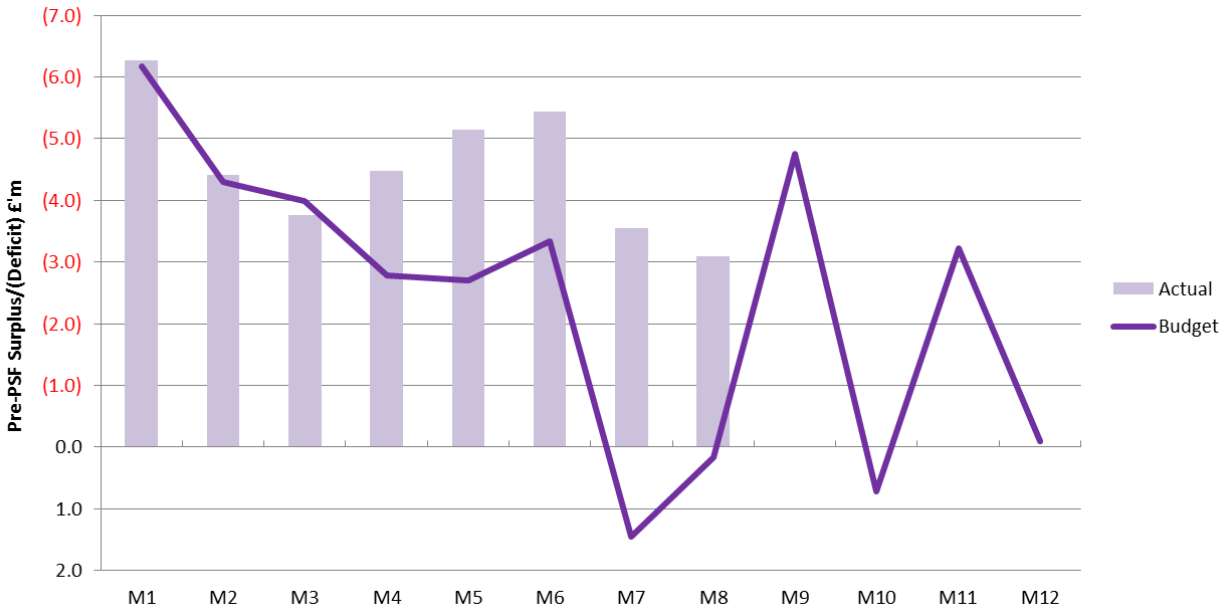
Note: All figures and commentary in this report refer to the revised Trust plan submitted to NHS Improvement on 20th June.

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The trust is reporting a Pre-PSF deficit of £36.1m** at the end of November, which is **£14.5m adverse to plan**. Within the position, income is adverse to plan by £6.6m, and expenditure is overspent by £7.9m. There also remains an element of income estimation in the position which will need to be validated ahead of freeze dates. **M4-8 PSF income of £5.0m** 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.	£14.5m Adv to plan	£11.2m Adv to plan
Income	Income is reported at £6.6m adverse to plan year to date. Elective is the main area of lower than planned performance; with shortfalls in volume (£9.5m) being offset by pricing gains (£3.2m) in other areas. Non-SLA income is also adverse to plan, with shortfalls private patient income the major cause.	£6.6m Adv to plan	£6.8m Adv to plan
Expenditure	Expenditure is £7.9m adverse to plan year to date in November. This is caused by Non Pay adverse variance of £7.3m (although a large proportion of this is offset in Income as pass-through is over-performing). Pay is adverse to plan by £0.9m, in month where medical pay is not being offset by other categories as it had been in previous months.	£7.9m Adv to plan	£4.4m Adv to plan
CIP	The Trust planned to deliver £29.0m of CIPs by the end of November. To date, £26.3m of CIPs have been delivered; which is £2.7m behind plan. Income actions of £6.6m and Expenditure reductions of £19.7m have impacted on the position.	£2.7m Adv to plan	£2.3m Adv to plan
Capital	Capital expenditure of £17.9m has been incurred year to date. This is £0.1m above 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.	£0.1m Adv to plan	£0.9m Fav to plan
Cash	At the end of Month 8, the Trust's cash balance was £3.2m, which is better than plan by £0.2m. The Trust has borrowed £24.5m YTD which is in more than planned due to the I&E Deficit incurred. The Trust secured a loan of £12.2m for December and has requested £5.6m for January. If approved the January drawdown will exceed the cumulative borrowings to M10 that is in the plan by approx £20.5m due to the higher deficit .The borrowings drawn are subject to an interest rate 3.5%.	£0.2m Fav to plan	£0.5m Fav to plan
Use of Resources (UOR)	The Regulators Financial Risk Rating. At the end of November, the Trust's UOR score was 4 as per plan.	Overall score 4	Overall score 4

Contents

1. Month 8 Financial Performance

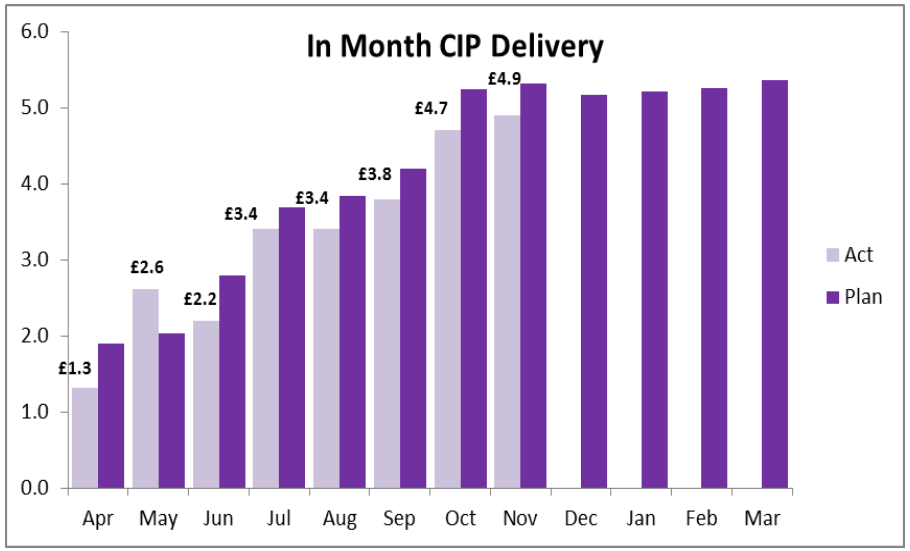
			Full Year Budget (£m)	M8 Budget (£m)	M8 Actual (£m)	M8 Variance (£m)	M8 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF	**Income**	SLA Income	664.3	57.0	56.9	(0.1)	(0.2%)	442.1	436.0	(6.2)	(1.4%)
		Other Income	158.0	13.0	13.4	0.4	2.8%	107.0	106.6	(0.4)	(0.4%)
	Income Total		**822.3**	**70.0**	**70.3**	**0.2**	**0.3%**	**549.1**	**542.5**	**(6.6)**	**(1.2%)**
	Expenditure	Pay	(509.7)	(41.8)	(42.7)	(0.9)	(2.2%)	(342.1)	(342.9)	(0.9)	(0.3%)
		Non Pay	(307.6)	(25.2)	(27.9)	(2.6)	(10.5%)	(206.3)	(213.6)	(7.3)	(3.6%)
	Expenditure Total		**(817.3)**	**(67.0)**	**(70.6)**	**(3.6)**	**(5.3%)**	**(548.3)**	**(556.5)**	**(8.2)**	**(1.5%)**
	Post Ebitda		(34.0)	(2.9)	(2.8)	0.0	1.5%	(22.4)	(22.1)	0.3	1.3%
Pre-PSF Total			**(29.0)**	**0.2**	**(3.1)**	**(3.3)**	**(1967.0%)**	**(21.7)**	**(36.1)**	**(14.5)**	**(66.8%)**
PSF			12.6	1.3	0.0	(1.3)	(100.0%)	6.9	1.9	(5.0)	(72.7%)
Grand Total			**(16.4)**	**1.4**	**(3.1)**	**(4.5)**	**(317.1%)**	**(14.7)**	**(34.2)**	**(19.5)**	**(132.6%)**

