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NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting
Thursday, 28 November 2019

Agenda and papers

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NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: **Thursday, 28 November 2019, 10:00-13:05**
Venue: **Hyde Park Room, 1st Lanesborough Wing**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the site**	**Board Members**	Note	Oral
STAFF VALUES AWARD					
10:25	**B**	**Staff Values Award Presentation – Medicines Information Team**	**Chairman**	-	Oral
1.0 OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Chairman**	Note	Oral
	1.2	**Declarations of interest**	**All**	Assure	Report
	1.3	**Minutes of meeting on 31 October 2019**	**Chairman**	Approve	Report
	1.4	**Action log and matters arising** • ***Update on (September) Patient Story – Paediatric Journey***	**All**	Review	Report
10:35	**1.5**	**CEO's Report**	**Chief Executive Officer**	Inform	Report
2.0 QUALITY & PERFORMANCE					
10:45	**2.1**	**Quality and Safety Committee Report**	**Committee Chairman**	Assure	Report
	2.1.1	***Medicines Management Annual Report***	***Chief Medical Officer***	*Assure*	*Report*
	2.1.2	***Research Annual Report***		*Assure*	*Report*
	2.1.3	***Seven Day Working Self-Assessment***		*Approve*	*Report*
11:05	**2.2**	**Integrated Quality & Performance Report**	**Chief Transformation Officer**	Assure	Report
11:20	**2.3**	**Emergency Care Update**	**Chief Operating Officer**	Assure	Report
11:40	**2.4**	**Cardiac Surgery Update**	**Chief Medical Officer**	Assure	Report
3.0 FINANCE					
11:50	**3.1**	**Finance and Investment Committee Report**	**Committee Chairman**	Assure	Report
12:00	**3.2**	**FIC (Estates) Report**	**NED Estates Lead**	Assure	Report
12:10	**3.3**	**Finance Report (Month 07)**	**Chief Financial Officer**	Update	Report
4.0 STRATEGY & GOVERNANCE					
12:20	**4.1**	**Workforce Strategy**	**Chief People Officer**	Approve	Report
12:30	**4.2**	**Fit and Proper Person Test**	**Chief People Officer**	Assure	Report
12:40	**4.3**	**Care Quality Commission - Statement of Purpose**	**Chief Nurse**	Approve	Report
5.0 CLOSING ADMINISTRATION					

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Time	Item	Subject	Lead	Action	Format
12:45	5.1	**Questions from the public**	**Chairman**	Note	Oral
	5.2	**Any new risks or issues identified**	**All**	Note	
	5.3	**Any Other Business**		Note	
	5.4	**Reflections on the meeting**		Note	
6.0 PATIENT/STAFF STORY					
12:55	6.1	**Patient Experience of the Midwife-led Juniper Continuity of Care Team**	**Gemma Legge (Patient)**	Note	Oral
13:05 CLOSE					
Resolution to move to closed session **In accordance with Section 1 (2) Public Bodies (Admissions to Meeting) Act 1960, the Board is invited to approve the following resolution: "That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".**					

Thursday, 19 December 2019, 10:00-12:30
Hyde Park Meeting Room

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Trust Board
Purpose, Meetings and Membership

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

Meetings in 2019-20 (Thursdays)									
28.03.19	25.04.19	30.05.19 (QMH)	27.06.19	25.07.19	29.08.19	26.09.19	31.10.19 (QMH)	28.11.19	19.12.19
30.01.20	27.02.20	26.03.20							

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Deputy Chairman	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		
Suzanne Marsello	Chief Strategy Officer	CSO
Ellis Pullinger	Chief Operating Officer	COO
Harbhajan Brar	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Sally Herne	Quality Improvement Director – NHS Improvement	QID
Secretariat		
Tamara Croud	Interim Assistant Trust Secretary	IATS
Apologies		
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

St George's University Hospitals NHS
NHS Foundation Trust

Board Walkabout - Thursday 28th November 2019, 08:30 – 09:45

Meet in the Lanesborough Wing Hyde Park Room at 08:30

At the time of your visit the wards and departments will be extremely busy. This is one of the busiest times for areas with morning ward rounds, medication and assistance with patient care being completed.

Please ensure that your team is in room Hyde Park Room for 09:45 to provide verbal feedback on your areas visited. Please nominate one individual to provide a summary of the findings who will be given 3 minutes to complete this.

During your visit to areas this is an opportunity to meet with staff and understand the breadth of services that are provided. You are encouraged to discuss with staff the services they provide and challenges they may face.

In addition to this we would ask that you continue to observe environmental cleanliness and infection control principles and therefore the following points may assist you in this process.

1. **Are staff bare below the elbows in clinical areas and adhering to principles of hand washing?**
2. **Is the ward/department clutter free?**
3. **What impression are you given on entering?**
4. **Is the ward calm and organised? Is the ward odor free?**
5. **Are signs and notice boards clear and well displayed?**
6. **Is any unused equipment clean and labeled as clean and ready for use?**
7. **Are resus trollies, ledges etc free from dust?**
8. **Are there any outstanding urgent estates or maintenance issues?**
9. **What do staff enjoy most about working at St Georges Hospital?**
10. **What do staff feel the barriers are to undertaking their job?**
11. **How do staff feel the board can support them in delivering care to patients or undertaking their job?**
12. **Are there any outstanding urgent estates or maintenance issues?**

These visits are not “inspections” as these will be done using a more formalised approach.

Practicalities

- This is usually conducive to visiting two clinical / non clinical areas but need to be flexible and go to another area if it is not a suitable to visit at that time or visit finishes early.
- When arriving in a clinical area always ask to speak to Nurse in Charge (NIC), if NIC and other staff are busy ask for the Matron or Head of Nursing to be bleeped if they are not already on the ward.
- Board members must be ‘bare below the elbow’, including the removal of any rings with stones.
- All belongings can be left in the Hyde Park room as a member of staff will stay with the belongings while you are out visiting the wards.
- If you need to make notes please do so and let the staff know that you are doing so to feedback to the Board.

The table overleaf sets out group and areas to visit. We will start from the Hyde Park Room at 08:30 and return to there for 09:45 to report our observations and findings to the other groups at the start of the Board meeting at 10:00.

Finally – enjoy! Staff really appreciate visits by Board members and welcome the opportunity to speak to us directly.

Groupings- 28th November 2019

NED	Exec / Divisional Chair	Divisional Representation	Area Visiting, 08:30 – 09:45
Gillian Norton, Chair	Suzanne Marsello Richard Jennings	Fiona Tucker (Matron) Vicki Hedley (Lead Nurse)	Allingham (3rd Floor STJ) Endoscopy (1st Floor STJ)
Tim Wright	James Friend Stephen Jones Ellis Pullinger	Ewa Ogbonna (Matron) Tammy Stracey (Matron)	Cardiac Theatres (1st Floor AMW) CTICU (1st Floor AMW)
	Avey Bhatia Jacqueline Totterdell	Ana Seco Ferreira Vaz (Matron)	Keate Ward (5th Floor STJ) Florence Ward (4th Floor STJ)
Anne Beasley	Harbhajan Brar Andrew Grimshaw	Vin Kumar (Chief Pharmacist) Christine Wood (Matron)	Pharmacy (Ground Floor LNS) Jungle Ward (1st Floor LNS)

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Meeting Title:	**TRUST BOARD**		
Date:	**28 November 2019**	**Agenda No.**	**1.2**
Report Title:	**Board Member Declarations of Interest**		
Lead Director/ Manager:	**Stephen Jones, Chief Corporate Affairs Officer**		
Report Author:	**Stephen Jones, Chief Corporate Affairs Officer**		
Presented for:	**For Information**		
Executive Summary:	The updated Register of Board Members' interests is attached as Appendix A. It was agreed, in March 2019, that a report on Board Members' Interests be presented at each Board meeting to ensure transparency, public record and afford members the opportunity to update their interests and to declare any conflicts. Since the 1 October 2019, members of the public have been able to see what declarations our staff, including Board members, have made via our Declare portal. Given that this information is now readily accessible in the public domain we propose to cease bringing this paper as a regular item to the Board from January 2020, and will instead prompt members to update on any declarations as an oral update on the agenda. Members are asked to note that after expiry, an interest will remain on the public register for a minimum of 6 months with an end date recorded within the specific entry.		
Recommendation:	The Board is asked to note, review and provide any relevant updates.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and improvement capability (well-led) – Effective boards and governance.		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The public rightly expect the highest standards of behaviour in the NHS. Decisions involving the use of NHS funds should not be influenced by outside interests or expectations or private gain.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix A. Register of Board Members' interests		

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Appendix A. Register of Board Members' interests

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Gillian Norton	Chairman	Deputy Lieutenant (DL) Greater London Lieutenancy Representative DL for Richmond	October 2016	Present	
Gillian Norton	Chairman	Chairman of Epsom and St Helier Hospitals	October 2019	Present	Remunerated
Gillian Norton	Chairman	Chair of Trustees of Richmond upon Thames Voluntary Fund	September 2019	Present	Non remunerated
Ann Beasley	NED, Deputy Chairman, Chair of the Finance and Investment Committee	ACAS Independent Financial Adviser ACAS Audit Committee Member	December 2017	Present	Remunerated
Ann Beasley	NED, Deputy Chairman, Chair of the Finance and Investment Committee	Florence Nightingale Foundation, Mentor	April 2018	Present	Non remunerated
Ann Beasley	NED, Deputy Chairman, Chair of the Finance and Investment Committee	South West London and St George's mental Health NHS Trust, Chair	1 October 2018	Present	Remunerated
Ann Beasley	Company Director	Alzheimer's Trading Limited	October 2019	Present	Non-Remunerated

Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Advisory Board: Healthcare Market News (monthly publication)	2015	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Advisory Board: Cielo Healthcare (Milwaukee, USA)	2015	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Member, Health Leaders Panel: Nuffield Trust	2014	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Trustee: ReSurge Africa (medical charity)	2015	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	External Advisor: Schoen Klinik (German provider of mental health and surgical services)	2018	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	External Advisor: Imperial College, in relation to potential academic / research-led medical & technology developments / collaborations on the new White City campus	2016	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Independent Advisor to the Inquiry into Issues raised by Patterson	2018	Present	

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman of NHS professionals Limited (provider of managed staff services to the NHS)	2018	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman and shareholder: Eden Futures (supported living provider)	2016	Present	
Stephen Collier	Non-Executive Director & Workforce and Education Committee Chair	Chairman and shareholder: Cornerstone Healthcare group (dementia care provider)	2018	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Board Governor: Kingston University	November 2015	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Principal: St George's, University of London	November 2015	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Visiting Professor: Lee Kong Chian School of Medicine in Singapore	January 2010	Present	

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Honorary Consultant: Imperial College London	November 2011	Present	
Jenny Higham	Non-Executive Director (St George's University of London University Representative)	Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Non-remunerated Board Member	2017	Present	
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Non-Executive Director, and Audit and Risk Committee Chair - Capita Managing Agency Limited	2004	Present	Remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Non-Executive Director, and Audit and Risk Committee Chair - Hampden Members' Agencies Limited	2008	Present	Remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Trustee and Vice Chair - Paul's Cancer Support Centre	1995	Present	Non remunerated
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Magistrate – South West London Magistrates Court and Central London Family Court	2005	Present	Non remunerated

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Chairman and Non-Executive Board Members					
Sarah Wilton	Non-Executive Director and Audit Committee Chair	Co-opted Member – Wimbledon and Putney Commons Conservators Audit and Risk Committee	2019 (January)	Present	Non remunerated
Timothy Wright	Non-Executive Director	Owner/Director, Isotate Consulting Limited	January 2013	Present	IT advisory and consulting services to private and public sector clients (none of whom are in the healthcare sector)
Timothy Wright	Non-Executive Director	Trustee, St George's Hospital Charity	19 January 2018	Present	Non-remunerated

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Executive Board Members					
Jacqueline Totterdell	Chief Executive	Partner, NHS Interim Management and Support	2005	Present	
Jacqueline Totterdell	Chair	Chair of the Clinical Research Network (CRN) South London Partnership Board	2019	Present	
Avinderjit (Avey) Bhatia	Chief Nurse and Director of Infection Prevention and Control	None			
Harbhajan Brar	Chief of People	Ethics Committee Member, Institute for Arts in Therapy and Education (IATE)	1 May 2018	Present	Ad-hoc role
Andrew Grimshaw	Chief Finance Officer	None			
Dr Richard Jennings	Chief Medical Officer	None			

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Chief Transformation Officer	Trustee, Carrie's Home Foundation	2018	Present	Non-remunerated
James Friend	Chief Transformation Officer	Trustee, Westcott Sports Club	2018	Present	Non-remunerated
James Friend	Chief Transformation Officer	Council Liaison Officer, Mole Valley Conservative Association	2017	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member Hut Management Committee, Westcott	2012	Present	Non-remunerated
James Friend	Chief Transformation Officer	District Councillor Westcott, Mole Valley District Council	2008	Present	Leader of the Opposition

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Name	Role	Description of Interest	Relevant Dates		Comments
			From	To	
Non-Voting Board Members					
James Friend	Chief Transformation Officer	Church Warden, St John's The Evangelist, Wotton	2004	Present	Non-remunerated
James Friend	Chief Transformation Officer	Volunteer, Radio Wey	1994	Present	Non-remunerated
James Friend	Chief Transformation Officer	Associate Member, Association of Corporate Treasurers	1998	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member Westcott Cricket Club	1996	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member Chartered Institute of Bankers	1996	Present	Non-remunerated
James Friend	Chief Transformation Officer	Member, National Trust	1992	Present	Non-remunerated
Stephen Jones	Chief Corporate Affairs Officer	Wife is a senior manager at NHS England	5 March 2018	Present	
Suzanne Marsello	Chief Strategy Officer	None			
Ellis Pullinger	Chief Operating Officer	None			

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Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 31 October 2019, 10:00 – 13:30
Barnes, Richmond, Sheen Rooms, Queen Mary's Hospital, Roehampton

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Jacqueline Totterdell	Chief Executive Officer	CEO
Andrew Grimshaw	Chief Finance Officer/Deputy Chief Executive Officer	CFO/DCEO
Avey Bhatia	Chief Nurse and Director of Infection Prevention & Control	CN
Richard Jennings	Chief Medical Officer	CMO
IN ATTENDANCE		
Harbhajan Brar	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Ellis Pullinger	Chief Operating Officer	COO
Ralph Michell	Head of Strategy (deputising for the CSO)	HoS
SECRETARIAT		
Tamara Croud	Interim Assistant Trust Secretary (Minutes)	IATS
APOLOGIES		
Suzanne Marsello	Chief Strategy Officer	CSO
Sally Herne	NHSI Improvement Director	NHSI-ID

Feedback from Board Visits

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

- Outpatients and Minor Injuries Unit (MIU) – Chairman and CN
- Bryson Whyte Rehabilitation Unit and Mary Seacole Ward – Ann Beasley and CMO
- Gwynne Holford Ward and Wolfson Rehabilitation Unit – Jenny Higham, CPO and CCAO
- Douglas Bader Rehabilitation Centre – Stephen Collier and COO
- Day Case and Endoscopy and Dermatology – Tim Wright and CFO

The Board members witnessed and heard about some very positive themes during the visits including the high quality of the estates infrastructure at Queen Mary's Hospital (QMH), the dedication of QMH staff who demonstrated high levels of competence, commitment and

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Feedback from Board Visits
understanding of the pathway flows between the Trust and external organisations, and the high quality of care and services provided on the site. The rehabilitation and limbs service stood out as innovative and exemplary, for example, demonstrated by the high quality of orthotics and prosthetics for children and the Dermatology service was rated as the best in London. A number of significant issues were raised during the visits in relation to the recent deployment of iClip at QMH. The feedback was variable. Some staff had welcomed and praised the new system, but there had been challenges, notably some clinicians reporting that their productivity had been adversely affected. Additionally, patients had been arriving for outpatient clinics that did not exist. There was recognition that this needed to be addressed immediately. Conversely, staff noted that iClip had increased the visibility of the patient pathway and had supported staff in tracking patients, for example by dealing with the issue of the unsociable hours transfer between the Tooting and Roehampton sites, which had been raised on previous visits. Staff also highlighted the benefits of the new system in completing the drugs round. Other material issues raised included the single point of access for MSK which had presented challenges for the therapies staff, the perception that there was a lack of senior management visibility at QMH, and the dermatology team reporting issues with activity flows due to the joint service model adopted across both sites. The Board noted and agreed that the COO would address the issues related to dermatology activity flows, single point of access issues for MSK, and iClip. The Trust Executive Committee would look at the issues related to senior management visibility at QMH.

Values Award
The Board welcomed Hayley Blanchett who, with colleague Caroline Van Marle, had been nominated for a Living Our Values Award for going above and beyond to ensure patients who had been referred to the Queen Mary Hospital Physiotherapy Services were booked in a timely manner despite the challenges over the last few months with the change to a new system. The Chairman presented Hayley with the award and expressed the Board's gratitude.

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting and noted the apologies as set out above. Governors Mia Bayles, Nick de Bellaigue, Alfredo Benedicto, Anneke de Boer, John Hallmark, Sarah McDermott and Richard Mycroft were in attendance as observers. The Chairman advised that the following arrangements had been made in relation to the non-executive membership of Board Committees: • Quality and Safety Committee: Tim Wright would Chair the Committee until the new clinical NED took up post. Sarah Wilton would become a formal member of the Committee alongside continuing her membership of the Workforce and Education Committee, Finance & Investment Committee and chairmanship of the Audit Committee; and • Finance & Investment Committee: Tim Wright would become a formal member of the Committee. The Board approved Ann Beasley's appointment as Senior Independent Director, noting that this had also been endorsed by the Council of Governors at	

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		Action
	its meeting on 22 October 2019. The Board also noted and endorsed the appointment of Stephen Collier has the NED lead for Freedom to Speak Up. The Board, having previously noted and endorsed the appointment of the Chairman as Chair-in-Common for the Trust and Epsom and St Helier University Hospitals NHS Trust, discussed the potential that a conflict of interest may arise and considered how this should be addressed. The Board noted that the Trust's Constitution, and the provisions of the NHS Act 2006 on which it was based, permitted directors to have conflicts of interest where these were authorised by the Board. The Board recognised that the Chairman's role as Chair-in-Common across the two Trusts did represent a potential conflict of interest, but agreed that this could exist on the basis that: • The appointment would assist with facilitating closer collaboration between two major hospitals in South West London, with potentially significant benefit to the patients of both organisations; • The appointment was made and supported by NHS England and NHS Improvement; and • The Trust's Council of Governors, while acknowledging the challenges involved, were supportive of the Chairman fulfilling the role of Chair-in-Common and had discussed this at its October 2019 meeting. In addition, the Board acknowledged that the Chairman would formally declare any explicit conflicts of interest in matters to be discussed and agreed by the Board or its Committees.	
1.2	**Declarations of Interest** The Board noted the register of Board members' interests. Ann Beasley reported that she had recently been appointed as a non-remunerated Company Director of Alzheimer's Trading Limited.	
1.3	**Minutes of the meetings held on 26 September 2019** The minutes of the meeting held on 26 September 2019 were agreed as an accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log. The Chairman reiterated the importance that the Board receive a more comprehensive report on cardiac surgery at its November 2019 meeting which included an update on the Trust's progress against the recommendations of the Bewick Review. The CTO clarified that in relation to action item TB.26.09.19/05, there would be no visits to Orlando Health.	
1.5	**Chief Executive Officer's Update** The CEO presented the Chief Executive Officer's Update and highlighted the following: • The Trust currently had a 48.5% uptake among staff of the flu vaccination and 34% of staff had completed the staff survey to date. Considerable work was being undertaken to ensure that the Trust remained among the best for flu vaccination uptake and to increase the survey response rate. • The Trust celebrated Black History Month in October, which was welcomed by the staff, and held an event to celebrate Diwali. The Trust's Freedom to	

		Action
	Speak Up Month in October had been very successful and formed part of the programme of work to encourage and support staff in feeling confident to raise concerns. • The Trust had been told it would be receiving funding for two new Magnetic Resonance Imaging (MRI) scanners and a mammography machine as part of NHS England and NHS Improvement's recent announcements on capital funding. The Board welcomed celebration of different cultures but queried the breadth of engagement with the local communities. The CEO acknowledged that more needed to be done to engage with local communities and reassured the Board that there was fair access to the Trust's services. The Chairman noted that it was important for the Trust to continue engaging and supporting staff members but it was time to review the Trust's external stakeholder engagement programme and commented that it was important that the Trust more transparently considers equality impact assessments. On flu, the Board welcomed the progress with the vaccination programme but expressed concerns about the poor uptake of flu vaccination by staff in the midwifery service. It was noted that the Trust was closely monitoring uptake by staff group and targeted work was being conducted within the services where uptake was low.	
2.0	**QUALITY AND PERFORMANCE**	
2.1	**Quality and Safety Committee Report** Tim Wright, Interim Chair of the Committee, presented the report of the meeting held on 24 October 2019 flagging key issues raised at the meeting. The Committee welcomed the feedback from the deep dive and notably the implementation of the training programme on human factors to improve quality and communication. The good performance in relation to cancer and methicillin resistant staphylococcus aureus (MRSA) was also noteworthy. In addition, the Committee could see that while there were early challenges with the implementation of iClip, the deployment across the Trust was improving data flows and the management of patients. The Board queried the degree to which the Trust monitored outcomes especially in relation to Black, Asian and Ethnic Minority (BAME) women. It was noted that the maternity service did monitor outcomes based on ethnicity and experience and the Trust, as a tertiary referral hospital, did receive high risk cases. The Trust's Diversity and Inclusion Strategy included a component related to service delivery and outcomes. The Board noted the report.	
2.1.1	**Infection, Prevention and Control Annual Report 2018-19** The Board received the annual report on infection prevention and control for 2018-19. The report had been considered at the Quality and Safety Committee which reported its assurance to the Board in September 2019. Ann Beasley commented that it was important the Board was reminded about how the Committee gained its assurance on the matters raised both in this report and others considered by the Committee. This was particularly important where the Board received a report a month after it had been considered by the Committee. The Board noted that the Committee had reported its assurance on the contents	

		Action
	of the report the previous month via the Committee chair's report to the Board on the basis that it was not only comprehensive but also did not present any surprises which reflected that the Trust now had greater transparency and grip on infection prevention and control issues.	
2.1.2	**Learning Disability Services** The Board received and noted the annual report from the Learning Disability Services. The report had been considered at the Quality and Safety Committee in September 2019 and the Board reflected that the high quality of service, good outcomes and support provided to patients with learning disabilities was exemplary. The Board noted the report.	
2.1.3	**Learning from Deaths Quarter Two Report** The CMO presented the quarter two learning from deaths report reporting that the Medical Examiner's service would begin in November 2019. The Mortality Monitoring Committee was currently reviewing 93.5% of deaths and there were no deaths banded as avoidable during quarters one and two and the Trust's Summary Hospital-Level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) scores were rated 'lower than expected'. Work was underway to strengthen the Trust's clinical governance processes and multidisciplinary team meetings which would enhance the Trust's level of scrutiny and assurance. The CMO was now chairing the Mortality Monitoring Committee on a temporary basis as Dr Nigel Kennea, the former chair, had taken on the role of lead Medical Examiner for the Trust. The Board welcomed the inclusion of learning disabilities in the report but flagged that it was also important to reflect data on patients with mental health issues. It was noted that the report would be enhanced to reflect learning from deaths and data which help the Trust track key trends. The Board noted the report.	
2.2	**Integrated Quality and Performance Report (IQPR)** The CTO gave an overview of the IQPR at Month 06 (September 2019). The key challenges in the report related to 18 week referral to treatment (RTT) targets which in subsequent months would include data from the Queen Mary's Hospital site. Overall RTT performance was in line with the forecast and the Trust was in line with the 52 week waits trajectory at the end of September. Appraisals rates for non-clinical staff remained a challenge and were below target and the Trust was engaging with managers to improve performance. The Workforce and Education Committee is monitoring this closely. The Board noted the report.	
2.3	**Emergency Care Performance Report** The COO presented the report on emergency care performance and acknowledged that the report did not cover all the elements that the Board had asked to be addressed at the last meeting. The Board raised concerns about the level of grip on emergency department performance, the short timescales to	

		Action
	address the issues, and the lack or prioritisation for each workstream. The COO reported that the key priority was improving the processes around emergency care management. The Chairman also queried the lack of progress made on triaging patients to other areas of the organisations rather than through the emergency department. The CTO reported that whilst there were opportunities to drive productivity at the front line the key to improving performance was to reduce length of stay and ensure that patients were being cared for in the right place at the right time which required improvements in processes such as discharge. The CEO reported that all divisions were now focused on how to work together to drive improvements in the pathway as well as in the emergency department but it was important that the Trust focused on doing the right thing for the patients. In response to a query from Sarah Wilton, the CEO reported that she was now chairing a weekly meeting to oversee the improvements in emergency care performance and the Finance and Investment Committee and the Board would be able to track progress against the actions to address the ED issues by reviewing the scorecard. The Board noted the report and the Chairman reiterated the importance of the Board seeing tangible delivery of the actions and improvements that were needed in the ED pathway and as such would continue to review performance each month.	
2.4	**Cardiac Surgery Update** The Board received and noted the cardiac surgery update. The CMO reported that the Trust had received a communication from the National Institute of Cardiovascular Outcomes Research (NICOR) on its outcomes for the period April 2015 to March 2018. This showed that the outcomes in cardiac surgery during this period were within limits which reflected a positive movement and significant external assurance around the current safety of the unit. The Chairman reiterated that the Board would like to see a comprehensive cardiac surgery report at its meeting in November 2019 and that this should include a full update on the Trust's actions in response to the independent report by Professor Mike Bewick which the Trust had received in July 2018. **The Board noted the report, requested a comprehensive report at the next meeting and agreed that the CMO would circulate the letter from NICOR confirming the Trust was now out of alert to the Board.**	**CMO**
2.5	**Transformation Quarter 2 Report** The CTO reported that the Trust had recently received an award for being the most innovative trust in South London from the Health Improvement Network. The Trust was already delivering aspects of the vision of the NHS Long Term Plan in relation to patients admitted on a non-elective basis having been assessed, treated and cared for through ambulatory care. In response to queries from the Board about the level of patient engagement in the transformation programme, the CTO reported that patient engagement and involvement was a key element of the transformation work and, as an example, the maternity transformation programme involved a wide range of stakeholders and patients. The Board noted the report.	
3.0	**Workforce**	

		Action
3.1	**Workforce & Education Committee Report** Stephen Collier, Chair of the Committee, presented the report of the meeting held on 10 October 2019. The Committee wanted to flag three matters for the Board's attention. First, the Trust was keeping up with the demand for staff and filling vacant posts as required. Second, having received the key plans and progress against the diversity and inclusion actions the Committee agreed to reduce the risk scores. Finally, while the safe working trends for junior doctors were moving in the right direction there were a couple of areas which remained challenged and the Committee asked the Guardian of Safe Working to take steps to engage early and directly with the divisional leads to address issues as they arise. The Committee also endorsed the addition of the corporate risk related to staffing following the UK's Exit from the European Union. The Board noted that it was very disappointing that the go-engage tool had not been launched as planned, which impacted on the Trust's ability to complete the internal staff survey in quarter two. **The Board noted the report and agreed that the Trust would find another means of conducting the quarter two internal staff survey.**	**CPO**
3.2	**Health Workers Flu Vaccination** The CPO presented the report which outlined the Trust's self-assessment of the staff uptake of the flu vaccination as discussed above under agenda item 1.5. The Board received and endorsed the self-assessment noting that the Trust would continue with its programme of work to improve staff uptake of the flu vaccination with the ambition of being among the best trusts for take up of the vaccination in London.	
4.0	**FINANCE**	
4.1	**Finance and Investment Committee Report** Ann Beasley, Chair of the Committee, provided an update on the meeting held on 24 October 2019. While the Trust's financial performance was on plan, for now, the Committee raised concerns about the lack of progress on delivering the savings targets and heard about plans to retain and enhance grip on the financial position until year-end. The Committee agreed that the overall risk rating for the financial position would remain one of limited assurance. It also welcomed the progress made on ICT, noting its assurance remained limited for quarter two. The Board noted the report.	
4.2	**Finance and Investment Committee (Estates) Report (FIC(E))** Tim Wright, NED Estates Lead, provided an update on the meeting held on 24 October 2019. It was now evident that the Trust had a grip on the estates issues. The recent audit of water safety by the Authorised Engineer had resulted in an improved assurance rating (moved from no assurance to limited assurance). While there remained some areas of challenge the Trust had made good progress with the management of the new cleaning contract with MITIE. The Trust would be inspected by the Health and Safety Executive in	

		Action
	early November 2019 and the estates team were preparing for the visit. The Committee had supported the proposal to engage additional external resources to develop the estates strategy. In response to the query about securing permanent leadership for estates and facilitates, the CEO advised that the Trust would be seeking to appoint a Director of Estates and Facilities. This role would not be a member of the Board but would report to the CFO. In response to a question related to fire safety, the CFO committed to reviewing the issues raised in the Grenfell tragedy in relation to evacuation protocols as part of the broader fire safety review providing updates to the FIC(E) as relevant. The Board noted the report.	
4.3	**Month 06 Finance Report** The Board noted the Month 06 finance report and the CFO reported that although the Trust remained on plan this did not adequately illustrate the underlying position which reflected that the Trust's run rate was very challenged. The most significant issue for the Trust related to delivering the agreed savings plan. As a result, a robust regime to address grip and control was being instigated. Cash and capital was on plan but if the current level of pressure continued it would begin to impact on the expenditure position. The Board noted the report.	
5.0	**Governance**	
5.1	**Audit Committee Report** Sarah Wilton, Chair of the Committee, provided an update on the meeting held on 10 October 2019. The Committee considered and endorsed the revised internal audit plan for 2019/20. It had reviewed three internal audit reports which had a limited assurance rating (diagnostic testing, estates and facilities reactive maintenance, and ICT review of cyber security), one which had a reasonable assurance rating (safeguarding adults), and one with substantial assurance (financial reporting: Board budget setting). The Committee also heard that the CPO would progress the terms of reference for the internal audit of Diversity and Inclusion and the CPO confirmed the terms of reference had now been drafted and agreed with internal auditors. The Committee would review its effectiveness with a report to be presented at its next meeting in January 2020. The Board noted the report.	
5.2	**Draft Research Strategy** The Board received and discussed the draft research strategy noting the engagement programme which had been undertaken to develop the strategy. The draft strategy had been considered and endorsed at a Board seminar earlier in the month, the Trust Executive Committee, Quality and Safety Committee and had also been discussed by the Council of Governors at its meeting on 22 October 2019. A fundamental element of the strategy, which aligned the Trust and the University's research priorities, was the creation of the virtual St George's Institute for Clinical Research. The strategy would provide the infrastructure to enable the Trust to access additional funding from	

		Action
	the National Institute for Health Research. The Board approved the research strategy for 2019-2024 subject to the additional funding bid going through the normal approval processes.	
5.3	**Corporate Objectives Quarterly Report** The Board noted the report on the corporate objectives and its disappointment that more progress had not been made against delivering the agreed actions. The CEO noted that the objectives should be directing what the organisation focused on and more work was needed to ensure that the actions were being delivered. The CFO advised that the Trust Executive Committee could focus more on the objectives as part of the monthly programme board meetings and that this should help with delivery. **The Board agreed that:** • **The CEO would speak to the CSO about how best to embed the objectives across the organisation;** • **The objective related to Estates Strategy would be updated to reflect the decision to engage external support to develop the strategy; and** • **The Board would start the process for developing the objectives for 2020-21 at a Board Seminar.**	**CEO/CSO** **CFO/CSO** **CSO/CCAO**
5.4	**St George's Hospital Charity Quarterly Report** The Board received and noted the quarterly report from the Charity. The Chairman added that the relationship with the Charity had improved substantially and because of this, she had agreed with the Charity's Chairman that the Board would now receive reports every six months.	
5.5	**Board Assurance Framework Q2 report** The Board received and discussed the Board Assurance Framework report for quarter two. The Board agreed the risks score, assurance ratings and assurance statements in relation to strategic risks five and six, which were reserved to the Board. The Board also endorsed the movements in risks and the assurance ratings for the strategic risks assigned to the Board Committees.	
5.6	**Horizon Scanning Reports:**	
5.6.1	**Policy, Legislative and Regulatory Issues – Quarter Two** The CCAO introduced the report and flagged the extensive new guidance that had been published since the Q1 report in July in relation to freedom to speak up, which the Workforce and Education Committee would consider. He also noted that the Board had held a seminar on preparedness for the UK's withdrawal from the European Union earlier in the month. Legislative changes that had been announced in the Queen's Speech to promote greater integration and system working were potentially significant, though would be subject to the outcome of the general election. The Board noted the report on emerging political, legislative, policy and	

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	regulatory issues covering Q2 2019/20 developments and agreed it was a useful update.	
5.6.2	**Regional and Local Updates** The Board noted the report on local developments in south west London, based on CCG Governing Body and Health and Wellbeing Board papers, and on current and future Clinical Tender opportunities.	
6.0	**CLOSING ADMINISTRATION**	
6.1	**Questions from the public** There were no questions from the public.	
6.2	**Any other risks or issues identified** There were no other risks or issues identified.	
6.3	**Any Other Business** There were no matters of any other business raised.	
6.4	**Reflections on the meeting** The Chairman invited Ann Beasley to offer reflections on the meeting. Ann Beasley noted that the Board's focus was predominately on assurance and to a lesser degree on risk and strategic matters. It was evident the Board was being responsive and people had come to the meeting well prepared. It was positive that the Trust celebrated the good things that were happening across the Trust. However, while there had been challenge on difficult issues such as the emergency department and financial position the Board may need to reflect on its approach and on whether or not it needed to be more directive and take a stronger stance on holding people to account. The Board's approach in this regard may be reflective of the wider culture in the organisation. Tim Wright commented that there was a greater degree of challenge and holding to account in the Board Committees which may not be as immediately apparent at the Board meeting and the CFO noted that it may be useful to highlight the challenges from the Committees in the reports to the Board. Finally, Ann Beasley suggested that it may be useful to pose one question during Board visits which related to a corporate objective or priority which Board members fed back on following the visits. Jenny Higham queried the feasibility/appropriateness of moving the timings of the Board visits. The Chairman noted that the CN had asked the Board to consider how to develop the next stage of the Board visits programme and in the coming months this would be given some focus. The CEO also suggested that NEDs would be welcome to conduct informal visits outside the formal Board visit programme and invited them to contact executive colleagues to arrange these.	
7.0	**PATIENT & STAFF STORIES**	
7.1	**Staff Story: Physiotherapist Case Study – Learning From Patients with Complex Rehabilitation Needs** The Board welcomed Arnie Puntis, Clinical Team Leader for Community	

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	Therapies, who outlined the reflection activity she had recently undertaken with the physiotherapists caring for a patient with complex rehabilitation needs. The reflection exercise had helped staff to understand and vocalise the core values and beliefs which underpinned how they had cared for the patient, including the unconscious bias about the patient's level of understanding which stemmed from issues connected with a language barrier, the drivers which impacted on the decision-making, and actions such as taking things at face value rather than assessing the patient's past in relation to previous falls, the social norms which dictated some of the behaviours of the staff, and the perceptions of therapists versus doctors. In summary, physiotherapists had a deep sense of personal responsibility and took on an advocate role for a patient's therapeutic and rehabilitation progress. This could give rise to perceived conflicts with the acute model which sought to discharge patients once they were medically fit. This could lead to disagreements in the multidisciplinary team meetings (MDTs). The Board thanked Arnie Puntis for relaying the patient's story and the insights gained from the reflection activity with the physiotherapists. The Board also strongly supported the proposed rotation of the MDT chair role between clinicians and therapists and suggested the team may also like to consider taking a quality improvement approach to addressing some of the issues raised.	
Date of next meeting: Thursday, 28 November 2019 in the Hyde Park Room, St George's Hospital, Tooting		

Trust Board Action Log Part 1 - November 2019

Action Ref	Section	Action	Due	Lead	Commentary	Status
TB27.06.19/01	**Integrated Quality and Performance Report (IQPR) (Month 02)**	It was agreed that the CMO and CPO would look into reviewing quality of appraisals and report to the Workforce and Education Committee.	19/12/2019	CMO & CPO	**Not yet due.**	**NOT DUE**
TB27.06.19/02	**Clinical Governance Review**	The CMO agreed to present a formal report to the Board on the metrics which will be used to measure impact of implementing the recommendations in the clinical review.	~~31/10/2019~~ ~~28/11/2019~~ 19/12/2019	CMO	**Update22/11/2019: This report is in draft but further work is required to ensure it address the key points raised by the Board and with the agreement of the Trust Chairman the action is deferred until December with the view that the report is considered at Quality & Safety Committee via Trust Executive Committee.**	**OPEN**
TB27.06.19/03	**Clinical Governance Review**	It was important to maintain the balance between pace and realism and CMO should include an update on implementation of the action plan in the next report to the Board.	~~31/10/2019~~ ~~28/11/2019~~ 19/12/2019	CMO	*Same as above update for TB27.06.19/02*	**OPEN**
TB26.09.19/01	**Patient Stories: Paediatric Patient Journey**	It was agreed that the Board would receive a follow-up report on actions taken in relation to the patient story on Paediatric Patient Journey.	28/11/2019	CN	**See attached 1.4b - Appendix 1 - Update on Patient Story**	**OPEN**
TB26.09.19/02b	**Cardiac Surgery Update**	The Board agreed that a future report on cardiac surgery would be presented to the Board before the end of 2019 which would review the actions from the Bewick Review.	28/11/2019 ~~19/12/2019~~	CMO	**See agenda item 2.4 - Cardiac Report includes update on Bewick Review recommendations.**	**PROPOSED FOR CLOSURE**
TB26.09.19/04	Mental Capacity Act and Deprivation of Liberty Standards (Annual Report 18-19) **- Developing Annual Reports for other performance areas**	The Board agreed that it would be useful to complete annual reports for certain other performance areas such as treatment escalation plans and that proposals on which areas would benefit from this approach would be presented to the Quality and Safety Committee for consideration.	26/03/2020	CN/CTO	**Not yet due.**	**NOT DUE**
TB31.10.19/01	**Cardiac Surgery Update**	**NICOR Letter to Board and Comprehensive Cardiac Surgery Report:** The Board noted the report, requested a comprehensive report at the next meeting and agreed that the CMO would circulate the letter from NICOR confirming the Trust was now out of alert to the Board.	28/11/2019	CMO	**See agenda item 2.4**	**OPEN**
TB31.10.19/02	**Workforce & Education Committee Report**	**Staff Friends & Family Test for Quarter 2:** The Board noted the report and agreed that the Trust would find another means of conducting the quarter two internal staff survey.	19/12/2019	CPO	**This action will be assigned to the Workforce and Education Committee and copied to its action log. An update will be provided in the Committee's Report to the Board in December**	**NOT DUE**
TB31.10.19/03	**Corporate Objectives Quarterly Report**	**Embedding Corporate Objectives across Trust:** The CEO would speak to the CSO about how best to embed the corporate objectives across the organisation.	19/12/2019	CSO/CEO-DCEO	**Core reports to be made by each director lead to the relevant Board Sub-Committee on a monthly basis so that assurance can be provided on monthly basis as well as the formal quarterly report to Board.**	**NOT DUE**
TB31.10.19/04	**Corporate Objectives Quarterly Report**	**Estates Strategy Objectives Moving Milestones:** The objective related to Estates Strategy would be updated to reflect the decision to engage external support to develop the strategy.	21/11/2019	CSO/CFO	**Verbal Update to be provided to the meeting.**	**PROPOSED FOR CLOSURE**
TB31.10.19/05	**Corporate Objectives Quarterly Report**	**Board Seminar to Discuss Corporate Objectives 20/21**: The Board would start the process for developing the objectives for 2020-21 at a Board Seminar.	28/11/2019	CSO/CCAO	**Corporate Objectives Forward Planning Scheduled for Board Seminar on 18/02/2020**	**PROPOSED FOR CLOSURE**

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Meeting Title:	Trust Board		
Date:	28 November 2019	**Agenda No**	**1.4b**
Report Title:	Update on Patient Story to Board: Paediatric Service September 2019		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Terence Joe, Head of Patient Experience and Partnership Sue Affleck, Head of Nursing for Children and Young Persons Services		
Presented for:	Update		
Executive Summary:	This paper is to provide an update on the actions taken by the paediatric service following the patient story to Board in September 2019. The Paediatric service has maintained continued contact with the mother of the patient and a plan is in place for the mother to present this patient story to the team for their reflection and learning. Since Trust Board in September 2019 the senior team has reviewed the patient record. This has highlighted that although appropriate action was being taken by the teams involved with reference to clinical care and treatment, the communication with the family should have been better.		
Recommendation:	The Board is asked to note the update as provided within this report.		
Supports			
Trust Strategic Objective:	Ensuring quality of care and positive patient experience		
CQC Theme:	Safe, Effective, Responsive, Caring, Well-led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	There is a risk that poor patient experience can impact on the reputation of the service.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	N/A	**Date**	
Appendices:	N/A		

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Update on Patient Story to Board: Paediatric Service September 2019

28 November 2019

1.0 PURPOSE

1.1 This paper is to provide an update on the actions taken following the September 2019 patient story to the Trust Board which outlined the experience of a child as presented by his mother.

2.0 BACKGROUND

2.1 The patient story was referred from Ashford and St Peter's Hospital by the Director of Corporate Governance. The patient's mother had presented at their Board and it was felt that her experience of the St George's paediatric pathway with her son would provide useful feedback for our Trust. Initial contact took place with the mother and after outlining the key areas on which she would focus and key questions it was confirmed her approach would be to use her own script to present. It was confirmed by the mother that she had not gone through the process of making a formal complaint as once her son was discharged her sense of gratitude for the diagnosis was greater than the need to make a formal complaint and her focus moved towards supporting his recovery. At the Trust Board meeting in September 2019 the mother was pleased with the direct feedback from Board members and a service representative and welcomed the further opportunity to contribute to learning for the team.

3.0 Paediatric Response and action taken

3.1 Following the Trust Board meeting the Paediatric senior team have reviewed the script which they agreed was an extremely disappointing account of the child's and family's experience. The senior team has confirmed that since the child's admission much progress has been made with the ward staff to implement the fundamentals of care to improve care and enhance communication. There is a plan in place for the mother to attend and present to the paediatric team meeting on Nicholls ward. This will enable staff to listen and reflect on her account and demonstrate the progress made on improving care and communication.

3.2 Questions the mother raised at September 2019 Board meeting

Four questions were posed as part of the presentation by the mother for further consideration for the service to answer as follows:

1. When a patient is admitted as a potentially surgical case and then becomes a non-surgical case, what's the best way of dealing with this to ensure that patients still receive the care they need, even if they are on the 'wrong' ward?

2. My son was a shared care case between Paediatrics, Surgical and Infectious diseases. Is there an issue with communication when there is shared care, or was this a one-off?

3. Regarding cannulation - when it's not going well, the escalation needs to be up, not across and when a case has caused acute distress, I'd suggest a follow up needs to be made shortly after to discuss the next steps and provide emotional support to the child and parent.

4. Why did I feel the need to continually raise my son's profile? I call it 'waving the flag of my son'. What happened that made me feel that my child was repeatedly overlooked or forgotten?

3.3 Paediatric Service response

Question 1 and 2: Nicholls ward is a surgical paediatric ward where children often present with various other conditions. The nurses are skilled to look after all presenting conditions. The documentation showed the doctors were trying to arrange various tests and examinations and the nurse in charge should have kept the mother and family updated, providing greater assurance that action was being taken and thereby allaying the family's distress. Paediatric surgeons and the paediatric Infectious diseases team were liaising, planning treatment and this was documented in the patient notes. The paediatric teams were working to get the best care for the patient; however this was poorly communicated to the family.

Question 3: Cannulation Process. A review of care regarding cannulation had previously taken place in 2017, and in line with the guidelines for nursing staff published by the NICE. The cannulation attempts were not handled in line with the guidelines in that escalation to a senior staff member did not occur after two unsuccessful attempts, as recommended. More support should have been offered to the patient through the additional involvement of the play therapist, as cannulating children can be difficult on occasions.

Regarding restrictive physical interventions and the clinical holding of children and young people, further training is currently being provided for staff in line with the 'Restrictive physical interventions and the clinical holding of children and young people: Guidance for Nursing Staff' published by the Royal College of Nursing in 2019. It was noted by the mother the process of clinical holding of her son was distressing to witness. In addition to this the ward have 'Buzzies' available which is a cold vibration device providing natural pain management for stimulating a vein within a child, as well as providing a distraction for the cannulation process for children. The ward team have reflected and recognised that more support should have been provided to both mother and child immediately following this distressing episode and this point will be discussed further when the ward team meet with the mother.

Question 4: Communication with the family. The Head of Nursing and senior team are disappointed that the family "felt they had to wave a flag for the patient." Multidisciplinary ward rounds take place every morning and discussions regarding the child's care were taking place and were documented. The team should have kept the mother updated. Further work to improve communication and involvement with families is taking place. The ethos of the paediatric service is toward family-centred care and staff will be expected to achieve this for every patient.

4.0 Further support

A date is being confirmed with the mother, to meet with nursing staff and the play therapists. The senior team acknowledge that this situation was difficult for the family and are grateful these experiences have been highlighted so we can learn and ensure other children have a better experience under our care. The planned meeting will allow the mother to present to the team, offer staff time to reflect and discuss what further improvements may be required. The senior team will provide further assurance for the mother of progress made on the ward so far, as well as further action to be taken. The mother was happy with the response and feedback from the Board and pleased to provide further input to support the paediatric team's reflection and learning.