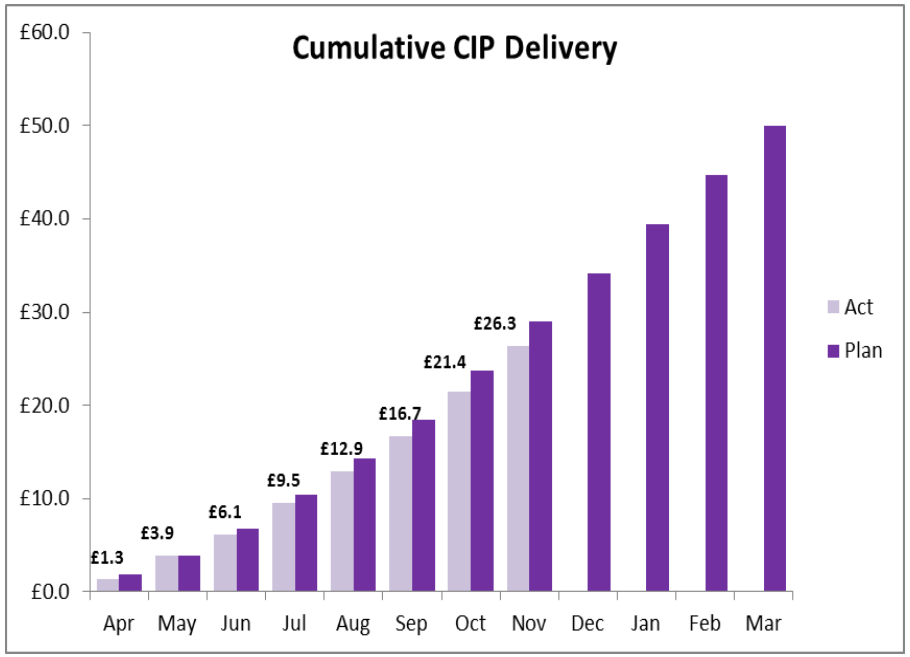


Trust Overview

- Overall the Trust is reporting a Pre-PSF deficit of £36.1m at the end of Month 8, which is £14.5m behind plan.
- **SLA Income** is £6.2m under plan. The main area of note is Elective with a material adverse variance (£6.3m), which is driven by lower than planned volumes of activity (£9.5m) partially offset with increased income per case (£3.2m).
- **Other income** is £0.4m under plan, which is primarily Private patient income shortfall in Cardiology CAG.
- **Pay** is £0.9m overspent. Medical staffing overspends of £4.3m are partially offset by non-medical staffing underspends of £3.4m due to vacancies. It should be noted that within staff groups there are areas of over as well as under spending.
- **Non-pay** is £7.3m overspent, mainly owing to increased pass-through costs and delay in Procurement CIP delivery.
- **PSF Income** is adverse to plan in M7 by £5.0m, as the Trust has not met the pre-PSF control total target of a £21.7m deficit.
- **CIP delivery** of £26.3m is £2.7m 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 £0.5m adverse
  - Income £2.2m adverse

2. Month 8 CIP Performance





CIP Delivery Overview

- At the end of Month 8, the Trust is reporting delivery of £26.3m of savings /additional income through its Cost Improvement Programme.
- This compares to an external plan to have delivered £29.0m of savings/ additional income by Month 8. Overall delivery is adverse of plan by £2.7m.
- The adverse variance to plan is due to under delivery of CIPs across all divisions as follows:
  - CWDTC - £619k
  - MedCard - £881k
  - SCNT - £1,126k

  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 8

	Mar-18 Audited (£m)	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Fixed assets	**377.2**	**392.5**	**379.5**	**-13.0**
Stock	**6.4**	5.9	7.8	1.9
Debtors	**112.3**	105.3	94.5	-10.8
Cash	**3.5**	3.0	3.2	0.2
Creditors	**-118.4**	-113.7	-127.0	-13.3
Capital creditors	**-15.4**	-9.6	-5.8	3.8
PDC div creditor	**0.0**	0.0	-0.1	-0.1
Int payable creditor	**-0.7**	-1.9	-1.7	0.2
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**	**-69.5**	**-87.0**	**-17.5**
Provisions> 1 year	**-1.0**	-0.7	-1.0	-0.3
Borrowings> 1 year	**-241.6**	-273.6	-260.8	12.8
Long-term liabilities	**-242.6**	**-274.3**	**-261.8**	**12.5**
Net assets	**64.4**	**48.7**	**30.7**	**-18.0**
Taxpayer's equity				
Public Dividend Capital	**133.2**	133.2	133.4	0.2
Retained Earnings	**-167.9**	-183.4	-201.8	-18.4
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**	**48.9**	**30.7**	**-18.2**

M01-M8 YTD Balance Sheet movement

- Fixed assets are £13.0m 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 £0.4m and remains £1.9m higher than plan due mainly to increase in Pharmacy and Cardiac stock. Pharmacy stock should reduce significantly over the remainder of the year.
- Overall debtors are £10.8m lower than plan.
- Creditors are £13.3m higher than plan relating mainly to the rescheduling of the payment of NHSPS rental charges and other NHS suppliers.
- Capital creditors are lower £3.8m than plan due to lower capital expenditure (no DH capital loans received yet)
- The cash position is £0.2m 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 £24.5m YTD for deficit financing which is more than the plan. The Trust will drawdown £12.2m for December and has requested £5.6m for January to finance the deficit. This would exceed the borrowing requirement in the YTD plan by £20.5m.
- 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 8 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	-15.4	-34.9	-19.5
Depreciation	15.7	15.7	0.0
Interest payable	7.1	7.0	-0.1
PDC dividend	0.5	0.5	0.0
Other non-cash items	-0.1	-0.1	0.0
Operating deficit	**7.8**	**-11.8**	**-19.6**
Change in stock	0.5	-1.4	-1.9
Change in debtors	9.0	12.5	3.5
Change in creditors	-6.8	13.2	20.0
Net change in working capital	**2.7**	**24.3**	**21.6**
Capital spend (excl leases)	-35.3	-27.2	8.1
Interest paid	-6.1	-6.1	0.0
PDC dividend paid	-0.5	1.5	2.0
Other	-0.2	-0.1	0.1
Investing activities	**-42.1**	**-31.9**	**10.2**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	21.8	24.5	2.7
Capital loans	14.8	0.0	-14.8
Loan/finance lease repayments	-5.5	-5.4	0.1
Cash balance 30.11.18	**3.0**	**3.2**	**0.2**

M01-M8 YTD cash movement

- The cumulative M8 I&E deficit is £34.9m, £19.5m 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 £34.9m, depreciation (£15.7m) does not impact cash. The charges for interest payable (£7.0m) 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 £11.8m.
- The operating deficit variance from plan of £19.6m.
- Working capital is better than plan by £21.6m. The favourable variance on debt comprises £1.0m favourable variance on invoiced debt and a £2.4m favourable variance on accrued debt. The £20.0m favourable variance on creditors relates mainly to the timing of payments for the CNST premiums and other NHS bodies.
- The Trust has borrowed £24.5m YTD which is in higher than the YTD plan. The Trust drew down £3.3m November and has secured £12.2m in December and requested £5.6m for January. If the January draw down is approved, cumulative working capital borrowings would be £20.5m 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.