5.0 RECOMMENDATION

5.1 The Board is asked to note the update as provided within this report.

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Meeting Title:	Trust Board		
Date:	28 November 2019	**Agenda No.**	**1.5**
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is asked to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

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Chief Executive's Report to the Trust Board – November 2019

Developments in our external environment

Since our last Trust Board meeting, a date has been set for the General Election, which will take place on Thursday 12 December.

As you might expect, the NHS – as always – is a matter for debate and conjecture in the run up to a General Election. Like all NHS organisations, it is important we continue to remain politically impartial at this time, and official pre-election 'purdah' guidance has been shared with staff as well.

The latest NHS monthly performance data generated headlines last week. This is not surprising, and it is clear that demand for NHS services is increasing all the time, across emergency, cancer and elective care.

The toll this takes on NHS staff across the country shouldn't be under-estimated, and a key part of my role – and the wider executive team, plus our senior clinicians and managers – is to support all of our clinicians and non-clinical staff here at St George's during what is already proving to be a difficult winter period.

In October, the then Government confirmed an additional £200 million investment into cancer screening equipment, which St George's and many other Trusts are in line to benefit from. This is a positive step forward, given the priority we have put behind improving cancer care at the Trust.

Delivering on our vision and strategy

It is now more than six months since we published our new five year strategy, *Delivering outstanding care, every time*, in which we set out four strategic priorities; **strong foundations; excellent local services; closer collaboration; leading specialist healthcare.**

At last month's Trust Board, we agreed our new research strategy, which is one of a number of supporting strategies to be agreed this year. Our research strategy will build on our many successes in this area in recent years, particularly in relation to clinical trials, where patient recruitment was the highest it has ever been here at St George's in 2017/18, and again in 2018/19.

Our major trauma service has been a key part of the service we provide for a number of years. Our new strategy prioritises major trauma as a key service for the Trust, with over 120 trauma patients treated at St George's each month. In keeping with this, I was particularly pleased to hear this month that we have launched the first, fully multi-disciplinary major trauma clinic in the country for our patients.

Previously, major trauma patients would need to visit different clinics to access the care they need; now, a new consultant led clinic has been set up at St George's to meet all their needs in one facility, so improving their experience of hospital, and reducing the need for multiple visits to hospital. This is a fantastic example of working both more innovatively *and* effectively.

Unfortunately, our ambition to provide excellent local services is particularly challenged at present, specifically emergency care performance, which we will discuss in detail at November's Trust Board meeting. Improvement actions are in place, and the recent ECIST visit has helped clarify thoughts; but we need to see greater traction, and at pace.

The same is true of our financial position. At the end of 2018/19, we agreed budgets and cost improvement plans with our clinical and managerial teams, with the aim of delivering a control total deficit of £3 million by March 2020. As things currently stand, we have not seen the step-change required that will enable us to deliver the financial savings we said we would – so something has to change.

At the same time, we continue to keep a focus on health and safety. In June, we commissioned an external report on health and safety governance at the Trust. The report has been received, and its findings reported to both the Trust Executive Committee and Finance and Investment Committee. The report has highlighted a range of issues that need to be addressed in relation to health and safety leadership, systems, communication and incident management.

We have recently appointed an Assistant Director of Health and Safety, Fire and Security to strengthen management in this area, and he is working to ensure we address the issues raised in the report. The FIC has asked that this plan is presented to the Trust Board in January. I welcome the report as it will help us to maintain an effective health and safety environment for both patients and staff.

Our staff

In my update to the Trust Board last month, I talked about the successful events we held to mark both Black History Month and Diwali.

Last week, we officially launched our LGBTQ+ network, which was attended by over 90 staff, with external speakers, including Paul Deemer, Head of Diversity and Inclusion at NHS Employers, and Liam Wardley, Head of Purpose Transformation at Pinsent Masons LLP, a Stonewall Employer of the Year for 2019.

It was a fantastic event, and I really feel as though – with four staff network groups now established (LGBTQ+; Women's; Disability and Wellbeing; plus BAME) - we are starting to reflect the true diversity of this organisation, and the communities we serve.

I am confident we will see an improvement in response rates to the NHS staff survey this year. Last year, 54% of staff completed the survey – and our target this year is 60%. Of

course, high response rates are important, but we also need to demonstrate to staff that we've listened to what they told us – hence the 'you said, we did' campaign we've adopted this year, with a 52% completion rate more than one week before the deadline for responses closes.

Update for flu vaccination is currently at 76%, but we aren't complacent, with aspirations to beat last year's total of 87%. Patricia Campbell is once again our flu vaccination lead, and she continues to run regular clinics at St George's, with a network of peer vaccinators at both main sites.

At the start of next month, we will be holding our now annual Quality Improvement Week, with events happening every day between Tuesday 3-Friday 6 of December. The event also sees the return of our Dragons' Den panel, which has previously generated fantastic and now embedded quality improvement initiatives, including our point of care flu testing in our Emergency Department.

Finally, I would like to say how grateful I am to St George's Hospital Charity for the support they have given our staff. Their new appeal – Campaign for Renal – is designed to benefit both patients and staff, with an ambition to raise £1 million towards the refurbishment of the Courtyard Clinic building at St George's.

At present, our facilities for renal patients and staff do not match the high quality renal service our teams provide. Our renal team serve a population of 2.6 million people across south west London and Surrey, but are currently located in different parts of the hospital, so by bringing them together in the refurbished Courtyard Clinic, I am confident we will improve the service we offer.

Trust Executive Committee

Since my last report to the Board, we have held four Trust Executive Committee (TEC) meetings. In line with our new structure and rhythm for these meetings, we have focused on:

- Corporate reporting in week 1 to ensure the Committee has effective oversight of each corporate area and the work of the governance groups reporting into TEC;

- Consideration of our key priority areas in week 2 to ensure we are making the necessary progress to deliver the changes we need to make to deliver against our priorities and strategic aims;

- Consideration of reports coming to the Board in week 3 to ensure that what we bring to the Board is robust and has had the necessary input across the executive team and the divisions; and

- Performance scrutiny of each of the clinical and corporate divisions in week 4, with two divisions considered on alternative months, to ensure there is effective

accountability and reporting from the TEC down through the divisions to our clinical services and from the services up to the executive.

A key area of focus at TEC in the past month has been financial recovery - the steps needed to deliver against our plan for 2019/20, including realising our CIPs. This has been a challenging area, and the papers on the Board agenda reflect this.

We have continued to focus at TEC on addressing staff vacancies and turnover rates, the steps needed to increase appraisal rates for non-clinical staff, and to improve our plans around medical staffing. Our vacancy rates have improved and are again below 10%, but we recognise that our use of agency staff has increased and we are taking action to address this.

We have also focused on improving our planned care in theatres and outpatients. In addition, we have continued to focus on unplanned care and the steps needed to improve emergency care performance, flow, waiting times and to embed our inter-professional standards across the organisation. I continue to chair a weekly emergency performance board which ensures that there is a real focus on the actions needed to get our performance where it needs to be.

While we await the report of our latest CQC inspection, we continue to focus on our three clinical priorities – treatment escalation plans, the deteriorating patient, and mental capacity and deprivation of liberty safeguards. Good progress is being made in these areas albeit we need to work on embedding them further.

We are also implementing the recommendations of the clinical governance review, which the Board considered in June 2019 and we plan to bring a paper on this to the Board next month.

Jacqueline Totterdell
Chief Executive
28 November 2019

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St George's University Hospitals NHS Foundation Trust

2.1

Meeting Title:	**Trust Board**		
Date:	**Thursday, 21 November 2019**	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	**Tim Wright, Chairman of the Quality and Safety Committee**		
Report Author:	**Tim Wright, Chairman of the Quality and Safety Committee**		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting in November 2019.		
Recommendation:	The Board is asked to note this report.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

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2.1

Quality and Safety Committee Report

Matters for the Board's attention

The Quality and Safety Committee met on 21 November 2019 and agreed to bring the following matters to the Board's attention:

1. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality performance at month 7. In relation to infection control and prevention the Committee noted that there was one patient who acquired MRSA bacteraemia at the end of October 2019 which was disappointing given there had been no cases in the previous 12 months. The number of clostridium difficile cases in October 2019 was 31 against the threshold of 48 cases for 2019/20. The Committee noted that this is higher than expected even with the implementation of the new national definitions for recording hospital acquired and community associated infections. The Committee was encouraged to learn that from initial reviews there were no significant themes and the Trust is focusing on this area and conducting a root cause analysis for each case to determine if there have been any lapses in care.

The Committee were advised that the Trust carries out quarterly audits and audits as part of the ward accreditation programme to assess compliance with the Early Warning Score (EWS) indicator but there is an issue related to appropriate responses which resulted in a dip in performance. The Committee noted that the Critical Care Outreach team would help manage compliance with appropriate response relating to the EWS indicator but the Committee asked for further assurance on any variances to compliance out of hours which would be provided in future reports.

The Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) level 2 training performance had plateaued and the Committee was reassured to hear about the enhanced communication to divisions and monitoring that is currently underway to ensure that the Trust can improve performance. The Committee also noted the work underway to develop a South West London standard audit tool which will ensure there is consistency and effective benchmarking. The Committee will continue to closely monitor the above areas to ensure that as training compliance is increased that quality is maintained.

2. Exception Report: Care Quality Commission Outstanding Actions

The Committee noted that action related to achieving mandatory training targets remained below target as a result of not being able to achieve 85% on resuscitation training. The Committee were assured that the Trust has sufficient resources to deliver the required training. The key factor to meeting the December 2019 deadline involves managing the 'did not attends' (DNAs). A robust process of twice weekly scrutiny and engagement with divisions is underway using the commcell approach to track and manage attendance at training sessions. It was agreed that staff members who DNA without a valid reason would receive a letter from Chief Medical Officer and/ or Chief Nurse outlining the importance of completing the training and identifying any support required and next steps.

3. Nurse Staffing Report (Planned vs Actual)

The Committee considered the nurse staffing reports and noted the overall fill rate for October 2019 of 94.8%. These fill rates were within the normal limits with any exceptions effectively managed to ensure there were no outstanding safety issues. Whilst safe staffing red flags related to increased acuity and dependency of patients were raised in October 2019, these were effectively managed and mitigated.

4. Cardiac Surgery Update

The Committee considered the monthly Cardiac Surgery Updates which is discussed later on the Board agenda.

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

The Committee received a summary report from the PSQG meeting held in October 2019. The Committee heard about the results from the PSQG'S deep dive into the Surgery, Neurosciences, Cancer and Therapies division performance and were advised that the Cancer team's annual cancer peer review reflected that the team were 100% compliant with 13 out of 15 of the measures required to enable the team to sign-off against the NHS England Quality Surveillance Team tool. The Trust along with other London trusts face challenges with cancer performance. Nationally the Trust's overall score is 8.7 (with zero being very poor and ten being very good) which is above other peer organisations in London.

6. Research Annual Report (2018-2019)

The Committee considered the annual report for research which is covered later on the Board agenda (item 2.1.2). The Committee was pleased to note the demonstrable progress made on patient recruitment to clinical trials.

7. NICE Compliance (Bi-Annual) Report

The Committee received the report which provided an update on the Trust's implementation and assessment of all relevant NICE guidance. The Committee noted its limited assurance on the level of compliance across the Trust. The Committee was advised that from further review it was evident that the Trust is complying with relevant NICE guidance but there is an issue with teams not completing the appropriate assessment documentation. Additional processes to ensure that there are named individuals responsible for completing the assessments and that there is increased visibility at Divisional Governance Boards are being put in place to improve performance. The Committee reiterated the importance that the Trust can identify areas of compliance, audit compliance and gain assurance and that the Committee expects the next report to reflect a marked improvement in performance.

8. Medication Incident and Controlled Drugs Management

The Committee considered the quarter 1 and 2 review into Medication Incident and Controlled Drugs Management. This report will be discussed under agenda item 2.1.1. The Committee, in particular, noted that of the 904 incidents recorded on Datix (the Trust's incident reporting system) there were 41 instances of low harm and one of moderate harm, all of which have been fully investigated with none declared as serious incidents. The Committee was pleased to note that there have been no never events related to medication incidents. The Committee reflected that the barcode scanning rates of medication and patient wristbands were low. The issue relates in part to the absence of barcodes on the packaging of some medicines and in some areas a lack of barcode scanning equipment. There is also a need to encourage more staff to use barcode scanning routinely as their normal practice. The Trust is proactively promoting the use of barcode scanning and is currently piloting new drug trollies which it is hoped will help improve performance.

9. Seven Day Services – Self Assessment

The Trust's seven day services autumn self-assessment will be presented under agenda item 2.1.3 for the Board's consideration and approval before it is submitted to NHS Improvement on 29 November 2019. The Committee endorsed the current self-assessment for submission noting the improvement in patients being seen within 14 hours by a consultant from the time of admission on weekdays and noted the challenge related to the weekends. The Committee noted that the Trust must be fully compliant with all standards by April 2020 and will receive a follow-up report in January 2020 to ensure that the Trust has the required level of traction to meet all the standards.

10. Friends and Family Test – Updated National Guidance

The Committee heard about the national changes to the Friends and Family Test survey which included a change to the mandatory question, the addition of a free text response, and the removal of the restrictions to only take the survey at point of discharge or 48 hours thereafter and at four specific points in midwifery services. This will mean response rates can no longer be uniformly tracked. The Trust is looking at how to refine its processes to meet the national guidance.

11. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Registers focusing on the four strategic risks (SR) which fall within its remit. The Committee agreed that in relation to strategic risks SR1, SR2, SR3 and SR16 to accept the partial assurance rating, the risk reduction schedule and risk scores but noted that some updates where required on the risk reduction schedule.

12. Other matters

The Committee did not consider a deep dive review this month but instead, focused discussion on how to develop a robust deep dive programme to ensure that the Committee is examining those areas which require the greatest focus in order to provide the Board with assurance. As part of the discussion, the Committee also considered how to best synthesise its forward plan and provide guidance to authors to improve the quality of reports presented for consideration. The Committee agreed to review its forward plan for the last quarter of 2019/20 agreeing that a more detailed report on serious incidents would be included in the forward planner with the view that a report is presented to the Board periodically. It was also agreed that a detailed forward programme of deep dives on alternate months would be presented to the Committee for approval in January 2020.

Tim Wright
Committee Chair
21 November 2019

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2.1

Meeting Title:	**Trust Board**		
Date:	28 November 2019	**Agenda No**	**2.1.1**
Report Title:	Medication Incident and Controlled Drugs - Review of Q1-2 2019/20		
Lead Director/ Manager:	Vinodh Kumar, Chief Pharmacist		
Report Author:	Kara Spiteri, Medication Safety Officer		
Presented for:	Assurance		
Executive Summary:	This report provides a review of the medication and controlled drugs related incidents for the Trust during the period of quarter 1 and 2 2019/20. The material points in the report are as follows: • There were 904 incidents reported as 'patient – medication' recorded on DATIX, with 4.6% being reported as causing harm (41 low harm, 1 moderate harm) • There have been no medication related Serious Incidents declared during this time • There have been no NHS England Never Events related to medication declared in this reporting period • On review of the data submitted to the NRLS for the Trust, medication incidents accounts for 13.2% of the Trust total. When comparing this to similar sized organisations their reporting figure is 10.8% • During this period there has been a trend showing a reduction in the number of reported medication related incidents • The proportion of incidents resulting in harm has remained broadly unchanged • The proportion of harm incidents graded as low harm has increased to 97.7% • 111/904 (12.3%) incidents involved the safe and secure handling of Controlled Drugs (CDs) compared to 8.0% for the same period in 18/19. On review the dominant theme is incorrect balance of controlled drugs • Following the successful deployment of ePMA across the Trust the average wristband scanning rate is currently 76% compared to 86% for the same period in 18/19 against the target of 100% • The average medication scanning rate is currently 35% compared to 43% for the same period in 18/19 against a target of 80% • Scanning is critical to achieving the "5 rights" of closed loop medicines administration and enhances patient safety • Learning from incidents is discussed with Divisional Director of Nursing Governance (DDNG's) and Heads of Nursing (HON) and actions plans are co-created and presented to Divisions and Directorates		
Recommendation:	The Board is asked to note the content of the report which was also considered at the Quality and Safety Committee on 21 November 2019.		
Supports			
Trust Strategic Objective:	Strong Foundations Excellent local services		
CQC Theme:	Safe, Effective, Well Lead		
Single Oversight Framework	N/A		
Implications			
Risk:	- Risk of patient harm to delays and omissions in administration of medicines - Risk of patient harm due to delays and omissions in prescribing of medicines - Risk of patient harm due to wrong patient/wrong drug incidents as scanning rates are decreasing		

Legal/Regulatory:	N/A		
Resources:	- Training places and funding to increase and maintain critical staffing levels of non-medical prescribing pharmacists - Continued support and resource for satellite dispensing pharmacies to facilitate discharge		
Previously Considered by:	Patient Safety and Quality Group Trust Executive Committee Quality & Safety Committee	**Date**	20/11/2019 20/11/2019 21/11/2019
Appendices:	None		

Medication Incident and Controlled Drugs
A Review of Quarter 1 and 2 2019/20

Executive Summary

Medication incidents

904 incidents reported as 'patient – medication' on DATIX incident reporting system for Q1-2 2019/20 across Trust
Of these incidents, 42 (4.6%) involved patient harm: 41 low harm, 1 moderate harm
Nil medication related Serious Incidents declared
Nil NHS England Never Evens related to medication declared

The Trust has a high level of reporting medication incidents compared with national figures. This is encouraged in order to facilitate awareness and learning – and is in line with an NHSE Patient Safety Alert published in 2014. Of all incidents reported by the Trust, latest figures from NRLS (National Reporting and Learning Service) show that medication incidents account for 13.2%, compared to 10.8% for like organisations (October 2018 – March 2019).

Following a steady increase in the number of medication incidents reported between 2012 and 2017, the number of medication incidents being reported has decreased within the Trust for the past 2 years. In Q1-2 2017.18 the number of medication incidents reported was 1024, 973 in Q1-2 2018/19 and 904 in Q1-2 2019/20. This represents an overall reduction of 11.7%

This decrease may be due one or a combination of factors: 1. Continued rollout of ePMA reducing prescribing/administration errors 2. Increase in Trust activity so staff may feel they are too busy to report an incident 3. Staff not aware of the importance of reporting incidents, in particular incidents that involve no harm or are near misses.

Whilst the number of medication incidents reported has decreased, the proportion of those incidents resulting in harm has remained broadly similar – 4.4%% in Q1-2 2018/19 (43/973 incidents) to 4.6% in Q1-2 2019/20 (42/904 incidents). Within this the severity of harm is decreasing, with the proportion of harm incidents graded as low harm 83.7% (36/43 incidents involving harm) in 2018/19 to 97.7% (41/42 incidents involving harm) in 2019/20.

In Q1-2 2019/20 14.3% of medication administration events on iClip generated an alert (patient mismatch, incorrect drug dose/form or route). This equates to a total near miss of medication administration of 39.0% (i.e. Patient mismatch = 2.9%, drug mismatch alert = 36.1%).

Trust average wristband scanning rate is currently 76% (86% in Q1-2 18/19, 79% in 19/20) (target is 100%) and average medication scanning rate is currently 35% (43% in Q1-2 18/19, 38% in 19/20) (target is 80%). Weekly scanning rates are available for Matron and Ward manager review on Tableau.

Closed loop administration is electronic verification of the '5 rights' – by digitalising this practice, which includes the scanning process, patient safety is significantly enhanced, and the entire medication management process is more efficient, from prescription ordering and supply to the administration of the medication.

Learning from incidents

Discussed at the Medicines Optimisation Group (MOG)
Discussed with DDNGs and HONs bi-annually
Highlighted at DGB meetings by Directorate Pharmacists
Shared Trust wide via the quarterly Medication Safety newsletter: *Medicines Matter.*

Controlled Drugs

111(12.3%) incidents in Q1-2 2019/20 involved the safe and secure handling of Controlled Drugs (CDs). Dominant theme was incorrect balance.

Main themes of medication incidents:

- Delay and Omission

Incidents involving Delay and Omission account for 22.7% (205/904) of all medication incidents reported with 8.3% (17/205) involving low harm. The majority of these (61.5%; 126/205) were administration incidents, with 11.1% (14/126) involving low harm).

Actions:

- Satellite dispensaries in strategic locations across hospital to reduce turnaround time for discharge medicines.
- Use of an external partner to provide Monitored Dosage Systems (MDS – 'Blister Packs') to prevent delayed discharge
- Use of Pharmacist Independent Prescribers and Pharmacist Transcribers to write discharge prescriptions (TTOs) in advance of planned discharge to support patient flow
- Provision of a 24/7 Pharmacy service with an on-call Pharmacist onsite out of hours for advice and timely supply of critical medicines
- Critical medicines list displayed in all treatment rooms and available on intranet highlighting medicines that must be administered within 2 hours of the prescribed time
- Promotion of Pharmacy services: Nurse induction, Harm-free training to new nursing staff, posters displayed in all treatment rooms highlighting how to access Pharmacy out of hours
- The MSO worked with the Lead Nurse for Diabetes and Endocrinology in preparation for National Insulin Safety Week (May 2019). During this week teaching sessions on insulin safety for staff were held and the fourteenth edition of Medicines Matter newsletter which promoted safer use of insulin was released Trust wide.
- Pharmacy have introduced new governance arrangements (drug trolley checklist) for the use of medication trolleys on wards to support nursing staff on drug administration rounds. Feedback from wards using the trolley checklist is that the medicine trolleys are facilitating timely administration of medicines to patients and preventing unnecessary delays due to needing fewer visits to the treatment room to access medicines

- CD Balance Incorrect

Following the introduction of ENFit® compatible bottle adapters ("bungs") for liquid CDs the number of CD balance incidents involving liquid CDs has decreased from 21/46 (45.7%) in Q3-4 2017/18 to 18/64 (28.1%) in Q1-2 2018/19. It then increased to 13/34 (38.2%) in Q3-4 2018/19 and decreased again to 20/58 (34.5%) in Q1-2 2019/20.

Actions

- A snap shot audit was completed in Q3 2018/19 to ensure all areas with liquid CD stock are using ENFit® "bungs". To ensure ongoing awareness & compliance with the use of ENFit® bottle adaptors for liquid CDs a question has been incorporated into the Trust Quarterly CD audit from Q2 2019/20 onwards. Incidents will be discussed with DDNGs at 1:1 meetings.

Medicines Optimisation Group (MOG) Summary:
In Q1-2 2019/20 key work overseen by the group included:

- Progress with Medicines Optimisation CQIN
- Progress with the Pharmacy Quality Improvement Report
- Physician Associates – reviewing existing governance structure
- Nurse Associates – defining Medicines Management competencies in conjunction with Corporate Nursing
- Supported the development of an Insulin MAST training package
- Reviewed Medication Incident & Controlled Drug reports
- Developed a governance framework & SOP for the medicine trolley project
- Monitored compliance with previous NPSA alert (Concentrated Potassium)
- Approved the Gosport action plan for Pharmacy & Palliative Care
- SI review of incidents involving medication
- Risk Assessment approvals for storage of medicine in clinical areas which are exceptions to the Medicines Management Policy
- Approved numerous medication related policies

PGD Approval Group (PAG) Summary:
In Q1-2 2019/20 the PAG group approved 4 new PGDs, and renewed a further 9 PGDs. At the time of writing this report there were 165 PGDs in use the Trust with a further 11 new PGD applications under review and 1 new PGD proposal to be reviewed.

Drugs and Therapeutics Committee (DTC) Summary:
in Q1-2 2019/20 the DTC reviewed 97 drug applications. Of these 77 were approved, 9 were removed from the formulary, 4 were updated on the formulary, 2 were rejected, 1 is pending further information from the applicant, and 1 application was withdrawn. 59 of these applications related to updating the Trust formulary in line with the psychiatric drugs used at South West London and St George's Mental Health Trust.

SWL Acute Provider Collaborative Formulary Harmonisation Project Report

The Formulary Harmonisation Project aims to produce ONE harmonised SWL Acute Medicines Formulary, which will take into account tertiary services and variation by Trust for specialist formulary areas.

Each chapter of the BNF is undergoing a collaborative clinical review across a SWL Acute Trusts. Currently 6 of 18 chapters have been reviewed and are awaiting ratification by the SWL Joint Formulary Committee that will also manage the Joint Formulary moving forward.

1.0 PURPOSE

1.1 The purpose of the paper is to update the Group on the themes of medication errors identified by a review of all medication incidents reported in Q1-2 2019/20 and to highlight the work being done by Pharmacy to mitigate these risks and promote the safe and efficient storage and use of medications throughout the Trust.

2.0 BACKGROUND

Medication Incidents Q1-2 2019/20

2.1 904 incidents reported as 'patient – medication' on DATIX incident reporting system for Q1-2 2019/20 across Trust.
Of these incidents, 42 (4.6%) involved patient harm: 41 low harm, 1 moderate harm.
Nil medication related Serious Incidents declared
Nil NHS England Never Evens related to medication declared

2.2 The Trust has a high level of reporting medication incidents compared with national figures. This is encouraged in order to facilitate awareness and learning – and is in line with an NHSE Patient Safety Alert published in 2014. Of all incidents reported by the Trust, latest figures from NRLS (National Reporting and Learning Service) show that medication incidents account for 13.2%, compared to 10.8% for like organisations (October 2018 – March 2019).

2.3 Following a steady increase in the number of medication incidents reported between 2012 and 2017, the number of medication incidents being reported has decreased within the Trust for the past 2 years. In Q1-2 2017.18 the number of medication incidents reported was 1024, 973 in Q1-2 2018/19 and 904 in Q1-2 2019/20. This represents an overall reduction of 11.7%

2.4 This decrease may be due one or a combination of factors: 1. Continued rollout of ePMA reducing prescribing/administration errors 2. Increase in Trust activity so staff may feel they are too busy to report an incident 3. Staff not aware of the importance of reporting incidents, in particular incidents that involve no harm or are near misses.

2.5 Whilst the number of medication incidents reported has decreased, the proportion of those incidents resulting in harm has remained broadly similar – 4.4%% in Q1-2 2018/19 (43/973 incidents) to 4.6% in Q1-2 2019/20 (42/904 incidents). Within this the severity of harm is

decreasing, with the proportion of harm incidents graded as low harm 83.7% (36/43 incidents involving harm) in 2018/19 to 97.7% (41/42 incidents involving harm) in 2019/20.

2.6 In Q1-2 2019/20 14.3% of medication administration events on iClip generated an alert (patient mismatch, incorrect drug dose/form or route). This equates to a total near miss of medication administration of 39.0% (i.e. Patient mismatch = 2.9%, drug mismatch alert = 36.1%).

2.7 Trust average wristband scanning rate is currently 76% (86% in Q1-2 18/19, 79% in 19/20) (target is 100%) and average medication scanning rate is currently 35% (43% in Q1-2 18/19, 38% in 19/20) (target is 80%). Weekly scanning rates are available for Matron and Ward manager review on Tableau.

2.8 Closed loop administration is electronic verification of the '5 rights' – by digitalising this practice, which includes the scanning process, patient safety is significantly enhanced, and the entire medication management process is more efficient, from prescription ordering and supply to the administration of the medication.

Learning from Medication Incidents

2.9 Medication incidents are reviewed quarterly to highlight issues across the organisation and raise awareness of medication safety. A Trust report providing an overall analysis is presented at the Medicines Optimisation Group. In addition, this report is discussed with DDNGs, Heads of Nursing (HoNs) and Lead Pharmacists in each division to provide tailored feedback. Key themes are discussed at relevant Divisional Governance Board meetings and action plans are developed as necessary.

2.10 National medication safety themes, Trust wide trends, and feedback from medication related Serious Incidents are included in the Trust Medication Safety newsletter: *Medicines Matter* which is circulated Trust wide via eG. Paper copies are also circulated to all wards at time of publication. Issue 15 was released in November 2019.

Controlled Drugs Q1-2 2019/20

2.11 111 incidents (12.3%; 111/904) in Q1-2 2019/20 involved Controlled Drugs (CDs) (Schedules 1-5). Of these, the main incident type was incorrect CD balance (57/111; 53.3).

2.12 CD incidents are reviewed every quarter for thematic analysis and actions. A Trust report is discussed at the Medication Optimisation Group. This includes the results of the CD audit which is conducted in every area of the Trust holding CDs (>100 locations) every quarter. A bespoke summary is produced for each division, enabling individual areas to focus their medication safety agenda and tackle specific issues of medication safety, reporting and timely investigation of incidents. These reports are discussed with DDNGs, HoNs and Lead Pharmacists in each division and key themes are discussed at relevant Divisional Governance meetings.

3.0 ANALYSIS

Themes from medication incidents: Delay and Omission

3.1 Incidents involving Delay and Omission account for 22.7% (205/904) of all medication incidents reported with 8.3% (17/205) involving low harm. This is a slight decrease on Q3-4 19/20 where delay and omission accounted for 25.3% (235/930) of all medication incidents.

3.3 The majority of these (61.5%; 126/205) were administration incidents, with 11.1% (14/126) involving low harm). 25.2% (52/206) were prescribing incidents with 5.8% (3/52) involving low harm. 16.2% (27/205) were pharmacy incidents, none involving harm. A similar pattern was reported in Q3-4 19/20 – 57.9% (136/235) administration (11.0%; 15/136 involving harm), 26% (61/235), prescribing (19.7%; 12/61 involving harm), 16.2% (38/235) pharmacy (7.9%; 3/38 involving harm).

3.4 To support patient flow at time of discharge, Pharmacy established satellite dispensaries in strategic locations across the hospital to facilitate timely supply of TTOs. Pharmacy utilise Pharmacist independent prescribers and Pharmacist transcribers to write discharge prescriptions (TTOs) in advance of planned discharges to support patient flow. In addition, supply of Medication Dosage Systems (MDS – 'Blister packs') is being completed by an external partner to prevent delayed discharge. This has reduced turnaround times from 48 hours previously to 3 hours, thereby facilitating patient flow and saving more than 800 bed days in the Trust.

3.5 Pharmacy operate a 24/7 service with on call Pharmacists based onsite overnight to facilitate the timely supply of critical medicines out of hours. In line with guidance from a previous NPSA alert, the Trust has a 'Critical Medicines List' which lists all medicines where timeliness of administration is crucial. Critical medicines list displayed in all treatment rooms and available on intranet highlighting medicines that must be administered within 2 hours of the

prescribed time. New nursing staff receive training from Pharmacy on the importance of timely administration of critical medicines and how to escalate requests for supplies during the day and out of hours. Posters displayed in all treatment rooms highlighting how to access Pharmacy out of hours.

3.6 The MSO worked with the Lead Nurse for Diabetes and Endocrinology in preparation for National Insulin Safety Week (20th – 26th May 2019). During this week teaching sessions on insulin safety for staff were held and the fourteenth edition of Medicines Matter newsletter which promoted safer use of insulin was released Trust wide.

3.7 Pharmacy have introduced new governance arrangements (drug trolley checklist) for the use of medication trolleys on wards to support nursing staff on drug administration rounds. Feedback from wards using the trolley checklist is that the medicine trolleys are facilitating timely administration of medicines to patients and preventing unnecessary delays due to needing fewer visits to the treatment room to access medicines

Themes from medication incidents: CD Balance Incorrect

3.8 Following the introduction of ENFit® compatible bottle adapters (“bungs”) for liquid CDs the number of CD balance incidents involving liquid CDs has decreased from 21/46 (45.7%) in Q3-4 2017/18 to 18/64 (28.1%) in Q1-2 2018/19. It then increased to 13/34 (38.2%) in Q3-4 2018/19 and decreased again to 20/58 (34.5%) in Q1-2 2019/20.

3.9 A snap shot audit was completed in Q3 2018/19 to ensure all areas with liquid CD stock are using ENFit® “bungs”. To ensure ongoing awareness & compliance with the use of ENFit® bottle adaptors for liquid CDs a question has been incorporated into the Trust Quarterly CD audit from Q2 2019/20 onwards. Incidents will be discussed with DDNGs at 1:1 meetings.

3.10 Pharmacy staff have identified the need for CD training in key areas, to include how to order CDs, entering CDs into registers and calculating the amount of medication required to prevent CD balance discrepancies. Over recent quarters pharmacy staff have rolled out brief training sessions on controlled drugs directly to nurses in clinical areas.

Medicines Optimisation Group (MOG) Report

3.11 MOG provides leadership to ensure that systems and processes are in place throughout the organisation to support medicines risk management and ensure that each stage of the

medicines management process is underpinned by safety, process, quality, clarity of role and responsibility and training.

3.12 In Q1-2 2019/20 key work overseen by the group included:

- Progress with Medicines Optimisation CQIN
- Progress with the Pharmacy Quality Improvement Report
- Physician Associates – reviewing existing governance structure
- Nurse Associates – defining Medicines Management competencies in conjunction with Corporate Nursing
- Supported the development of an Insulin MAST training package
- Reviewed Medication Incident & Controlled Drug reports
- Developed a governance framework & SOP for the medicine trolley project
- Monitored compliance with previous NPSA alert (Concentrated Potassium)
- Approved the Gosport action plan for Pharmacy & Palliative Care
- SI review of incidents involving medication
- Risk Assessment approvals for storage of medicine in clinical areas which are exceptions to the Medicines Management Policy
- Approved the following medication related policies:
    - Medicines Management
    - Controlled Drugs
    - Policy for the supply, storage, prescribing and administration of intravenous concentrated potassium
    - Oral/Enteral Syringe
    - Medicines Reconciliation
    - PGD Policy
    - Management of acutely agitated adult patients

PGD Approval Group (PAG) Report

3.13 PGDs (Patient Group Directions) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicine(s) to a pre-defined group of patients, without them having to see a prescriber. Supplying and/or administering medicines under PGDs should be reserved for situations in which this offers and advantage for patient care without compromising patient safety and there are clear governance arrangements and accountability.

3.14 The purpose of the PGD Approval Group (PAG) is to ensure there are clear systems and processes in place for considering the need for, developing, authorising, using and updating

PGDs. PAG also ensures governance arrangements are in place to ensure patients receive safe and appropriate care and timely access to medicines in line with legislation.

3.15 PGDs need to be reviewed every three years to ensure the guidance is still in line with current practice. There are 58 PGDs due to expire in the next 6 months which each need to be reviewed by a working group before being resubmitted to PAG for final approval for a another 3 year period.

3.16 In Q1-2 2019/20 the PAG group approved 4 new PGDs, and renewed a further 9 PGDs. At the time of writing this report there were 165 PGDs in use in the Trust with a further 11 new PGD applications under review and 1 new PGD proposal to be reviewed.

3.17 PGDs are used by various specialities across the Trust with ED (in particular Minor Injuries Unit) the main user (101/165 PGDs; 66%).

Drugs and Therapeutics Committee (DTC) Report

3.18 The Drug & Therapeutics Committee (DTC) reviews and oversees all aspects of medicine usage relating to safety, efficacy and patient acceptability. It maintains the Trust Formulary which is a list of drugs that can be prescribed by clinicians/prescribers working for the Trust and that are stocked in Pharmacy. The formulary also includes protocols and guidelines advising on the use of these medicines in the Trust and is available on the Intranet.

3.19 DTC is working with SWL Acute Provider Collaborative to produce one harmonised SWL Acute Medicines Formulary based on existing Trust Formularies (recognising the separate tertiary services and variation for specialist areas). Following this there will be a harmonised entry of new drugs process across the SWL Acute Providers and harmonised DTC governance. Currently acute providers are working together to review, harmonise and ratify each chapter of the BNF. Once completed, the SWL Acute Provider Collaborative will function as a joint formulary committee where new drugs are ratified for SWL

3.20 in Q1-2 2019/20 the DTC reviewed 97 drug applications. Of these 77 were approved, 9 were removed from the formulary, 4 were updated on the formulary, 2 were rejected, 1 is pending further information from the applicant, and 1 application was withdrawn. 59 of these applications related to updating the Trust formulary in line with the psychiatric drugs used at South West London and St George's Mental Health Trust.

SWL Acute Provider Collaborative Formulary Harmonisation Project Report

3.21 The Formulary Harmonisation Project aims to produce ONE harmonised SWL Acute Medicines Formulary, which will take into account tertiary services and variation by Trust for specialist formulary areas. The project also aims to harmonise the entry of new drugs across

SWL acute providers, via a collaborative New Drugs process. This project has been endorsed and supported by the Chief Executives of each Trust in the Acute Provider Collaborative (APC).

3.22 A collaboratively developed Joint Formulary will support best practice in medicines use, making it easier for staff to do the right thing for the patient, first time. This is an opportunity to share decisions in efficacy, safety, and place in therapy that optimises the use of medicines for patients in SWL.

3.23 Each chapter of the BNF is undergoing a collaborative clinical review across all SWL Acute Trusts. Currently 6 of 18 chapters have been reviewed and are awaiting ratification by the SWL Joint Formulary Committee that will also manage the Joint Formulary moving forward.

4.0 IMPLICATIONS

Risks

4.1 Risk of patient harm to delays and omissions in administration of medicines

4.2 Risk of patient harm due to delays and omissions in prescribing of medicines

4.3 Risk of patient harm due to wrong patient/wrong drug incidents as scanning rates are decreasing

4.3 Risk of delayed patient discharge due to delay in processing discharge medication (TTO's)

Legal/Regulatory

Resources

4.4 Training places and funding to increase and maintain critical staffing levels of non-medical prescribing pharmacists

4.5 Continued support & resource for satellite dispensing pharmacies to facilitate discharge

6.0 RECOMMENDATIONS

The Board is asked to note the content of the report which was also considered at the Quality and Safety Committee on 21 November 2019.

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2.1

Meeting Title:	**Trust Board**		
Date:	28 November 2019	**Agenda No**	2.1.2
Report Title:	Annual Research Report 2018/19		
Lead Director:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Mark Cranmer, Director of Joint Research & Enterprise Services		
Presented for:	Assurance		
Executive Summary:	Research is important in healthcare because it provides evidence-based treatment options for patients. In recent years there have been a number of studies that have shown that research-active hospitals have better patient outcomes. This paper gives an update to the Board on the Trust's research performance in 2018/19, which saw a doubling of patient recruitment to clinical research studies. Nationally, St George's saw its position improve in the NIHR Research Activity League Table to 17th for both the number of clinical research studies (up from 20th in 2017/18) and the number of patient recruited to clinical research studies (up from 25th in 2017/18). The paper also provides an update on the Trust's strategic development and plans and research infrastructure. The Trust's 2019-24 Research Strategy was approved by the Trust Board in October 2019. The strategy outlines 6 key elements: 1) St George's will seek NIHR core funding to underpin our academic ambition. 2) To establish a St George's Institute of Clinical Research, alongside the existing Clinical Academic Groups. 3) The Trust will continue to support delivery of research across all of its specialities. 4) There will be investment in the IT infrastructure for research. 5) St George's will treat research as 'core business'. 6) St George's will invest in its staff to support their research ambitions.		
Recommendation:	The Board is asked to: • Receive this report which was also considered by the Quality & Safety Committee on 21 November 2019; • Note the update on the Trust's research activity and the improvement in both the number of research studies and the number of patients recruited to patient studies; and • Note the Trust's Research Strategy (2019-24) and the key elements to ensure that the strategic aims are met.		
Supports			
Trust Strategic Objective:	Develop tomorrow's treatments today.		
CQC Theme:	Well Led		

Single Oversight Framework Theme:	Operational Performance.		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee Quality & Safety Committee	**Date**	20/11/2019 21/11/2019

ANNUAL RESEARCH REPORT 2018/19

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Board with an overview on the Trust's research performance in 2018/19, a summary of the strategic development and plans and research infrastructure at the Trust.

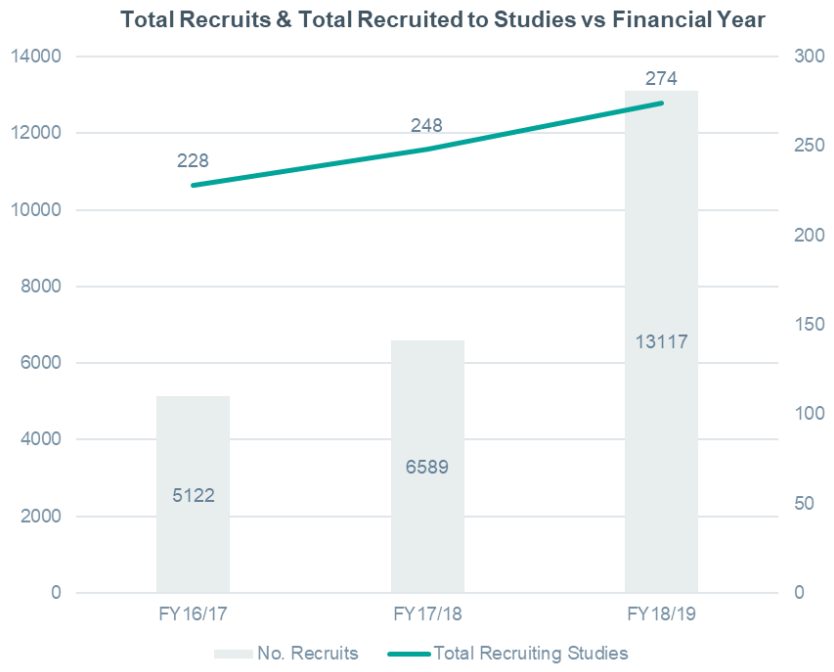
2.0 EXECUTIVE SUMMARY

2.1 Clinical research at St George's increased significantly in 2018/19, with twice as many patients recruited to clinical research studies as the previous year, and a 10% increase in the number of studies.

2.2 A new Research Strategy 2019-24 was approved by the board in October, and we will begin implementation of this. The new strategy is focussed on improving our academic outputs and leading more research, which will require internal investment, seeking core National Institute for Health Research (NIHR) funding, and working in close partnership with St George's University.

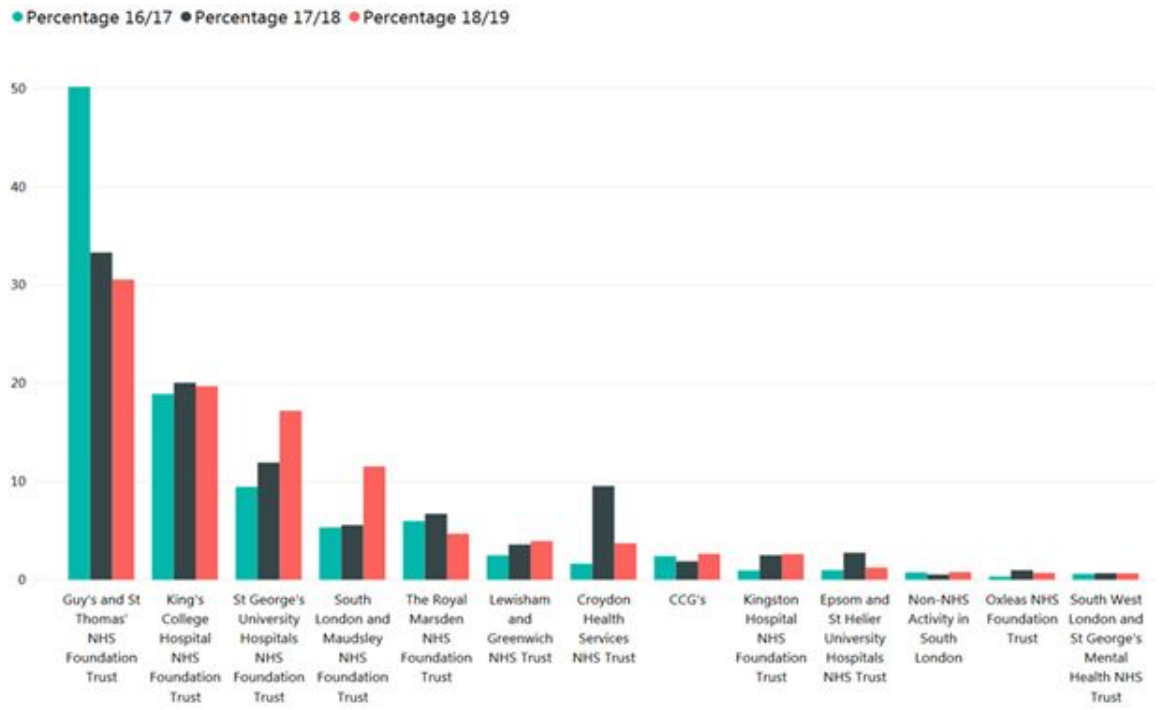
2.3 The recruitment of St George's patients to clinical research studies has increased considerably over the last two years, as have the number of studies which St George's recruits patients to.

Graph 1: Total number of recruited patient and total number of recruited to studies by financial year 16/17, 17/18 and 18/19



2.4 We have also seen big improvement in St George's performance relative to other NHS Trusts in the South London Clinical Research Network (CRN). Our share of 'weighted recruitment' (which gives more weight to complex/costly research) in South London has increased from 9% in 2016/17 to 17% in 2018/19. This is particularly important as it directly affects the amount of CRN funding which St George's receives for research delivery: this has increased from £1.69M in 2017/18 to £1.97M in 2019/20.

Graph 2: The % of patient recruitment in the South London Clinical Research Network at St George's vs. other South London NHS Trusts



2.5 Nationally, St George's saw its position improve in the NIHR Research Activity League Table:

- We increased to **17th nationally in 2018/19** (up from 20th in 2017/18) **for the number of clinical research studies**
- We increased to **17th nationally in 2018/19** (up from 25th in 2017/18) **for the number of patients recruited to clinical research studies**

2.6 Several St George's specialities also performed very well nationally, and also in South London, for patient recruitment to clinical research studies in 2018/19:

Table 1: Trust specialities with a high ranking regionally and nationally

CRN Specialty	South London Ranking	National Ranking
Children	1st	11th
Genetics	2nd	5th
Cardiovascular Disease	1st	3rd
Injuries and Emergencies	1st	1st
Stroke	1st	4th
Neurological Disorders	3rd	14th

3.0 RESEARCH STRATEGY

3.1 The Trust's 2019-24 Research Strategy was approved by the board in October 2019. The Trust's vision is that by 2024 St George's will be a thriving centre for research, ranking in the top ten NHS Trusts nationally for research outputs and performance, with an NIHR-funded Clinical Research Facility, acting as a hub for research in South West London and having an international reputation for research.

The plans set out in the new Research Strategy are:

1) **St George's will seek NIHR core funding to underpin our academic ambition:** The most successful NHS Trusts for research have core NIHR funding, which allows them to develop greater academic outputs and lead more research. St George's aims to bid for NIHR Clinical Research Facility funding at the next available opportunity (expected in 2021), which if successful would allow us to develop more of our own research programmes.

2) **To establish a St George's Institute of Clinical Research, alongside the existing Clinical Academic Groups:** St George's already has four Clinical Academic Groups (CAGs), which are formal structures overlapping St George's Trust and University that bring academics and clinicians together to further research and education. There are CAGs in cardiology, neuroscience, infection/immunity and genetics/genomics. The Trust and University's Joint Strategy Board is revising the Terms of Reference for CAGs to ensure that they are fit for purpose.

   St George's Institute of Clinical Research will sit alongside the CAGs, and will be a joint structure between the Trust and University to provide critical mass and a communication network for clinical researchers (medical, AHPs and nurses) to collaborate and to develop research interests, skills and careers.

3) **The Trust will continue to support delivery of research across all of its specialities,** building upon our success in recent years.

4) **There will be investment in the IT infrastructure for research.** A key step will be ensuring that the Trust's new data warehouse – incorporating linked and searchable clinical, radiological and pathological datasets - can act as a research resource for investigators.

5) **St George's will treat research as 'core business' –** ensuring that research is the responsibility of all Trust staff, and is reflected in planning, objective setting and governance arrangements.

6) **St George's will invest in its staff to support their research ambitions:** This will include reviewing the way in which we fund training for AHPs and nurses on research skills and methods, funding research sabbaticals for new consultants and providing time in job plans for successful researchers.

4.0 RESEARCH INFRASTRUCTURE

4.1 Joint Research and Enterprise Services

Joint Research and Enterprise Services (JRES) supports, manages and facilitates research and enterprise across St George's University and NHS Trust. This includes grant applications, clinical trial set-up and intellectual property protection and licencing, as well as responsibility for clinical research governance and sponsorship of research.

JRES supports clinical research delivery, including through horizon scanning relevant studies, operationally managing the CRN funds which St George's Trust receives for research, and advising and supporting investigators.

Recently, JRES has engaged Health Enterprise East, an NHS innovations hub which provides technology advisory services and innovation management to the NHS. This is already starting to improve the management of our innovations.

The JRES has also entered into an agreement to provide research governance and management services to Epsom & St Helier NHS Trust, which commenced in October. This involves the JRES providing the line management and support for the Epsom & St Helier R&D office, and sharing JRES policies and training. This helps our ambition to become a hub for research in South West London.

4.2 Clinical Research Facility and research delivery teams

The delivery of our clinical research is carried out by teams of research delivery staff (approximately 80 FTE), consisting of research nurses and midwives, clinical research practitioners, research coordinators and other support staff. Many areas have their own speciality teams, such as Stroke, Reproductive Health and Oncology.

In addition, there is a Clinical Research Facility core team of around 15, who support research across specialities, in particular those areas who don't have the critical mass to have their own dedicated team. The Clinical Research Facility also provides a physical space where researchers can see patients, and also a laboratory.

We are introducing more structure and consistency within the research delivery workforce, to improve its cohesiveness, better support staff and provide more job stability. Following a recent consultation, most staff will be moved to permanent contracts, staff will be issued with consistent job descriptions and there will be more flexibility in roles, so that staff can be moved should research increase or decrease in a particular area.

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St George's University Hospitals NHS Foundation Trust

2.1

Meeting Title:	**Trust Board**		
Date:	28 November 2019	**Agenda No**	2.1.3
Report Title:	Seven-Day Services Update and Self-Assessment (Board assurance framework for seven day hospital services)		
Lead Director:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Dr Mark Hamilton, Associate Medical Director for Quality Improvement		
Presented for:	Discussion/Update		
Executive Summary:	Ten clinical standards for seven-day services in hospitals were developed in 2013 through the Seven Day Services Forum. These standards define what seven day services should achieve, no matter when or where patients are admitted. Four of the ten clinical standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These are: • Standard 2 – Time to first consultant review • Standard 5 – Access to diagnostic tests • Standard 6 – Access to consultant-directed interventions • Standard 8 – On-going review by consultant twice daily if high dependency patients, daily for others NHS England and Improvement moved from a survey based approach to monitoring compliance with the national seven-day services model to a bi-annual board assurance model. The Trust is required to submit the next self-assessment (appendix 1) on 29th November 2019. The Trust aims to be compliant with the four priority standards for seven day services for emergency care patients by April 2020. The Trust has continued to make good improvement in its performance over the last two years against standard 2 in particular (to be seen within 14 hours by a consultant from the time of admission). It has now met this standard with 90% of patients admitted as an emergency seen within 14 hours during the weekday, but not weekends. The number of patients seen within 14 hours during the weekend is more difficult to quantify; approximately 83% of patients are seen within 14 hours at the weekends, this represents an improvement of 8% since the last report received by Quality and Safety Committee in May 2019. The Trust meets the standards required for the other standards (5, 6 & 8). There are still a few specialities that are not fully compliant with standard 2, although they represent a small number of patients. These specialties have been asked to re-audit their current performance for weekend and weekday provision against standard 2 and work within their divisions to produce appropriate action plans. The Trust has 24/7 access to MRI for regional neurology and neurosurgical		

	patients. For other patients, MRI at the weekends is only available via informal arrangement. A business case is being formulated to provide the capacity to deliver a formal and robust arrangement for weekend MRI.		
Recommendation:	The Board is asked to: • Note the improvements made, while recognising the on-going need for some specialties to become compliant to ensure a robust approach for all patients; • Discuss/approve the self-assessment which the Trust is required to submit to NHS Improvement/England at the end of November 2019 submission (Appendix 1) which was considered by the Quality & Safety Committee on 21 November 2019; and • Note that a further report would be presented to the Board via the Quality and Safety Committee before the April 2020 deadline to ensure full compliance against the standards is achieved.		
Supports			
Trust Strategic Objective:	Outstanding care every time.		
CQC Theme:	Safe, Effective and Well Led		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	There is a potential financial risk to the Trust through non-compliance of the standards. There is a reputational risk to the Trust through not providing timely and appropriate care to patients if not fully compliant.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee Quality & Safety Committee	**Date**	20/11/2019 21/11/2019

SEVEN-DAY SERVICES UPDATE – NOVEMBER 2019

1.0 PURPOSE

1.1 Sir Bruce Keogh's plan to drive seven-day services across the NHS aims to reduce mortality rates and length of stay, improve patient experiences and reduce readmission rate has been implemented by and NHSE led programme of achieving a number of clinical standards. There are 10 standards overall, but there is a greater emphasis on four, and an expectation that these four standards will be achieved for >90% of emergency admissions by April 2020.

1.2 These standards are set out below:

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

1.3 NHSE/I asked Trusts to perform national auditing submissions until April 2018; however, they have moved to asking Trusts to undertake self-assurance and build that into a Board Assurance Framework locally. Appendix 1 is the draft self-assessment return to NHSE/I for Autumn/Winter 2019/20.

2.0 CURRENT PERFORMANCE AND CHANGES SINCE THE LAST REPORT

2.1 90% of patients admitted as an emergency on a weekday are being seen within 14 hours of admission. This represents a significant improvement for the Trust compared to two years ago, but there is still more work to do to meet this priority standard on the weekend.

2.2 Although no current national benchmarking data are available from NHSE/I to see how we perform against our peers, in April 2018 we compared favorably with other similar size Trusts.

2.3 Areas of improvement

2.3.1 Neurology and stroke services are now compliant with standard 2.

2.4 Areas not compliant against the priority standards

2.4.1 Weekday

Both Urology and ENT remain non-compliant with standard 2 and represent approximately 2.4% and 3.5% of emergency admissions respectively. However, the consultants within these services now have job plans to support the delivery of standard 2.

2.4.2 Weekend

General surgery, ENT, Haematology and Infectious Diseases remain non-compliant with standard 2 and represent 10.5%, 3.5%, 1% & 2.6% of emergency admissions respectively.

The Trust has 24/7 access to MRI for regional neurology and neurosurgical patients. For other patients, MRI at the weekends is only available via informal arrangement. A business case is being formulated to provide the capacity to deliver a formal and robust arrangement for weekend MRI.

2.4.3 Areas where more information is needed

An audit of Paediatric Surgery is awaited, which represents approximately 2% of emergency admissions, but it is not possible to ascertain their performance until the audit is completed. Additionally, an audit of Neurosurgical performance against standard 2 is awaited.

3.0 ACTIONS BEING UNDERTAKEN TO ADDRESS AREAS OF NON-COMPLIANCE

3.1 General Surgery

General Surgery is due to re-audit its compliance against standard 2 within the next 2 months. There will also be a discussion at Care Group level on how to increase the number of patients seen by a consultant within 14 hours at the weekend.

3.2 ENT

The service is working on pathways of care for common conditions to improve its performance against standard 2

3.3 Haematology and Infectious Diseases

Both services are considering the use of pathways but also exploring the option to increase their consultant numbers to become compliant.

3.4 Urology

The service has just audited its performance and is holding discussions at care group level to work out a plan of action for the way forward. It currently stands with an approximately 75% performance against standard 2.

4.0 RECOMMENDED ACTION BY DIVISION TO IMPROVE COMPLIANCE

4.1 MedCard

a. To work with Haematology and Infectious Diseases to understand the need for more consultant cover if that is the desired action.

b. To work with both specialties to create and approve appropriate clinical pathways to assist achieving standard 2 if that is the desired action.
c. Both of these options should be reported through their Divisional Governance Board to provide a route of assurance for the Quality & Safety Committee.

4.2 SNCT

a. To work with ENT on desired clinical pathways to achieve standard 2.
b. To work with Urology to understand barriers to becoming fully compliant.
c. To similarly work with and support General surgery to compliance and to ensure a re-audit of their services.
d. To ensure that Neurosurgical Services complete an audit of their performance to ascertain any improvement actions that need to be taken.
e. All of the above options should be monitored through Divisional Governance Board to assure the Quality & Safety Committee of progress.

4.3 CWDT

a. To ensure Paediatric Surgery Services complete an audit of their performance to ascertain any improvement actions that need to be taken.
b. To ensure the process for accessing MRI at the weekends goes through an appropriate governance process and is communicated within the Trust.
c. These should be monitored through Divisional Governance Board to assure the Quality & Safety Committee of progress.

5.0 CONCLUSION

5.1 The Trust has improved is compliance with standard 2 significantly over the past 2 years with 90% of patients and specialties seeing a consultant within 14 hours. For standards 5, 6 & 8 the Trust is compliant.

5.2 Divisions have also been working to get every inpatient seen by a consultant on a daily basis and in the large part have job plans to support that. The Trust is very close to achieving full compliance with all four of the standards and Divisions are aware of the areas that need further attention to support full compliance as outlined in the recommendations below.

6.0 RECOMMENDATIONS

The Board is asked to:

- Note the improvements made, while recognising the on-going need for some specialties to become compliant to ensure a robust approach for all patients;
- Discuss/approve the self-assessment which the Trust is required to submit to NHS Improvement/England at the end of November 2019 submission (Appendix 1) which was considered by the Quality & Safety Committee on 21 November 2019; and
- Note that a further report would be presented to the Board via the Quality and Safety Committee before the April 2020 deadline to ensure full compliance against the standards is achieved.

7.0 REFERENCES

1. NHS England, 'Seven Day Services Clinical Standards' (September 2017), available from https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

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Appendix 1: Self-assessment against priority 7DS Clinical Standards

NHS St George's University Hospitals NHS Foundation Trust : 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

Priority 7DS Clinical Standards

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

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

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Clinical standard	Self-assessment of performance		Weekday	Weekend	Overall score
Clinical Standard 6: Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant-directed interventions seven days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional radiology	Yes available on site	Yes available on site	
		Interventional endoscopy	Yes available on site	Yes available on site	
		Emergency surgery	Yes available on site	Yes available on site	
	No change	Emergency renal replacement therapy	Yes available on site	Yes available on site	
		Urgent radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous coronary intervention	Yes available on site	Yes available on site	
		Cardiac pacing	Yes available on site	Yes available on site	

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

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7DS Clinical Standards for Continuous Improvement

Self-assessment of performance against clinical standards 1, 3, 4, 7, 9 and 10
There has been no change in these standards

7DS and urgent network clinical services

	Hyperacute stroke	Paediatric intensive care	STEMI heart attack	Major trauma centres	Emergency vascular services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency

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2.2

Meeting Title:	**Trust Board**		
Date:	28 November 2019	**Agenda No**	**2.2**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	James Friend, Chief Transformation Officer		
Report Author:	Emma Hedges, Mable Wu, Kaye Glover		
Presented for:	Information and assurance about Quality and Performance for Month 7		
Executive Summary:	This report consolidates the latest management information and improvement actions across our quality, patient access, performance and workforce objectives. The Trust is performing positively against a number of indicators. Cancer performance continues to be compliant against all seven standards and 18 week wait RTT has recovered to meet the Trust's trajectory. However the Four Hour Operating Standard continues to be below trajectory with performance of 83.2% against a recovery plan of target 91.3%. The Trust was also not compliant with the Six Week Diagnostic Standard with a performance of 3.32%. There was one Never Event declared in October which is under investigation and one MRSA incident. Other Patient Safety metrics were within expected process limits for the reporting period and the Quality Improvement Key Programmes show steady progress. Metrics for the Quality Improvement Programme are under continual development and will be modified in upcoming reports.		
Recommendation:	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Treat the Patient, Treat the Person Right Care, Right Place, Right Time		
CQC Theme:	Safe; Caring; Responsive; Effective; Well Led		
Single Oversight 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:	Finance and Investment Committee Quality and Safety Committee	**Date**	23/11/19 23/11/19
Equality Impact Assessment:			
Appendices:			

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 28 November 2019
Reporting Period – October 2019

James Friend
Chief Transformation Officer

15 November 2019

Our Outcomes

How Are We Doing?

October 2019

Daycase and Elective Surgery operations

Actual: 5,426

Target: 5,813

AMU bed occupancy at 12 Noon

Actual: 95% Target: 85%

Four Hour Emergency Standard

Actual: 83.2%

Plan: 95%

Whole Trust Inpatient Friends and Family Test

Actual 96%

Target 95%

Outpatient First Attendence

Actual 17,414

Plan 19,026

September 2019

Referral to Treatment Standard - Incomplete pathways

Actual: 86%

Target: 92%

Balanced Scorecard Approach

Executive Summary – October 2019

Our Finance and Productivity Perspective

- Both financial performance against budget, and Cost Improvement Plan delivery are on plan at month 7, although a level of risk exists to delivery of the financial plan in the latter part of the year. Mitigations are being worked though as part of the Trust financial recovery plan.
- Outpatient Activity at Trust level has been below SLA and mean for the past quarter though the activity level remained within normal process limits and showed no sign of special cause variation.
- Theatre average cases per session has been below the mean since Feb 2019 however in Month 7, the average cases per session fell below the lower process limit.
- Non-elective lengths of stay have increased in the previous two months with Acute Medicine and Senior Health displaying similar patterns from 2017/18.

Our Patient Perspective

- There was one MRSA incident in October 2019 and the YTD number of C.diff cases is 31 against a target of 48.
- Complaints continues to meet all of its compliance targets.
- There was one Never Event declared in October and is under investigations as per Trust policy.
- After a significant deterioration in VTE performance due to a change in National guidance, performance for the last three months has seen an improvement.

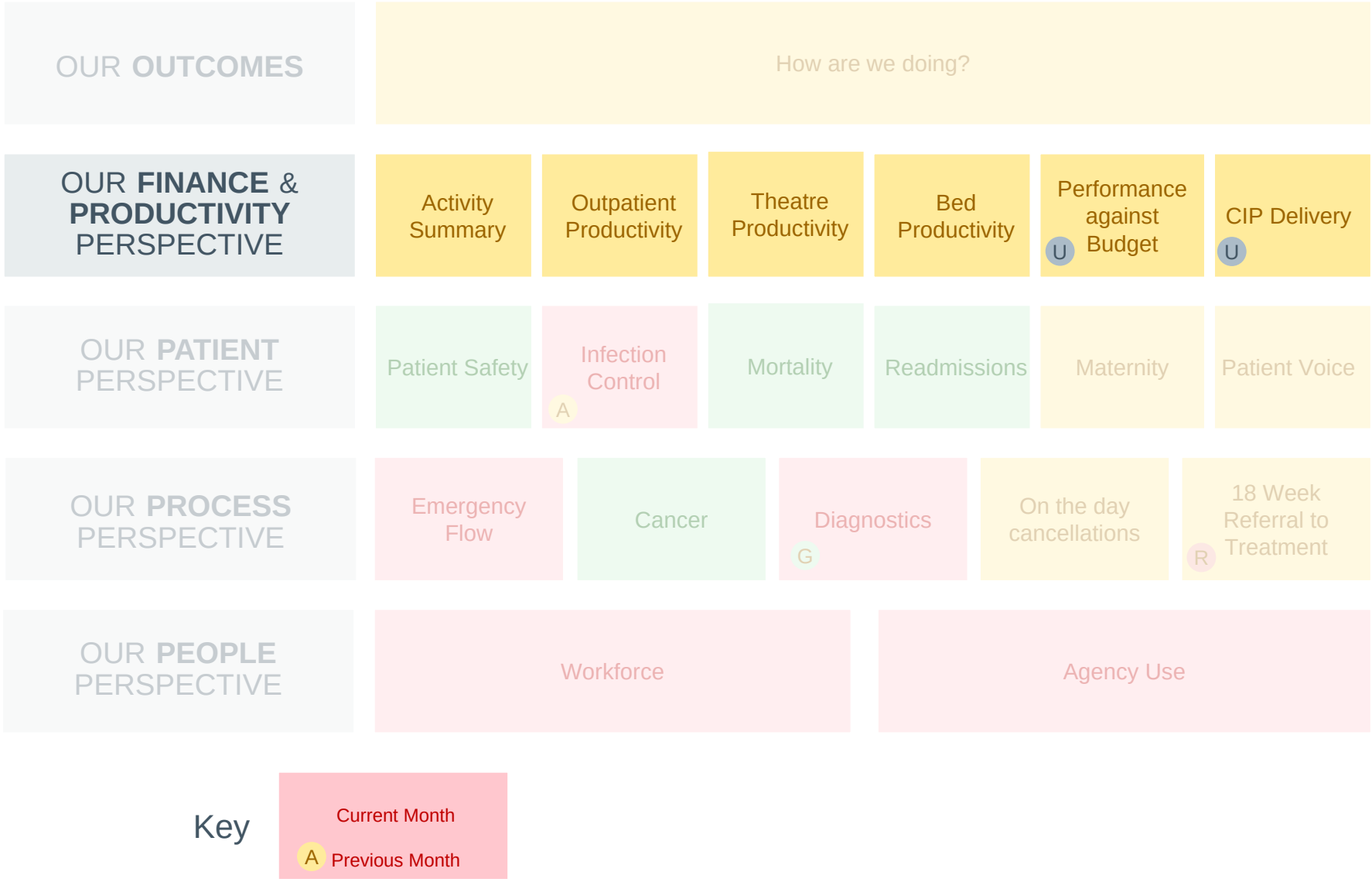
Our Process Perspective

- Performance against the Four Hour Operating Standard in October was 83.2% and performance continues to be below the lower process limit.
- Ambulance handover performance has not improved though the number of ambulances arriving daily has fallen below the lower process limits for the previous two months with an increase seen in the number of sixty minute breaches reported..
- 14 day long stays and 21 day long stays are both above their upper process control limits for this first time since April 2017 which is also driving up length of stays in non-elective activity
- The Trust achieved all seven Cancer standards in the September. The Trust remained compliant against the 14 day standard and 62 day standard.
- The Trust has exceeded its RTT incomplete trajectory in September with a performance of 86.1% against a target of 85.8%.
- The rebooking process continues its sustained success with 98.1% of patients rebooked within 28 days.
- In October, the Trust performance was not compliant against the six week diagnostic standard with a total of 300 patients waiting greater than six weeks and a performance of 3.32%.

Our People Perspective

- The Trust's Total Funded Establishment and Trust Vacancy rate are both below the lower control limits
- The Trust's total pay for October was £44.14m. This is £1.10m adverse to a plan of £43.05m.
- For October, agency spend was £1.86m compared to a target of £1.25m. The total agency cost is worse than the target by £0.61m.
- Junior Doctor agency spend continues to increase above plan and has been above cap for the past seven months.

Balanced Scorecard Approach



Activity against our Plan

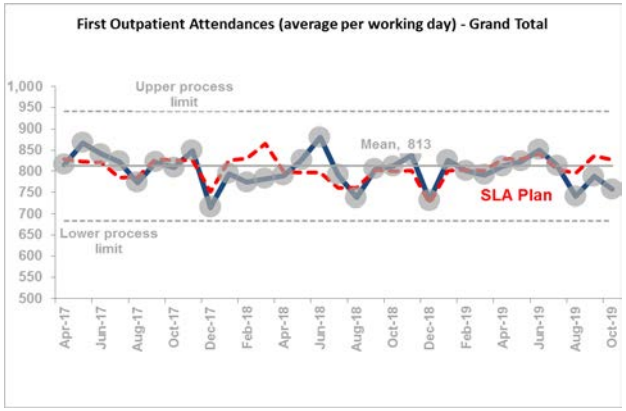
		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Oct-18	Oct-19	Variance	Plan Oct-19	Variance	YTD 18/19	YTD 19/20	Variance	Plan YTD	Variance
ED	ED Attendances	14,278	14,308	0.21%	14,375	-0.47%	98,037	99,701	1.70%	99,233	0.47%
Inpatient	Non Elective	4,175	4,328	3.66%	4,020	7.66%	27,867	28,031	0.59%	27,777	0.91%
	Elective & Daycase	5,334	5,426	1.72%	5,813	-6.66%	34,015	35,975	5.76%	36,639	-1.81%
Outpatient	OP Attendances	54,834	58,473	6.64%	63,007	-7.20%	392,709	391,108	-0.41%	405,917	-3.65%

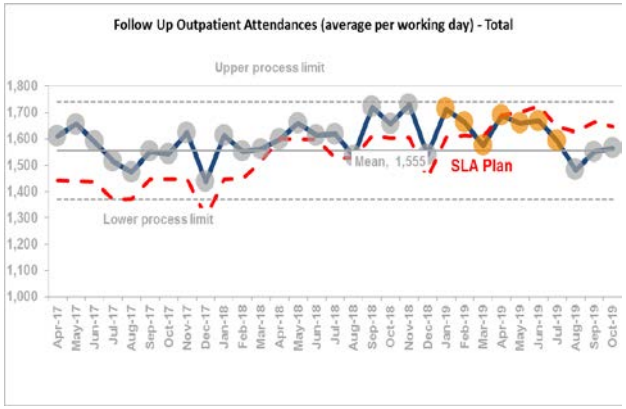
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

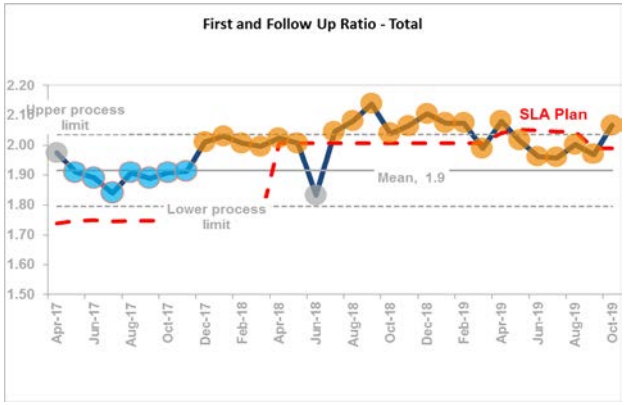
Note: Figures quoted are as at 08/11/2019, and do not include an estimate for activity not yet recorded (eg. un-cashed clinics). The expected performance vs. plan by Point of Delivery (POD) post catch up is:

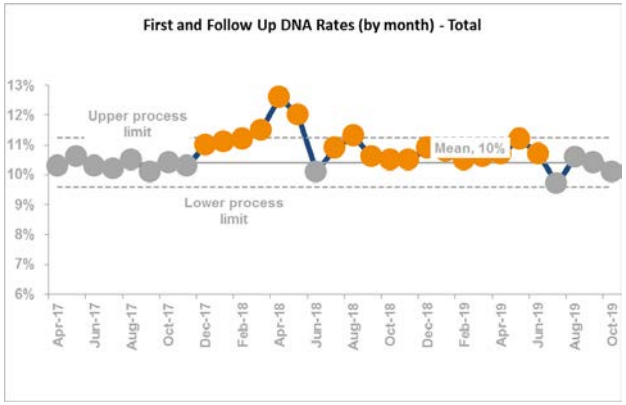
ED – No change
Elective and Daycase – On Plan
Outpatients – Underperformance against plan (c3%)

Outpatient Productivity









Actions and Quality Improvement Projects

- Services are reviewing the recording of particular appointments as some will be classified as outpatient procedures.
- Women's services are meeting weekly to ensure that referrals are being triaged and appointments booked in a timely manner,
- Model Hospital data is being reviewed to identify opportunities.
- The Trust is working in partnership with other hospitals across South West London to redesign six specific outpatient pathways.
- Divisions are currently scoping opportunities to implement virtual follow-up appointments and open access to support reducing follow-up attendances and improve first to follow-up ratios across the services. Virtual clinics have are now established in Neurosciences.
- Additional appointment types have been added to the two way text reminder service in Dermatology, Plastics, Trauma & Orthopaedics, Haematology, Audiology, Audiology Medicine and Ear Nose & Throat.
- Two way text reminder roll out continues.

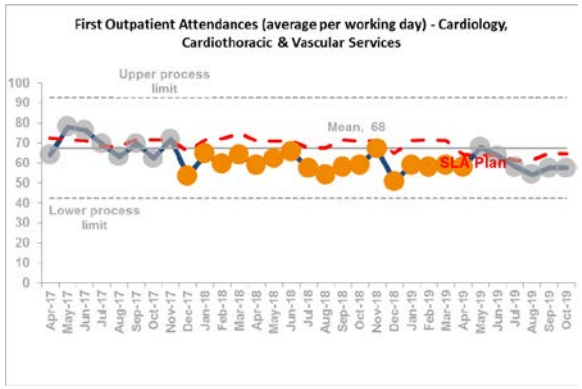
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

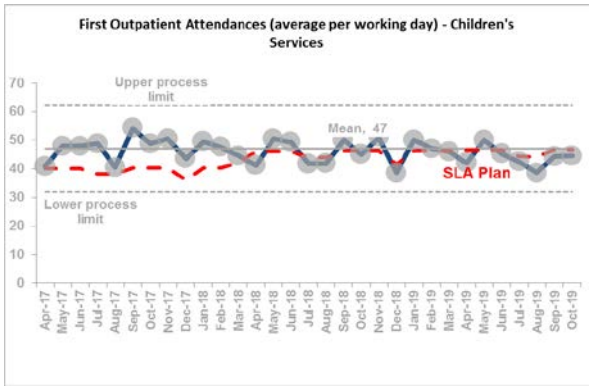
What the information tells us

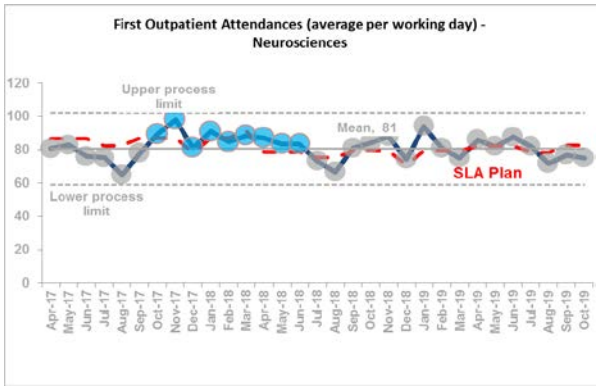
- Outpatient first and follow-up activity remains within the upper and lower control limits at Trust level however overall activity has fallen below plan for the previous two months.
- Renal & Oncology continue to have outpatient first activity consistently above their mean. All other services showing common cause variation.
- At Trust level follow-up activity has remained within its process limits with a dip below the mean in August and September.
- Cardiothoracic Surgery outpatient follow-up activity has had several months with their follow-up activities below the however in October, activity was above their mean.
- Surgery and Trauma and Orthopaedics show consistent follow up activity below their means where as Renal and Oncology, Specialty Medicine and Women's Services outpatient follow-up activity remain above their mean.
- The Trusts first to follow-up ratio continues to be above the mean showing special cause variation for the month of September.
- Neurosciences and Specialty Medicine continue to see the ratio above the mean reflecting the increase in follow-up activity. Women's services are above the upper process limit showing special cause variation.
- The Trust DNA rate is within its process limits and shows common cause variation.
- Women's services and Renal & Oncology DNA rates have consistently been below its means whereas Neurosciences and Other (Acute Medicine, Therapies and Diagnostics) have all been consistently above their means for over a year.

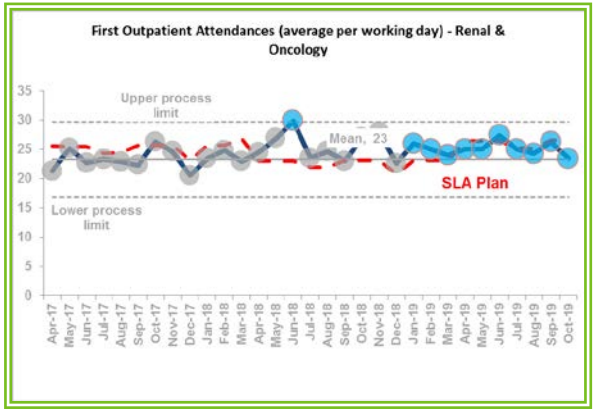
Number of First Outpatient attendances per Working Day

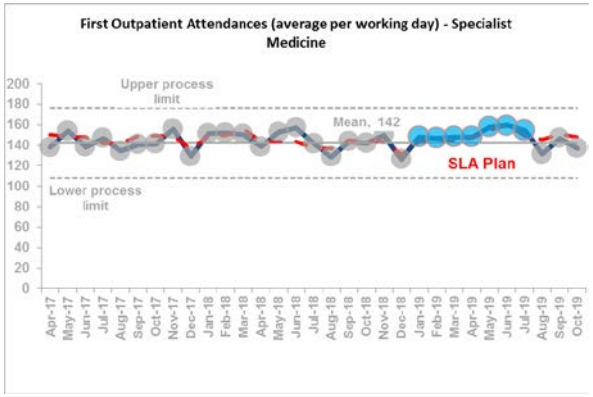
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

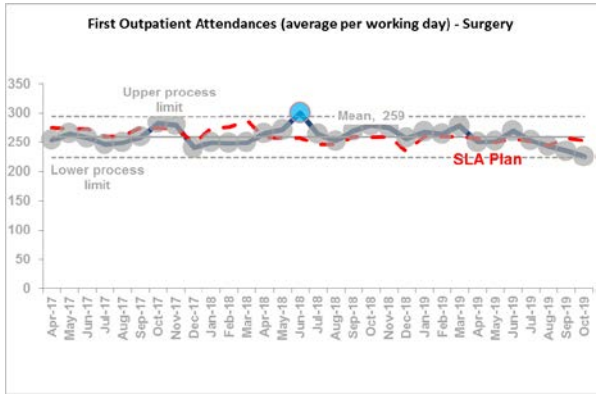


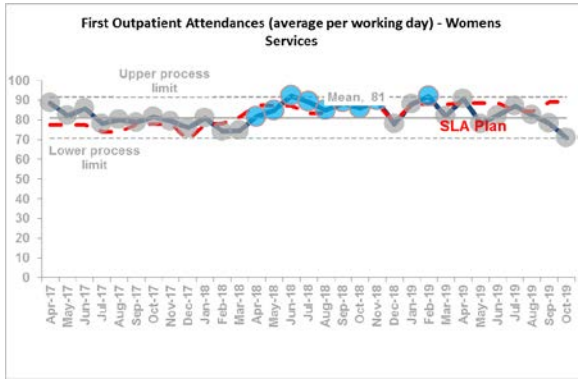


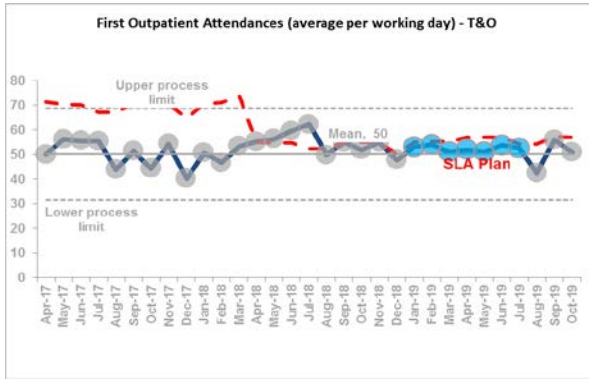






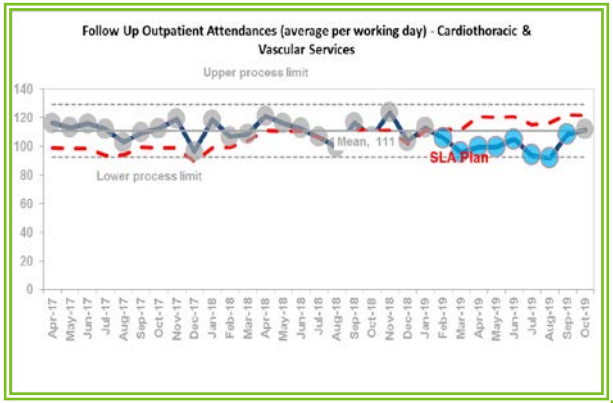


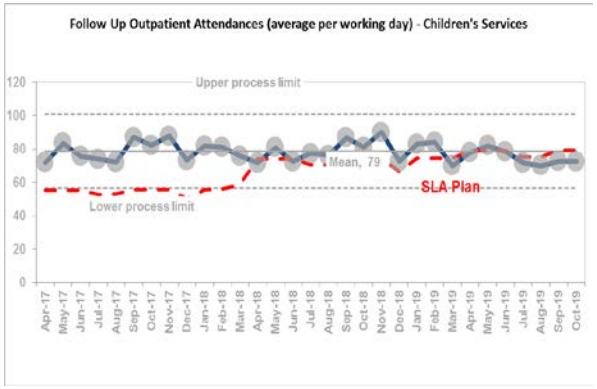


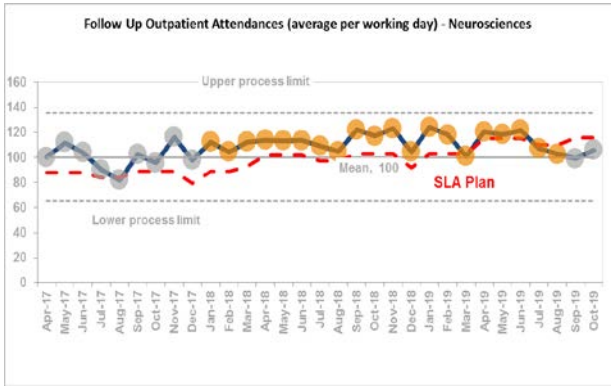


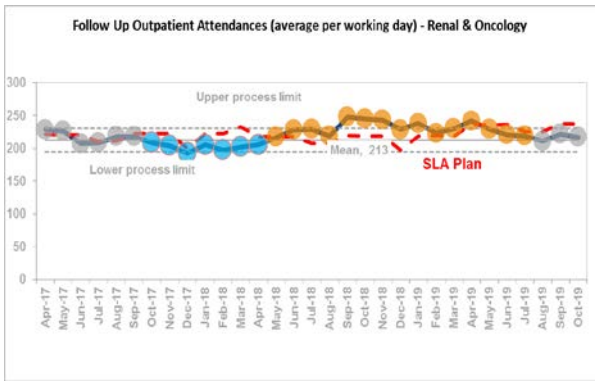
Number of Follow Up Outpatient attendances per Working Day

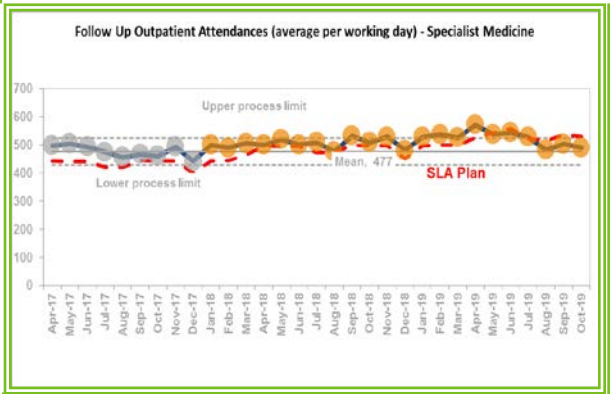
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

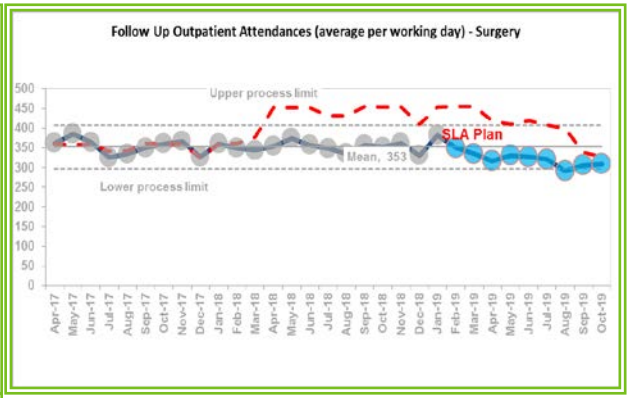


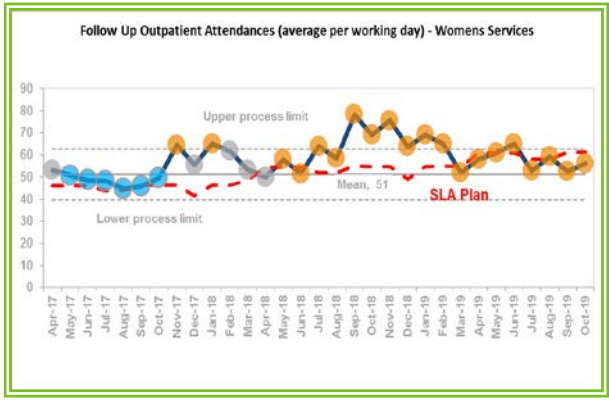


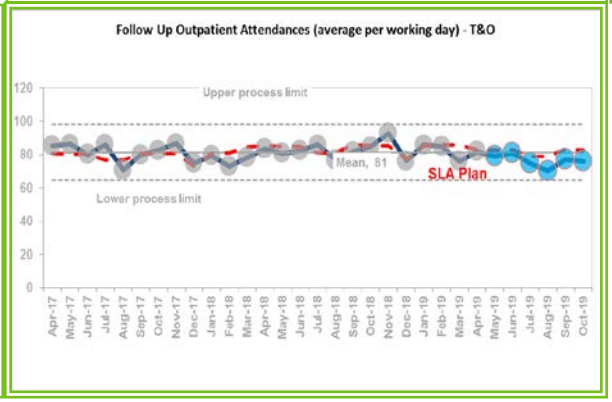






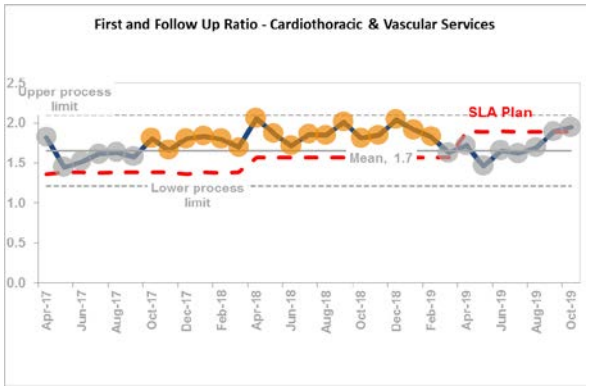


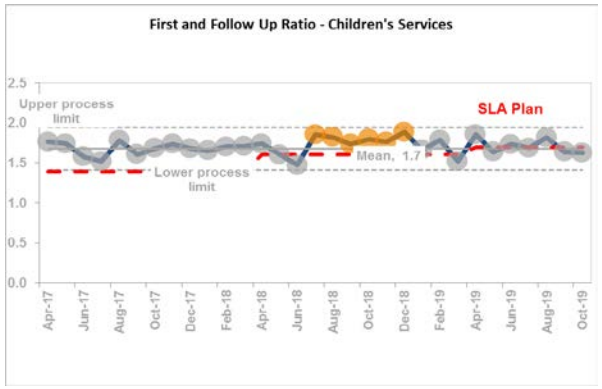


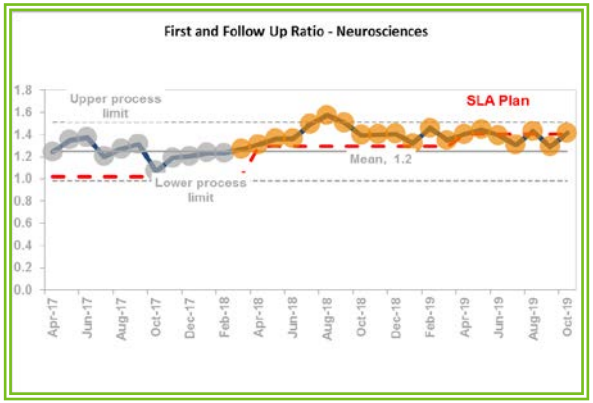


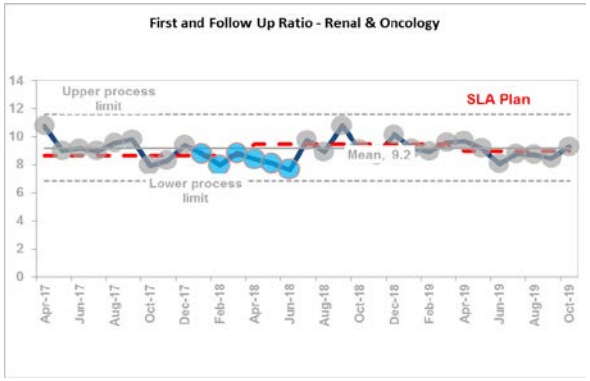
New to Follow Up Ratios

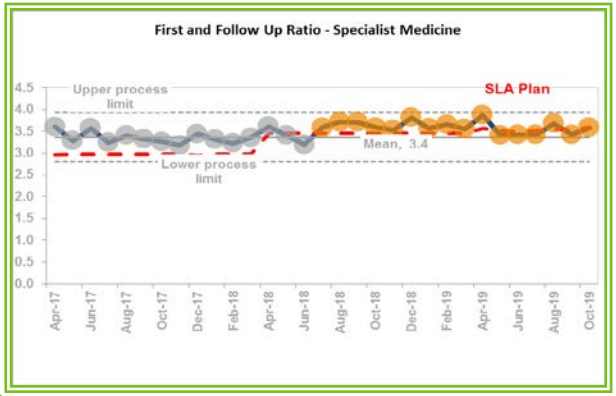
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