December cash position

- The Trust achieved a cash balance of £3.2m on 30 November 2018, £0.2m 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	M08 YTD budget £000	M08 YTD exp £000	*M08 YTD var £000*
Infrastructure renewal	**5,732**	**5,492**	4,696	*796*
IT	**3,220**	**3,064**	5,138	*-2,074*
Medical equipment	**1,890**	**1,689**	862	*827*
Major projects	**5,756**	**5,422**	5,007	*415*
Other	**1,108**	**808**	938	*-130*
SWLP	**545**	**544**	158	*386*
Urgent £11.8m March 2018 projects	**711**	**710**	1,049	*-339*
Total	**18,963**	**17,730**	17,848	*-118*

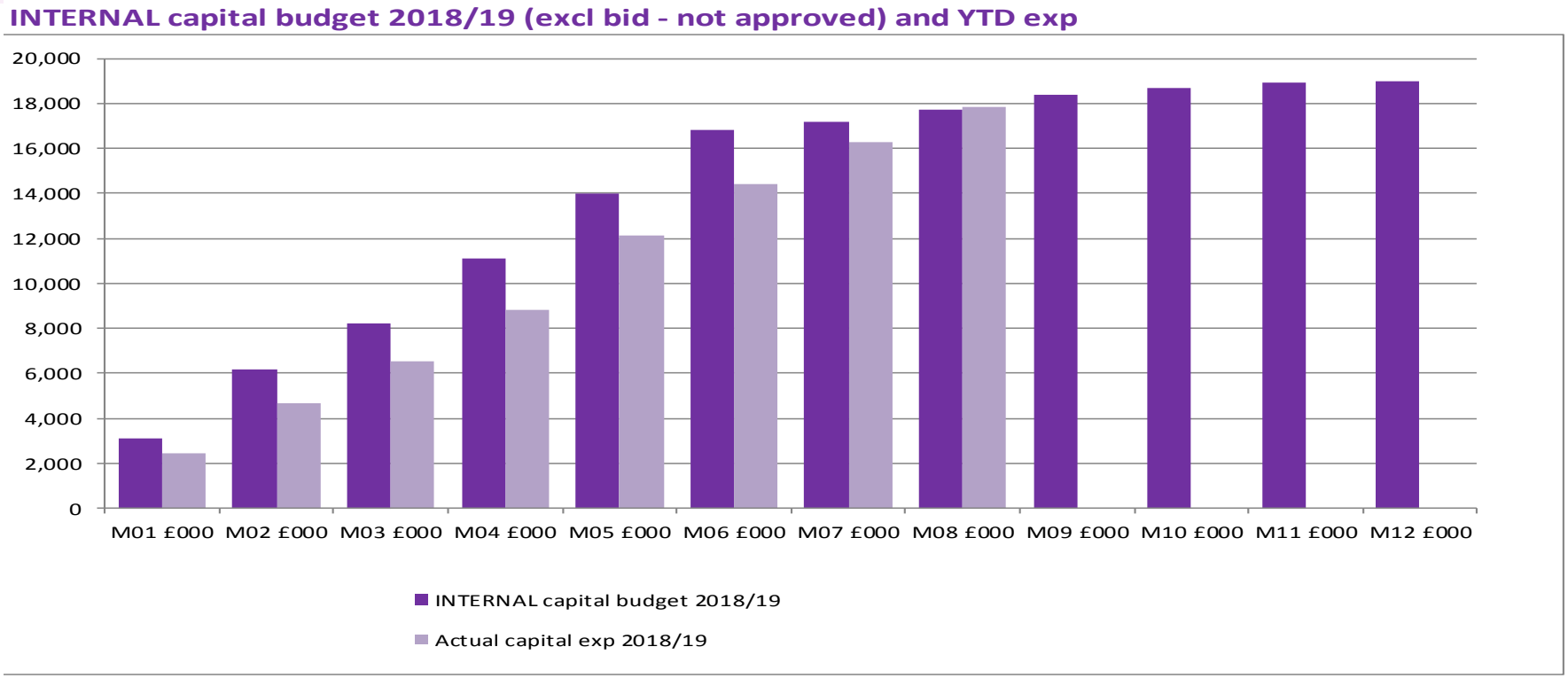
INTERNAL CAPITAL BUDGET only

Spend category	Internal Budget £000	M08 YTD budget £000	M08 YTD exp £000	*M08 YTD var £000*
Infrastructure renewal	**5,732**	**5,492**	4,524	*968*
IT	**3,220**	**3,064**	2,989	*75*
Medical equipment	**1,890**	**1,689**	862	*827*
Major projects	**5,756**	**5,422**	5,004	*418*
Other	**1,108**	**808**	938	*-130*
SWLP	**545**	**544**	158	*386*
Urgent £11.8m March 2018 projects	**711**	**710**	1,049	*-339*
Total	**18,963**	**17,730**	15,524	*2,206*

CAPITAL AT RISK EXPENDITURE only

Spend category			M08 YTD exp £000	*M08 YTD var £000*
Infrastructure renewal			172	*-172*
IT			2,149	*-2,149*
Medical equipment			0	*0*
Major projects			3	*-3*
Other			0	*0*
SWLP			0	*0*
Urgent £11.8m March 2018 projects			0	*0*
Total			2,324	*-2,324*

5b. Internal capital budget and expenditure M8



- The Trust's internally funded capital expenditure budget for 2018/19 is £18.9m.
- The Trust has incurred capital expenditure of £17.8m in the first eight months of the year. This comprises £15.5m against the YTD internal capital budget of £17.7m and £2.3m expenditure incurred 'at risk' on the projects for which the Trust has submitted a bid for capital funding to NHSI. Therefore the capital programme is over spent by approx £0.1m at M08 overall.
- *The £2.3m capital spend at risk total includes a provisional re-classification of £1.1m of IT expenditure from internal capital to capital spend at risk relating to the roll-out of iCLIP at QMR. The Finance and IT departments will finalise this re-classification for M09 reporting.*
- 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 £1.1m as at M08. The project is behind schedule but is forecast to come within budget and so the M08 YTD underspend represents a temporary timing difference.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M8 YTD)	Actual (M8 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 November, 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 % YTD I&E deficit (6.30%) minus planned % YTD I&E deficit (2.60%). This value is -3.70% 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 Meeting**		
Date:	20 December 2018	**Agenda No.**	**4.1**
Report Title:	**Workforce and Education Committee Report**		
Lead Director/ Manager:	Harbhajan Brar, HR & OD Director		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Assure		
Executive Summary:	This paper sets out the key issues reviewed and agreed by the Committee at its meeting on 6 December 2018, including commenting on assurance to the Board on key risks allocated to the Committee.		
Recommendation:	Receive this report		
Supports			
Trust Strategic Objective:	Champion Team St Georges		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Leadership and improvement capability Operational performance		
Implications			
Risk:	Review of the BAF risk 8 was undertaken and the risk was raised to 12		
Legal/Regulatory:	None		
Resources:	None.		
Previously considered by:	N/A	Date:	N/A
Appendices:	None		

1. Committee Chair's Overview

As we come to the turn of the calendar year it is a good time to take stock of the Committee's work. We have had a very busy 18 months, and much has been done by the Trust's executive management on the HR and OD front, and I hope the Committee has played a part in this by: helping frame a coherent HR and OD plan for the Trust which contributes to the overall Trust culture; helping define priority areas; and monitoring progress. More recently we have started to see welcome improvements in some areas, and anticipate that these will continue. However it is important that in measuring these successes we do not lose sight of the work still to be done. Changing the culture of the Trust is a long term project, which will only be delivered by continuing the programmes designed to improve behaviour and attitudes across the Trust. One risk is that initial gains lead to a view that we have the necessary momentum, and can therefore ease back on the pressure for change. This is inevitable as we start to see results, but those changes should be viewed as a lead indicator of progress rather than the trailing indicator of a job done. So we need to keep up the pressure.