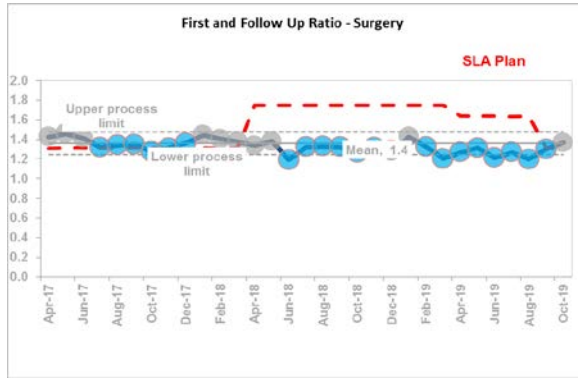


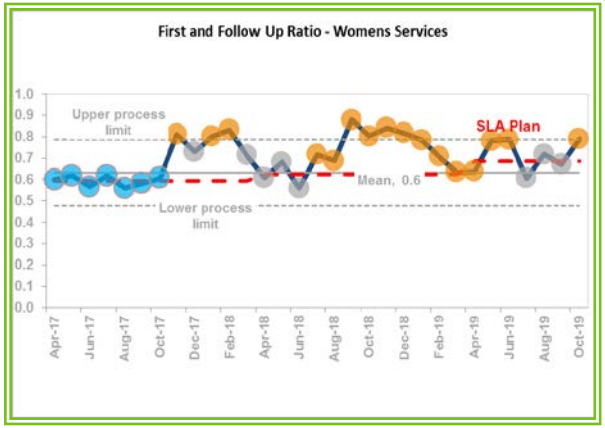


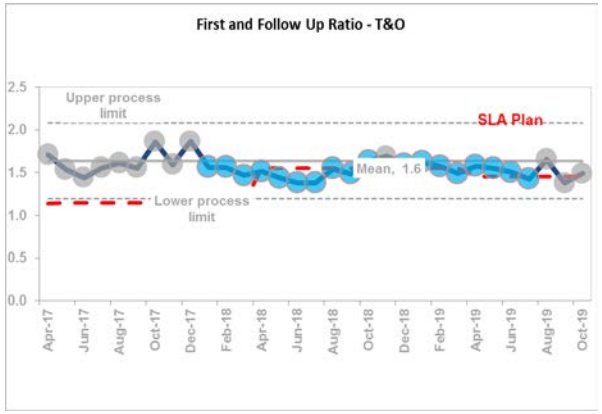






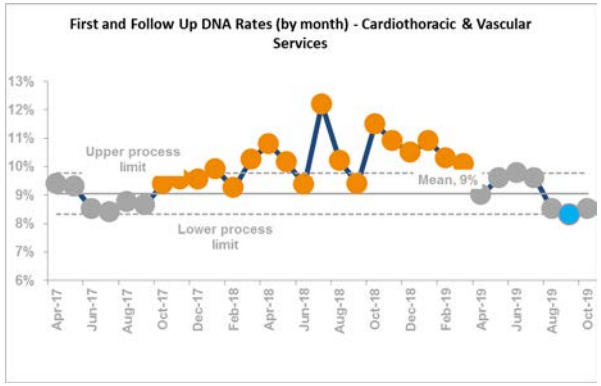


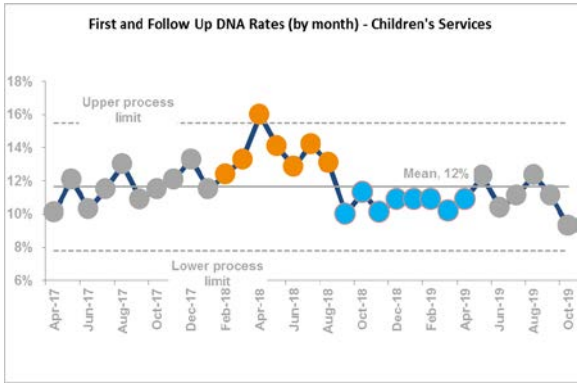


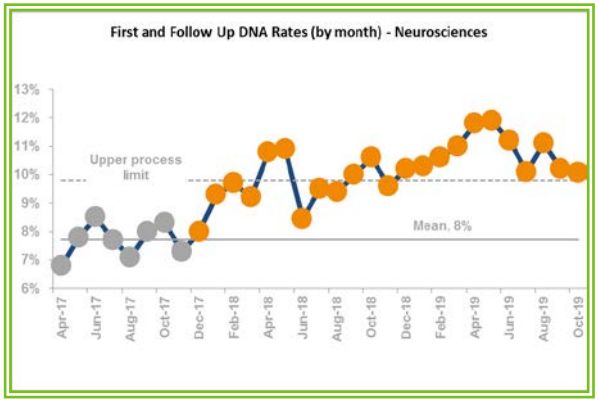


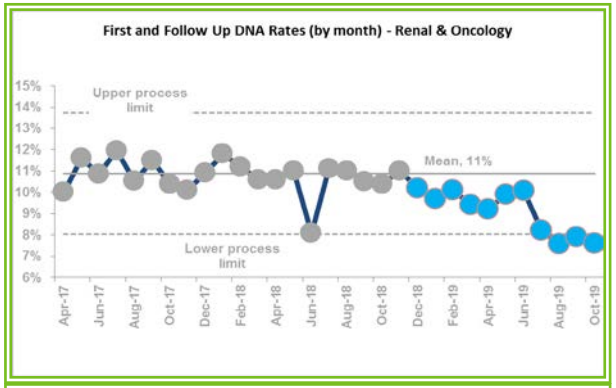
Number of Patients that do not attend

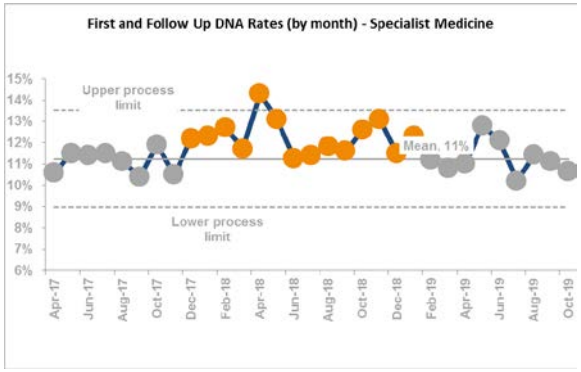
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

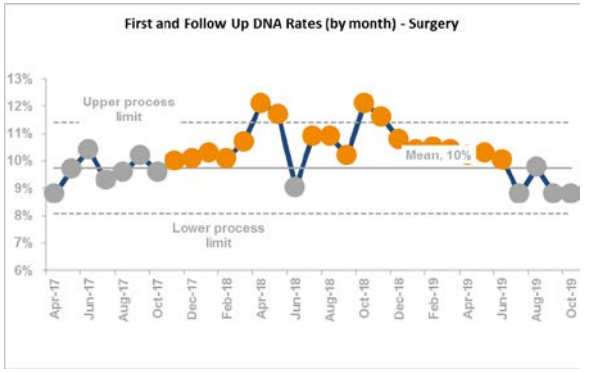


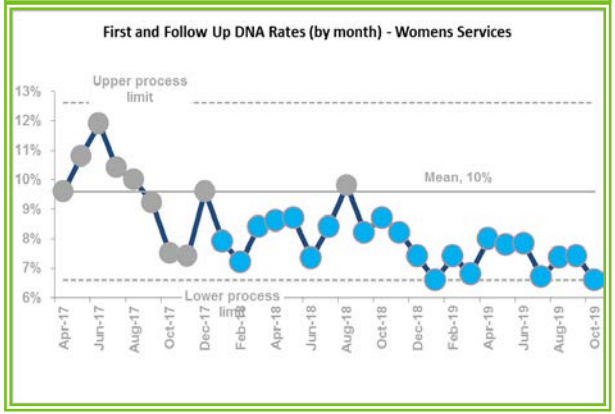


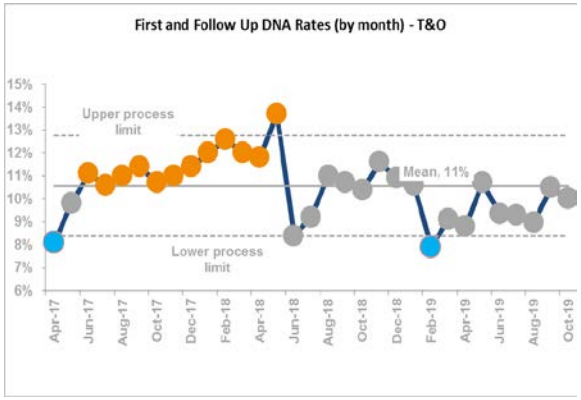


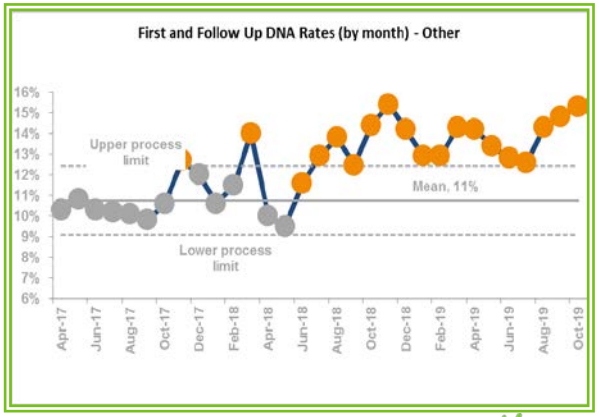






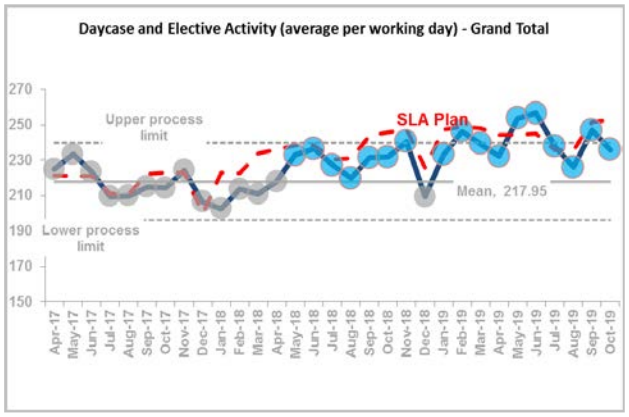


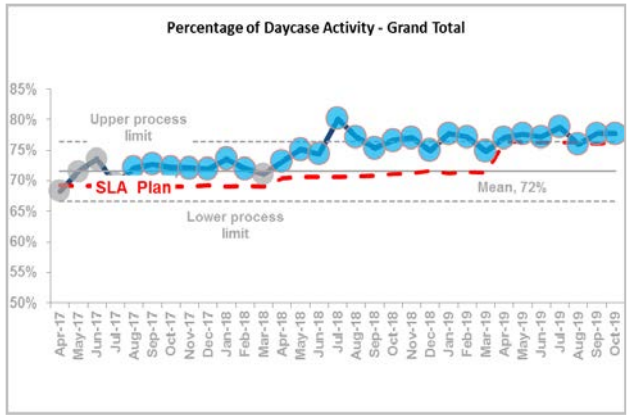


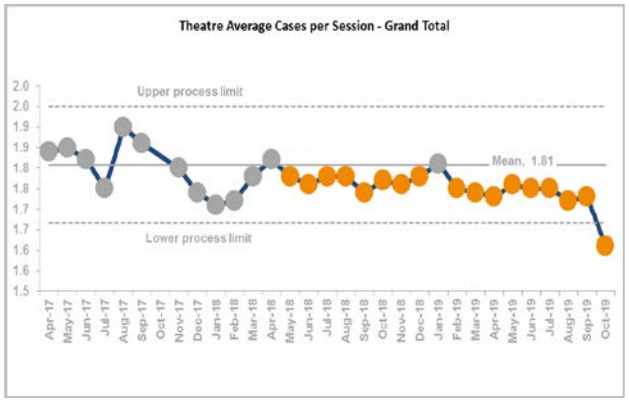


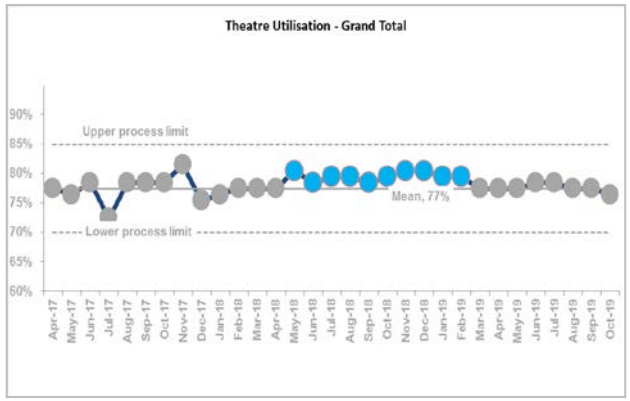
Theatre Productivity

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









Actions and Quality Improvement Projects

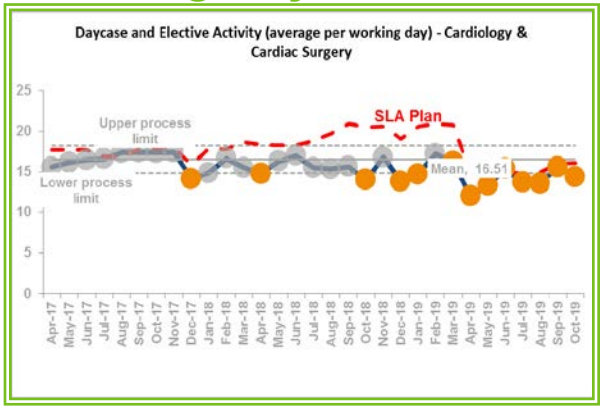
- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions. This is linked to a weekly task and finish group.
- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases and utilisation.
- SNTC Division finance has completed service specific one pagers in conjunction to identify actions required to support SLA achievement. The Theatre Improvement Programme has been re-launched reviewing at the entire admissions pathway, with a focus on patient and staff experience. The change management process is being led by staff in theatres and booking teams.
- The POA Steering Group is in place and looking to centralise IP and DSU areas into one area to make it an easy as possible for our patients to be assessed for surgery, and make the best use of our resources
- Trend analysis of Hospital-Led cancellations, Late starts, Overruns and Underruns to identify of common themes.

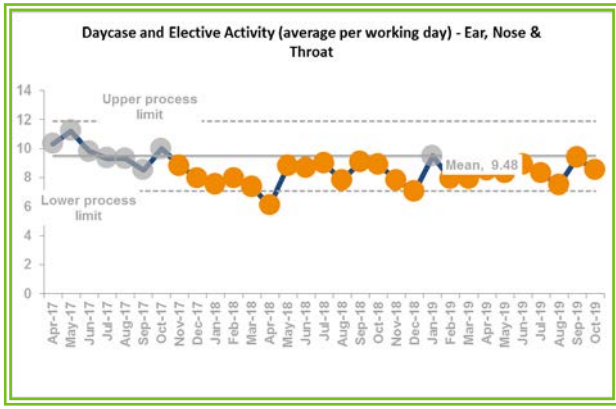
What the information tells us

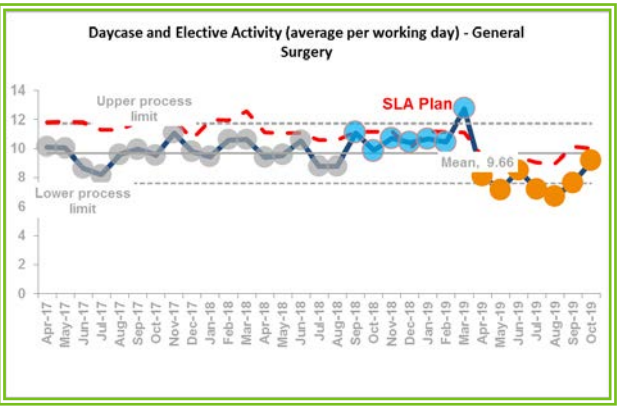
- Activity data for elective treatments remain above the mean however the previous three months have been below SLA plan.
- Neurology, Urology and Plastic Surgery are all performing above their means.
- Cardiology & Cardiac Surgery, General Surgery specialties are showing special cause variation as these specialties are below their means for over six months. Trauma and Orthopaedics have shown variability in recent months and have been below the lower confidence limit for the past three months.
- Ear Nose and Throat have been consistently below their mean for the past nine months
- All of the other specialties are within their expected process limits.
- The percentage of daycase activity is currently above the mean line at Trust level with a number of specialties above their target line. Trauma & Orthopaedics, Oncology and Plastic Surgery are above the upper control limit.
- The Trust's Cases per Session fell below its lower process control limit indicating special cause variation
- Ear, Nose & Throat have continued to increased throughput in the month of October staying above the mean. Paediatric Surgery have seen a significant increase in the number of cases per session in October and is above its upper control limit.
- Neurosurgery and General Surgery have been consistently performing below their means.
- The Trust's Theatre utilisation remains within its control limits.
- Cardiothoracic's utilisation is consistently below its mean.

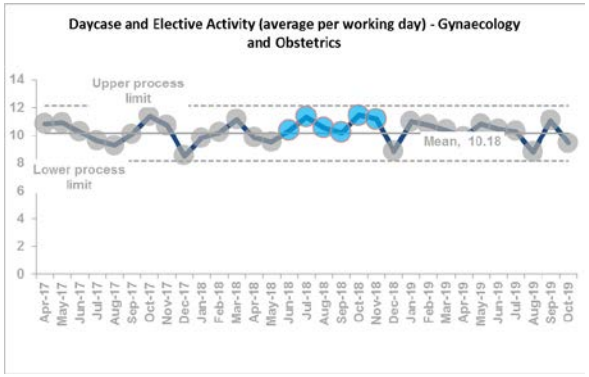
Number of Elective and Daycase Patients treated per Working Day

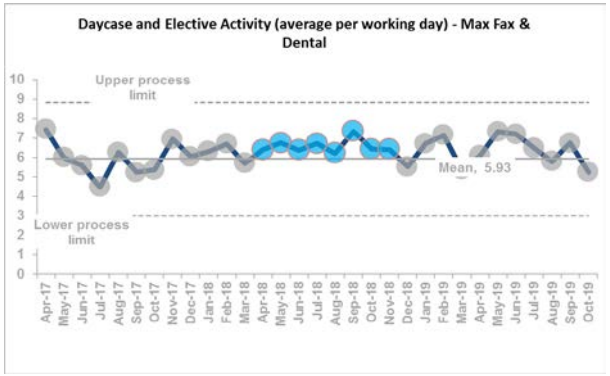
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

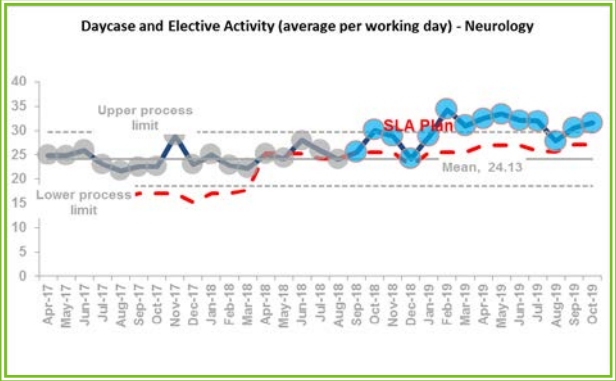


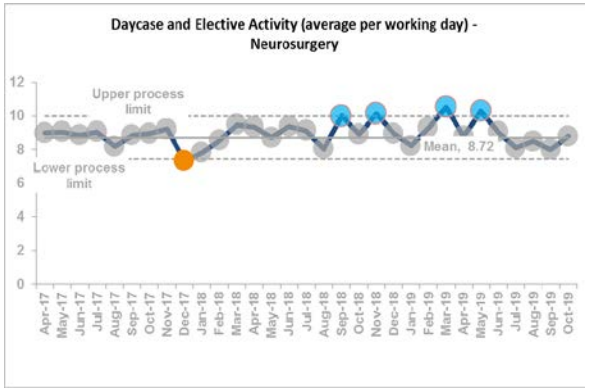


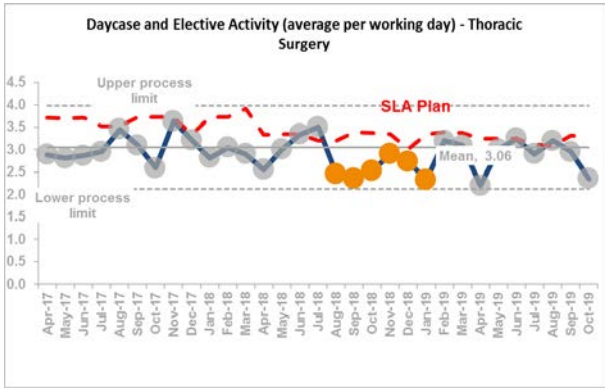


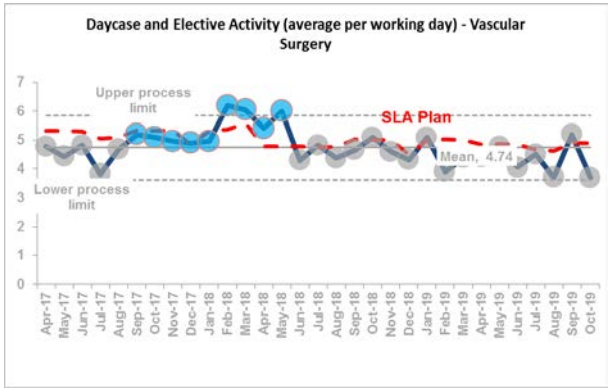










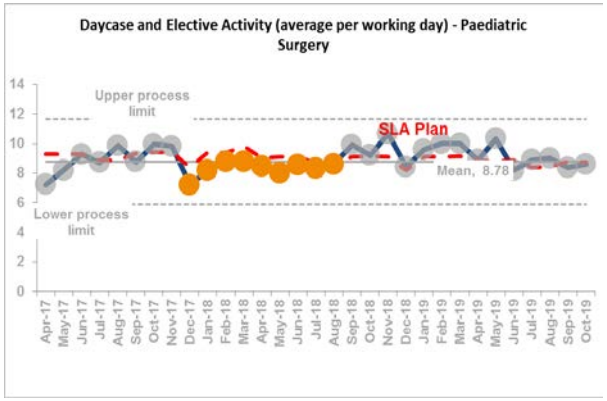


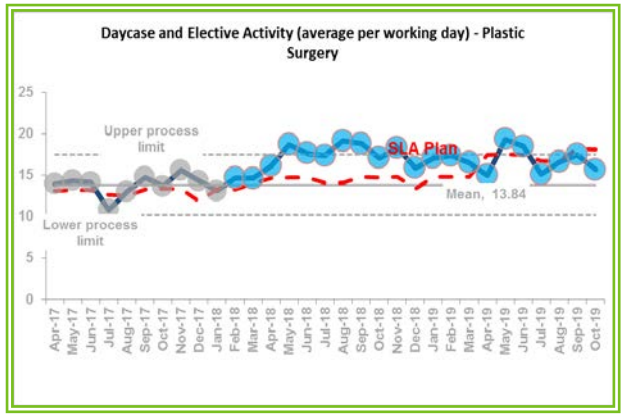
2.2

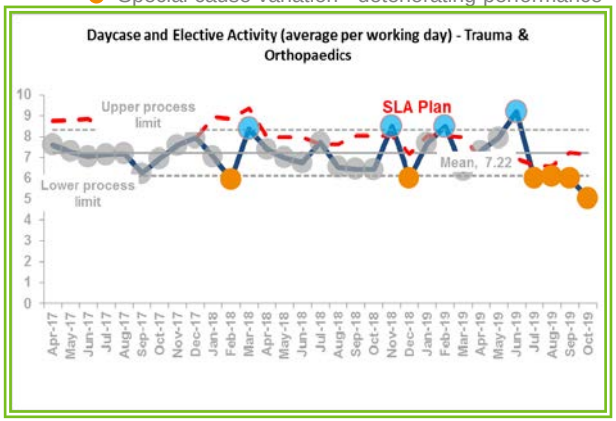
Our Finance & Productivity Perspective

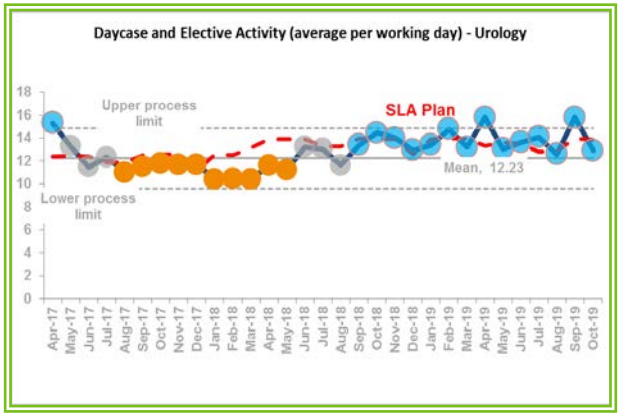
Number of Elective and Daycase Patients treated per Working Day

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



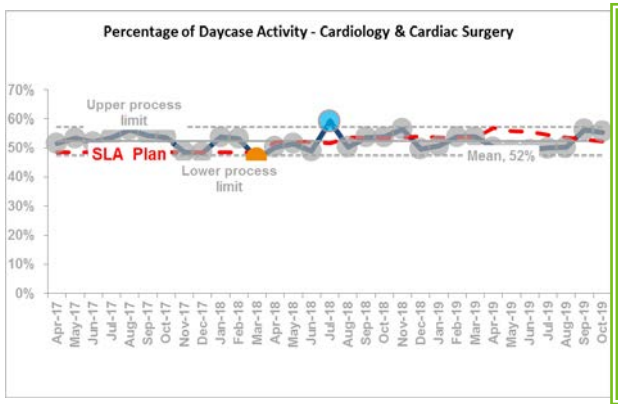


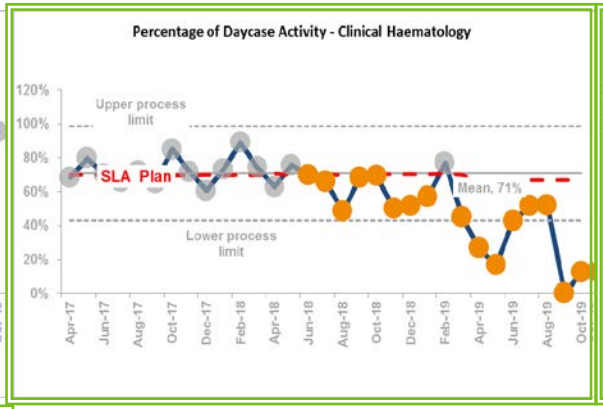


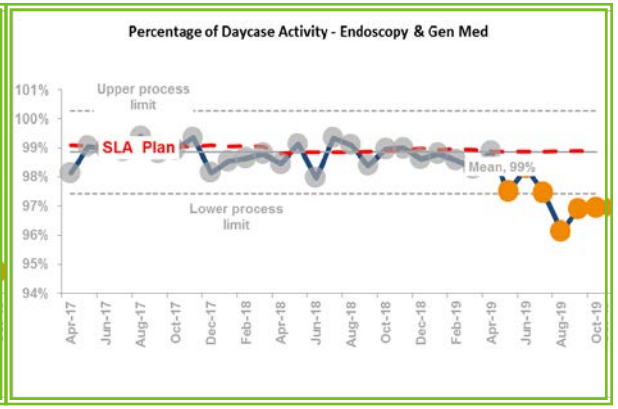


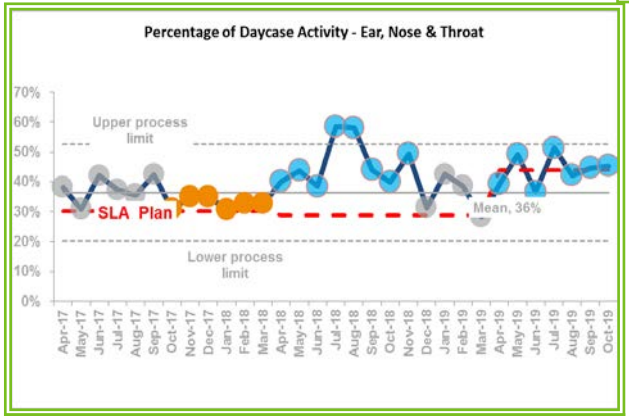
Percentage of daycase activity

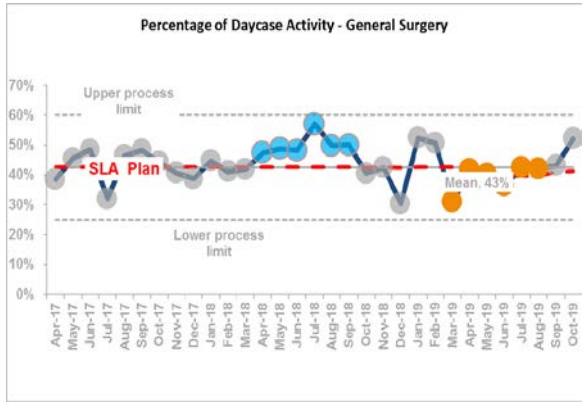
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

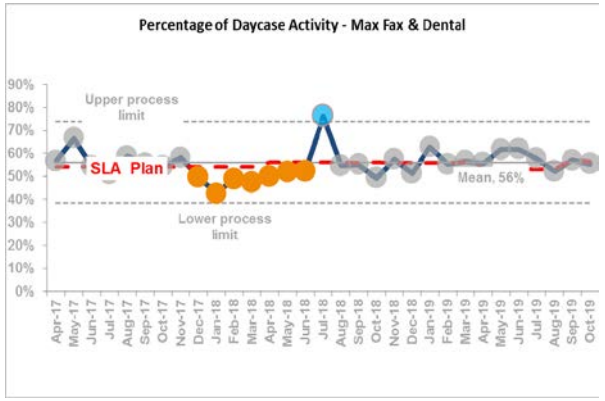


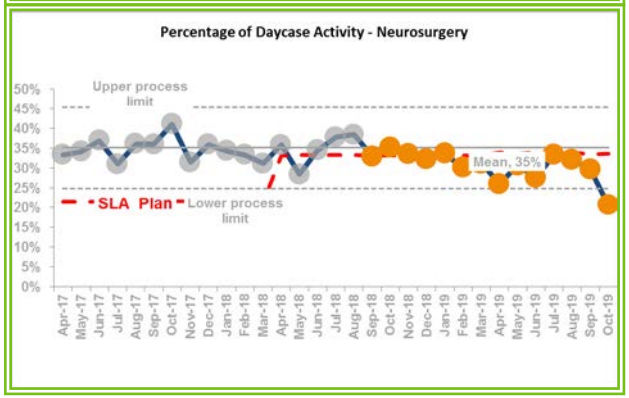


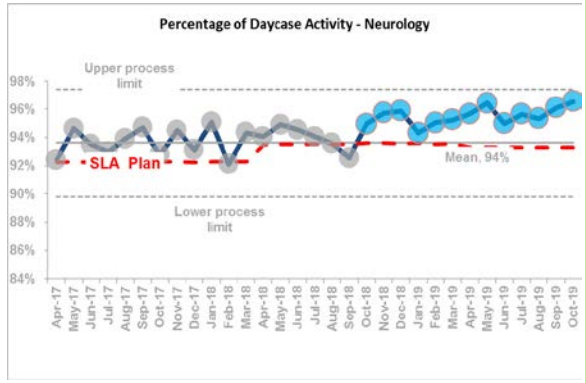


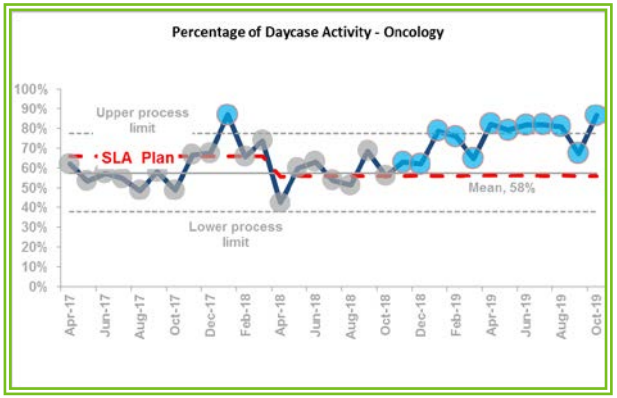






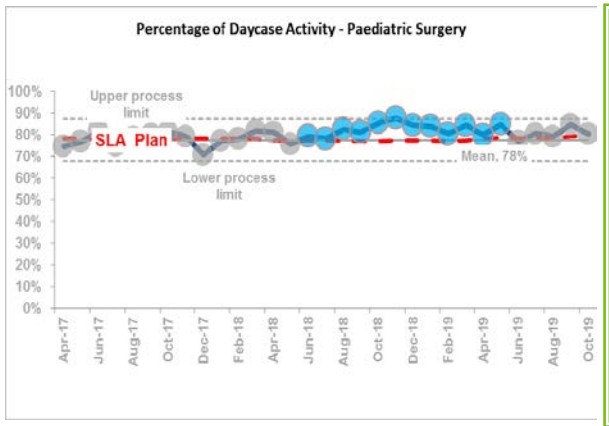


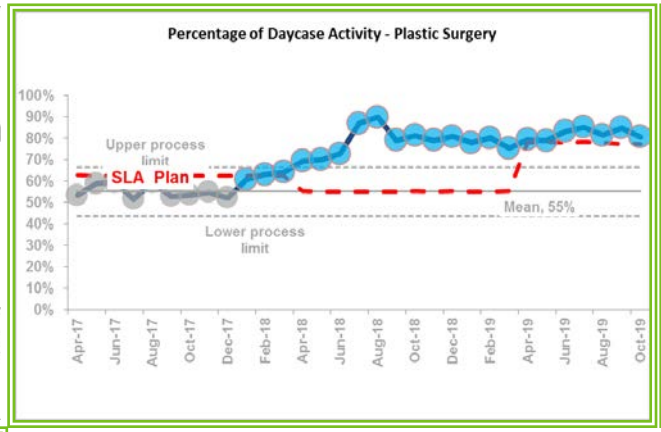


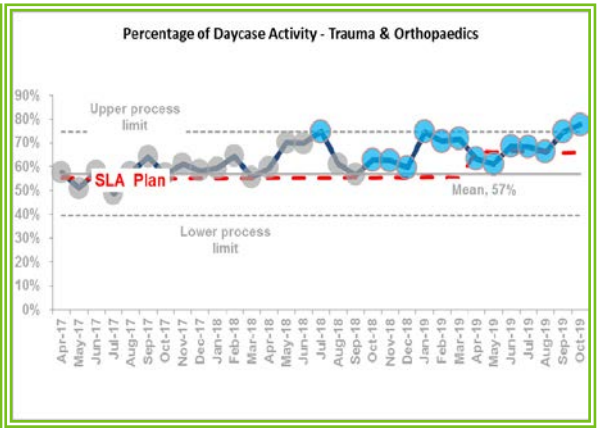


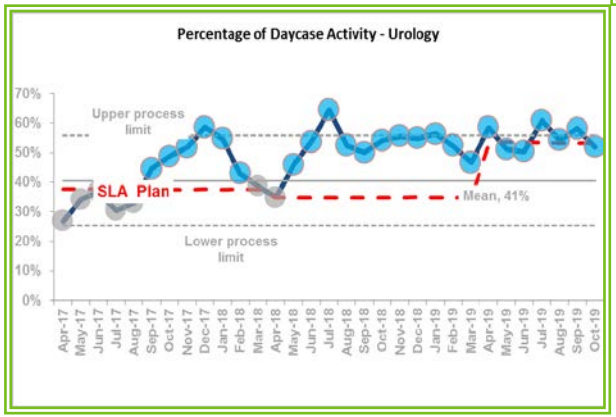
Percentage of daycase activity

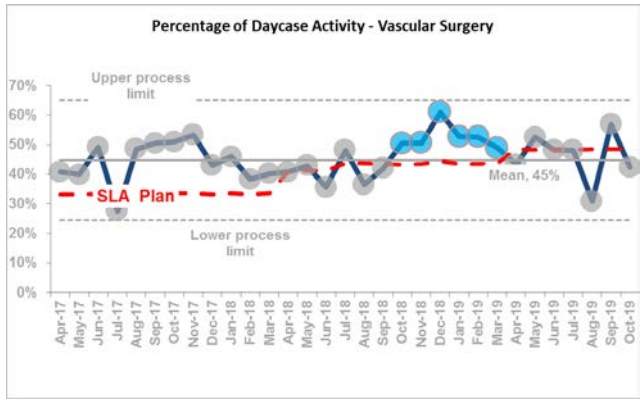
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance





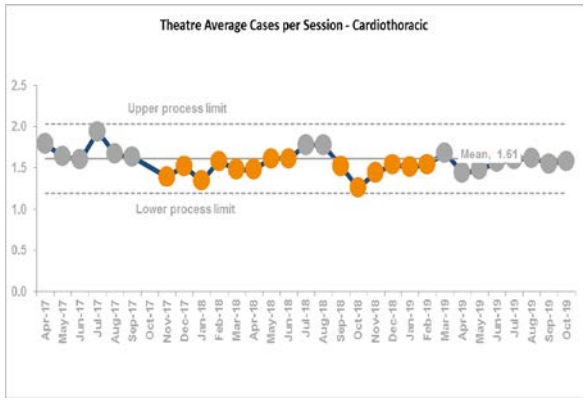


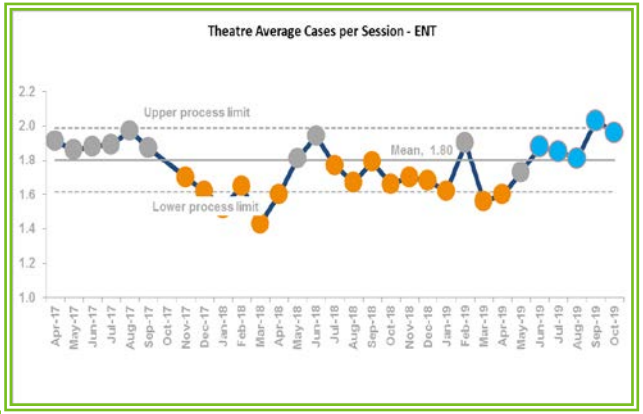


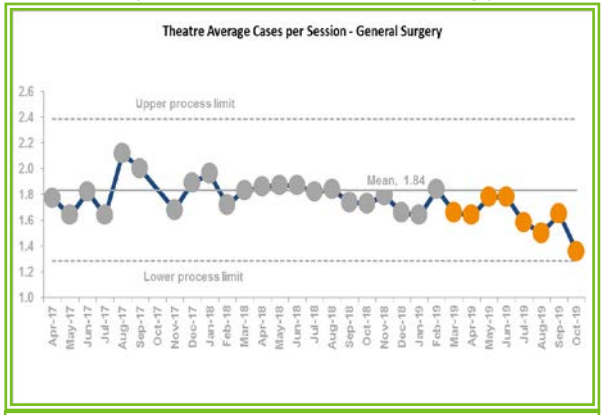


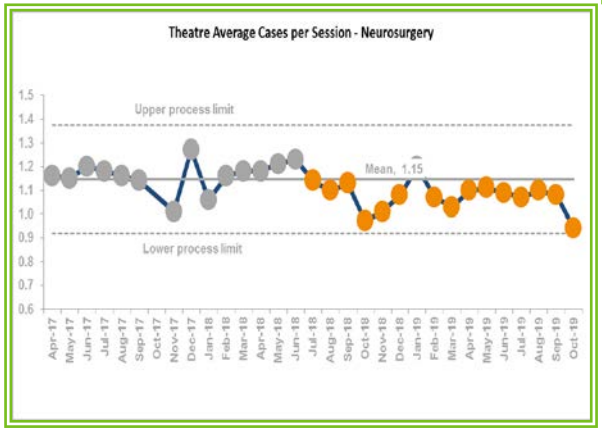
Theatre productivity – Cases per Session

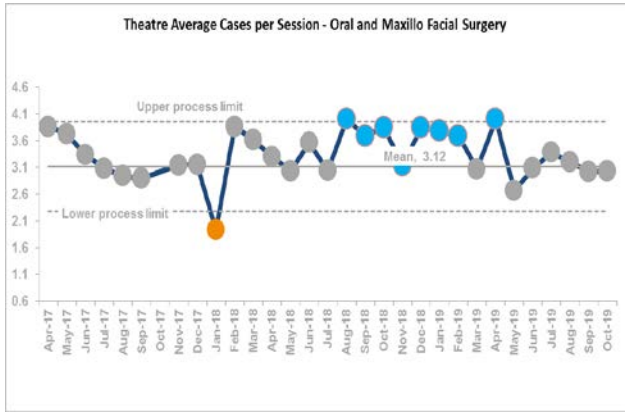
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

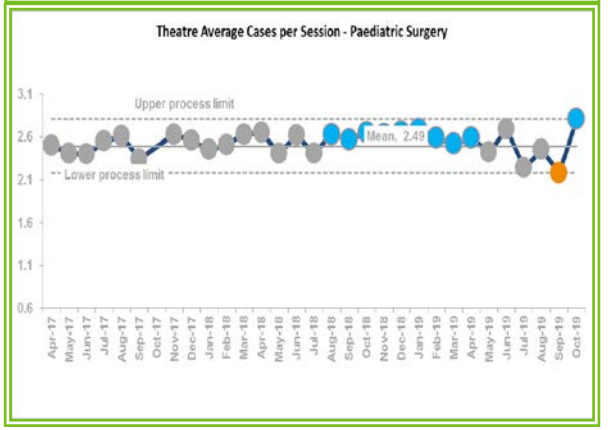


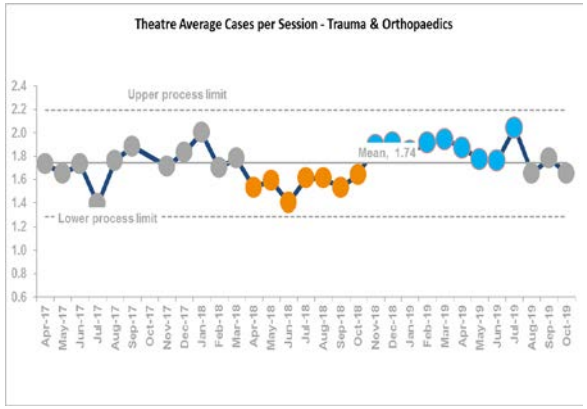


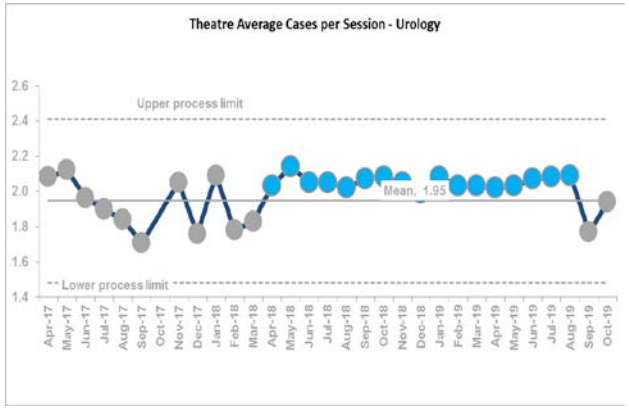


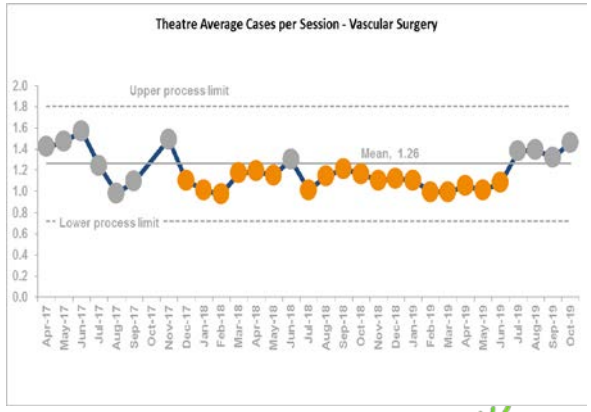






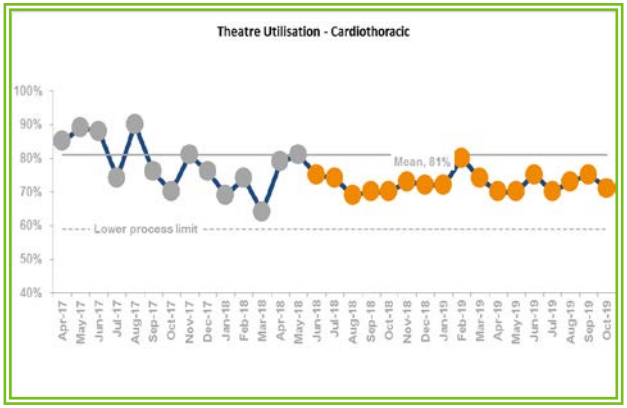


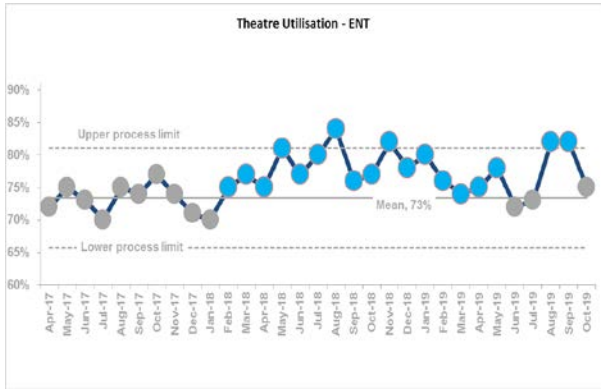


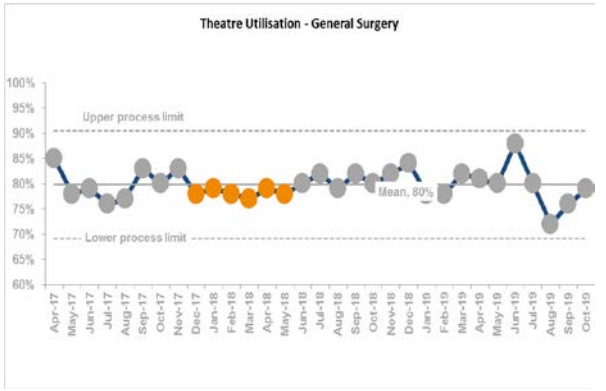


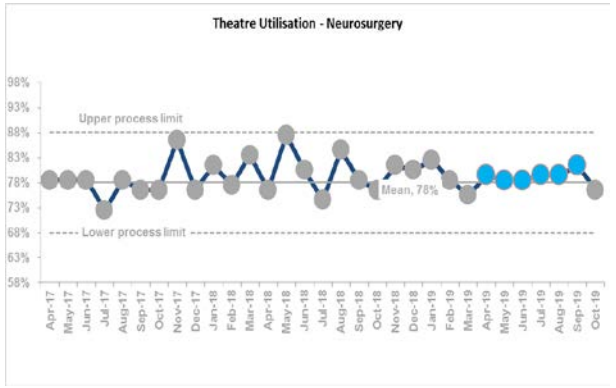
Theatre productivity – Utilisation

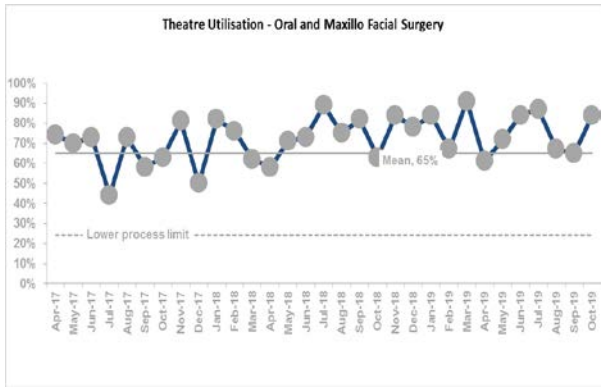
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

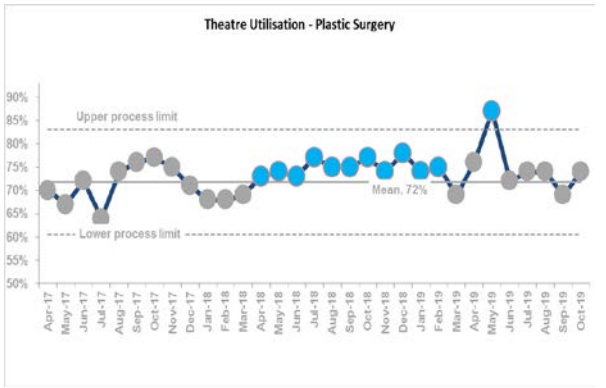


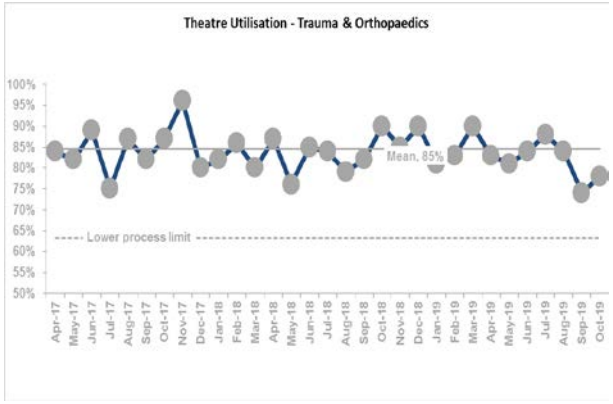


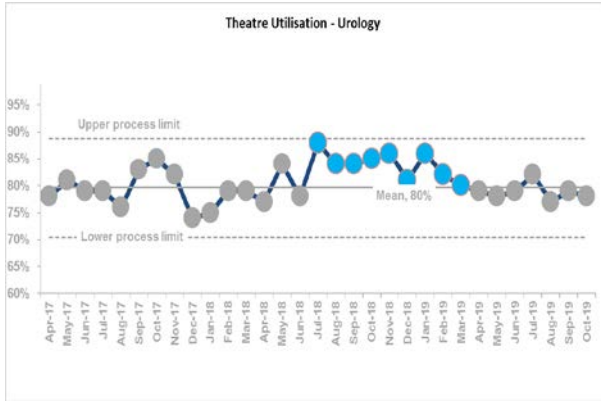


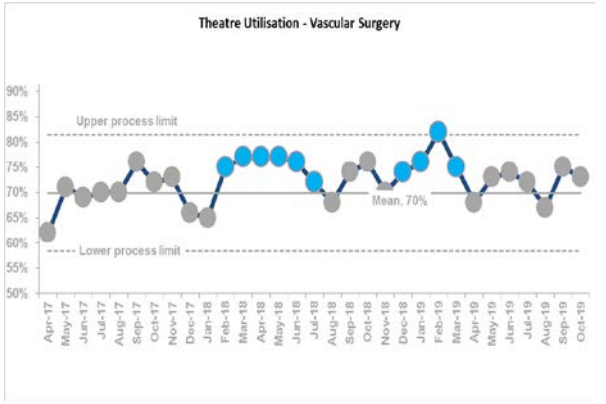








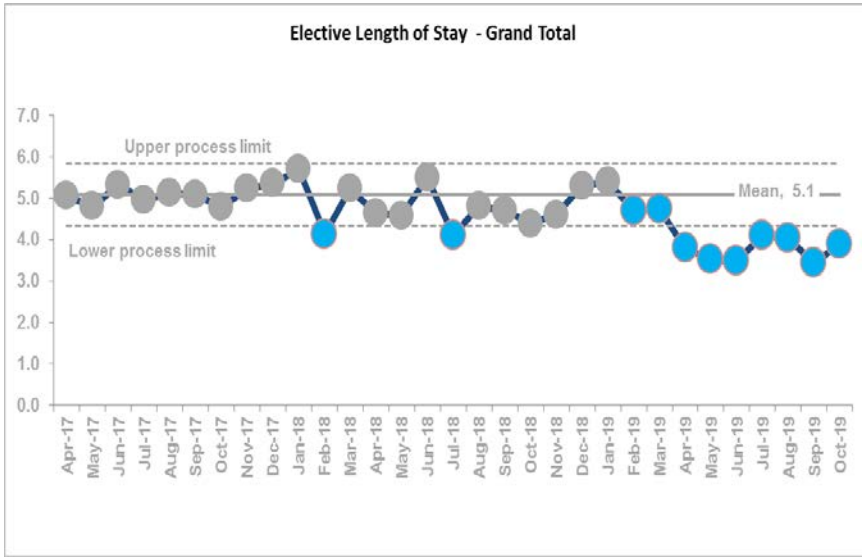


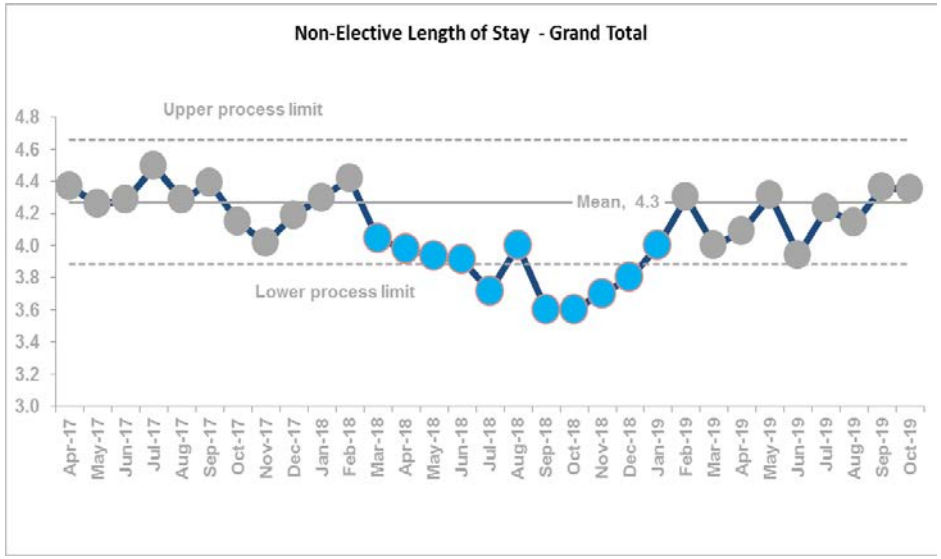


2.2

Our Finance & Productivity Perspective

Length of Stay





What the information tells us

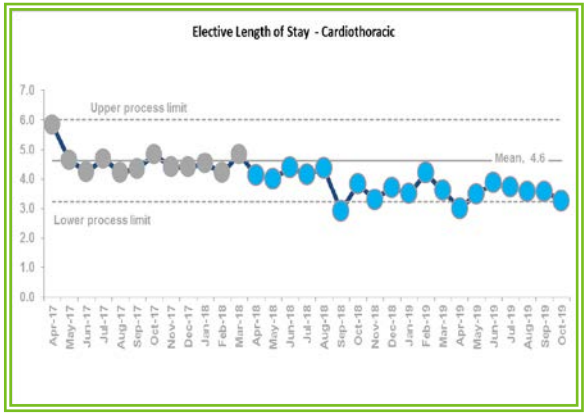
- The Trust's Elective overall elective length of stay is below its lower limit since February this year and has been consistently below its mean for the past six months showing a sustainable improvement.
- Cardiothoracic Length of Stay remains consistently below its mean as well as Surgery and Trauma.
- Children's and Women's Elective Length of Stay has increased above its upper process control limit.
- The Trust's Non-Elective length of stay is within the expected process limits.
- Cardiothoracic Non-Elective length of stay has returned to expected control limits however the specialty shows significant variability compared to the same period last year.
- The recent increase within Acute Medicine and Senior Health is driven by the inclusion of Mary Seacole ward at Queen Marys Hospital since the iClip roll out in September.
- All other directorates' variation are due to common cause.

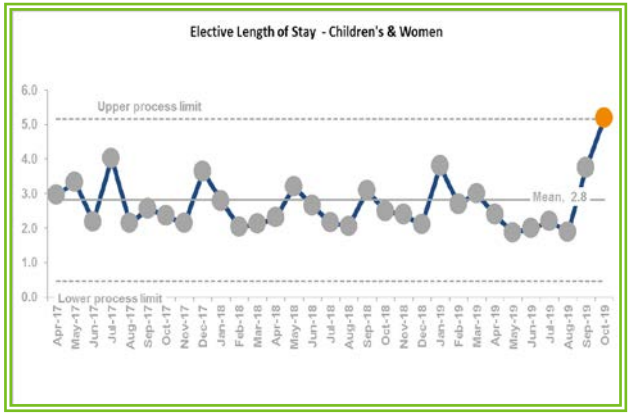
Actions and Quality Improvement Projects

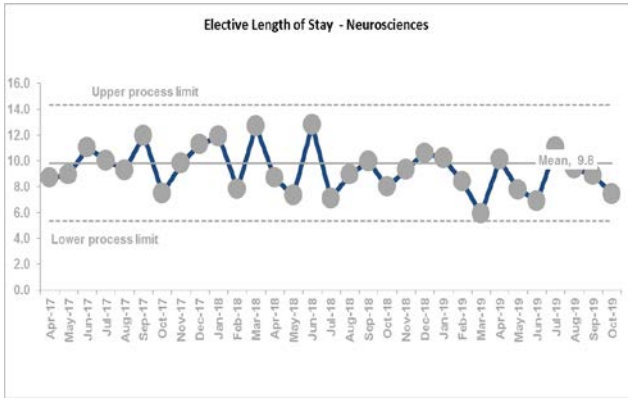
- A return to a concerted focus on long and extended length of stay patients is being implemented by the Medcard Division.
- The Inpatient Clinical teams have identified a range of patient experience, quality and productivity opportunities to evolve the processes embedded within iClip and this needs to be the immediate priority.
- Support Ward teams to deliver SAFER consistently.

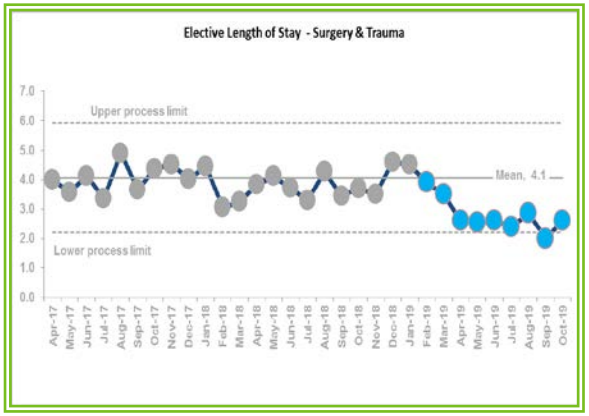
Elective Length of Stay (excluding daycase)

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





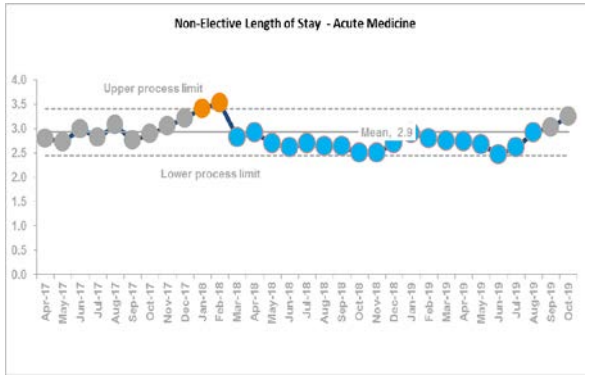


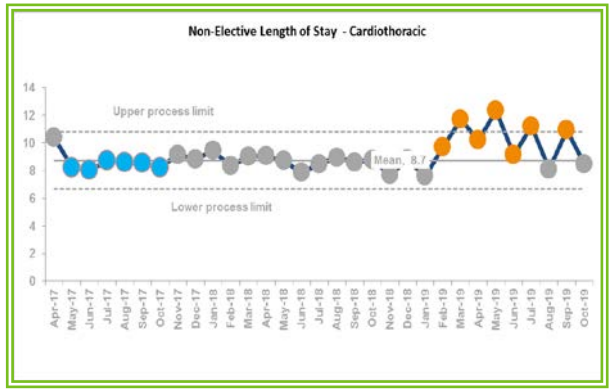


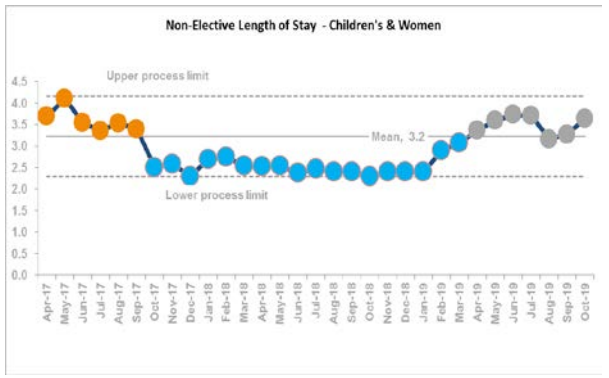
Our Finance & Productivity Perspective

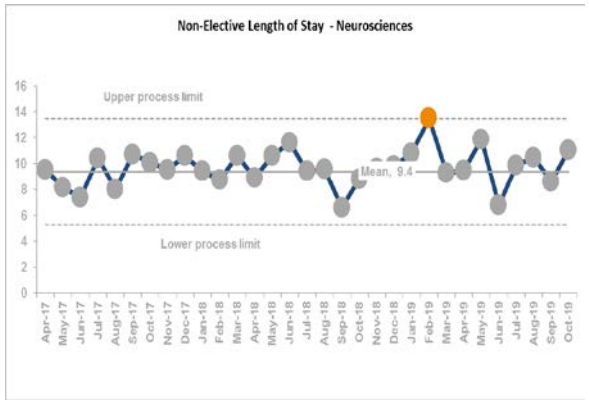
Non Elective Length of Stay

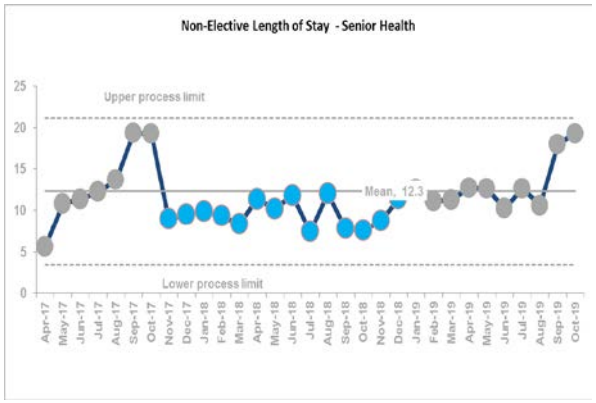
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

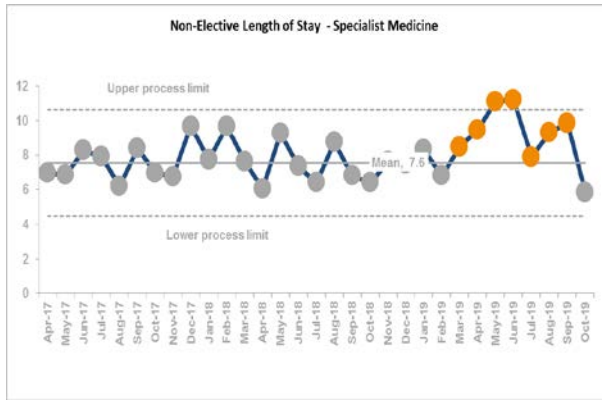


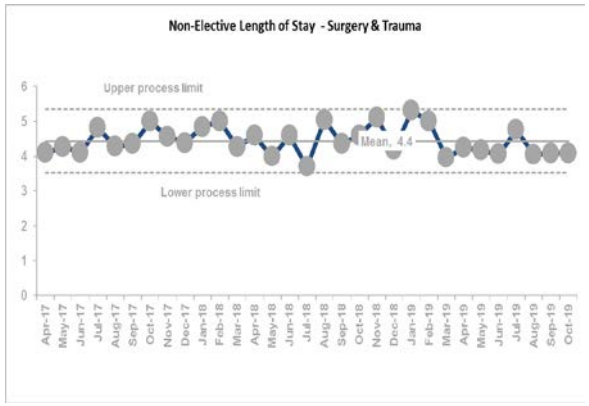


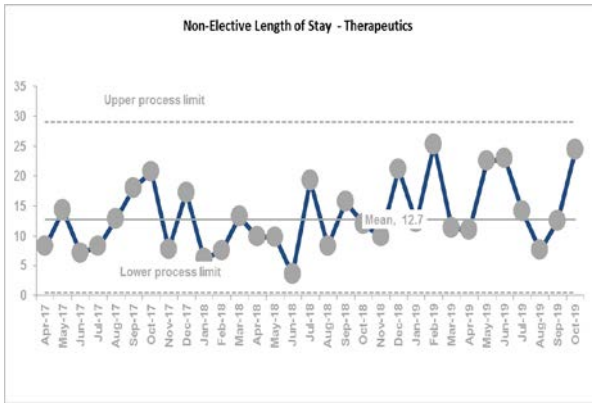










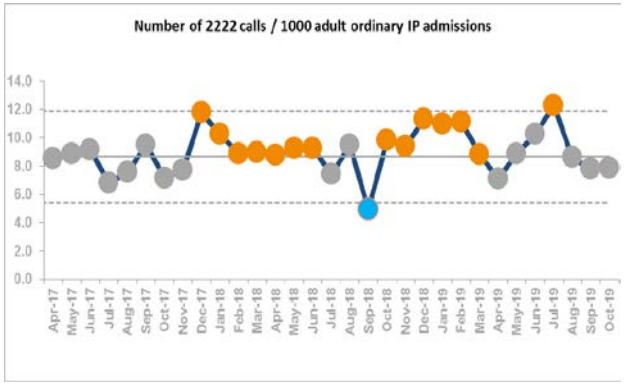


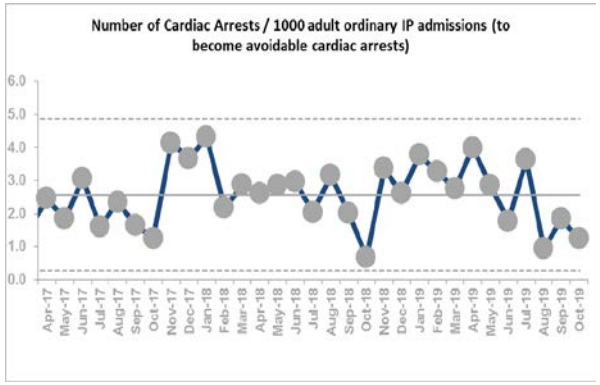
Balance Scorecard

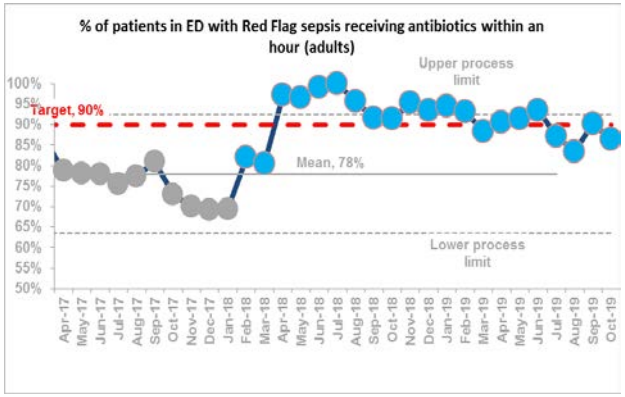
OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety	Infection Control A	Mortality	Readmissions	Maternity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

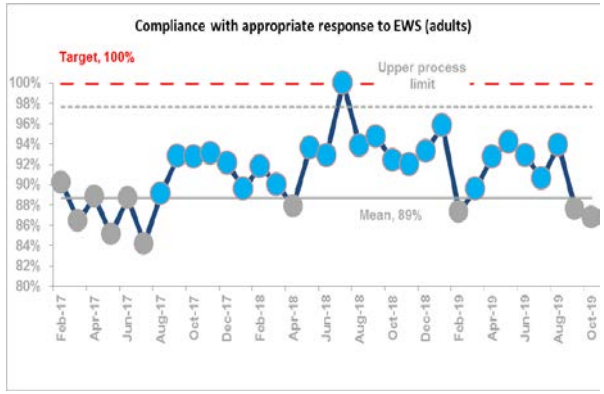
Our Patient Perspective

Quality Priorities – Treatment Escalation Plan









What the information tells us

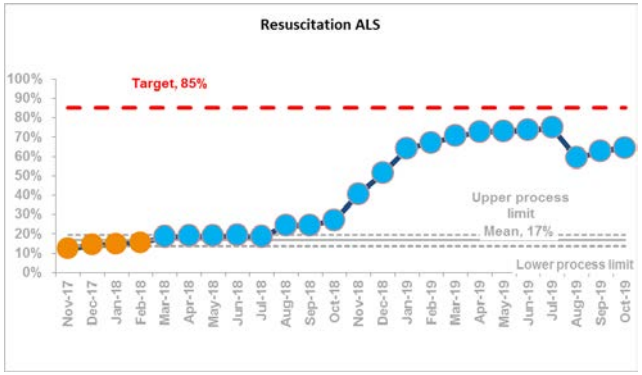
- The rate of 2222 calls and number of Cardiac Arrests remains within control limits
- The Trust position of treating at least 90% of adult patients in ED with Red Flag Sepsis receiving antibiotics within an hour is below the target but this remains within the control limits
- Compliance with appropriate response to EWS saw a further dip in performance and a review of the targets for this metric is being completed

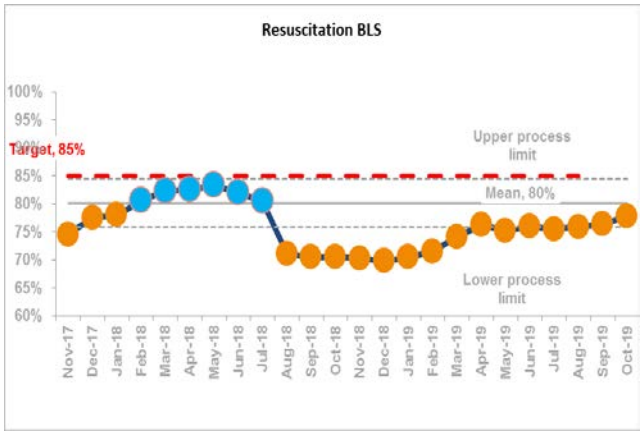
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

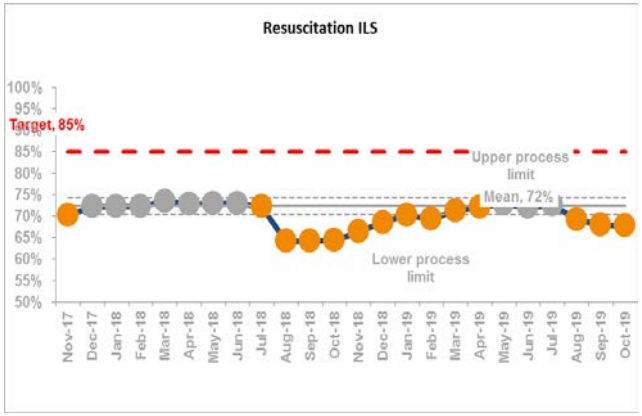
Actions and Quality Improvement Projects

- The emergency department (ED) team are continuing to work with the FLOW programme to decongest ED in order to improve sepsis performance
- Information Technology (IT) is working towards Treatment Escalation Plans being on iCLIP; this is currently in the test domain. Audit measures have been agreed with IT in readiness for electronic audit facility anticipated by end of Q3.
- The governance around the delivery of the clinical priorities has been reviewed and we have re-established a delivery group for the monitoring of progress and to support delivery.

Quality Priorities – Deteriorating Patients







What the information tells us

- Additional training capacity for ILS and BLS (Intermediate and Basic Life Support) in place.
- ALS (Advanced Life Support) training performance is also benefitting from additional training capacity as outlined above.

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

Actions and Quality Improvement Projects

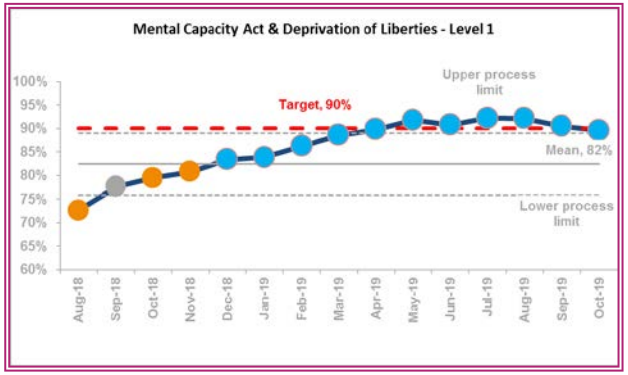
Deteriorating Patients

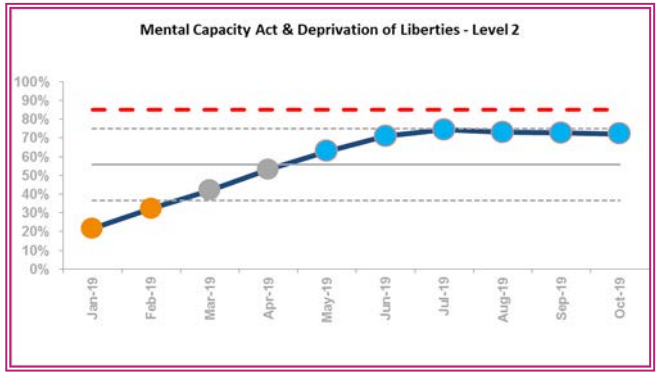
- Improved divisional engagement with Deteriorating Adults Group from nursing with responsibility for driving improvements across the Trust
- Developing management level and monthly audit data with IT for NEWS2 in iCLIP in readiness for electronic audit facility anticipated by end of Q3
- Critical Care Outreach team recruitment commenced with a view to service starting from Q3

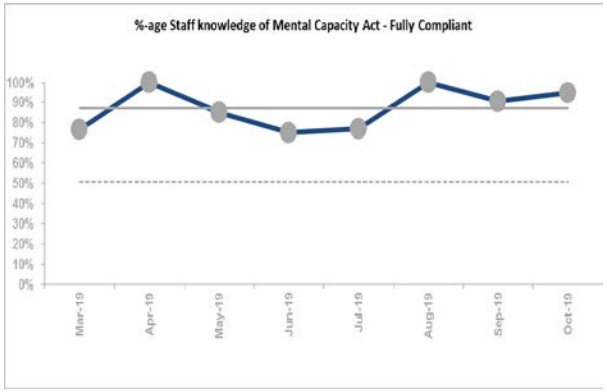
Resuscitation

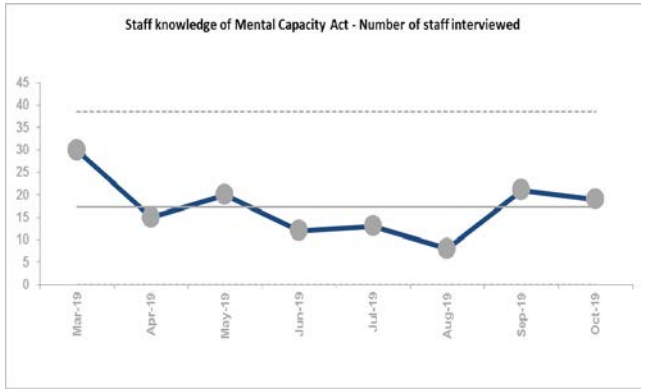
- Additional champions recruited to deliver training
- A review of capacity has been completed to confirm sufficient capacity is in place to deliver the trajectory of 85% compliance by the 31st December 2019.
- Daily CommCell established to monitor performance against the metrics to track attendance and reduce DNA rates.

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









What the information tells us

- Mental Capacity Act and Deprivation of Liberties – Level 1 remains above the Trust MAST target of 85%
- Level 2 training performance has plateaued
- New metrics taken from the ward accreditation system shows the number of staff interviewed and their level of knowledge. Of the 19 staff interviewed in October over 94% could fully answer the question on MCA/DoLs.

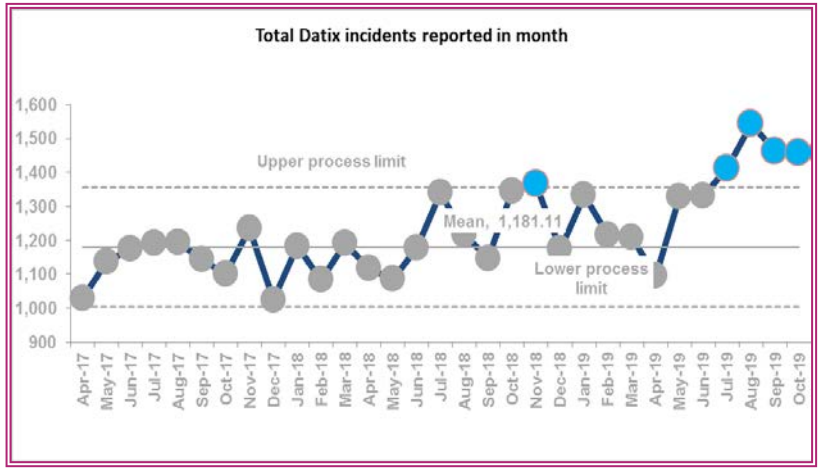
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

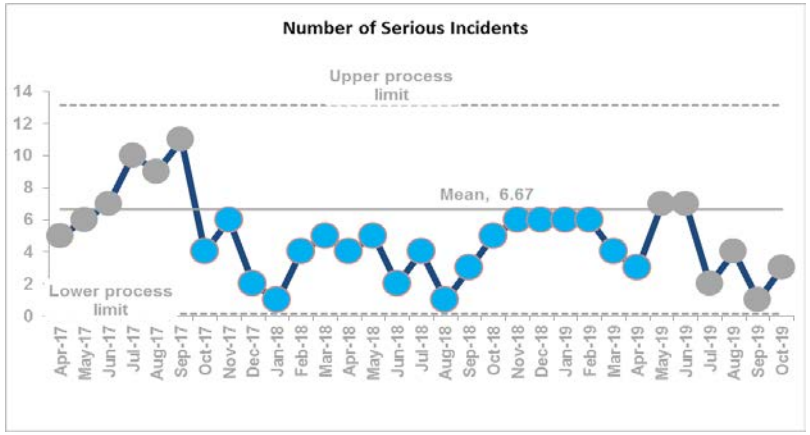
Actions and Quality Improvement Projects

- The Trust, along with SW London sector, has developed a draft standardised audit tool which is now under consultation. Taking a sector approach will enable to Trust to benchmark practice with similar Trusts and create a community of practice.
- Electronic templates in iClip for documentation of MCA and Best Interests decisions are being reviewed for testing in Q3
- Divisions receive monthly lists of staff who are non compliant for MCA training for action within teams.

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%							100.0%	92.0%	100.0%	97.0%	93.0%	data two months in arrears	
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	64%	66%	78%	67%	62%	Compliance timeframe changed from 10 working days to 20 working days							





What the information tells us

- There was no breach of the 60 day time scale for Serious Incident investigations.
- Improved performance maintained with performance above the upper process limits.
- A Never Event was declared

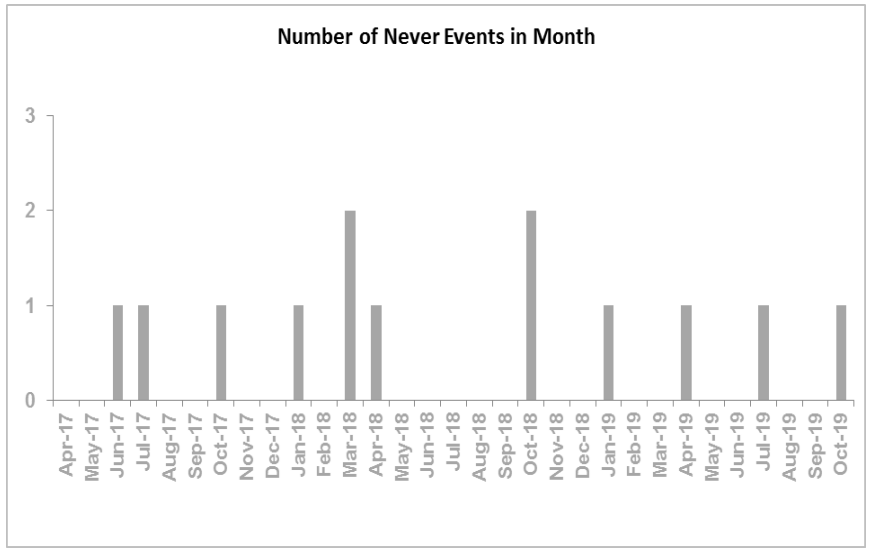
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

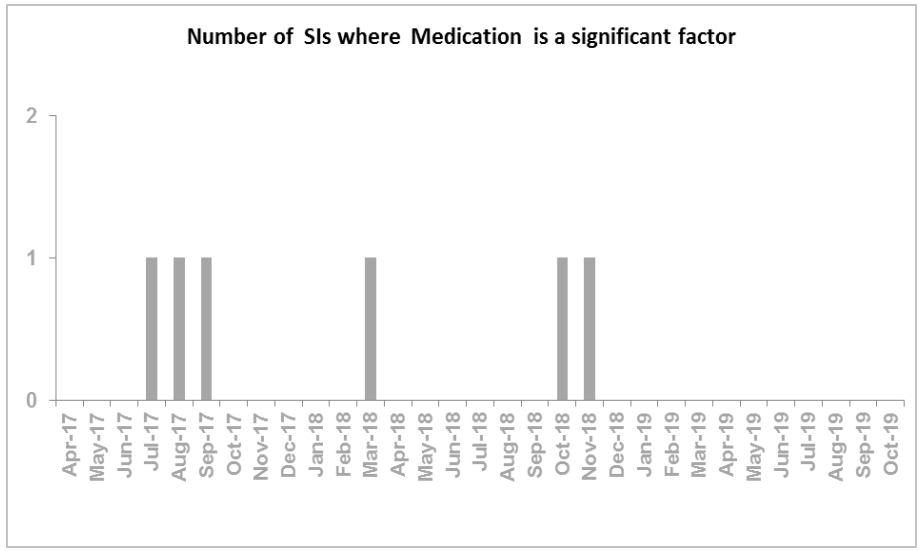
Actions and Quality Improvement Projects

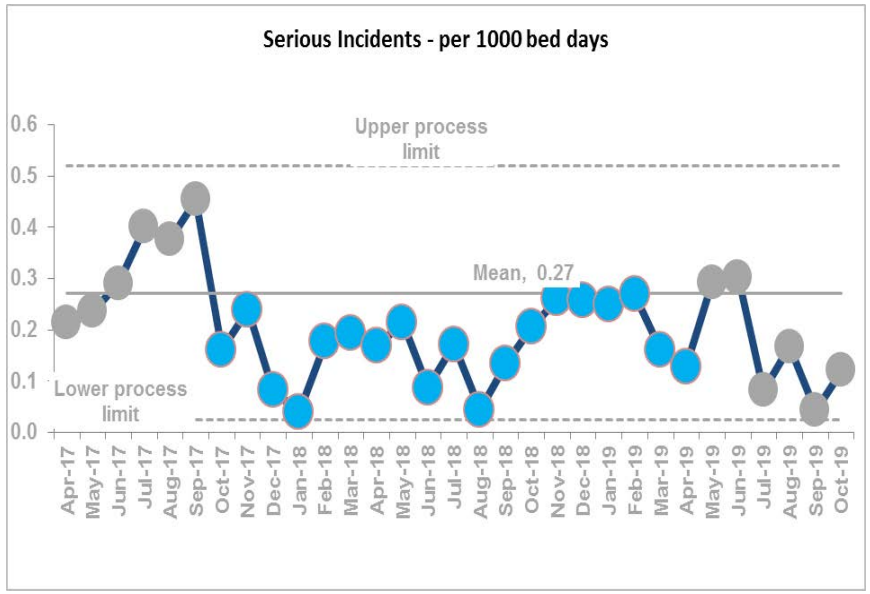
- The Never Event is currently being investigated and will report back to Quality and Safety Subcommittee upon completion.
- Incidents – The number of Datix incidents will be reported by severity and per 1000 bed days from Q4 with additional staff resource having started in November. This will allow for benchmarking against other Trusts and tracking of the harm profile

Quality Priorities – Learning from Incidents

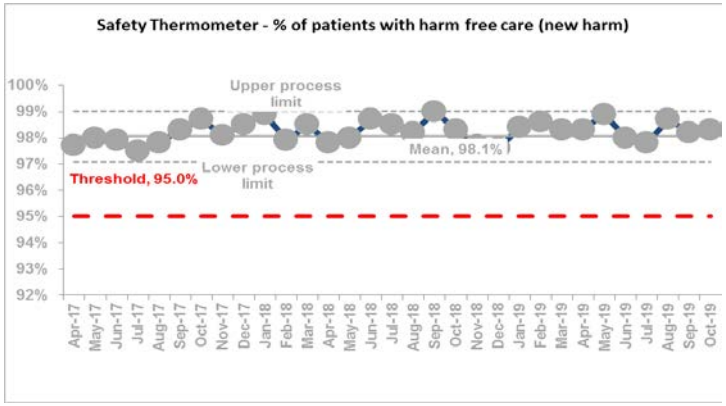
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

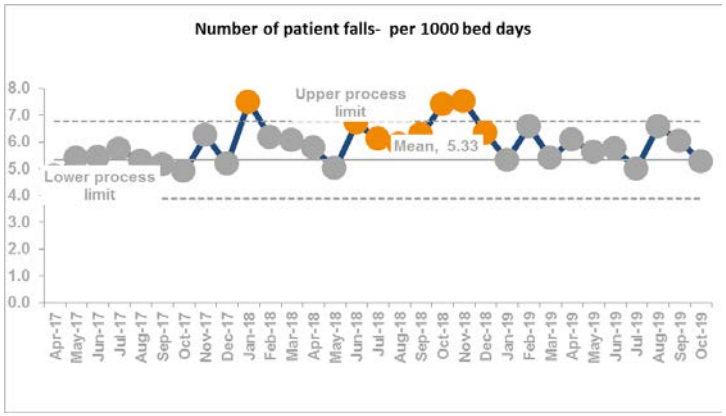


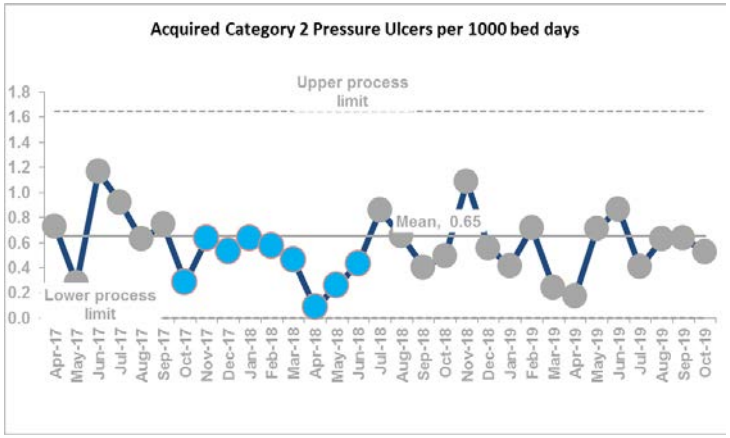




Patient Safety







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

What the information tells us

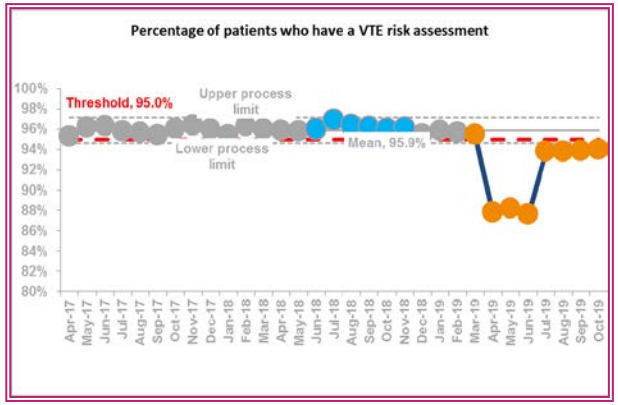
- There has been a step change in the percentage of patients with VTE assessments. This is due to a change in guidance and now includes areas such as maternity and CDU.
- All other metrics show variation due to common cause.

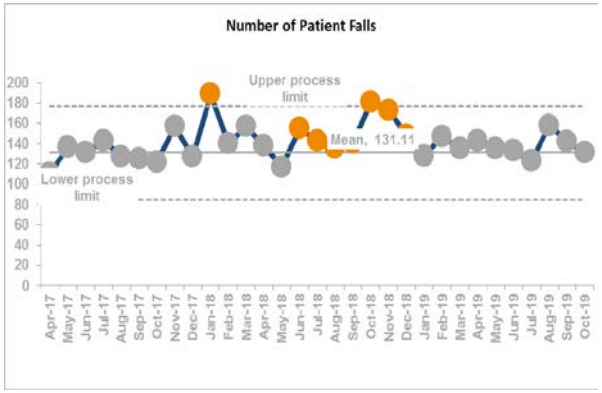
Actions and Quality Improvement Projects

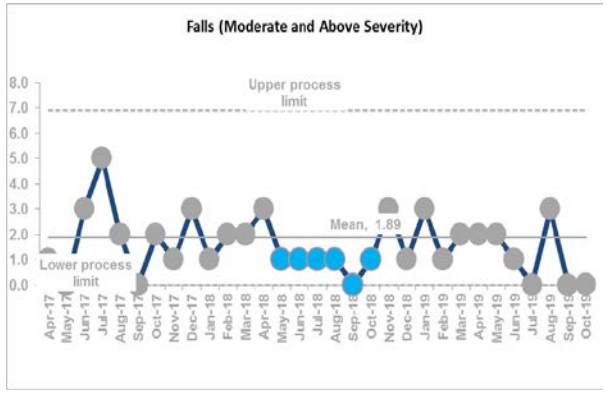
- Areas with low VTE compliance have been identified. These areas are receiving targeted support and monitoring.
- The Trust is working to deliver the Falls CQUIN, specifically focussing on lying and standing for patients over 65 in line with NICE guidance.