The remainder of this paper reports on the Workforce and Education Committee held on 6 December. We had a good attendance and some lively discussion. The main items for review were: (1) the update on staff engagement, following the disappointing Q2 staff survey results; (2) the assessment of our compliance with the NHSI standards on seven day working; and (3) the request from the Board that we re-assess our risk rating of certain matters within the Board Assurance Framework (BAF). Other items were also reviewed, and these are summarised below.

A number of items discussed at the Committee and reported on below have implications for more than one of the Committee's four[1] strategic priorities. The reporting of these under any specific theme should not be taken to imply that these wider implications are not also considered. Please also note that a number of areas that the Committee monitors, notably around HR service delivery, are not reported on here (other than by exception) given that they are now very much business as usual.

2. Key points:-

Board Assurance – The Board tasked the committee with reviewing the risk score allocated to two specific risks within the Trust's Strategic Risk 8[2]. We had a long discussion about this, within which were solid arguments for leaving that risk as currently scored or for increasing the risk. By a majority the Committee agreed that the risk should be scored as 12, instead of its current 10. As importantly, both viewpoints within the Committee agreed that - given the evolution in focus since the BAF was created - the specific risk relating to organisational culture should be re-stated. We understand this will be done early in the new year.

[1] Being (1) engagement; (2) leadership and development; (3) workforce planning; and (4) compliance.
[2] SR8 considers the risk of a negative organisational culture, or a workforce that does not regard itself as accountable.

Theme 1 - Engagement

The NHS Staff Survey is under way, and we should have informal results for the Trust early in 2019. At c 50%, our staff response rate is good, but not yet record-breaking. We will be looking at the results of this survey extremely carefully, given the slight downturn in the results of our Q2 Friends and Family survey.

The Equality and Diversity Strategy was formally launched at the end of November, as part of the Quality Improvement week.

Jacqueline McCullough updated us on progress with the implementation of the staff Engagement Plan, and the decision to consolidate various activity streams on a single platform 'GoEngage' which is being used to good effect elsewhere in the NHS. Moving onto this would allow for more dynamic testing of staff opinion and attitudes and we were supportive of it, provided its use was adopted progressively and we retained existing communications mechanisms (such as Listening into Action) until the new platform had been properly assessed.

The Committee received an update on the Trust's adoption of a health and wellbeing diagnostic tool and the initial self-assessed results of where the Trust stood. We found the results interesting, but agreed that what mattered was staff's perception of support in the event that they raised a health or wellbeing issue. One assessment was that whilst there were mechanisms in place to allow staff to raise wellbeing concerns, staff were not in fact using them – suggesting a cultural reluctance to come forward with concerns, or an anxiety about how they would be dealt with. We asked for an update on this in six months.

Improvements to the Trust's occupational health service and the appointment of a second full time consultant were noted. There is a renewed focus on needle-stick, sharps and splash injuries to staff.

The April 2018 pay award for the Trust's VSMs remains unimplemented, given that the national guidance on quantum remains outstanding. I personally think this whole process has been a shambles, and gives a very poor message about anticipation and organisation to our senior leadership.

We were really pleased to see evidence that the improvement in our recruitment processes, and the continuing reductions in timescales to recruit, were beginning to bear fruit. The reduction in our vacancy rate to sub-10%[3] has been a long time coming and reflects the results of a change of approach and pace. We asked specifically and were assured that the reduction is substantially due to change in recruitment practice, rather than to the continued reduction in the Trust's establishment (which played only a modest part). In parallel, the Trust's recruitment Team was voted public sector recruitment team of the year at a recent industry event.

[3] In fact, 9.27%

We received a comprehensive report on feedback from recent staff leavers. This compared the results from that cohort (2018) against a similar cohort from 2017. The top two reasons cited for leaving in 2017 (1 - did not feel valued; 2 - poor communication by senior management) had dropped, to be replaced by 1 – lack of promotion opportunities, and 2 – unclear as to how to progress. The Report also contained a deep dive on one clinical area, which showed very clearly how important early communication to staff of operational and financial pressures is. There were a number of other learnings from the report (around, for example, harassment and bullying, and diversity and inclusion) which are being taken forward by the HR team and executive management.

Dr Jonathan Round, the Trust's lead on Medical Education and Training, had prepared and circulated an excellent summary of the undergraduate and postgraduate training provided by the Trust (in partnership with SGUL), and its critical importance to service delivery. He reminded us that whilst there were some departments that did not score well in the GMC survey (bottom 10% nationally) there were in fact more that did score well (top 10% nationally). In Jonathan's absence, Mark Hamilton, Associate Medical Director, summarised the report and drew attention to a number of areas that the Trust could (and would) influence to ensure that St George's was a place where trainees wanted to come.

Theme 2 – Leadership and Progression

Mark Hamilton, Associate Medical Director, provided an update on our current capability in relation to seven day working. Mark assessed this against the 10 standards set out by NHSI, and in particular standards 2, 5, 6 and 8. Although the Trust is generally able to deliver compliance with the standards, the cost of delivering routinely for all patients against standard 2 is high. Standard 2 is read as requiring all patients to be seen by a consultant within 14 hours of admission. What the Trust currently delivers is that most patients are seen on this basis but there is a small number who are not, largely as result of the time of their admission versus normal consultant ward rounds. The cost of full compliance would be extremely high. The Committee agreed that this raised issues of clinical judgement and that therefore we needed a recommendation from the Trust's Medical Director before we could take a position on this. It will therefore come back to us once that assessment has been undertaken.

Theme 3 - Workforce Planning

The Trust made 50 offers of employment to nurses attending a nursing Open Day at the end of October. Of these, it looks as if the vast majority will be converted into new starters.

Although the take-up of the South West London Bank Collaborative has been good, it has not yet delivered material numbers of additional staff capacity. The Trust's agency spend remains under the cap we have set. There is good work being done by Justin Sharp (the Trust's recently appointed Staff Bank Manager) to bring locum doctors onto the same management platform as the nursing bank. This will help the Trust's control of this resource. The pan-London locum rates set by NHSI appear not to have had a material effect on market price, with a number of London Trusts achieving very low levels

of compliance. This remains a difficult staffing challenge in the London area and a potential overspend area for all Trusts, including St George's.

We were updated on the Trust's continuing response to the results of the GMC's survey of trainees, and the work being done to secure improvements where indicated. The Trust has (sensibly) decided to get ahead of things here by routinely undertaking its own survey of trainees so it can identify and correct issues at an earlier stage, rather than await the GMC's assessment.

Sion Pennant-Williams presented an interesting benchmark analysis of St George's against other London Trusts. We compared well on: vacancy rate. We compared reasonably on: sickness and turnover rates. We compared poorly on: appraisal rates; MAST; and FFT as a place to work. There is still much to do here.