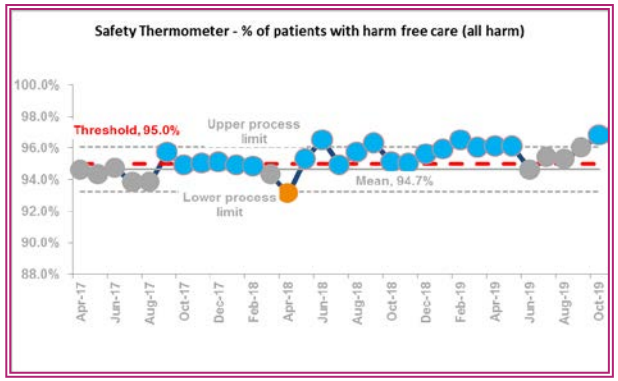
Patient Safety

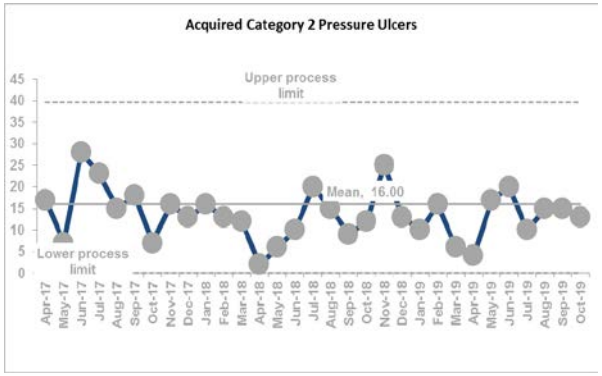
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

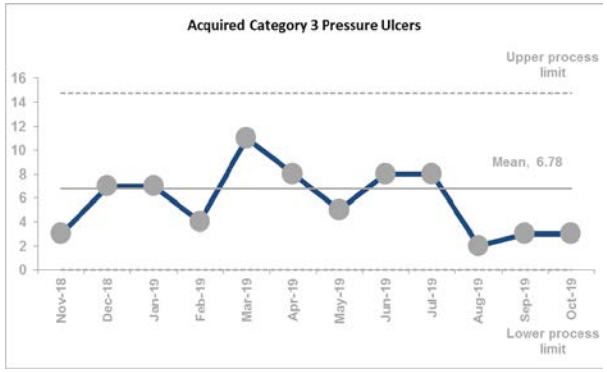


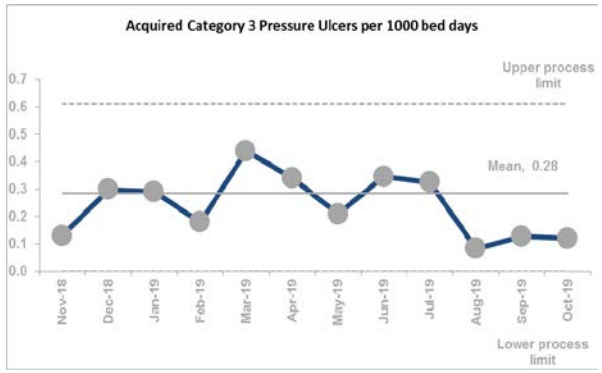












Our Patient Perspective

Outstanding care every time

Infection Control

Indicator Description	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Cdiff Hospital acquired infections	48	3	2	3	2	1	3	4	4	3	4	4	6	3	31
Cdiff Community Associated infections								0	0	2	0	1	0	0	
MSSA	25	4	2	5	3	2	2	4	6	1	0	3	2	2	18
E-Coli	60	2	4	3	1	4	6	4	7	5	7	7	8	6	44

What the information tells us

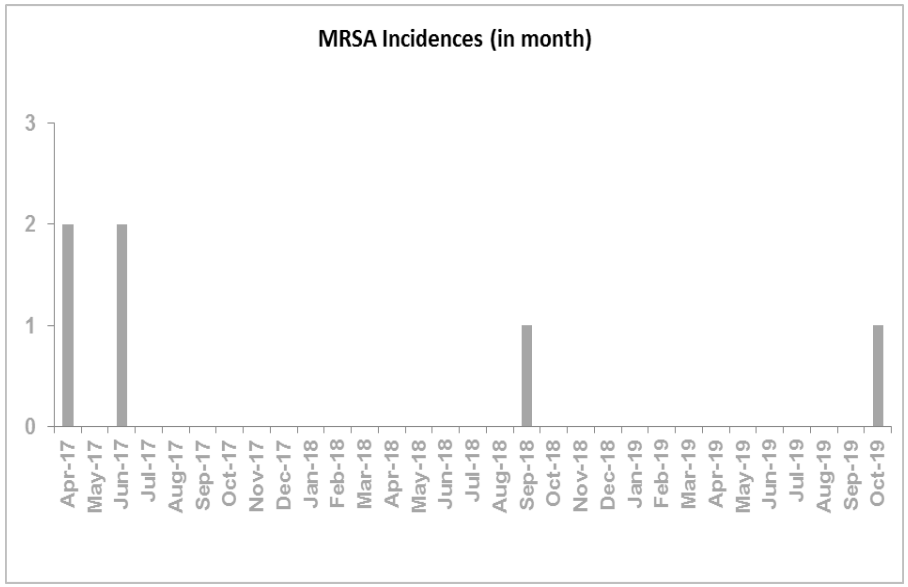
- The Trust MRSA position has increased with one MRSA incident this month the first seen since September 2018.
- This month there were 3 Cdiff incidents. All incidents were Hospital Acquired. The Cdiff YTD position is 31 with 28 Hospital Acquired infections and 3 Community Associated infections. This is very close to our yearly target of 48 and will be monitored closely.
- The number of Ecoli cases reported remains within the control limits. There was 6 cases this month and E-Coli rates show common cause variation, MSSA infection rates show common cause variation

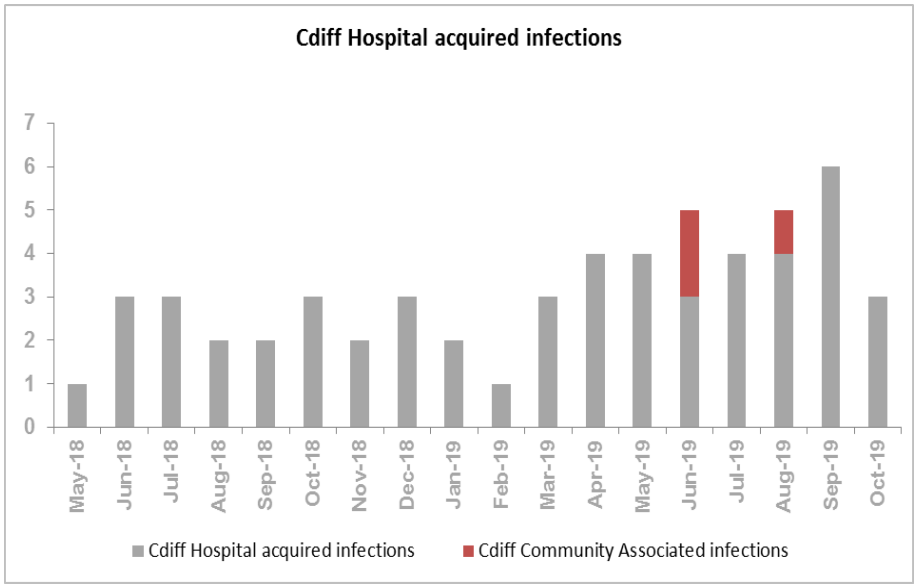
Actions and Quality Improvement Projects

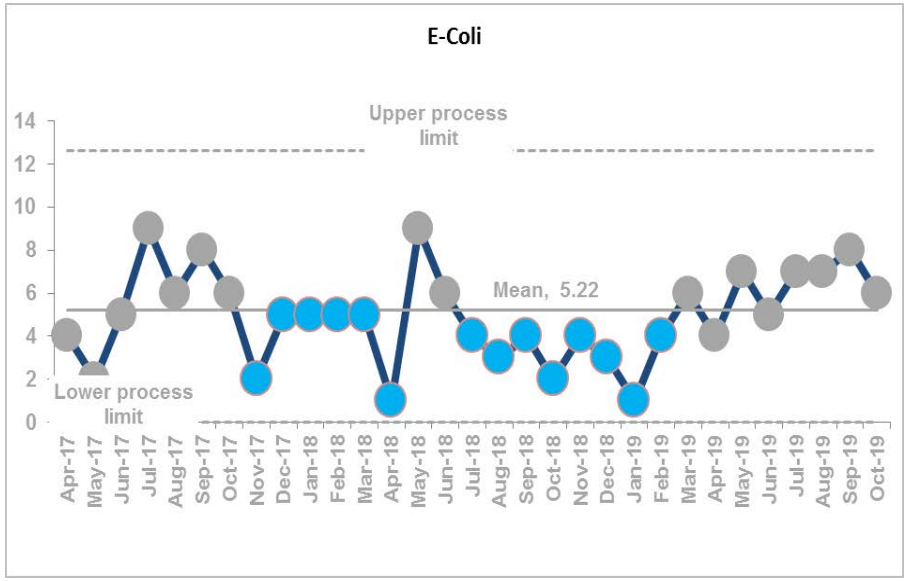
- All Cdiff cases have undergone a Root Cause Analysis (RCA) and are being reviewed for lapses in care. The reviews will be validated by the Clinical Commissioning Group (CCG) for reporting purposes
- All MSSA cases are now to undertake a RCA to establish any causes and opportunities for learning and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

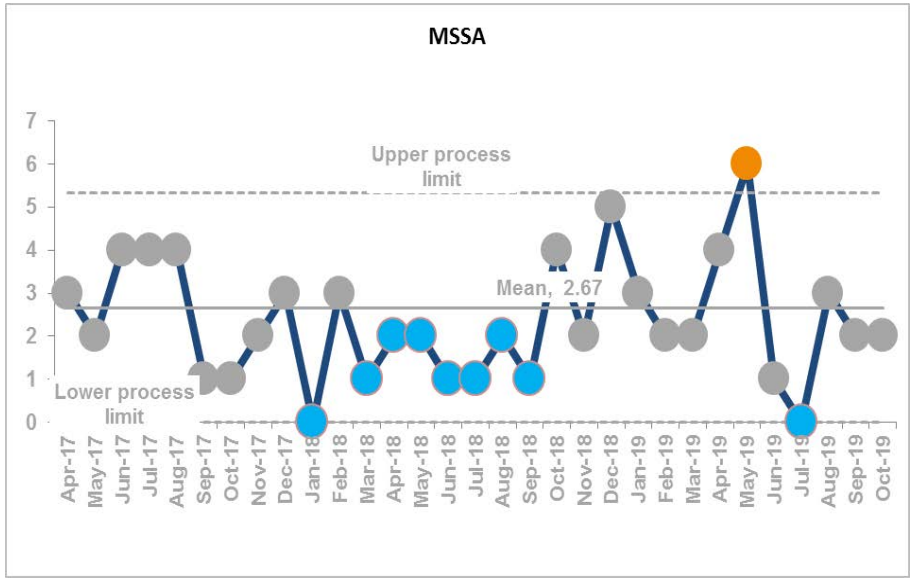
Infection Control

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



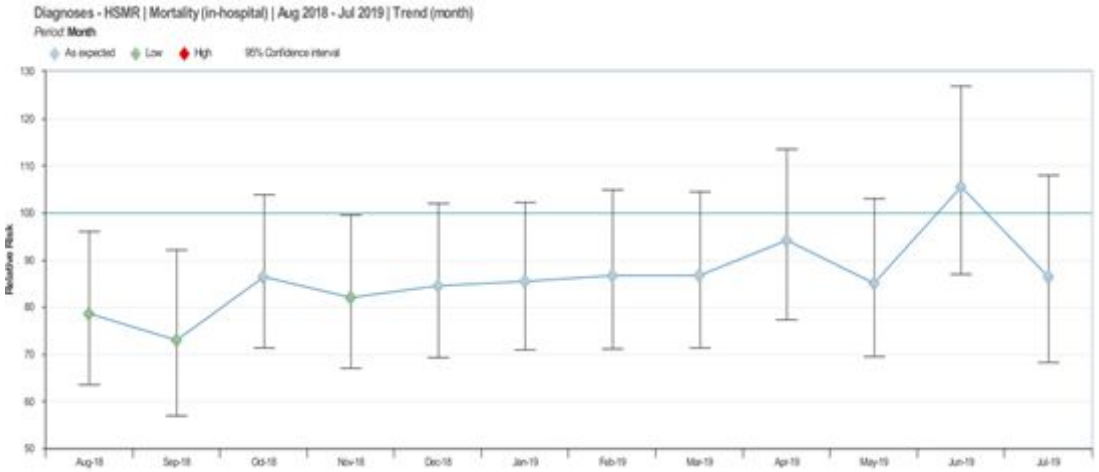


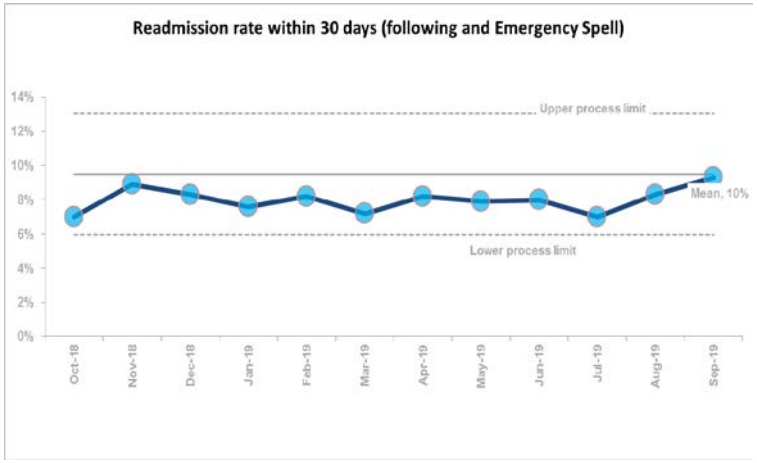




Mortality and Readmissions

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





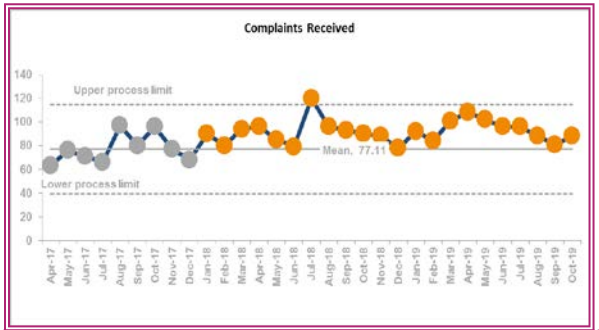
Please note SHMI data is based on a rolling 12 month period (published Sept 2019). HSMR data reflective of period Aug 2018 – July 2019 based on a monthly published position (published Sept 2019). Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways

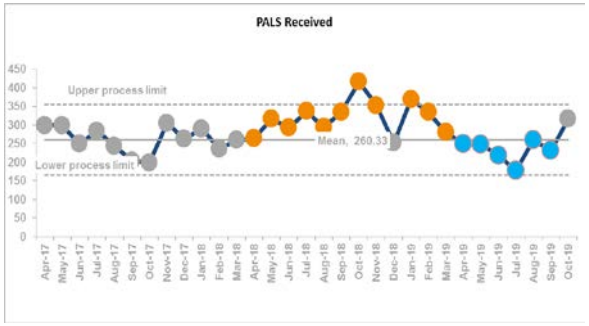
What the information tells us

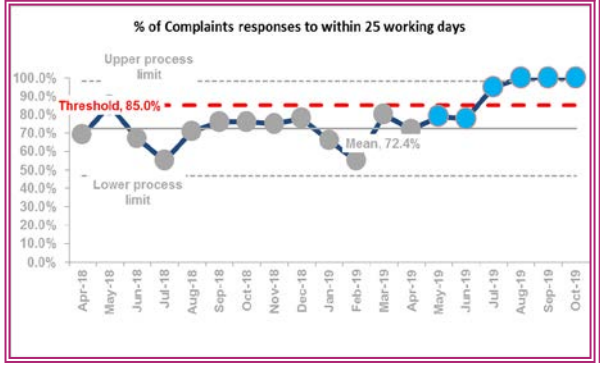
Both the Trust-level mortality indicators (SHMI and HSMR) remain within expected. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over performance and also under performance. We monitor and investigate mortality signals in discrete diagnostic and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

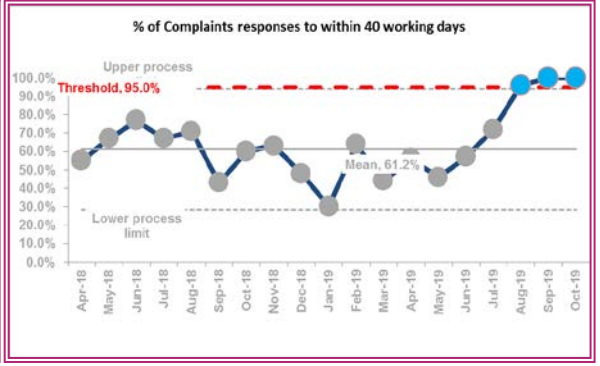
Complaints

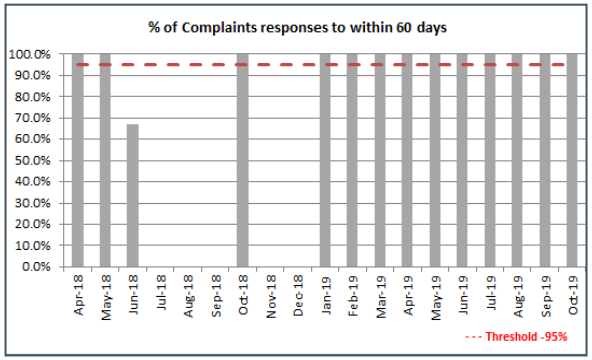
Indicator Description	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
% of Complaints responses to within 25 working days	85%	76%	75%	78%	66%	55%	80%	72%	79%	78%	95%	100%	100%	100%
% of Complaints responses to within 40 working days	95%	60%	63%	48%	30%	64%	44%	56%	46%	57%	72%	96%	100%	100%
% of Complaints responses to within 60 working days	95%	100%	None Due	None Due	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0











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

What the information tells us

- The number of complaints received is consistently above the 2017/18 average
- Response compliance for 25 working day complaints has reached 100%
- Response compliance for 40 working day has reached 100%
- Response compliance for 60 working day complaints continues to deliver against the performance target.

Actions and Quality Improvement Projects

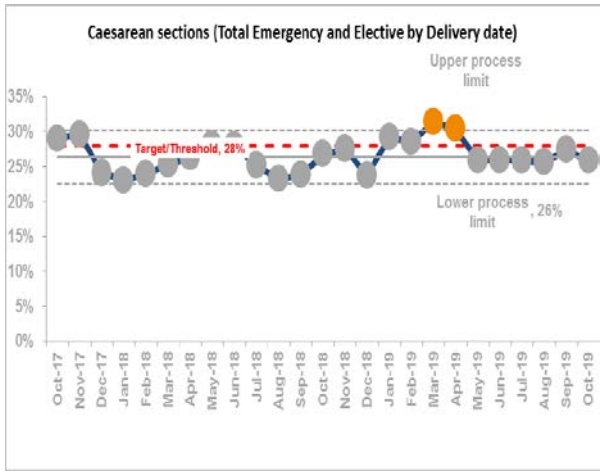
The daily complaints CommCell led by the Chief Nurse continues.

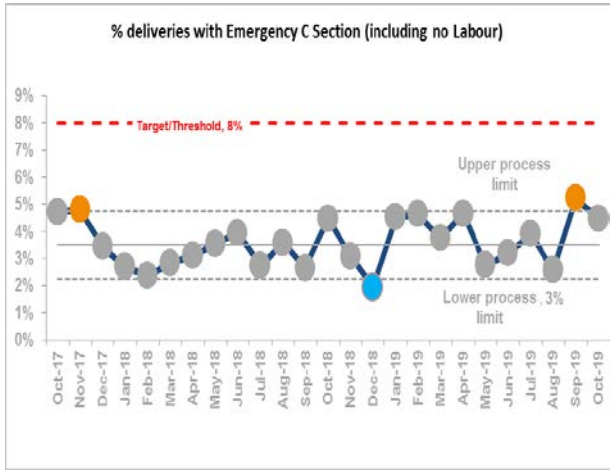
The change in process has had a positive impact on complaints performance with measures showing sustained improvement for the last three months

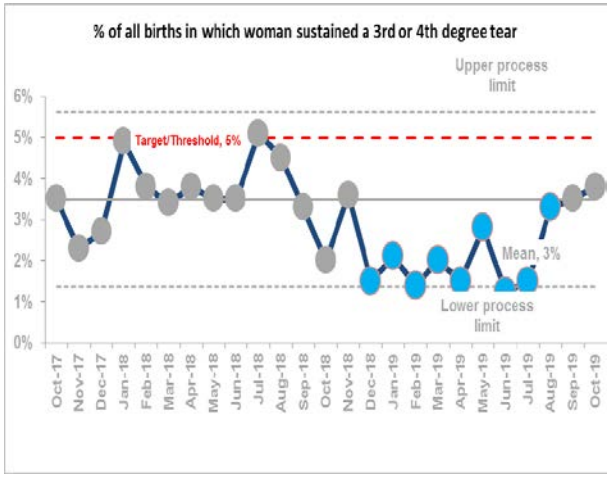
Our Patient Perspective

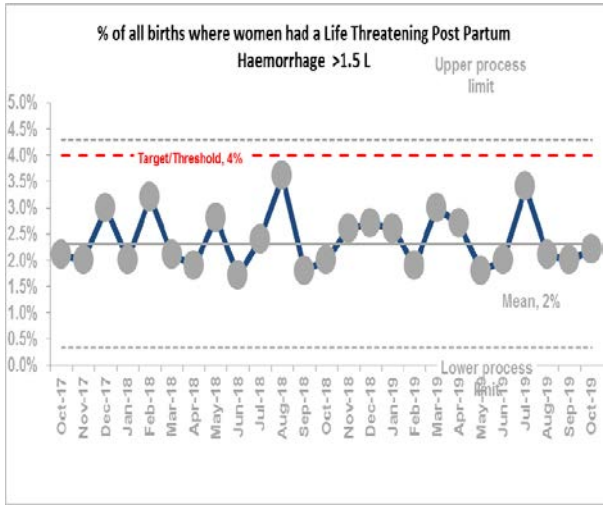
Maternity

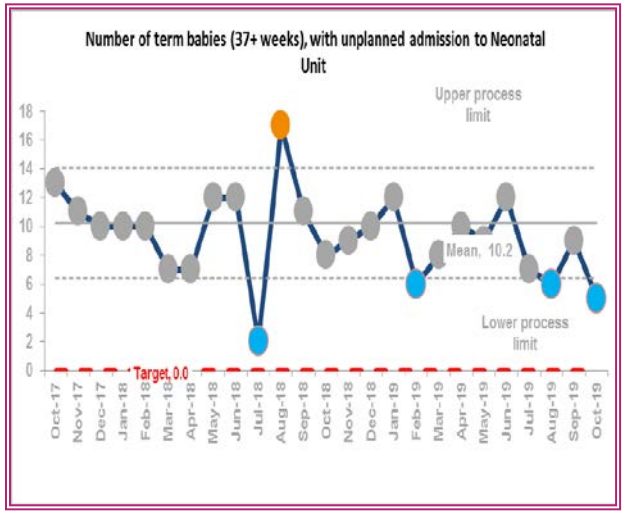
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance







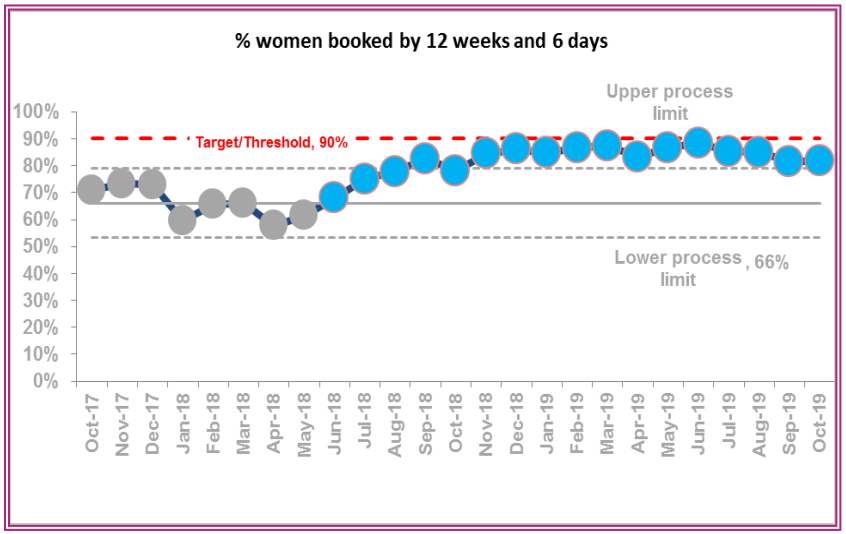


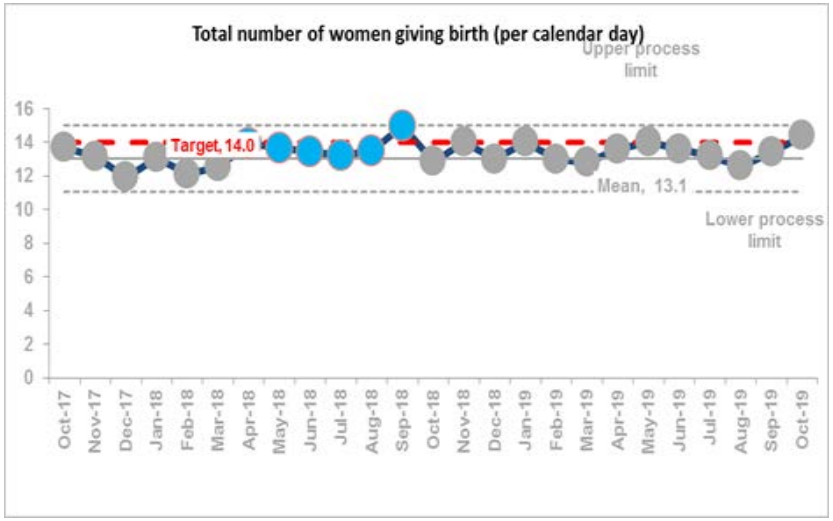


2.2

Our Patient Perspective

Maternity





What the information tells us

- The overall birth rate was at its highest in the calendar year, which is a common seasonal variation.
- Carmen Suite has been closed on more occasions than in previous months, due to workload pressures. Work continues with staff across the unit to try and ensure that the birth centre is open for women at all times.
- The overall emergency caesarean section rate remains stable, but there has been a re-classification of data within this, to ensure that we are correctly reporting 'no-labour' and 'intrapartum' emergencies. This means that the no labour rate is now lower than in previous months and the intrapartum higher, which is in line with experience.

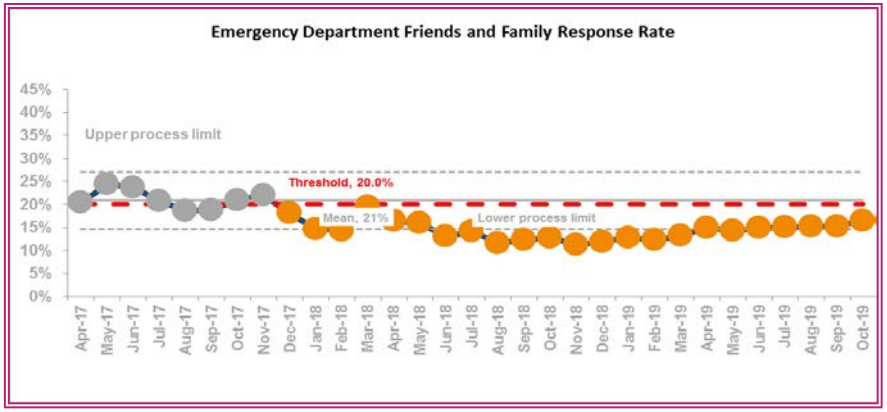
Actions and Quality Improvement Projects

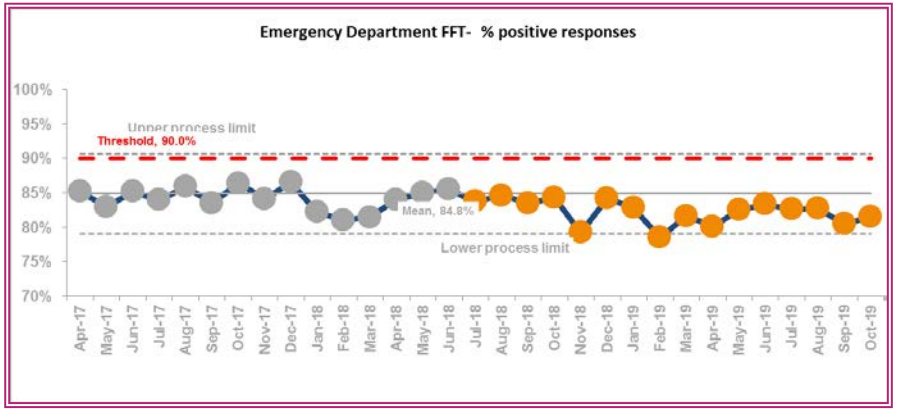
Work is on-going to understand the significant variation in 3rd and 4th degree tears between December and July and the subsequent return to previous levels. Investigation has not shown that the decrease was due to increased use of Episcissors.

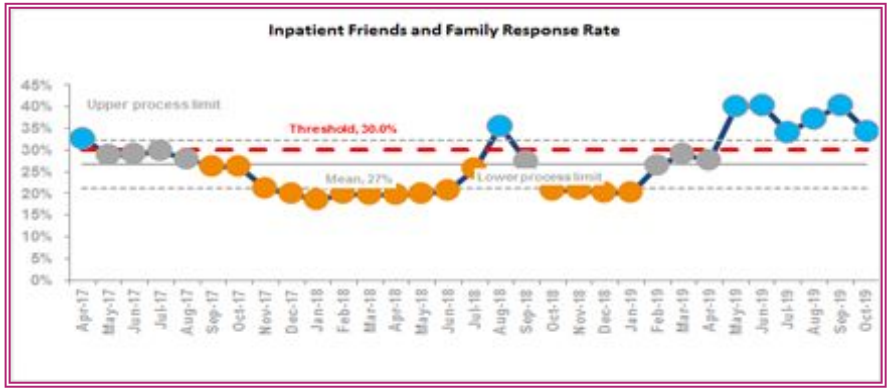
An analysis of the data regarding booking by 12+6 weeks will be carried out to see whether there are any significant variations associated with the ethnicity of the woman booking and whether any associated action is required to improve performance in this area.

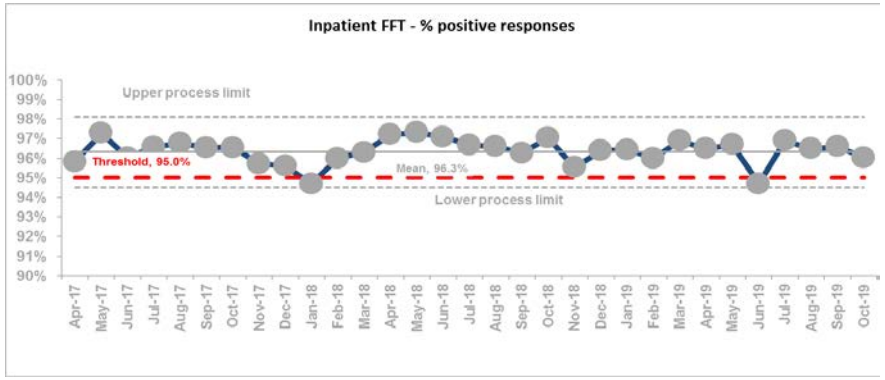
Friends and Family Test

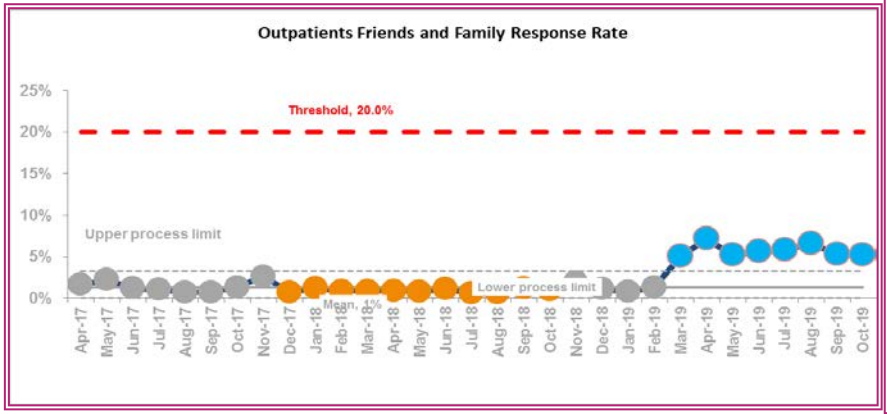
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

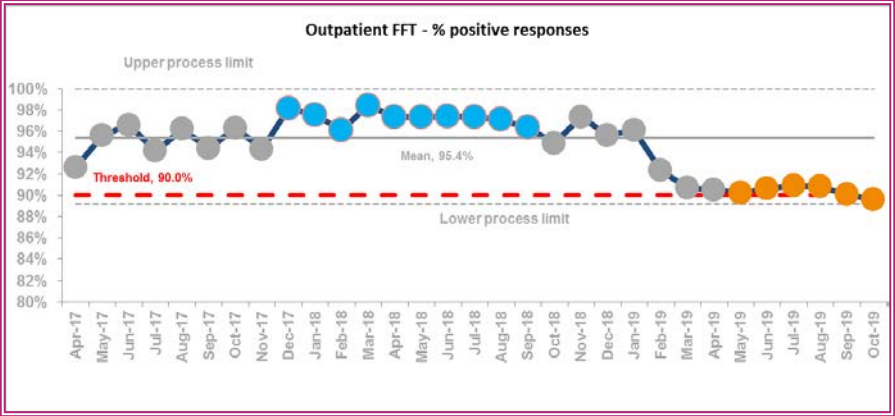






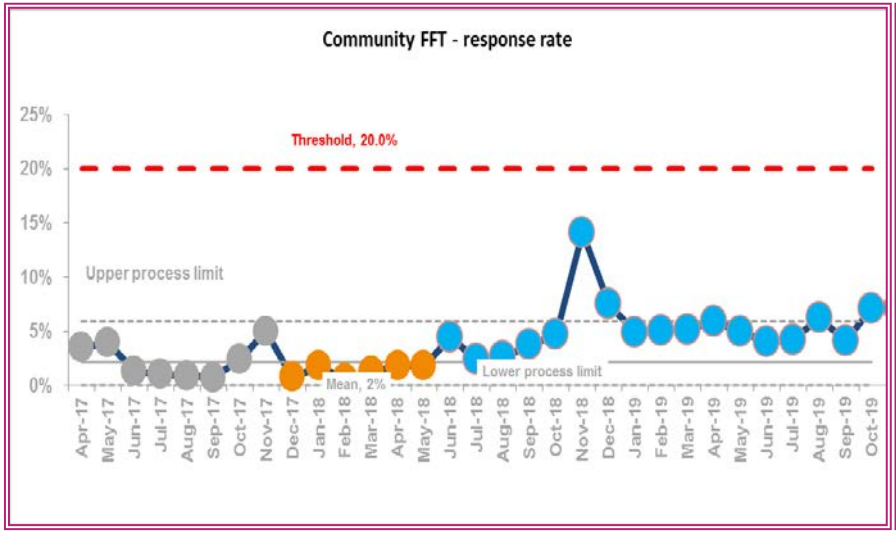


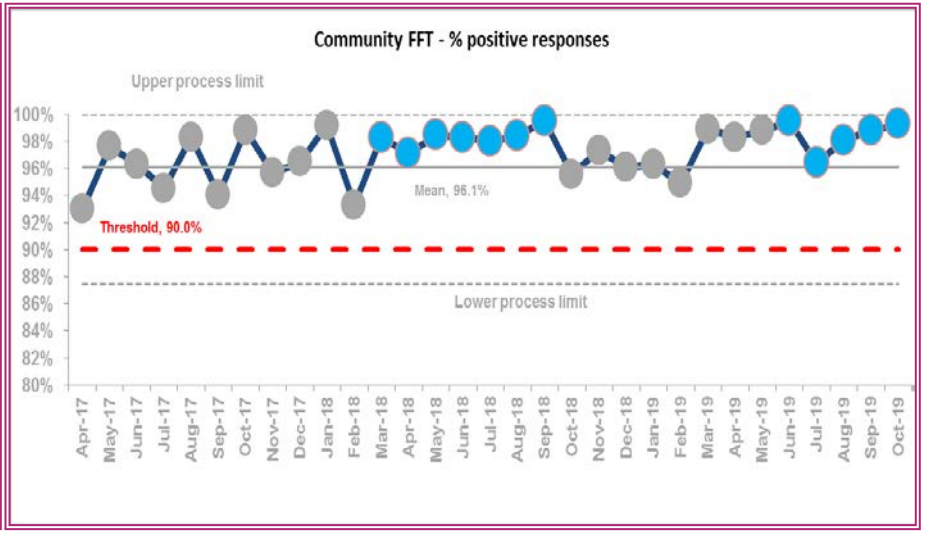


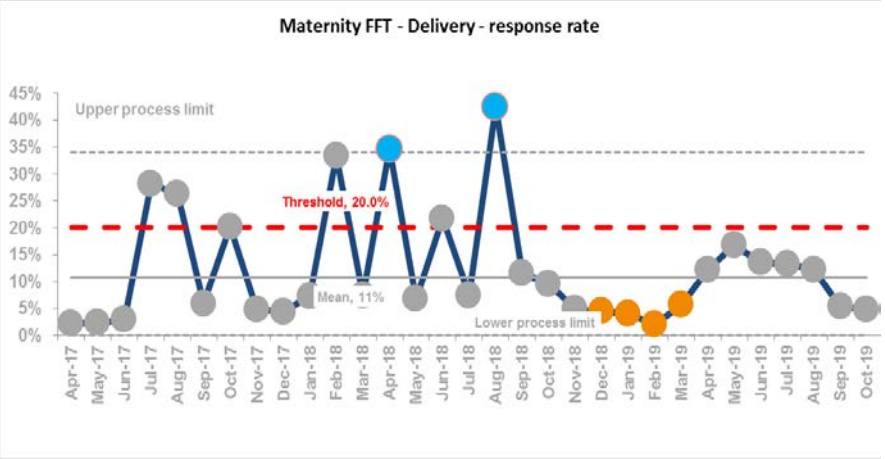


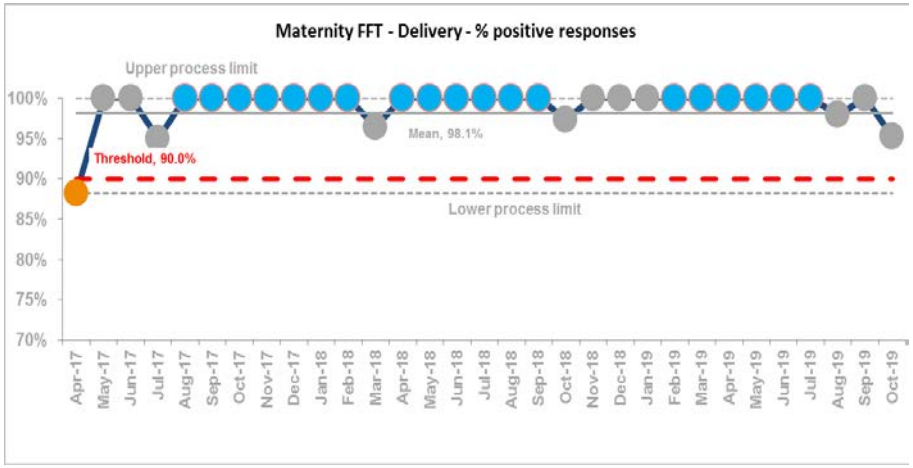
Friends and Family Test

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









2.2

Our Patient Perspective

Friends & Family Survey

Indicator Description	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Emergency Department FFT - % positive responses	90%	84.2%	79.2%	84.2%	82.8%	78.5%	81.6%	80.1%	82.5%	83.3%	82.6%	82.7%	80.5%	81.5%
Inpatient FFT - % positive responses	95%	97.0%	95.5%	96.4%	96.5%	96.0%	96.9%	96.5%	96.7%	94.7%	96.9%	96.5%	96.6%	96.0%
Maternity FFT - Antenatal - % positive responses	90%	100.0%						100.0%	90.0%	85.7%	100.0%		100.0%	
Maternity FFT - Delivery - % positive responses	90%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	95.2%
Maternity FFT - Postnatal Ward - % positive responses	90%	100.0%	100.0%	90.9%	95.6%	95.7%	91.7%	96.4%	94.6%	98.0%	100.0%	98.3%	95.2%	100.0%
Maternity FFT - Postnatal Community Care - % positive responses	90%			100.0%		100.0%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%
Community FFT - % positive responses	90%	95.6%	97.4%	96.1%	96.3%	94.9%	98.9%	98.3%	98.8%	99.5%	96.4%	98.1%	98.8%	99.3%
Outpatient FFT - % positive responses	90%	94.9%	97.3%	95.6%	96.1%	92.3%	90.7%	90.5%	90.2%	90.6%	90.9%	90.8%	90.1%	89.6%
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	0

What the information tells us

- The emergency department Friends and Family Test (FFT) – In the month of October 81.5% of patients attending the emergency department would recommend the service to family and friends. The response rate increased to 17% in the month of October, against our target of 20%
- We did not deliver against our outpatient recommend rate in October with performance just below target at 89.6%. The response rate remains below target despite a marked increase in our Outpatient activity (which is being reviewed). This has improved to consistently above 5%
- Maternity and Community FFT are above local thresholds in October and work continues to ensure patient responses improves. The London average response rate for community is 4.4% and England is 3.9%.

Actions and Quality Improvement Projects

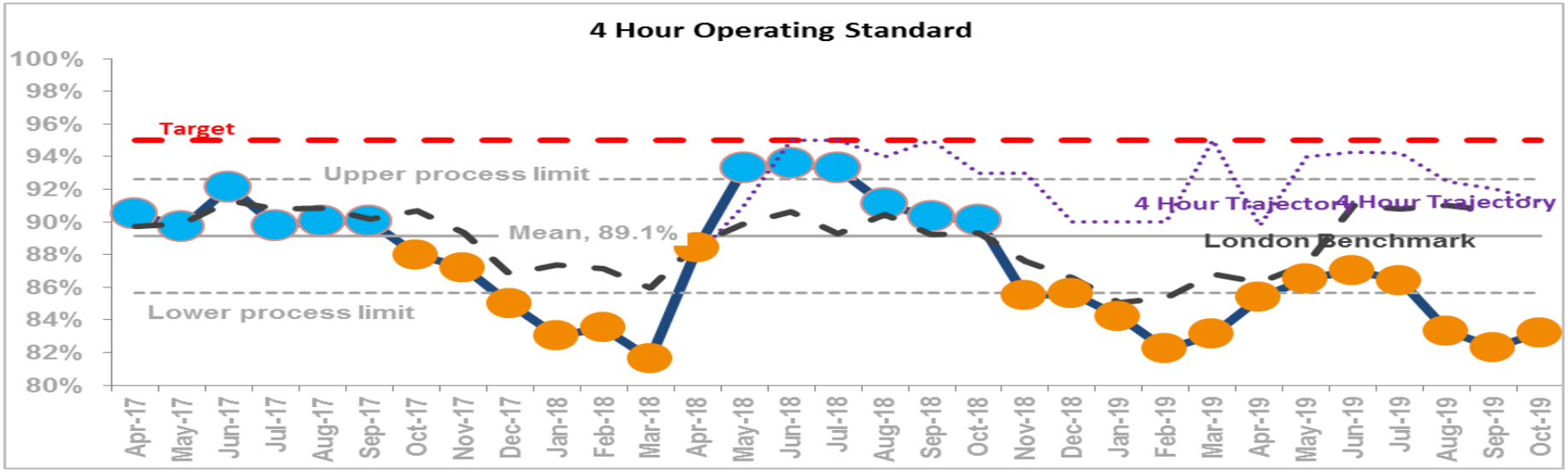
- Patients can now access the FFT on our website. In addition to the monthly reports of performance to ward areas a weekly report to matrons/ward managers is now in place. This gives the number of discharges versus the number of FFT responses completed and clearly identifies areas that need to improve. Text messaging the FFT after appointment has started in a number of outpatient clinics
- Review of London trusts that consistently achieve high response rates for ED and Maternity to be shared with services so that they can review practice
- Review of National guidance for changes in FFT reporting has been completed and changes will be implement to allow more opportunities to capture patient experience.

Balance Scorecard

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

Our Process Perspective

Emergency Flow



What the information tells us:

- The number of patients either discharged, admitted or transferred within four hours of arrival has seen an increase from 82.3% in September to 83.2% in October, with performance continuing to be below the lower control limits.
- Performance is currently below the monthly improvement trajectory of 91.3% for October in order to achieve a year end position of 90%.
- Attendance numbers remain within the upper and lower control limits, the number of patients are comparable to the same months last year however above plan and shows variability on a daily basis.
- Both admitted and non-admitted performance continues to be below its lower process limit.
- The AMU occupancy at midday is above the targeted 85% remaining above the mean and 4% higher than the same period last year.
- The general and acute bed occupancy remains has decreased slightly compared to the previous month however continues above the mean.
- The number of patients staying in a hospital bed greater than 7 days remains above the mean, however 14 and 21 days shows special cause concern reporting above the upper control limit for the first time.
- Ambulance handover times remain below the lower control limit and are below the London average. (Data quality issue currently being investigated with LAS)

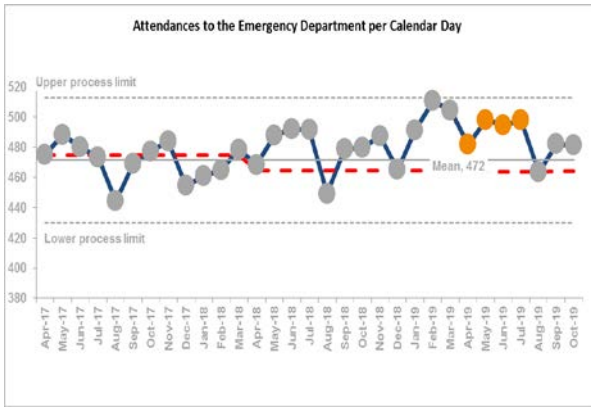
Actions and Quality Improvement Projects

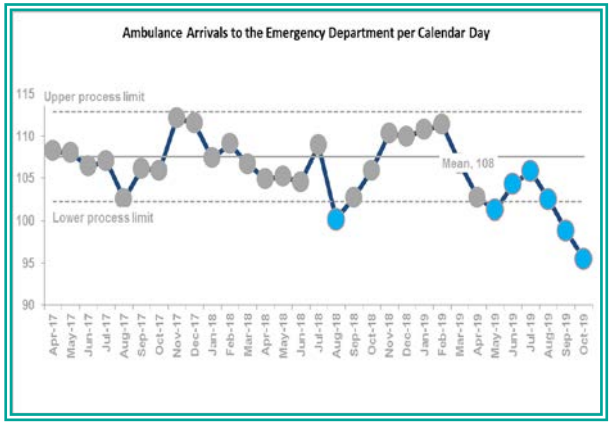
Specifically, in the last month we have undertaken the following to improve the emergency department (ED) Flow:

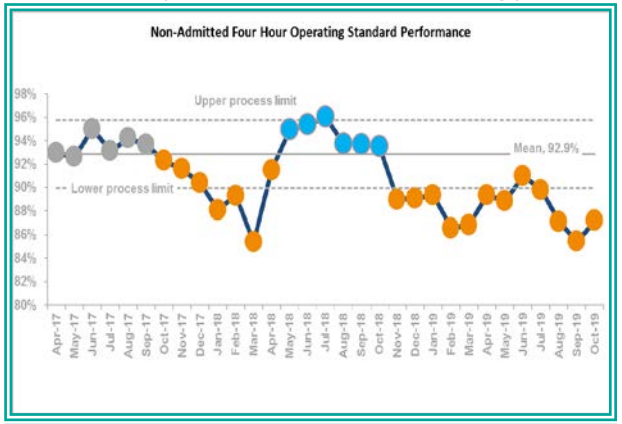
1. GP referred patients who have been accepted by Surgery & Medicine being redirected from ED front door to specialty unit
2. Undertaking PDSA cycle to monitor Implementation of senior decision maker within Ambulance RAT to reduce LOS within ED department
3. Inter Professional Standards – focus on 3 specialties (Cardiology / Plastics / ENT) to improve performance against the response time target aiding reduction in LOS within ED department
4. Initial joint meeting with ED senior nurses and consultants to improve collaborative team working on the shop floor
5. Final Emergency Care Intensive Support Team (ECIST) report received. Recommendations included within the Emergency Care Delivery Board (ECDB) action plan

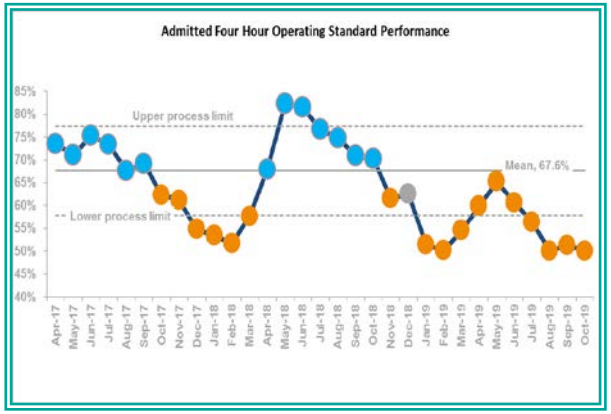
Emergency Flow

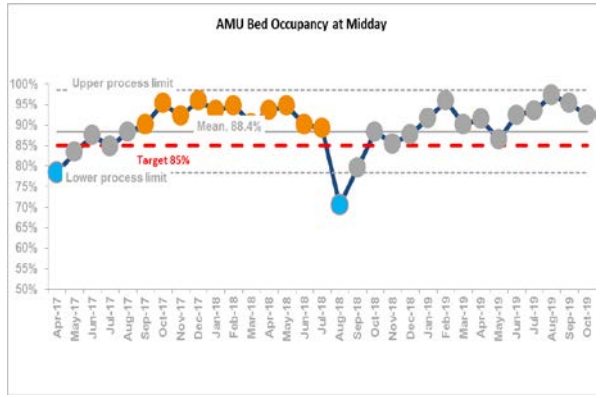
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

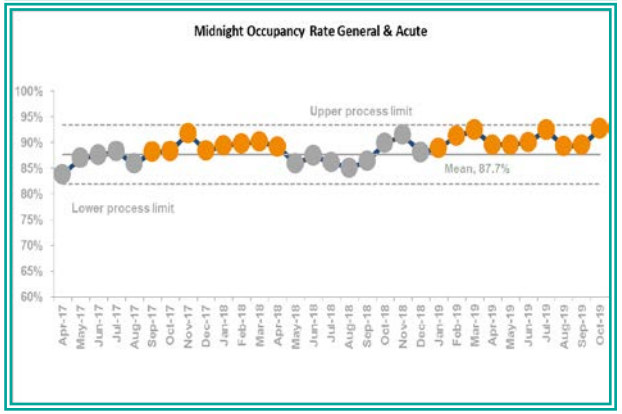


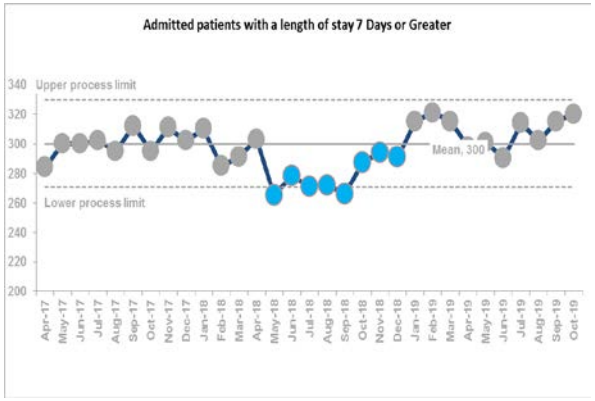


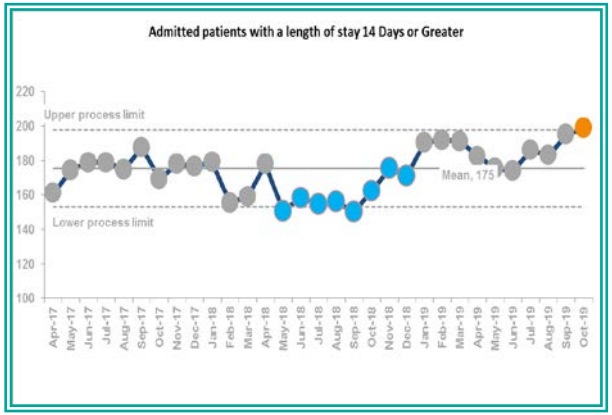


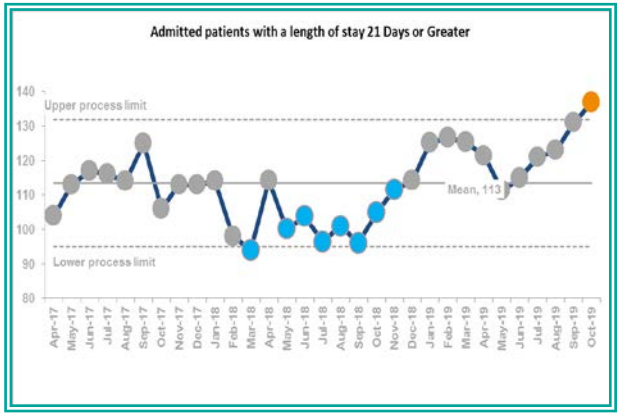






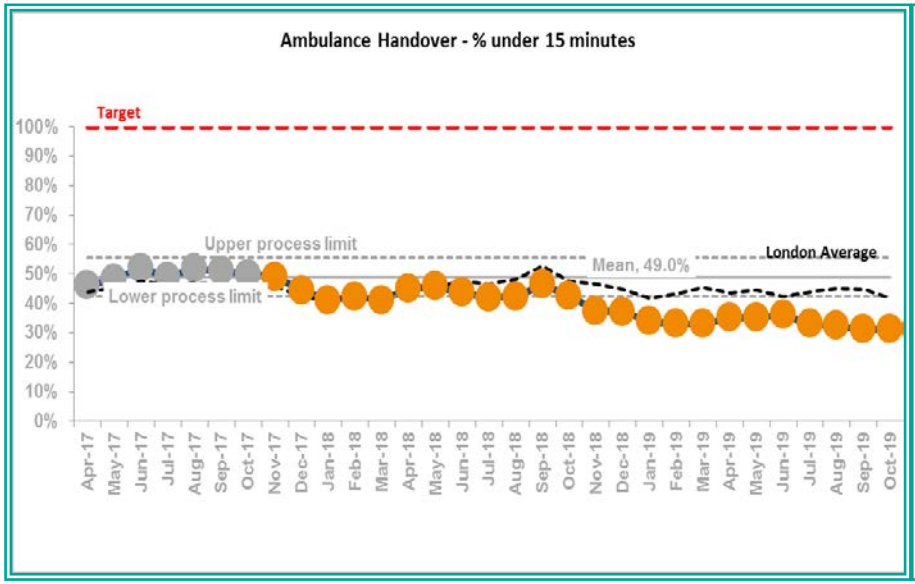


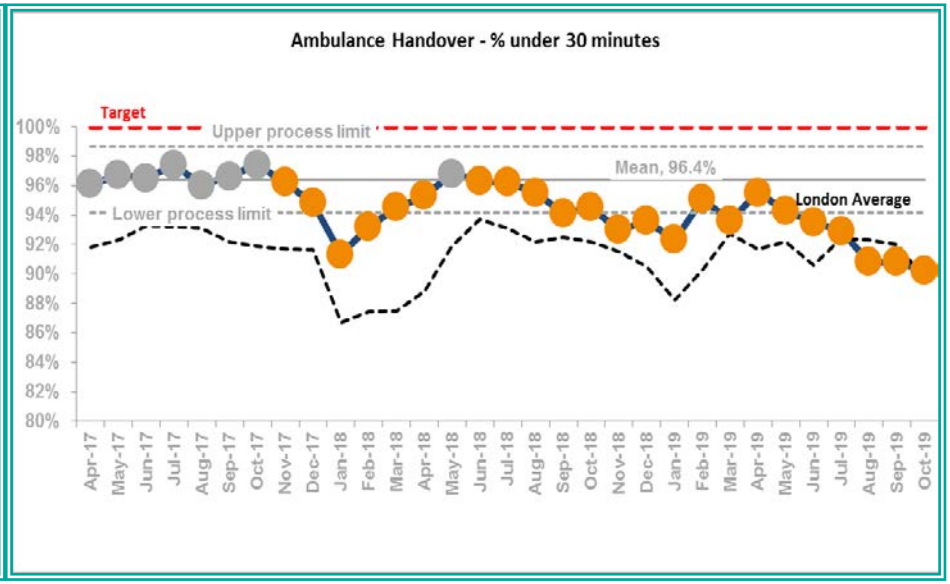


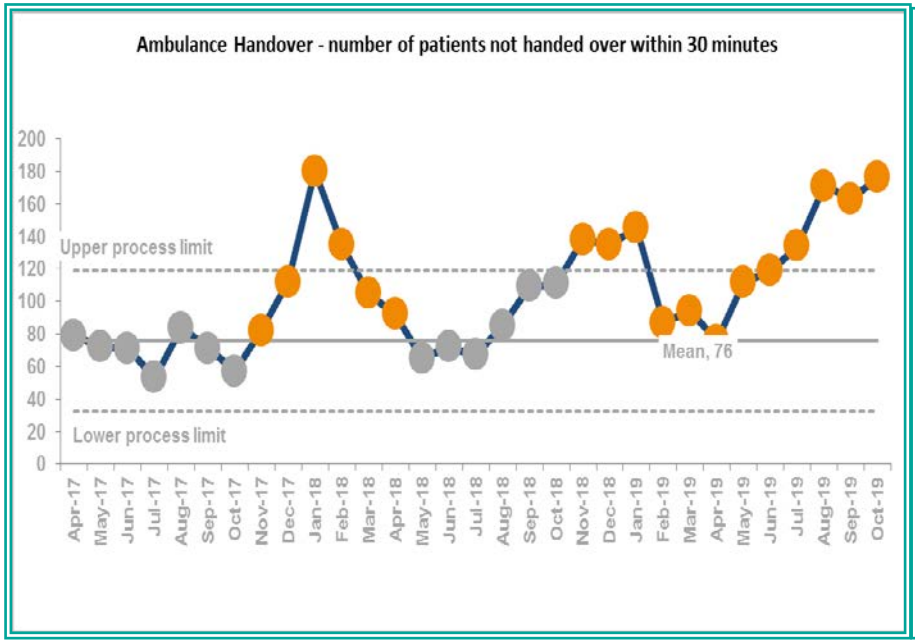


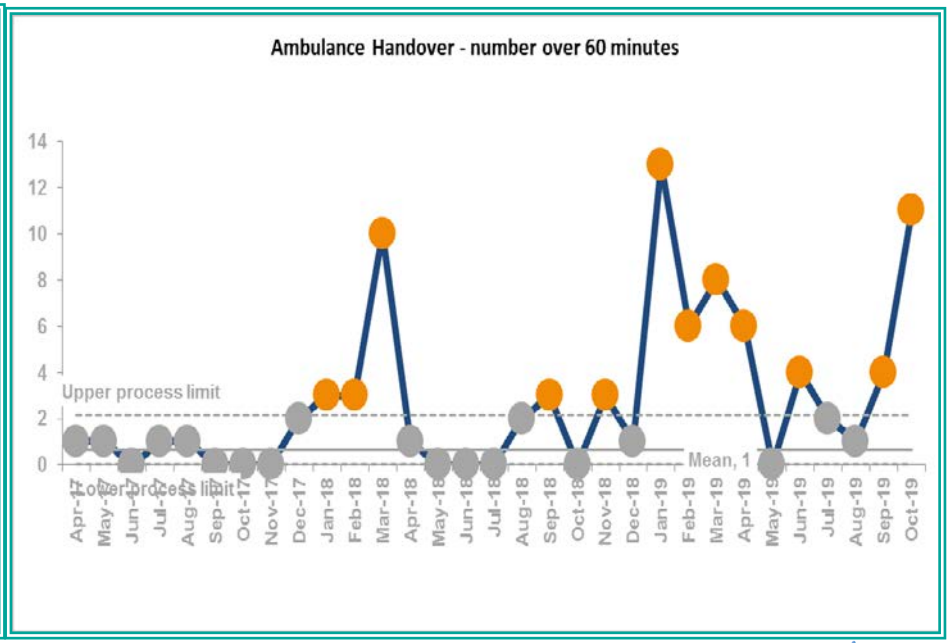
Emergency Flow

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





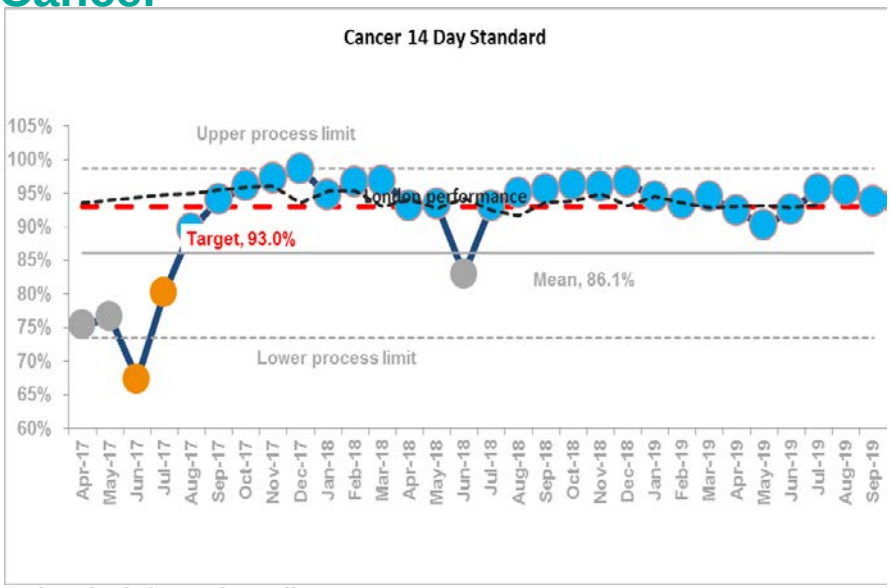


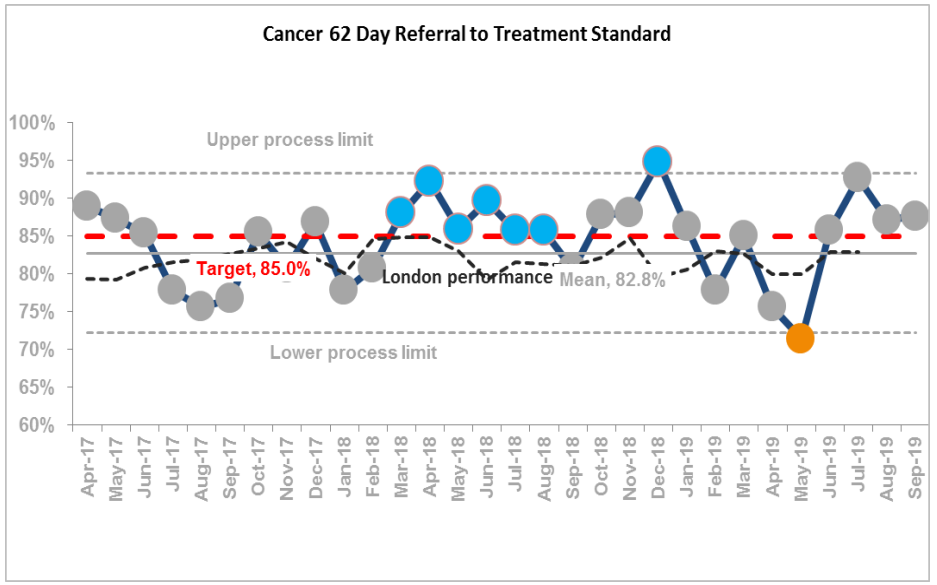


2.2

Our Process Perspective

Cancer





What the information tells us

- The Trust has achieved all seven cancer standards for the month of September, remaining compliant against the 14 Day Standard and 62 Day Standard.
- Within the 14 Day Standard, four tumour groups were non-compliant against the 93% national target, these were Haematology, Lower GI, Skin and Upper GI overall Trust performance remains within the upper and lower control limits. Improvement in Gynaecology has been maintained remaining above the mean for the third consecutive month.
- The number of patients awaiting treatment greater than 62 days from referral has continued above the mean with a performance of 87.6% in the month of September 2019 against the target of 85% with four tumour groups non-compliant (Head and Neck, Lung, Skin and Upper GI). All tumour groups remain within the upper and lower control limit with no special cause variation seen.
- Cancer 62 day screening performance has maintained compliance the past 6 months, reporting 100% in the month of September with performance showing above the mean for the fifth consecutive month.

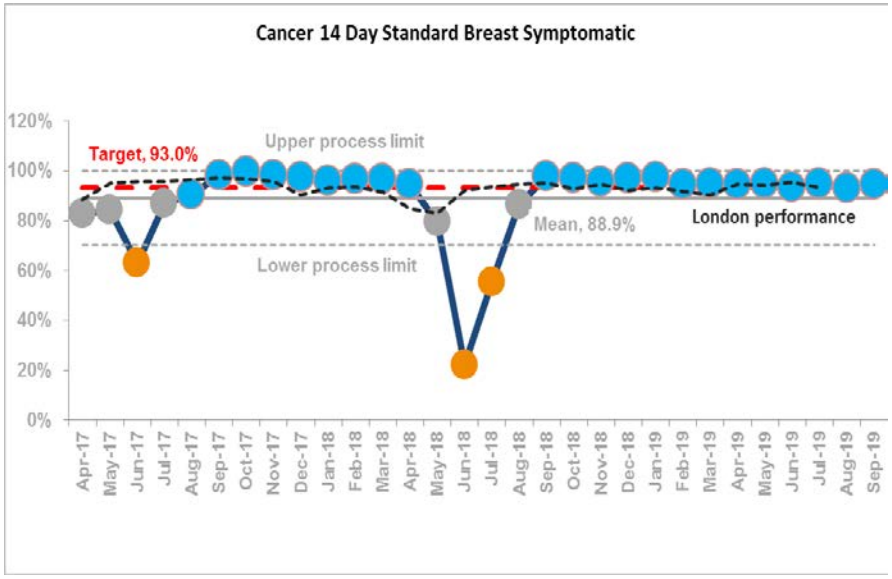
Actions and Quality Improvement Projects

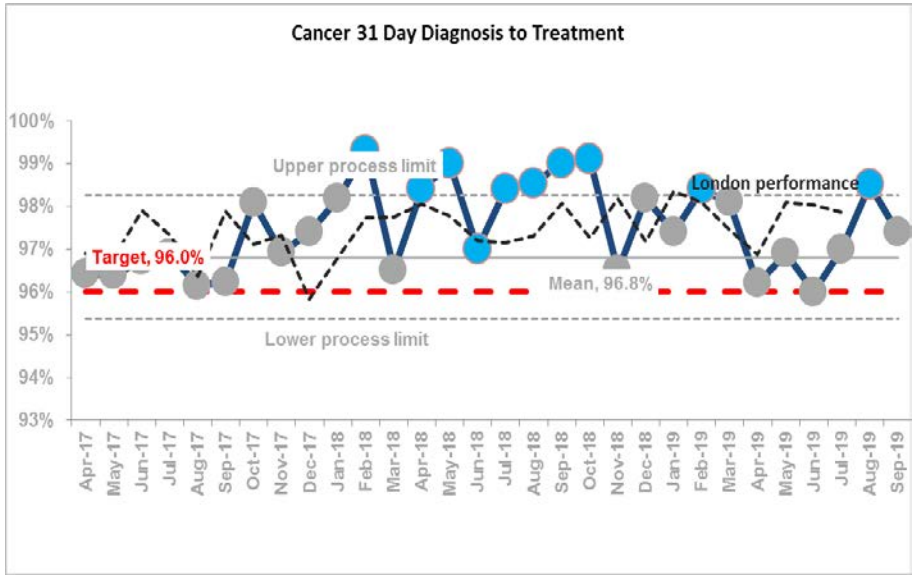
The recovery action plan has three key parts in it:

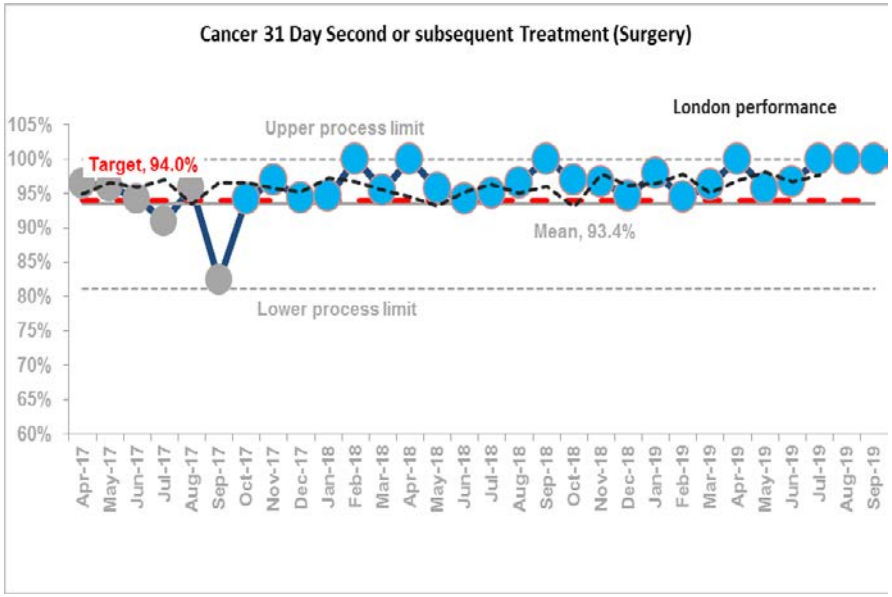
- Demand and capacity modelling continues with all services to ensure the right capacity is in place to meet the demand. Plans for services to review further demand and capacity planning to meet this requirement.
- Continued targeted support to the colorectal pathway (Upper and Lower GI). Access to endoscopy continues to be a challenge in view of increasing referrals (5%) which is factored in endoscopy planning. The main focus will be to increasing direct to test slots to 70 to meet current demand. Moreover on nurse led telephone triage being polled on ERS at day 3 for maximum efficiency and improved performance.
- 62 day focus has been on closer integration between Cancer and theatre teams to ensure that all opportunities to treat patients are maximised- including cancer theatres huddle and 642 attendance. Additional walk in slots for pre-assessment identified and slots ring fenced for services. Training & Development of internal and external staff as well as good service engagement.

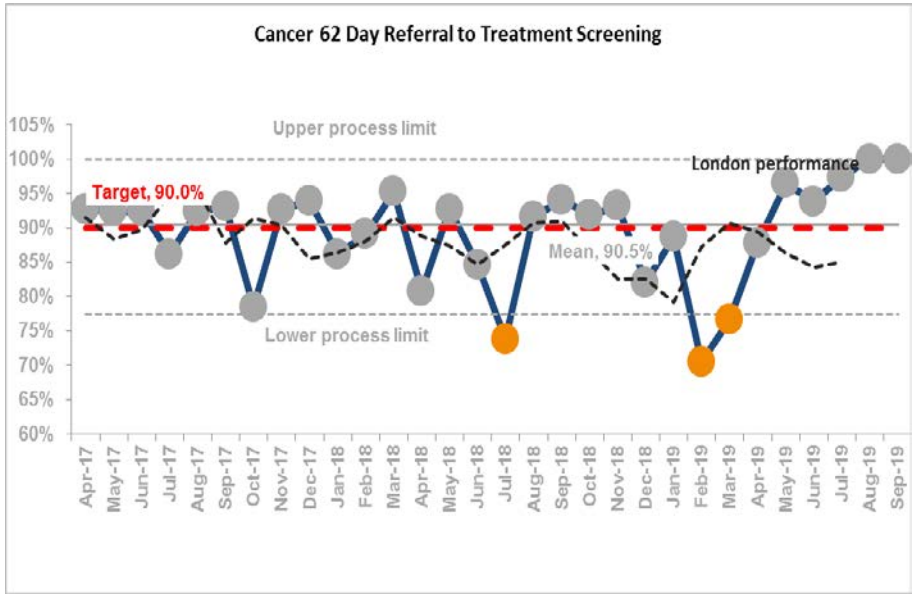
Cancer

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









Cancer

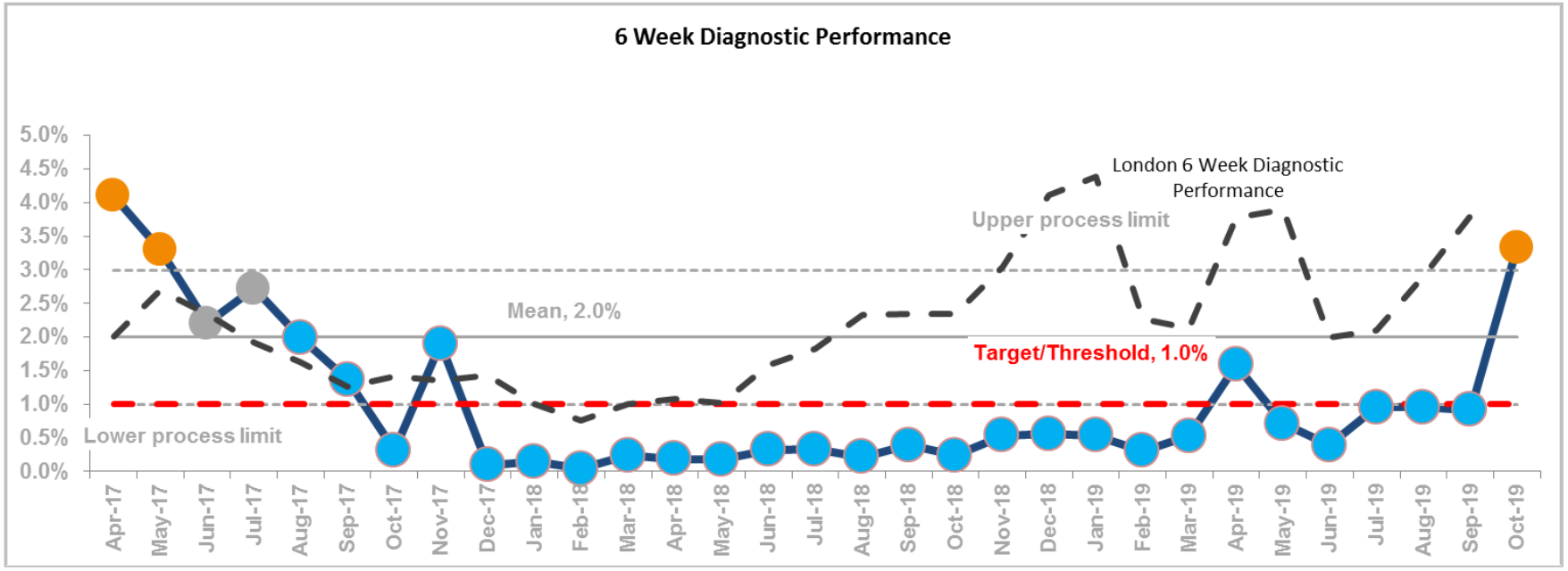
14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	No of Patients
Brain	93%	-	100.0%	-	100.0%	100.0%	100.0%	-	100.0%	-	100.0%	-	100.0%	100.0%	1
Breast	93%	94.5%	99.4%	97.4%	98.8%	97.4%	98.6%	97.9%	99.5%	96.3%	96.9%	95.4%	94.9%	95.9%	292
Children's	93%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	3
Gynaecology	93%	81.9%	87.8%	87.5%	95.9%	69.5%	65.3%	80.0%	75.0%	59.3%	78.0%	95.5%	97.2%	95.4%	108
Haematology	93%	100.0%	96.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	86.7%	15
Head & Neck	93%	99.3%	99.8%	98.1%	96.0%	98.5%	100.0%	99.3%	98.0%	97.8%	100.0%	98.9%	96.4%	96.6%	146
Lower Gastrointestinal	93%	94.3%	98.1%	95.8%	94.5%	97.2%	92.1%	94.5%	85.6%	91.1%	87.9%	93.7%	93.1%	92.8%	318
Lung	93%	95.2%	100.0%	100.0%	100.0%	93.3%	100.0%	96.9%	100.0%	95.6%	96.8%	95.7%	100.0%	97.1%	35
Skin	93%	97.4%	96.6%	97.4%	97.6%	97.1%	95.9%	97.6%	96.9%	95.5%	94.8%	96.0%	98.0%	91.8%	377
Upper Gastrointestinal	93%	96.7%	98.8%	95.4%	94.1%	91.8%	90.9%	83.5%	87.9%	70.2%	90.9%	95.1%	88.9%	87.2%	86
Urology	93%	96.8%	92.4%	93.4%	96.6%	94.5%	94.2%	92.2%	90.1%	95.4%	92.1%	93.8%	93.0%	97.0%	133

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	No of Treatments
Brain	85%	-	-	100.0%	100.0%	-	-	-	-	-	-	-	-	-	0
Breast	85%	100.0%	100.0%	100.0%	100.0%	100.0%	82.4%	90.9%	83.3%	80.0%	87.5%	73.3%	88.6%	100.0%	10.5
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	100.0%	-	0
Gynaecology	85%	80.0%	90.0%	100.0%	83.3%	88.9%	50.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%	3
Haematology	85%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	30.0%	33.3%	77.8%	100.0%	100.0%	100.0%	2
Head & Neck	85%	80.0%	100.0%	86.7%	87.5%	46.2%	85.7%	80.0%	77.8%	40.0%	28.6%	80.0%	80.0%	75.0%	8
Lower Gastrointestinal	85%	66.7%	88.9%	100.0%	100.0%	100.0%	81.8%	66.7%	41.7%	100.0%	69.2%	83.3%	63.6%	90.0%	5
Lung	85%	28.6%	50.0%	70.0%	72.7%	80.0%	75.0%	70.0%	71.4%	100.0%	100.0%	91.7%	89.5%	60.0%	5
Skin	85%	84.6%	92.3%	100.0%	100.0%	92.3%	100.0%	89.7%	100.0%	75.8%	95.7%	100.0%	100.0%	78.9%	9.5
Upper Gastrointestinal	85%	50.0%	54.5%	100.0%	100.0%	0.0%	50.0%	60.0%	100.0%	20.0%	75.0%	100.0%	53.8%	66.7%	6
Urology	85%	92.9%	88.9%	77.8%	95.0%	89.5%	71.1%	88.9%	83.0%	75.8%	93.9%	100.0%	94.4%	100.0%	19.5
Other	85%	-	100.0%	100.0%	-	0.0%	-	100.0%	-	-	100.0%	-	-	-	0

Diagnostics



What the information tells us

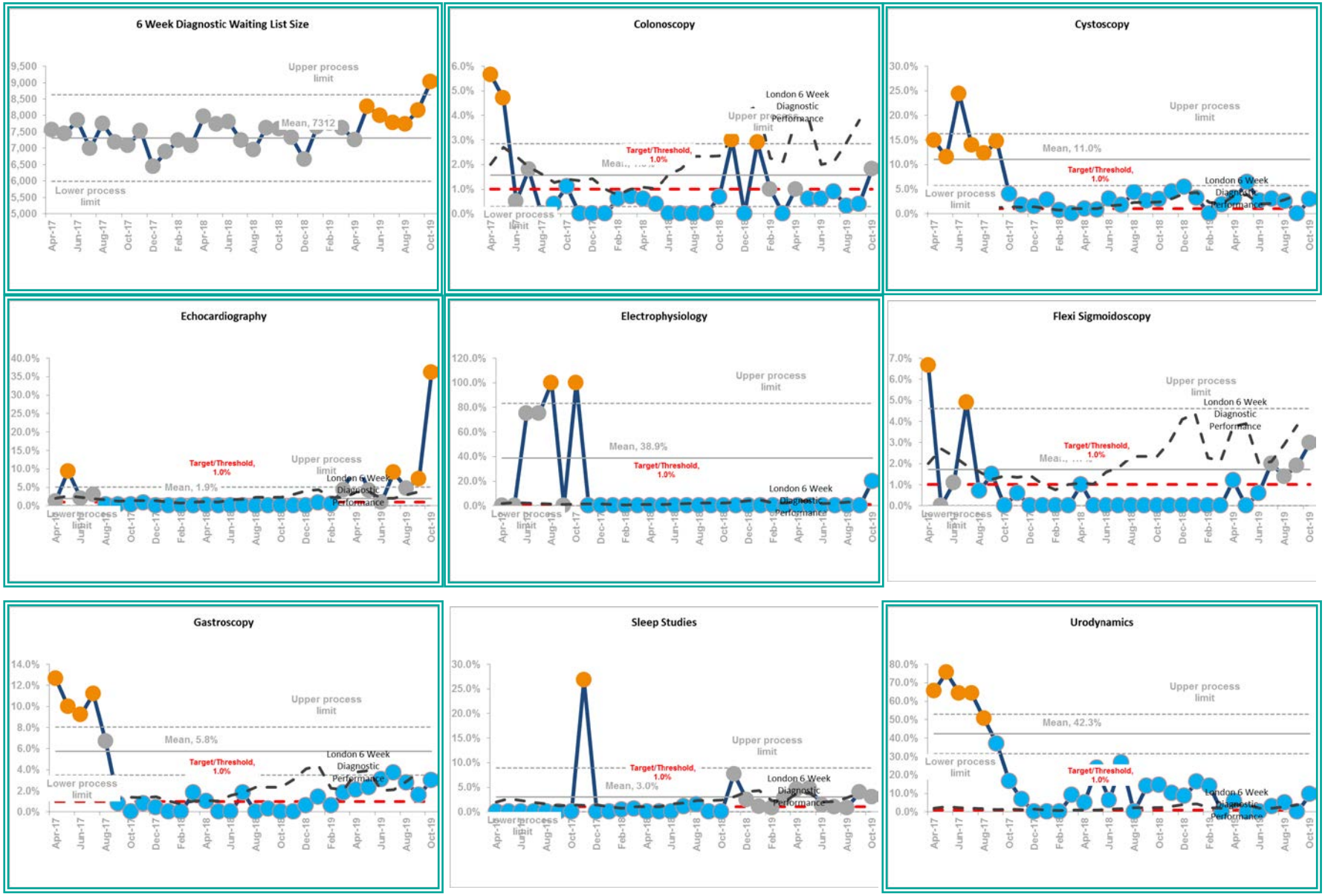
- In October, the Trust did not achieve the six week diagnostic standard with an adverse performance of 3.32% against a National Threshold of 1%.
- The diagnostic waiting list is now above the upper process limit and has been consistently above its mean for the past six months indicating special cause
- Compliance has not been achieved within eight modalities, with Echocardiography being the most challenged and performing above the upper control limit.
- Electrophysiology and urodynamics were not compliant however the numbers in the services are quite small with 5 patients and 21 patients in their waiting lists for October.
- Sleep studies, sigmoidoscopy, colonoscopy, cystoscopy, gastroscopy were also not compliant.

Actions and Quality Improvement Projects

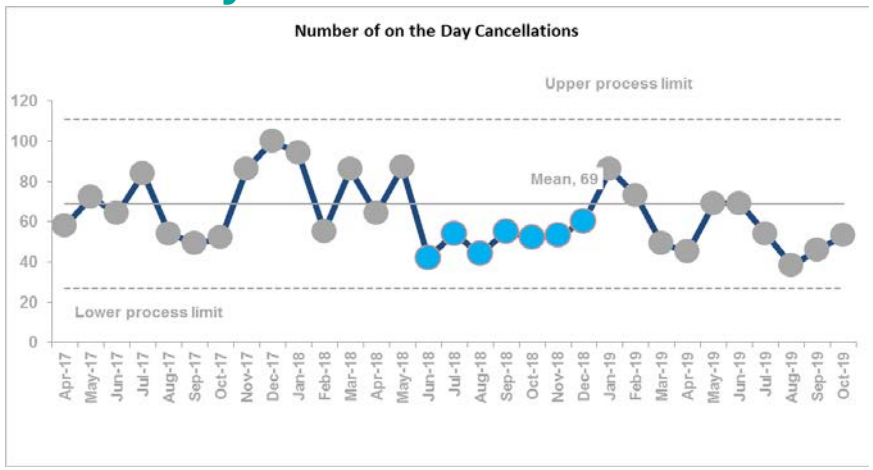
- Recovery plan for Echocardiography was submitted in October for long term impact and sustainability for the service
- In the short term, waiting lists are being validated using resources from the 18 week wait RTT team
- A service manager post will be dedicated to Diagnostics and RTT performance
- Additional administrative resource has been requested to ensure that booking processes are robust and to ensure adequate capacity.
- A dedicated resource from transformation will lead on reviewing the current administrative and booking process. In addition, a review of internal/external referral pathways for Cardiology Diagnostic will be undertaken.
- Insourcing will start middle of December to bridge echocardiography capacity gap.
- Paediatric Echocardiography issue has been identified and plans are in place to formulate an action plan.

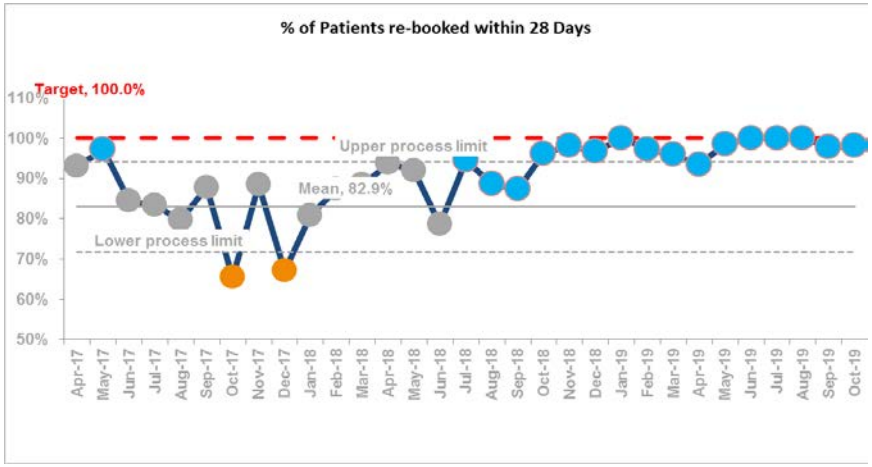
Diagnostics

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



On the Day Cancellations for Non Clinical Reasons





What the information tells us

- Performance remains within expected levels staying within the upper and lower control limits and has seen a reduction within the last three months reporting below the mean and cancelling a total of 53 on the day cancellations in the month of October.
- The rebooking process has maintained recent improvement and reduced the variability in the number of patients re-booked within the 28 day standard with on average, 99% rebooked within 28 days for the previous six months. In October, 98.1% of patients were re-booked within 28 days.

Actions and Quality Improvement Projects

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

Referral to Treatment

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RTT Incomplete Performance	92%	84.5%	85.2%	86.1%	85.8%	86.6%	86.0%	86.1%	85.0%	86.1%						
RTT Incomplete Trajectory		83%	84%	84%	84.3%	84.6%	84.9%	85.3%	85.5%	85.8%	86.1%	86.5%	86.8%	87.2%	87.7%	88.1%
RTT Total Incomplete Waiting Lize Size		40,016	40,037	39,674	41,013	42,671	41,658	41,259	41,945	47,714						
RTT Total Incomplete Waiting Lize Size Trajectory					39,890	39,880	39,870	39,860	39,850	39,840	39,830	39,820	39,810	39,800	39,790	39,780
Total waits greater than 18 weeks (inc 52Wk waiters)		5,921	5,929	5,515	5,812	5,717	5,820	5,739	6,305	6,651						
Total waits greater than 18 weeks Trajectory				6,400	6,263	6,142	6,020	5,859	5,779	5,657	5,536	5,376	5,255	5,095	4,894	4,734
Total waits greater than 52 weeks	0	118	116	27	22	16	7	5	6	6						
Total waits greater than 52 weeks Trajectory				31	23	16	9	5	5	5	0	0	0	0	0	0
RTT Incomplete Performance - Admitted		65.5%	65.5%	66.6%	65.3%	68.8%	68.7%	66.3%	63.7%	65.9						
Total waits greater than 18 weeks - Admitted		1,563	1,563	1,428	1,511	1,459	1,494	1,523	1,655	1,643						
Total waits greater than 52 weeks - Admitted	0	62	63	18	7	8	4	1	2	4						
RTT Incomplete Performance -Non Admitted		87.7%	87.7%	88.5%	88.3%	88.8%	88.3%	88.5%	87.6%	88.3%						
Total waits greater than 18 weeks - Non Admitted		4,358	4,366	4,087	4,301	4,258	4,326	4,216	4,650	5,008						
Total waits greater than 52 weeks - Non Admitted	0	56	53	9	15	8	3	4	4	2						

What the information tells us

- September month end performance (submitted 17th October 2019) includes Queen Mary's Hospital (QMH) for the first time following the Patient Administration System (PAS) migration which happened weekend 13th and 14th September 2019.
- The Trust reported 86.1% performance ahead of trajectory which was set at 85.8%.
- The Trust overall waiting list increase to 47,714 pathways. At the point the trajectory was set, the QMH waiting list was not included .
- The Trust reported six 52 week wait breaches against a trajectory of 5.

Actions and Quality Improvement Projects

- Detailed review of all un-outcomed out patient appointments. Closely working with the outpatients department to ensure deadlines are aligned to ensure all RTT activity is accurately recorded ahead of submission for October performance. (October performance will be submitted on Tuesday 19th November 2019
- Review of all past and historic To Come In (TCI) dates to ensure accurate reporting.
- Weekly monitoring and action planning of all Data Quality (DQ) metrics which now include all QMH activity.
- On-going daily review of all long waiting patients weeks 28 and above for month end 52 week reporting. This highlights month end high risk patients October 2019 – April 2020.
- Improvements in the General Surgery results review process . Patients to be booked early into specific results review clinics following diagnostic testing under Gastroenterology. This cohort of patients represents the highest number of long waiting patients on the Trust Patient Tracking List (PTL).
- Daily reporting on patients waiting list over 18 weeks for first outpatient appointment.

Referral to Treatment

Specialty	Admitted		Non Admitted		Incomplete Pathway					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
General Surgery	248	48.0%	1,047	82.5%	983	312	1,295	75.9%	59	3
Urology	295	56.9%	1,573	90.6%	1,593	275	1,868	85.3%	5	0
Trauma & Orthopaedics	170	55.9%	2,414	88.3%	2,226	358	2,584	86.1%	4	0
Ear, Nose & Throat (ENT)	518	47.9%	2,489	86.6%	2,404	603	3,007	79.9%	20	0
Ophthalmology	0	-	364	97.3%	354	10	364	97.3%	0	0
Oral Surgery	7	28.6%	570	94.9%	543	34	577	94.1%	2	0
Neurosurgery	155	66.5%	2,086	80.5%	1,782	459	2,241	79.5%	17	0
Plastic Surgery	615	61.1%	1,011	87.8%	1,264	362	1,626	77.7%	26	3
Cardiothoracic Surgery	0	-	0	-	0	0	0		0	0
General Medicine	0	-	44	97.7%	43	1	44	97.7%	0	0
Gastroenterology	565	93.5%	2,227	89.8%	2,528	264	2,792	90.5%	7	0
Cardiology	815	69.4%	3,164	85.8%	3,281	698	3,979	82.5%	12	0
Dermatology	2	50.0%	3,493	92.0%	3,215	280	3,495	92.0%	3	0
Thoracic Medicine	3	100.0%	1,883	88.4%	1,667	219	1,886	88.4%	0	0
Neurology	34	97.1%	2,834	90.8%	2,606	262	2,868	90.9%	2	0
Rheumatology	1	100.0%	1,140	84.8%	968	173	1,141	84.8%	0	0
Geriatric Medicine	0	-	108	99.1%	107	1	108	99.1%	0	0
Gynaecology	340	54.4%	2,513	94.0%	2,548	305	2,853	89.3%	3	0
Other	1,055	71.3%	13,931	87.6%	12,951	2,035	14,986	86.4%	59	0
Total	**4,823**	**63.7%**	**42,891**	**87.6%**	**41,063**	**6,651**	**47,714**	**86.1%**	**219**	**6**

- There are a number of specialties reported under speciality ‘Other’. This follows guidance set out in the documentation, “Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care” – produced by NHS England.
- The six 52 week breach patients reported were General Surgery (3) and Plastic Surgery (3). Trajectory was 5.

Balance Scorecard

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

Our People Perspective

Workforce

What the information tells us

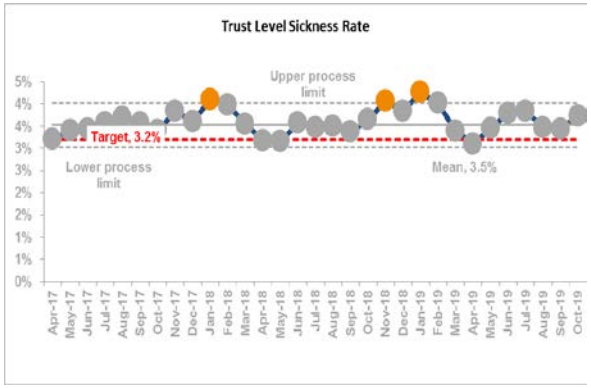
- Mandatory and Statutory Training figures for October were recorded at 89.8% with a mean of 86.2%, a reduction on last month's performance.
- Medical appraisal rates currently stands at 83.9% an improved performance on last month.
- Non-medical appraisal performance in October was 70.9% against a 90% target and is below the lower control limits.
- The Trust's Total Funded Establishment and Trust Vacancy rate are both below the lower control limits with both seeing further improved performance
- Agency cost in October was £1.86m or 4.2% of the total pay costs. For 2018/19, the average agency cost was 3.2% of total pay costs. For October, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.61m. .