Outside of the Committee, it was a real privilege to attend the passing-out parade of the first cohort of Nursing Associates at the Trust. This initiative, jointly supported by the Trust, Kingston University and SGUL has gained good traction and a second and third cohort is now coming through. The hope is that a significant proportion of these enthusiastic and capable home-grown Nursing Associates will go on to careers with the Trust.

Theme 4 – Compliance.

The HSE inspected the Trust in early November to assess the Trust's position on manual handling, and on the management of violence and aggression. The formal report back is awaited, although it is anticipated that no enforcement action will be needed.

The Trust has appointed a new Guardian of Safe Working, Dr Serena Haywood. We received the final report from Mr Sunil Dasan, who has now stepped down from this role. Sunil's report noted the fact that, unintentionally, the Trust had put in place rotas that breached the Safe Working guidelines. These were derived from a rostering system used by the Trust which was understood to contain rules to ensure compliance. Understandably, Trust management is disappointed at the fines levied as a result but the hard reality is that we were not in compliance and our Guardian has taken the correct course here. Aside from those instances there were other instances of non-compliant working which we reviewed, but the general trend is of continuing reduction in breaches.

Finally, could I apologise for my absence from the Board Meeting. As some of you know, I have recently joined another Board which for 2018 has a cycle of Thursday meetings. However, from January these will change to a Tuesday cycle. I should therefore be back in full attendance at St George's board meetings from next month.

Stephen J Collier

12 December 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	20 December 2018	**Agenda No**	**5.1**
Report Title:	**Clinical Strategy Highlight Report**		
Lead Director/ Manager:	Suzanne Marsello, Director of Strategy		
Report Author:	Ralph Michell, Head of Strategy		
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 Board on progress in the development of the 5-year Clinical Service Strategy to date (due end March 2019) and the deliverables in December, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales. It also includes a summary of feedback from staff and public engagement events undertaken in November and December.		
Recommendation:	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:	Trust Executive Committee	**Date:**	12th December 2018
Appendices:			

Trust Strategy: Highlight Report

1.0 Purpose

1.1 This paper advises the Board on the development of the 5-year Clinical Service Strategy to date (due end March 2019) and on the deliverables in December 2018, outlining progress so far, next steps and the identified issues and risks, in line with the agreed process and timescales.

2.0 Progress in December 2018:

2.1 All actions committed to are on plan for December 2018, although Board Strategy Seminar dates in January 2019 were being finalised at the time of submission of papers for Trust Board; any further delay could lead to a delay in delivering the Strategy in March 2019 as agreed.

Deliverables/ Milestones for December 2018	Progress	Actions for January 2019	Completion Date/ RAG*
Overall Programme Plan (Workstream 1)	Programme Plan 'live' and ongoing progress on workstreams Project Risk Register reviewed and linked to Strategy Department risk register.	Delivery ongoing	**Board Seminar dates in Jan/ Feb 2019 still TBC and risk to Strategy timeline**
Development of Options (Workstream 2)	Board Seminar on Strategy for Vascular (18 December)	Completion of deliverables to enable Board Seminars to cover Medical and Surgical Specialties (TBC, January 2019)	**On plan**
Alignment, Deliverability and Prioritisation (Workstream 3)	<u>Alignment</u> Alignment of the different propositions and assessment of cohesion/ common themes, conflicts and likely reactions of stakeholders. <u>Initial Prioritisation</u> Criteria definitions developed and a framework for prioritisation (scoring and weighting) of propositions and services finalised and further refined. <u>Deliverability</u> Impact Modelling - assumptions discussed and finalisation of inputs with Specialist Services to quantify their propositions (Steps 1 and 2); - discussion of high-level impact and implications with Support Services and established high-level impact and implications for Estates and Workforce (Steps 3 and 4).	Completion of deliverables to enable final Strategy Wash-Up in February 2019 including Impact Modelling progression and refinement.	**On plan**

Communication and Stakeholder Engagement (Workstream 4)	Completed Engagement Events x 4: • Public x 1 St George's (10 December) • Staff x 2 Cancer (5 December) Cancer, Neurosciences and Renal (6 December) • Stakeholders x 1 Senior Health (4 December) A summary of feedback is presented in the annex.	1 Engagement Event was cancelled due to operational pressures and is to be discussed at an existing forum which will be repurposed – this is the staff engagement event for: Neurosciences Further Engagement Events planned in early January/ end February 2019: • Public x 3 • Staff x 4 (including 1 at Queen Mary's Hospital, Roehampton)	**On plan**
'Into Delivery' Planning (Workstream 5)	Alignment to 2019/20 Business Planning i.e. Y1 of a 5yr Strategy. Assessment of 2019/20 Business Plan submissions (30 November 2018) from Directorates/ Divisions for: • alignment and assurance of 2019/20- 2023/24 deliverables as explicitly linked to Service Strategies 'Challenge and Confirm' with Divisions, Finance and Strategy planned from December 2018 onwards	Confirm and challenge of Divisional Plans by corporate centre	**On plan**
Enablers and Interdependencies (Workstream 6)	Initial discussions with Diagnostics, Finance, Information (for Modelling purposes) and Workforce (October); Clinical Genetics, Theatres and Anaesthetics and Therapies (November), and; Breast, Estates, IT and Radiology (December) to agree approach and plan.	TBC- based on discussions	**On plan**
Production and Publication of Strategy (Workstream 7)	Review of published Strategies of other Trusts (content, format, priorities, strengths, weaknesses).	TBC	**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, and a summary of feedback from the engagement events held in November/December.

3.0 Key Milestones for January 2018

- Board Seminars to cover Medical and Surgical Specialties (January 2019), and Support Services plus an overall Strategy Wash-Up (February 2019), dates to be confirmed by Corporate Office.

4.0 Issues and Risks

Capacity in the Clinical Divisions 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 for February 2019, invitations to stakeholders and venues to be landed and locked down. Communications, Divisions, Strategy and Transformation teams working together on content/ format and delivery of events.	

5.0 Recommendation

Trust Board is asked to:

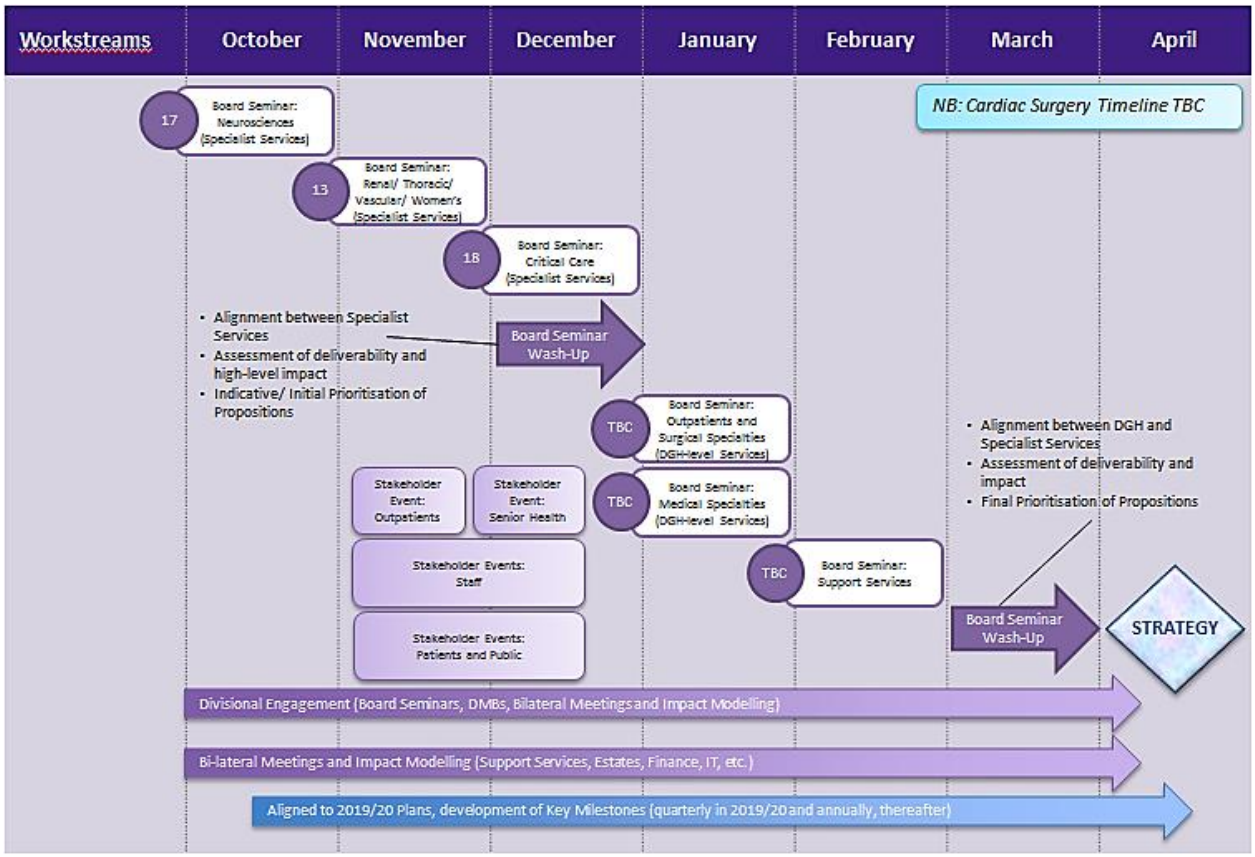
- Note the progress reported and the identified issues and risks.

Author: **Ralph Michell, Head of Strategy**

Date: **12th December 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: Summary of Feedback from Engagement Events

1.0 Introduction

As part of the development of the Trust's clinical strategy, a series of twelve events (three public and nine staff) were undertaken in November / early December. The focus was how stakeholders wanted our specialist services (those that the Board has been considering in Board strategy seminars to date) to develop in the future; particularly around how the Trust should interact with patients in the future and what it would take to make that happen. Stakeholders were sourced through a wide variety of media channels including poster drops, twitter, eG, senior leaders briefing and targeted staff / patient group emails.

2.0 Output of Events:

2.1 Stakeholders: 163 participants attended, with overall representative groupings:

- 27% AHPs
- 23% Medical
- 23% Nursing/Midwifery
- 11% Leadership/Management
- 7% Governors / Trust Members
- 7% Patients/Service Users
- 2% Corporate (e.g. Estates and Facilities and HR)

2.2 Common Themes:

There was significant consensus across all parties in relation to what interaction with patients should look like in the future and what would be required to deliver that e.g. up-skilling and workforce modernisation, digital solutions, overhaul of estates and facilities, partnership working and pathway redesign. The public were particularly keen to take responsibility for their own health which links with the prevention agenda which is a core priority for the SWL Health and Care Partnership.

Common themes, areas of concern and opportunities are summarised below (table 1).

Table 1: Public & Staff Comparable Themes:

STAFF	PUBLIC
Administration - IT / Digital. Two of the biggest recurrent themes were IT and digital - seen as prerequisite to new ways of working such as adaptive appointment systems, clinicians triaging and case loading at the front door and increased use of technology "at home".	The public expressed the need to work smarter in navigating appointments and moving away from silo working by utilising integrated system wide platforms. People voiced that the care and treatment they receive is fabulous - but the administration and support lets the hospital down.

	There was a strong desire to take responsibility for their own health e.g. book into clinics when they felt they needed to rather than an automatic call-back at 6 months (open access clinics).
Changes to Clinical Pathways. There was strong support to embed good practice and exemplar models of care e.g. surgical school, enhanced recovery and prehabilitation programmes, outreach and integrated health and social care pathways, rapid access clinics, one stop clinics for multidisciplinary long term conditions, virtual clinics and health promotion / self-care via social media and home based technology.	The public showed strong support to move care closer to home using health technology APPs and new ways of working (e.g. open access and group sessions, outreach to homes or GP practices, virtual clinics and self-management / shared experience clinics). Patients also referred to their experience of enhanced recovery programmes as being positive and something that should be expanded. It was frequently mentioned the need to feel empowered with accessible patient information (preferably within GP practices) so patients could self-manage and avoid coming to the hospital.
Workforce. Staff commonly mentioned the need/opportunity for a different workforce mix, with 'up-skilled' specialist nurses, physician associates and allied health professionals playing a greater role in a modernised workforce. Greater interaction with the medical school and academic roles was seen as an opportunity to raise the hospitals profile and as a recruitment and retention tool.	The public recognised that to attract the best staff, investment would be required. Patients recognised that skilled nurses or other healthcare professionals could often provide them with expertise that would mean they did not need to see a doctor.
Estates. Staff commonly expressed a desire for services currently provided over disparate locations across the Trust to be co-located (e.g. critical care); for more space (e.g. children's); or for improvements/refurbishments (e.g. women's and renal) to improve patient experience.	The public frequently mentioned the importance of estates towards the patient experience, which had been suffering for far too long; infrastructure was seen as a priority.
Partnerships and Marketing. There was strong support to investigate managed equipment services and collaborative partnerships to offer care closer to home in parallel with rebranding / research opportunities (e.g. Diagnostic Hub (PET-CT / MRI) and a Comprehensive Cancer Centre (radiotherapy). Staff expressed huge pride and loyalty to their	There was strong interest in having greater visibility of the Trust's partnership profile (e.g. Royal Marsden Health and radiotherapy) and clinical excellence (e.g. enhancing the Trust's online presence).

departments rather than a sense of belonging to a whole organisation. There was a strong sense of missed opportunities, which could be reversed through marketing and enhancing the Trust's online presence	
Volunteers and Support Mechanisms: Better use of charitable organisations and the voluntary sector was mentioned as a means of integrating services and social prescribing (e.g. Macmillan Cancer Support and shared experience clinics)	It was recognised that hospitals can be a frightening place and there was opportunity for better use of volunteers, buddying systems and patient advocacy to enhance the patient experience and recovery period. Enhanced use of the Patient and Public Engagement Group was seen as a critical lever in making a difference at the patient level.
Other: Staff commonly expressed scepticism that the strategy would be delivered, or lead to real change, citing previous experience of taking time to support the development of Trust strategies which were then abandoned, or replaced when the Trust leadership changed – *""we are not good at finishing something - we start it but don't see it through and then we start something else - people get frustrated with this".*	The public recognised that much aspiration and resource has gone in to strategy over the years with disappointing outcomes. They also recognised that the process felt different this time.

3.0 Next Steps

3.1 A third and final round of engagement sessions will be held January – March 2019, focused on the remaining clinical services.

3.2 Much of the feedback gained to date is relevant for the supporting strategies that will need to be developed once the clinical strategy is approved by the Board e.g. Estates, Workforce, Digital, and will be used to inform these as they are developed.

Appendix 3: 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:	20 December 2018	**Agenda No.**	6.1
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 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:	TEC	**Date:**	12/12/2018
Appendices:			

GDPR Implementation Update
Trust Board 20th December 2018

1.0 PURPOSE

1.1 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.

1.2 The GDPR will not be directly applicable in the UK post Brexit but the DPA18 will ensure continuity by putting in place the same data protection regime in UK law pre- and post-Brexit, equivalent to that introduced by the GDPR which will continue to be applicable throughout the EU member states.

1.3 DPA18 does not replicate all the provisions of the GDPR but cross-refers to the relevant provisions as appropriate. GDPR and DPA18 are now in force, it is now necessary to view the DPA18 and the GDPR side by side in order to see the complete picture of all the data protection legislation.

1.4 The GDPR requires that organisations (controllers) that process personal data demonstrate compliance with its provisions. Part of this involves establishing and publishing a basis for lawful processing, and where relevant, a condition for processing special categories data.

1.5 This is the UK's third generation of data protection law commenced on 25 May 2018. The new Act aims to modernise data protection laws to ensure they are effective in the years to come.

1.6 In Europe the General Data Protection Regulations (GDPR) have direct affect across all EU member states. This means organisations will still have to comply with this regulation and we will still have to look to the GDPR for most legal obligations. However, the GDPR gives member states limited opportunities to make provisions for how it applies in their country. One element of the DPA 2018 is the details of these.

1.7 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 and NHS Data Standards. http://stginet/Units%20and%20Departments/IT%20Department/InformationGovernance/InfoGovHomepage.aspx
- Prompt live on login on Data Protection Principles
- Development of Information Governance leaflets and engagement at Quality Improvement

- 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.
- For October 19 asset registers were completed, and 12 were signed off.
- For November 9 asset registers completed, and 14 were signed off.
- 77 out of 112 asset registers have been mapped to date, with 15 new areas identified in November.
- Asset registers slow response by estates, procurement, communications, cardiology, academic group & blood pressure, and gastroenterology (Not commenced).
- Endoscopy (sign off only)
- SWLP completed Information Asset register training and have commenced mapping

3.4 Contracts and Data Sharing

- Collaboration continuing with Procurement in line with Data Security Standard 10 – Accountable Suppliers

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 January
4.5 Identification of priority policies and procedures required under GDPR.
4.6 Conduct further training and awareness sessions (IAR and IG)
4.7 Audit of current status
4.8 Risk base analysis for contracts
4.9 Work under way on access to records processes

Meeting Title:	**Trust Board**		
Date:	20 December 2018	**Agenda No**	7.1
Report Title:	**Results from the Patient Led Assessment of the Care Environment (PLACE) 2018 for St. George's Hospital and Queen Mary's Hospital sites**		
Lead Director/ Manager:	Kevin Howell – Director of Estates & Facilities		
Report Author:	Mary Prior – Acting Assistant Director of Facilities		
Presented for:	Update		
Executive Summary:	The paper has previously been presented to Trust Executive Committee, Patient Safety Quality Board and Patent Partnership Experience Group to notify of the PLACE 2018 scores and summarises the key findings and plans to address any failings found in the assessment. A workshop was also undertaken with patients to share the result and agree actions needed to address areas of low scores.		
Recommendation:	The Board is asked to: • review and note the scores • support the requested actions from the patient representatives.		
Supports			
Trust Strategic Objective:	Build a Better St. George's Champion Team Georges Right Care, Right Place, Right Time Treat the patient, Treat the person		
CQC Theme:	Safe Well led		
Single Oversight Framework Theme:	Quality of care Operational performance		
Implications			
Risk:	Risk of inability to resolve the environmental upgrades as a result of a lack of capital funding.		
Legal/Regulatory:	**CQC Regulations 15: Premises and Equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15** The intention of this regulation is to make sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located, and that the equipment that is used to deliver care and treatment is clean, suitable for the intended purpose, maintained, stored securely and used properly		
Resources:	Patient workshop: September 2018		
Previously Considered by:	Patient Safety Quality Board Trust Executive Committee Patient Partners Experience Group	**Date** September 2018 October 2018 November 2018	
Equality Impact Assessment:	N/A		

Patient-Led Assessments of the Care Environment (PLACE) Programme 2018

What is a PLACE Inspection?

PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). This is a patient-led assessment and the teams must include a minimum of 50% being patient assessors.

PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability. (Full criteria included in the table below).

The Importance of the PLACE Inspections

PLACE aims to promote the principles established by the NHS Constitution that focus on areas that matter to patients, families and carers:

- Putting patients first
- Active feedback from the public, patients and staff
- Adhering to basics of quality care
- Ensuring services are provided in a clean and safe environment that is fit for purpose

How do the Assessments Work?

Over 25% of the St Georges Hospital (SGH) services were assessed including wards, outpatients, internal and external areas and the emergency department. 25% is the recommended amount for hospitals with 10 wards or more.

All Trust services at Queen Mary's Hospital (QMH) were assessed.

Food and Hydration were assessed on each site.

The patient-led assessments were assisted by Facilities staff, Corporate Nursing and our patient representatives. External validators from Kingston Hospital were present. Scores were not received until 16 August 2018.

The Assessments Areas – St George's Hospital site (SGH) & Queen Mary's Hospital (QMH)

The assessments took place throughout May 2018. Both of the site inspections at SGH and QMH were unannounced inspections. On an annual basis there are areas that **must be** assessed and these are mandatory. The other areas are chosen on a rational basis and must cover 25% of the site. Areas assessed were:

- Communal areas – Mandatory
- External areas - Mandatory
- Organisational questions on food - Mandatory
- Organisational questions on facilities - Mandatory
- Accident and Emergency - Mandatory

Summary

The majority of scores for the STG site have increased since the 2017 assessment. This is a positive result for the site with the largest increased performance within the food service. We have compared our scores with other London Teaching Trusts and these are comparable. All London Teaching Trusts have dementia and disability as the lowest scoring domain and this is likely to be a result of the ageing estates and the investment needed on backlog maintenance and refurbishment works. More detail on the actions for each area is covered in the areas of concern below.

Queen Mary's Hospital scored higher than the national average in most of the domains. There has been a reduction in 2018 scores compared to 2017. This has been the result of a different auditing team which varied from previous years. The scores are not reflective of declined services but a more robust audit regime. The food scores had to be re-audited in the assessment by the STG lead assessor and an external validator and the scores increased as a result. The decision to re audit was taken as the South West London & St George's Mental Health Trust share the same food service and had scored the service higher. For 2019 PLACE assessments there will be one assessment team across the Trust to ensure we can compare results.

Wards Assessed - SGH		**Outpatient Areas Assessed – SGH**	
Holdsworth Ward	Keate Ward	3T MRI	Haematology & Oncology
James Hope Ward	Caroline Ward	Courtyard Clinic	Pre-operative Assessment (Willow Annex)
Belgrave Ward	Champneys Ward	Phoenix Centre	Clinic 2 St James Wing OPD
Gwillim Ward	Carmen Suite	Endoscopy Clinic	Departure Lounge
Cavell Ward	Emergency Department		
Ward Assessed – QMH		**Outpatient Areas – QMH**	
Minor Injuries Unit	All Outpatient Areas	Gwynne Halford Ward	Mary Seacole Ward

Food Services Assessed - SGH		**Food Services Assessed – QMH**	
Holdsworth Ward	Benjamin Weir	Gwynne Halford Ward	Mary Seacole Ward
Caroline Ward	Gwillim Ward		
Cavell Ward			

The Scores

St George's Hospital

Results are provided for the following domains:-
(negative = lower than national average; positive = higher that national average)

St Georges Hospital	National Average	Site Score 2017 %	Site Score 2018 %	Variance from previous year %	Variance from National Average
Cleanliness	98.47	94.74	98	+3.26	-0.47
Food	90.17	82.97	90.11	+7.14	-0.06
Organisation Food	89.97	74.20	81.49	+7.29	-8.48
Ward Food	90.52	84.62	91.85	+7.23	+1.33
Privacy, Dignity & Wellbeing	84.16	79.02	81.51	+2.49	-2.65
Condition, Appearance and Maintenance	94.33	89.96	90.69	+1.00	-3.64
Dementia	78.89	70.28	74.53	+4.25	-4.36
Disability	84.19	73.47	73.19	-0.28	-11

Services at Queen Mary's Hospital **

Queen Mary's Hospital	National Average	Site Score 2017 %	Site Score 2018 %	Variance from previous year %	Variance from National Average
Cleanliness	98.47	100	98.57	-1.43	-0.1
Food	90.17	89.18	93.38	+4.2	+3.21
Organisation Food	89.97	84.02	88.99	+4.97	-0.98
Ward Food	90.52	93.39	96.31	+2.92	+5.79
Privacy, Dignity & Wellbeing	84.16	92.38	84.85	- 7.53	+0.69
Condition, Appearance and Maintenance	94.33	98.40	97.13	- 1.27	+2.8
Dementia	78.89	94.25	92.32	- 1.93	+13.43
Disability	84.19	95.89	91.60	- 4.29	+7.41

Areas of concern – main themes:

Cleanliness (*the cleanliness domain covers patient equipment, also bathrooms, showers, furniture, floors and fixtures and fittings)*	The cleaning results have reduced from previous years at QMH and improved at the SGH site. Main areas of actions were as follows: 1. Dust found on hard to reach areas behind some patient beds. 2. Cavell Ward had a high number of cleaning fails of particular concern was the use of the day room for storage which made cleaning difficult. There was a lot of clutter preventing access for cleaners to clean. 3. Internal glazing across a high number of wards and OP areas had lots of cellotape and markings.

	QMH: 1. There were lots of qualified passes for lime scale on taps and dusty skirting boards. 2. There were cleaning issues on the windows and behind furniture Sodexho have taken immediate action to address and rectified this.
Food & Ward Food *(Includes taste, texture, temperature, choice of food, 24 hour availability, meal times and access to menus)*	**SGH:** The assessment scored highly for food tasting and quality and all the patient representatives were impressed with the quality and taste of the food served. The score was higher compared to 2017 and the feedback from all assessors was the quality and taste of food was excellent. This improvement has also been recognised via the ward accreditation inspections. The areas of concern relates to 1. The food service on the ward as this varied in terms of support from nursing staff and the ceasing of clinical activity. 2. At the time of the assessment there wasn't 24 hour access to catering services for visitors and carers. Work is underway to address this. 3. Not all wards displayed the menus for patients to choose their meal. MITIE have reminded all hostesses to ensure the menus are displayed. 4. Scores were also lowered due to the lack of separate day rooms for patients to eat away from the bedside. There is a lack of space for day rooms on the majority of wards. **QMH:** The food scores have reduced since 2017 and immediate action has taken place: 1. Nutrition Steering Committee is in place and has corporate oversight on the service and plans being put in place to improve the service 2. Ensure menus are seen by patients – there is a handheld electronic menu in place but the requirement to provide paper menus has been reiterated to the catering and housekeeper staff. 3. A new Hotel Services Manager has been recruited to oversee the service
Organisation Food *The food domain includes a range of organisational questions relating to the catering service e.g. choice of food, 24-hour availability, meal times and access to menus.*	**QMH & SGH:** 1. Did not have 24/7 access to food services for families, carers and guardians. 2. Lack of toast available as a result of toasters being removed to reduce false fire alarms. 3. Lack of juice and soup options on the menu – these are available to order via the helpdesk. This has been agreed with the Trust dietetic lead as not required on the main menu (*SGH)

Privacy, Dignity & Wellbeing *(includes provision of outdoor and recreational area, changing and waiting facilities, access to TV/radios, it also includes the practicality of male and female services e.g sleeping, bathrooms, private space and appropriately dressed)*	**SGH:** The scores were improved this year. The recent investment in the lowering of ward curtains in St James Wing has contributed to this improved score. In addition the review and installation of blinds in clinical areas across Atkinson Morley Wing has helped with the increased score. **SGH & STG:** The main areas of areas to review were: 1. Some wards are not designed so that no patient needs to pass through an area of the opposite sex in order to access toilets, bathrooms or to leave the ward. 2. Not all wards have a separate treatment room. 3. Not all patients had access to lockable storage. An audit will follow to cost the provisions of lockable cabinets to all areas. 4. Patient notes were accessible in some ward and OP areas – this was verbally feedback to the Nurses in charge at the end of the assessment. This was noted in 2 areas on the SGH site.
Condition, Appearance and Maintenance *(includes various aspects of the general environment including décor, condition of fixtures and fittings, general tidiness, lighting, access to car parking, waste management and the external appearance of buildings/grounds)*	**SGH:** There were low levels of scores in a high number of areas assessed. Main themes were: 1. The toilets and bathrooms across the wards and outpatient areas are in urgent need of refurbishment. The capital team will review costings for upgrades. 2. Wards within St James and Lanesborough Wings had a lack of storage so items were stored in corridor areas. . **QMH:** 1. Minor damage to walls 2. Ceiling tiles were missing in some areas 3. A small number of lights were not working The estates team have rectified the areas from the audit.
Dementia Friendly environment *The Dementia domain focuses on flooring, décor and signage and also aspects such as availability of handrails, appropriate seating and, to a lesser extent, food. These represent key issues for providing for the needs of patients with dementia but do not constitute the full range of issues and organisations are encouraged to undertake more comprehensive assessments using one of the recognised environmental assessment tools.*	There is no open operational area that fully meets the standards required for dementia patients. Daly Ward is dementia friendly and will open in January 2019, in addition Heberden Ward has funding secured to improve the environment for patients with dementia. The dementia domain works and changes required will need to be supported via the Dementia Strategy group for future planning.

Disability *includes wheelchair access, hearing loops, visual announcements) handrails in corridor areas.*	**SGH:** The scoring was low for this area as: 1. The majority of wards and OPD do not have hearing loops or visual announcements. The disabled access audit will list the areas without these for costing. 2. A large number of areas had door signs on walls and not on doors. 3. Signage height needs changing across the site to fully comply. 4. Access from car parks to buildings entrances is not fully compliant for disabled access. The external pavement and paths are not 100% flat and accessible across the whole area. The estates team have a site map of areas of noncompliance. They will produce a specification to get this rectification works costed. Funding has been provided by the Charity to audit the Trust on the disability access and this commenced in October 2018. This audit will be completed by the not for profit organisation AccessAble. When the audit is completed any gaps in compliance will be costed for further consideration.

Recommendations and general actions

There is an action plan in place which will be shared with the Matrons and all relevant staff on 17 December 2018. The plan is monitored via the Matrons Environmental Action Team (MEAT). Immediate actions were put in place after the assessments and verbal feedback was provided to staff within the area on the day of the assessment. There are actions that will require funding which will need to be requested and approved via the usual Trust governance processes.

The plan will be shared once approved by MEAT and funding confirmed.

Information Governance
PLACE data will be published as Official Statistics and in particular be shared with the following organizations:

- Care Quality Commission
- Department of Health
- NHS Commissioning
- Clinical Commissioning Groups (when requested)
- National Audit Office (when requested)
- The Health and Social Care Information Centre (Clinical Quality Indicators)

The full set of assessment guidance and scoring forms are available from the NHS Digital website as per the link below:
http://www.digital.nhs.uk