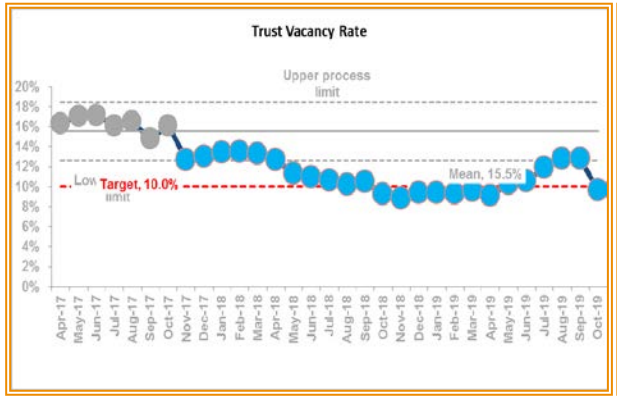
Actions and Quality Improvement Project
HR Managers will be meeting with Divisional Directors of Operations to discuss remedial actions to control agency costs.

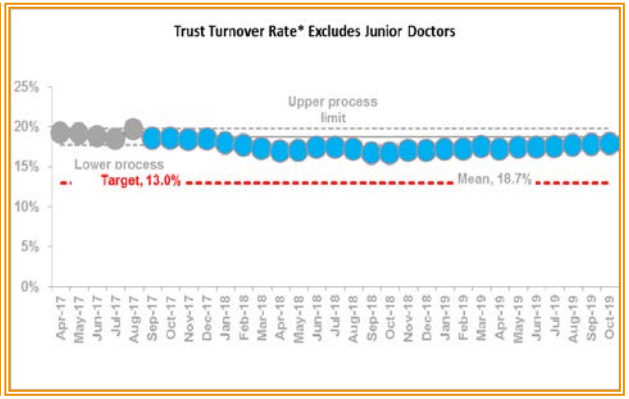
Indicator Description	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Trust Level Sickness Rate	3.2%	3.7%	4.1%	3.8%	4.3%	4.0%	3.4%	3.1%	3.5%	3.8%	3.8%	3.5%	3.4%	3.7%
Trust Vacancy Rate	10%	9.3%	8.9%	9.4%	9.4%	9.3%	9.6%	9.1%	10.3%	10.5%	11.9%	12.8%	12.8%	9.3%
Trust Turnover Rate* Excludes Junior Doctors	13%	16.6%	16.9%	16.9%	17.1%	17.1%	17.5%	17.1%	17.4%	17.4%	17.5%	17.7%	17.7%	17.8%
Total Funded Establishment		9,165	9,171	9,196	9,229	9,238	9,248	9,112	9,241	9,251	9,365	9,432	9,534	9,280
IPR Appraisal Rate - Medical Staff	90%	Data Unavailable							85.4%	84.5%	84.4%	85.7%	81.5%	83.9%
IPR Appraisal Rate - Non Medical Staff	90%	69.7%	71.8%	71.5%	70.9%	71.3%	70.4%	71.6%	72.5%	73.6%	73.3%	71.3%	70.4%	70.9%
Overall MAST Compliance %	85%	88.3%	88.3%	89.1%	89.3%	89.1%	89.4%	89.8%	90.6%	91.2%	91.2%	90.2%	89.9%	89.8%
Ward Staffing Unfilled Duty Hours	10%	6.6%	5.1%	6.1%	6.6%	6.7%	7.2%	5.7%	5.9%	6.1%	6.3%	5.4%	6.5%	6.1%

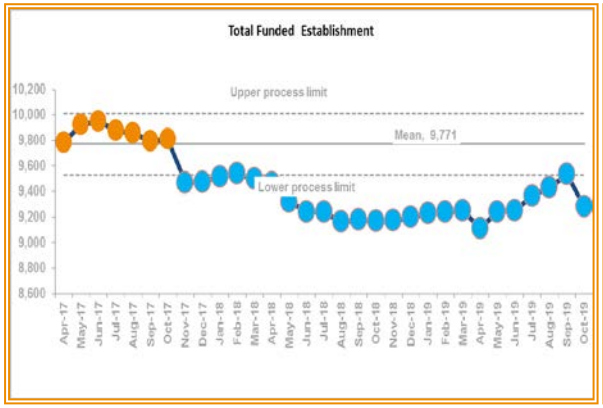
Workforce

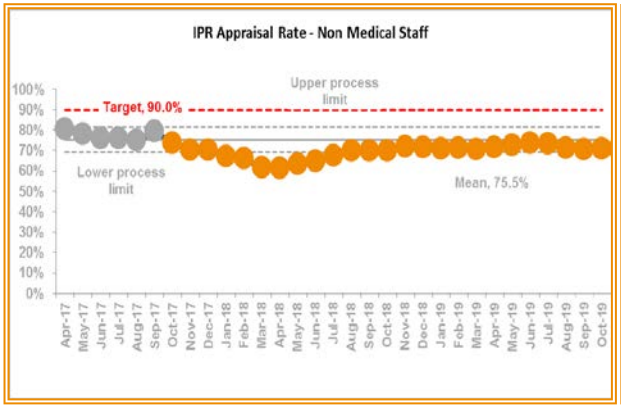
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

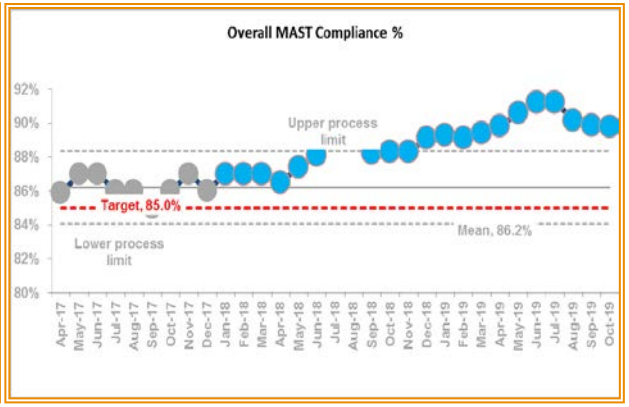


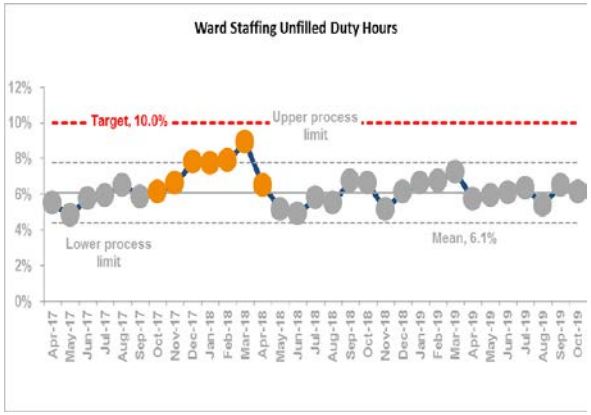




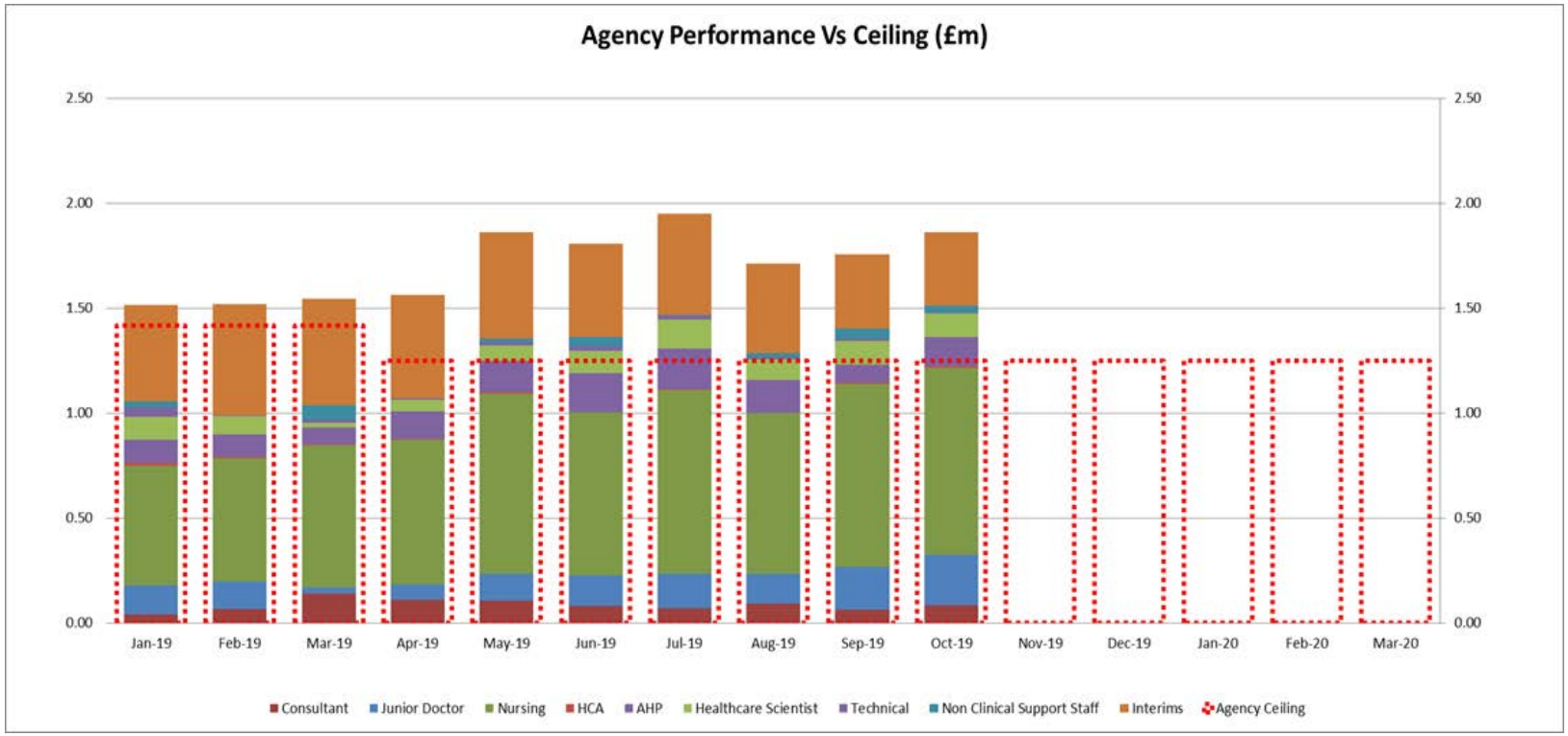






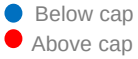


Agency use



- The Trust's total pay for October was £44.14m. This is £1.10m adverse to a plan of £43.05m.
- The Trust's 2019/20 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.
- Agency cost in October was £1.86m or 4.2% of the total pay costs. For 2018/19, the average agency cost was 3.2% of total pay costs.
- For October, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.61m.
- Agency cost is £0.11m higher compared to September. There have been increases mainly in AHP (£0.05m), Junior Doctor (£0.04m), Consultant (£0.02m) and Nursing (£0.02m).
- The biggest areas of overspend were Nursing (£0.31m) and Junior Doctor (£0.17m).

Agency use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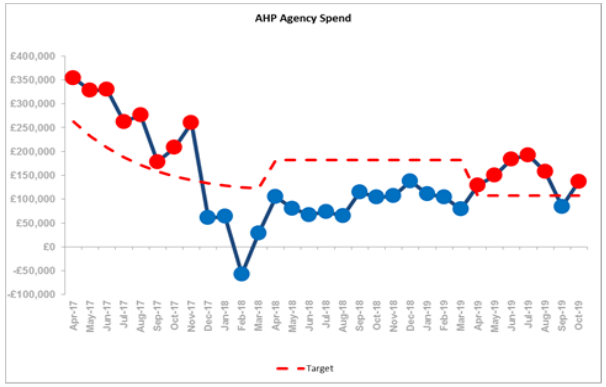
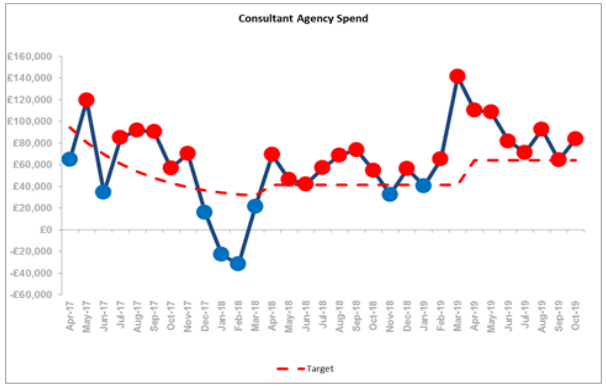
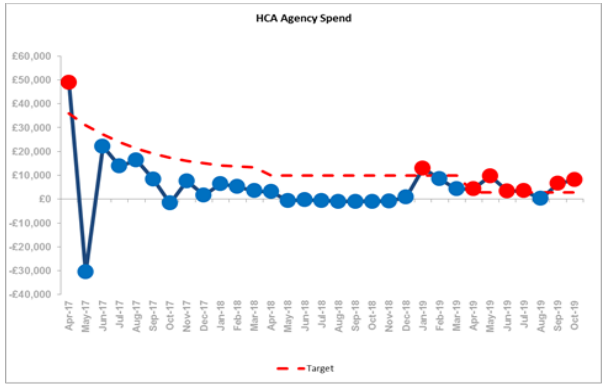
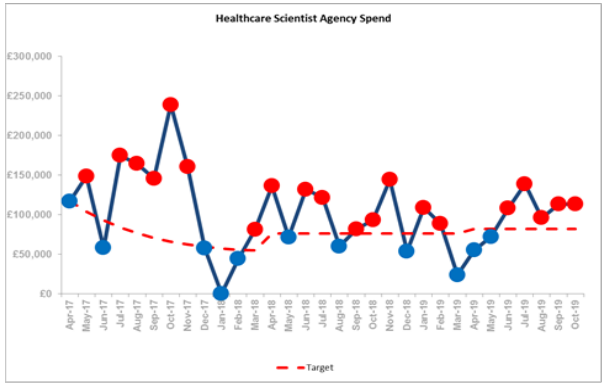
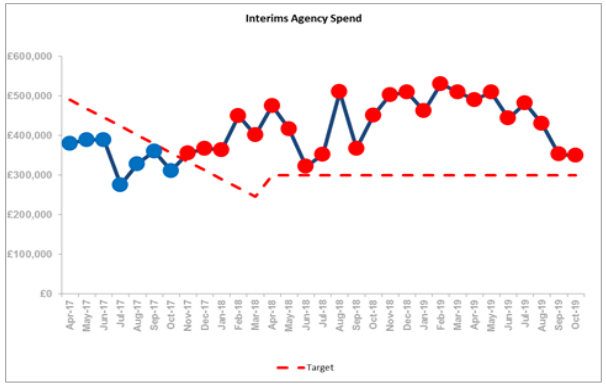
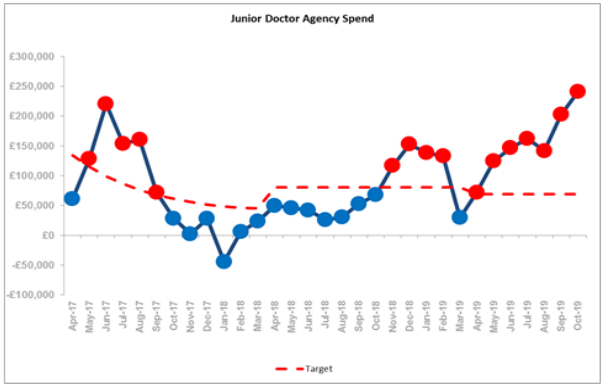

AHP Agency Spend
Target

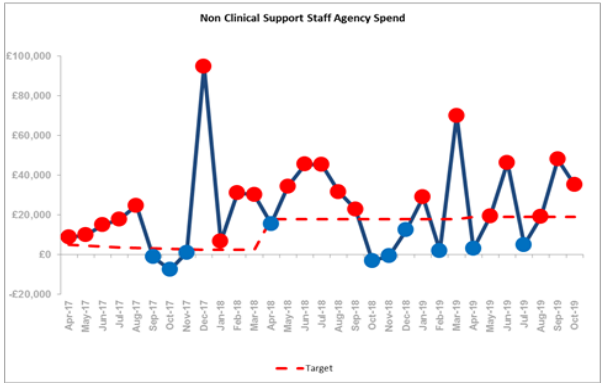

Consultant Agency Spend
Target

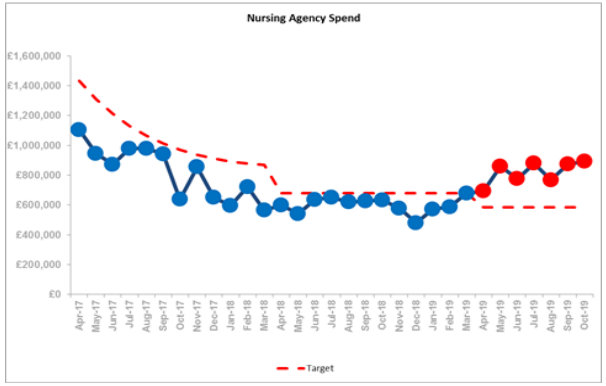

HCA Agency Spend
Target

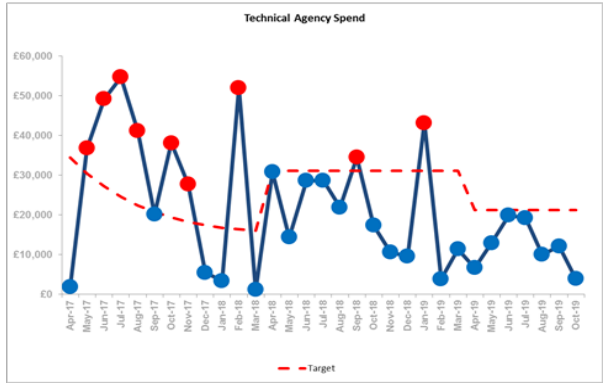

Healthcare Scientist Agency Spend
Target


Interims Agency Spend
Target


Junior Doctor Agency Spend
Target

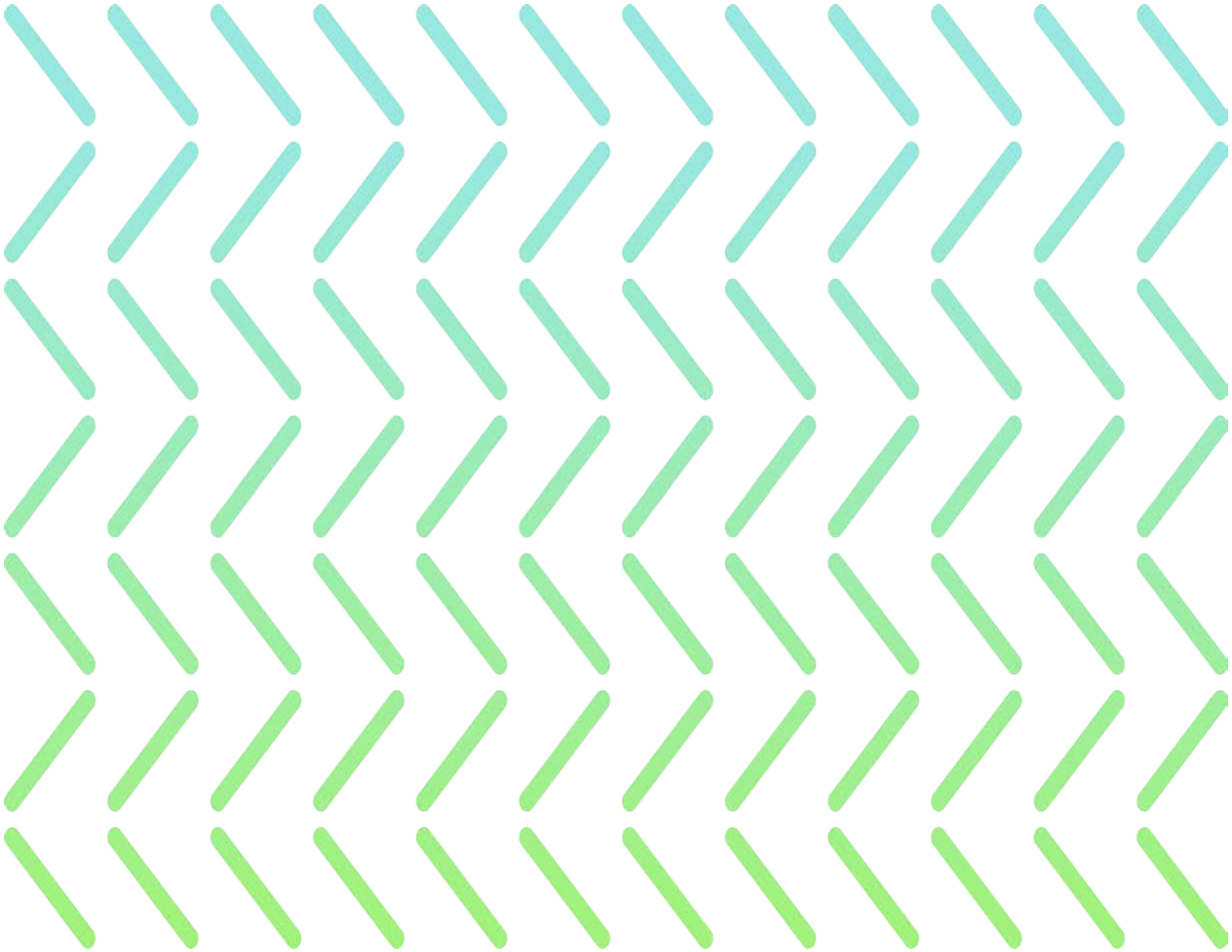

Non Clinical Support Staff Agency Spend
Target


Nursing Agency Spend
Target

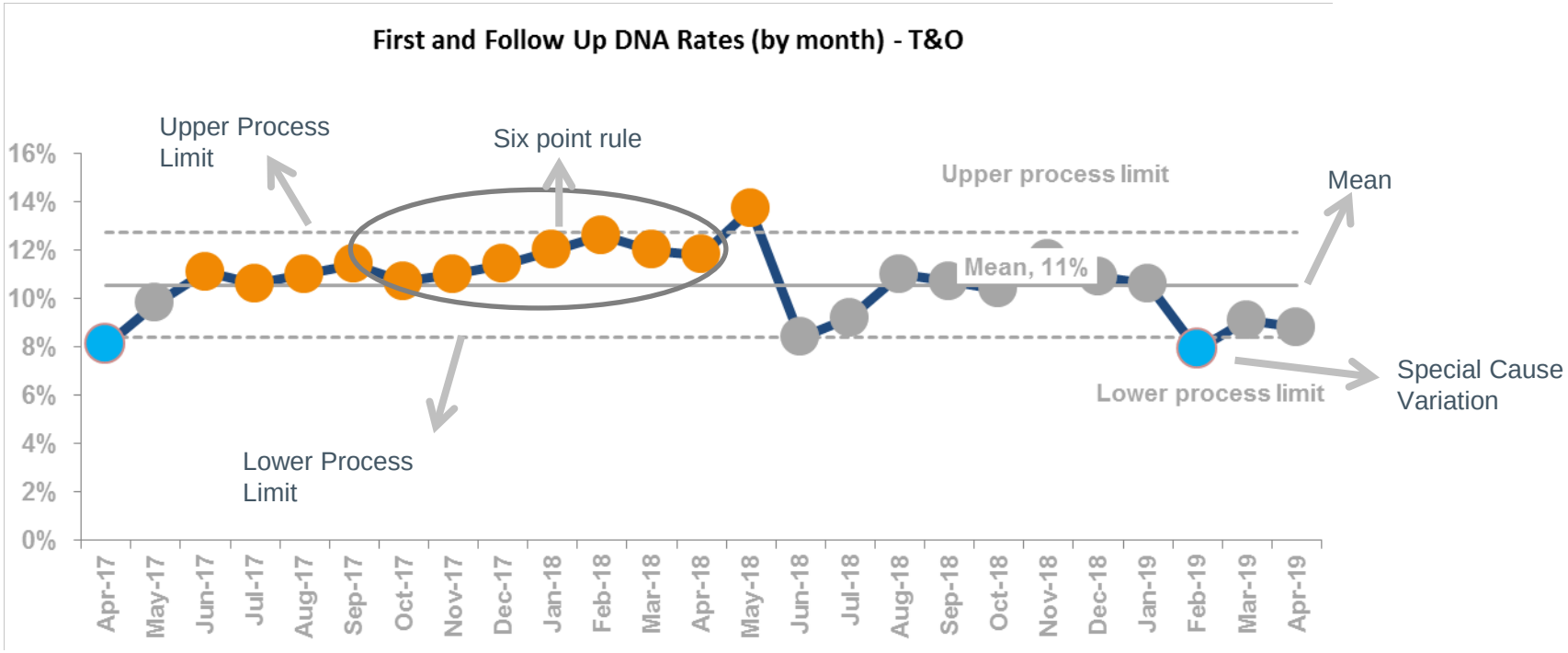

Technical Agency Spend
Target

Appendix

Additional Information and Data Tables



Interpreting SPC (Statistical Process Control) Charts



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

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

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

Productivity Tables

First Outpatient Attendances (average per working day)

Directorate	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Attendances in the last month	First Outpatient Attendances per 2018-19 YTD	2019-20 YTD	Variance
Cardiology, Cardiothoracic & Vascular Services	59	67	51	59	58	59	58	68	64	58	54	57	57	1,320	61	60	-1.7%
Children's Services	45	51	38	50	47	46	42	50	45	43	39	44	45	1,024	46	44	-4.2%
Neurosciences	84	88	74	94	81	75	86	82	88	82	72	77	75	1,723	85	80	-6.0%
Renal & Oncology	27	28	23	26	25	24	25	25	27	25	24	26	23	538	26	25	-2.0%
Specialist Medicine	142	150	126	148	147	148	148	158	159	155	131	147	137	3,154	146	148	1.5%
Surgery	279	275	257	268	264	278	250	252	269	253	243	235	226	247	268	247	-7.9%
Womens Services	86	90	78	88	92	82	91	78	82	87	83	78	71	78	83	82	-2.3%
T&O	52	55	48	53	54	51	52	51	54	53	42	56	51	1,168	56	51	-8.1%
Other	37	34	36	39	33	32	60	60	62	59	52	66	72	1,656	38	62	62.3%
Total	**812**	**838**	**731**	**826**	**801**	**791**	**812**	**823**	**850**	**813**	**740**	**787**	**757**	**17,414**	**808**	**798**	-1.31%

Follow-up Outpatient Attendances (average per working day)

Directorate	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Attendances in the last month	FollowUp Outpatient Attendances per working day 2018-19 YTD	2019-20 YTD	Variance
Cardiology, Cardiothoracic & Vascular Services	107	124	104	113	106	96	100	100	105	94	92	109	112	2,569	119	102	-14.5%
Children's Services	81	90	73	83	84	70	78	82	78	72	70	73	72	1,666	76	75	-1.7%
Neurosciences	117	123	104	124	118	101	121	118	122	107	103	99	106	2,434	114	111	-2.6%
Renal & Oncology	245	243	229	238	223	230	242	229	221	219	211	222	217	4,990	211	223	5.5%
Specialist Medicine	509	529	481	528	537	526	573	538	544	528	483	504	491	11,283	510	523	2.5%
Surgery	352	362	331	382	350	335	317	331	327	321	291	306	309	7,098	364	315	-13.6%
Womens Services	69	76	64	69	65	52	58	61	65	53	59	53	56	1,287	54	58	7.4%
T&O	85	93	76	86	85	76	82	79	81	75	70	77	76	1,748	82	77	-6.1%
Other	92	91	77	91	92	87	119	121	125	125	104	109	124	2,845	98	118	20.2%
Total	**1,656**	**1,730**	**1,539**	**1,713**	**1,661**	**1,574**	**1,689**	**1,659**	**1,668**	**1,593**	**1,483**	**1,550**	**1,564**	**35,920**	**1,629**	**1,601**	-1.7%

First to Follow-up Ratio

Directorate	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	First to FollowUp Ratio 2018-19 YTD	2019-20 YTD	Variance
Cardiothoracic & Vascular Services	1.81	1.85	2.04	1.92	1.83	1.63	1.72	1.46	1.65	1.62	1.69	1.89	1.95	1.88	1.71	-9.0%
Children's Services	1.80	1.77	1.89	1.66	1.79	1.52	1.85	1.64	1.73	1.69	1.82	1.64	1.63	1.72	1.71	-0.3%
Neurosciences	1.39	1.40	1.40	1.32	1.46	1.35	1.40	1.44	1.39	1.30	1.43	1.29	1.41	1.43	1.38	-3.2%
Renal & Oncology	9.08	8.68	10.13	9.15	8.92	9.58	9.68	9.17	8.06	8.76	8.70	8.45	9.27	8.94	8.87	-0.8%
Specialist Medicine	3.58	3.53	3.81	3.57	3.65	3.55	3.87	3.41	3.41	3.42	3.67	3.42	3.58	3.54	3.54	0.0%
Surgery	1.26	1.32	1.29	1.43	1.33	1.21	1.27	1.31	1.21	1.27	1.20	1.30	1.37	1.31	1.28	-2.3%
Womens Services	0.80	0.84	0.82	0.78	0.71	0.63	0.64	0.78	0.79	0.61	0.72	0.67	0.79	0.71	0.71	1.1%
T&O	1.63	1.69	1.59	1.62	1.57	1.49	1.58	1.55	1.51	1.43	1.65	1.38	1.49	1.48	1.51	2.0%
Other	2.49	2.69	2.16	2.33	2.79	2.72	1.98	2.02	2.03	2.11	1.99	1.65	1.72	2.49	1.93	-22.4%
Total	**2.04**	**2.06**	**2.10**	**2.07**	**2.07**	**1.99**	**2.08**	**2.02**	**1.96**	**1.96**	**2.00**	**1.97**	**2.07**	**2.02**	**2.01**	-0.8%

Productivity Tables

First and Follow-up DNA Rate

Directorate	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	DNA patients in the last month	Patients not attending rate 2018-19 YTD	Patients not attending rate 2019-20 YTD	Variance
Cardiothoracic & Vascular Services	11.5%	10.9%	10.5%	10.9%	10.3%	10.1%	9.0%	9.6%	9.8%	9.6%	8.5%	8.3%	8.5%	277	10.5%	9.0%	⇩ -1.5%
Children's Services	11.3%	10.1%	10.9%	10.9%	10.9%	10.2%	10.9%	12.3%	10.4%	11.1%	12.4%	11.1%	9.3%	287	13.1%	11.1%	⇩ -2.0%
Neurosciences	10.6%	9.6%	10.2%	10.3%	10.6%	11.0%	11.8%	11.9%	11.2%	10.1%	11.1%	10.2%	10.1%	448	10.0%	10.9%	⇧ 1.0%
Renal & Oncology	10.4%	11.0%	10.2%	9.7%	10.1%	9.4%	9.2%	9.9%	10.1%	8.2%	7.6%	7.9%	7.6%	293	10.4%	8.6%	⇩ -1.7%
Specialist Medicine	12.6%	13.1%	11.5%	12.3%	11.2%	10.8%	11.0%	12.8%	12.1%	10.2%	11.4%	11.1%	10.7%	1,518	12.3%	11.3%	⇩ -1.0%
Surgery	12.1%	11.6%	10.8%	10.4%	10.5%	10.4%	10.2%	10.3%	10.0%	8.8%	9.8%	8.8%	8.8%	1,276	11.0%	9.5%	⇩ -1.5%
Womens Services	8.7%	8.2%	7.4%	6.6%	7.4%	6.8%	8.0%	7.8%	7.8%	6.7%	7.4%	7.4%	6.6%	504	8.5%	7.4%	⇩ -1.1%
T&O	10.4%	11.6%	10.9%	10.6%	7.9%	9.1%	8.8%	10.7%	9.4%	9.3%	9.0%	10.5%	10.0%	328	10.7%	9.7%	⇩ -1.1%
Other	14.4%	15.4%	14.2%	12.9%	12.9%	14.3%	14.2%	13.4%	12.8%	12.6%	14.3%	14.8%	15.3%	1,654	12.1%	13.9%	⇧ 1.8%
Total	**10.5%**	**10.5%**	**10.9%**	**10.8%**	**10.5%**	**10.6%**	**10.7%**	**11.2%**	**10.7%**	**9.7%**	**10.6%**	**10.4%**	**10.1%**	**6,585**	**11.1%**	**10.5%**	⇩ -0.7%

Elective & Daycase activity (average per working day)

Months	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	2018-19 YTD	2019-20 YTD	Variance	Discharges for month
Cardiology & Cardiac Surgery	14.0	16.8	13.8	14.7	17.2	16.2	12.0	13.3	15.4	13.7	13.6	15.6	14.3	15.5	14.0	-9.8%	330
Clinical Haematology	1.7	1.5	1.8	1.0	1.3	1.4	0.8	0.8	0.7	1.4	1.1	0.4	0.7	1.9	0.8	-54.8%	16
Diabetes & Endocrinology	2.0	1.8	1.2	2.0	1.6	1.8	1.8	2.7	1.9	1.6	1.6	1.9	1.4	1.9	1.8	-3.7%	32
Endoscopy & Gen Med	54.6	59.2	49.7	57.3	56.4	61.6	57.4	68.5	70.8	65.3	61.7	61.4	59.6	57.0	63.5	11.4%	1,370
Ear, Nose & Throat	8.9	7.8	7.1	9.5	7.9	7.9	8.5	8.3	8.9	8.3	7.5	9.4	8.5	8.3	8.5	1.8%	196
General Surgery	9.9	10.7	10.4	10.7	10.5	12.8	8.1	7.1	8.5	7.2	6.7	7.6	9.2	9.7	7.8	-20.0%	211
Gynaecology and Obstetrics	11.4	11.2	8.8	11.0	10.8	10.4	9.9	10.8	10.5	10.3	8.8	11.0	9.5	10.5	10.1	-3.3%	218
Max Fax & Dental	6.4	6.4	5.5	6.7	7.2	5.4	6.1	7.3	7.2	6.5	5.8	6.8	5.3	6.6	6.4	-2.9%	121
Neurosurgery	8.9	10.1	8.9	8.2	9.3	10.5	8.8	10.3	9.1	8.1	8.5	8.0	8.8	9.1	8.8	-3.2%	202
Neurology	30.0	28.8	24.2	28.7	34.3	31.0	32.4	33.3	32.1	31.9	27.8	30.5	31.5	26.1	31.4	20.1%	725
Oncology	1.8	1.2	1.5	2.8	2.7	1.8	4.0	3.4	3.6	3.8	4.1	4.1	4.2	1.7	3.9	122.8%	97
Paediatric Medicine	12.0	10.3	10.9	10.5	12.5	11.9	12.9	12.3	12.6	11.2	10.5	13.0	10.9	10.0	11.9	19.5%	251
Paediatric Surgery	9.2	10.7	8.4	9.6	10.0	10.0	8.9	10.3	8.2	8.9	9.0	8.4	8.6	8.7	8.9	2.2%	198
Pain Clinic	5.3	6.2	5.2	5.1	5.3	5.3	4.5	3.1	5.2	3.3	2.3	4.9	3.8	5.2	3.9	-25.6%	88
Plastic Surgery	17.1	18.3	15.9	17.1	17.4	16.5	15.0	19.3	18.5	15.1	16.6	17.5	15.7	17.8	16.8	-5.7%	361
Renal Medicine	4.7	3.8	4.4	3.2	5.2	3.7	4.3	6.5	5.1	4.3	5.5	5.2	6.2	5.2	5.3	2.3%	142
Trauma & Orthopaedics	6.4	8.5	6.0	7.7	8.5	6.4	7.3	8.0	9.2	6.0	6.1	6.0	5.0	6.9	6.8	-1.5%	116
Urology	14.5	14.0	12.9	13.4	14.8	13.2	15.8	13.0	13.7	14.1	12.6	15.8	12.9	12.7	14.0	10.5%	297
Thoracic Surgery	2.5	2.9	2.7	2.3	3.2	3.1	2.2	3.0	3.3	2.9	3.2	3.0	2.3	2.8	2.8	0.7%	54
Vascular Surgery	5.1	4.6	4.3	5.1	3.9	4.4	4.4	4.8	4.1	4.5	3.7	5.2	3.7	4.9	4.3	-12.4%	85
Other	5.3	5.6	5.5	6.5	6.6	4.2	7.5	7.4	8.6	9.3	9.4	11.2	13.7	5.7	9.6	69.7%	316
Grand Total	**231.9**	**240.6**	**209.4**	**233.1**	**246.3**	**239.4**	**232.3**	**253.7**	**256.7**	**237.8**	**226.0**	**246.9**	**235.9**	**228.3**	**241.3**	**5.7%**	**5,426**

Productivity Tables

Percentage of Daycase Activity

Months	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	2018-19 YTD	2019-20 YTD	Variance
Cardiology & Cardiac Surgery	54%	56%	50%	51%	54%	54%	50%	49%	49%	50%	50%	56%	55%	53%	51%	-1.1%
Clinical Haematology	69%	50%	51%	57%	77%	45%	27%	17%	43%	52%	52%	0%	13%	66%	29%	-36.8%
Diabetes & Endocrinology	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	-0.4%
Endoscopy & Gen Med	99%	99%	99%	99%	99%	98%	99%	97%	98%	97%	96%	97%	97%	99%	97%	-1.3%
Ear, Nose & Throat	40%	49%	31%	43%	39%	28%	39%	49%	37%	51%	42%	45%	45%	46%	44%	-2.0%
General Surgery	41%	42%	30%	52%	51%	31%	42%	40%	36%	42%	42%	43%	52%	49%	43%	-6.2%
Gynaecology and Obstetrics	75%	76%	76%	75%	73%	74%	72%	72%	69%	68%	70%	76%	73%	74%	72%	-2.1%
Max Fax & Dental	49%	57%	51%	63%	55%	57%	56%	62%	62%	58%	52%	57%	55%	56%	57%	1.7%
Neurosurgery	35%	34%	32%	34%	30%	31%	26%	31%	28%	33%	32%	30%	21%	35%	29%	-6.1%
Neurology	95%	96%	96%	94%	95%	95%	96%	96%	95%	96%	95%	96%	97%	94%	96%	1.7%
Oncology	56%	63%	62%	79%	76%	65%	82%	79%	82%	82%	81%	67%	87%	57%	80%	23.5%
Paediatric Medicine	94%	93%	98%	94%	96%	94%	95%	96%	96%	98%	95%	94%	97%	90%	96%	6.1%
Paediatric Surgery	85%	88%	84%	84%	81%	84%	80%	85%	77%	80%	79%	85%	80%	80%	81%	0.4%
Pain Clinic	92%	93%	94%	91%	93%	100%	92%	88%	92%	92%	100%	92%	99%	92%	94%	1.3%
Plastic Surgery	81%	79%	81%	78%	80%	75%	79%	79%	83%	85%	81%	85%	81%	78%	82%	3.4%
Renal Medicine	81%	75%	81%	81%	81%	73%	77%	81%	84%	72%	73%	75%	67%	78%	75%	-3.0%
Trauma & Orthopaedics	63%	63%	60%	75%	71%	72%	63%	61%	69%	68%	66%	75%	78%	65%	69%	3.6%
Urology	54%	56%	55%	56%	52%	47%	58%	51%	50%	61%	54%	58%	52%	51%	55%	4.2%
Thoracic Surgery	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%	0%	0%	2%	0%	-1.9%
Vascular Surgery	50.4%	50.5%	61.0%	52.7%	52.6%	48.9%	43%	52.5%	48%	48%	31%	57%	42%	42%	46%	3.7%
Other	89%	85%	84%	92%	93%	84%	77%	76%	79%	86.9%	75%	74%	84%	90%	79%	-11.0%
Grand Total	**77%**	**77%**	**75%**	**78%**	**77%**	**75%**	**77%**	**78%**	**77%**	**79%**	**76%**	**78%**	**78%**	**76%**	**77%**	**1.5%**

Productivity Tables

Theatre Utilisation

Main List Specialty	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Number of Patients in the last month
Cardiothoracic	70%	73%	72%	72%	80%	74%	70%	70%	75%	70%	73%	75%	71%	75
ENT	77%	82%	78%	80%	76%	74%	75%	78%	72%	73%	82%	82%	75%	166
General Surgery	80%	82%	84%	78%	78%	82%	81%	80%	88%	80%	72%	76%	79%	129
Gynaecology	83%	87%	81%	79%	88%	74%	81%	71%	78%	84%	81%	84%	85%	144
Neurosurgery	76%	81%	80%	82%	78%	75%	79%	78%	78%	79%	79%	81%	76%	180
Oral and Maxillo Facial Surgery	63%	84%	78%	84%	67%	91%	61%	72%	84%	87%	67%	65%	84%	33
Paediatric Dentistry	56%	60%	62%	65%	68%	65%	58%	80%	64%	59%	74%	68%	48%	23
Paediatric Surgery	74%	72%	75%	76%	82%	74%	77%	79%	79%	80%	78%	80%	77%	116
Plastic Surgery	77%	74%	78%	74%	75%	69%	76%	87%	72%	74%	74%	69%	74%	159
Renal Medicine & Surgery	67%	82%	60%	66%	67%	83%	66%	88%	69%	79%	77%	77%	67%	20
Trauma & Orthopaedics	90%	85%	90%	81%	83%	90%	83%	81%	84%	88%	84%	74%	78%	103
Urology	85%	86%	81%	86%	82%	80%	79%	78%	79%	82%	77%	79%	78%	215
Vascular Surgery	76%	70%	74%	76%	82%	75%	68%	73%	74%	72%	67%	75%	73%	86
Grand Total	**79%**	**80%**	**80%**	**79%**	**79%**	**77%**	**77%**	**77%**	**78%**	**78%**	**77%**	**77%**	**76%**	**1,449**

Theatre Average Cases per Session

Main List Specialty	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Cardiothoracic	1.4	1.5	1.5	1.5	1.7	1.4	1.5	1.6	1.6	1.6	1.6	1.6	1.3
ENT	1.7	1.7	1.6	1.9	1.6	1.6	1.7	1.9	1.9	1.8	2.0	2.0	1.9
General Surgery	1.8	1.7	1.6	1.8	1.7	1.6	1.8	1.8	1.6	1.5	1.7	1.4	1.4
Gynaecology	2.6	2.5	2.9	2.7	2.6	2.3	2.5	2.2	2.4	2.5	2.4	2.7	2.6
Neurosurgery	1.0	1.1	1.2	1.1	1.0	1.1	1.1	1.1	1.1	1.1	1.1	0.9	1.0
Oral and Maxillo Facial Surgery	3.1	3.8	3.8	3.7	3.1	4.0	2.7	3.1	3.4	3.2	3.0	3.0	3.6
Paediatric Dentistry	3.9	4.5	4.7	4.4	4.3	4.1	3.9	4.9	4.2	3.8	3.8	3.8	2.8
Paediatric Surgery	2.6	2.7	2.7	2.6	2.5	2.6	2.4	2.7	2.2	2.5	2.2	2.8	2.5
Plastic Surgery	2.1	2.0	2.0	1.9	2.0	2.1	1.8	1.8	1.7	1.8	2.0	1.9	1.6
Renal Medicine & Surgery	1.6	1.5	1.4	1.2	1.8	1.5	1.9	2.0	1.2	1.1	1.0	1.4	1.3
Trauma & Orthopaedics	1.9	1.9	1.8	1.9	1.9	1.9	1.8	1.8	2.0	1.7	1.8	1.7	1.7
Urology	2.1	2.0	2.1	2.0	2.0	2.0	2.0	2.1	2.1	2.1	1.8	1.9	1.9
Vascular Surgery	1.1	1.1	1.1	1.0	1.0	1.1	1.0	1.1	1.4	1.4	1.3	1.5	1.3
Grand Total	1.8	1.8	1.8	1.8	1.8	1.7	1.7	1.8	1.8	1.8	1.7	1.7	1.6

Productivity Tables

Elective Length of Stay

Directorate	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Discharges in the last month	Average length of Stay 2018-19 YTD	Average length of Stay 2019-20 YTD	Variance
Cardiothoracic	3.8	3.3	3.7	3.5	4.2	3.6	3.0	3.5	3.9	3.7	3.6	3.6	3.2	209	4.0	3.5	⇩ -12%
Children's & Women	2.5	2.4	2.1	3.8	2.7	3.0	2.4	1.9	2.0	2.2	1.9	3.8	5.2	115	2.6	2.8	⇧ 7%
Neurosciences	8.0	9.3	10.6	10.2	8.4	5.9	10.1	7.8	6.9	11.1	9.4	8.9	7.4	193	9.0	8.8	⇩ -2%
Surgery & Trauma	3.7	3.5	4.6	4.5	3.9	3.5	2.6	2.5	2.6	2.4	2.9	2.0	2.6	546	3.8	2.5	⇩ -33%
Grand Total	**4.4**	**4.6**	**5.3**	**5.4**	**4.7**	**4.7**	**3.8**	**3.5**	**3.5**	**4.1**	**4.0**	**3.4**	**3.9**	**1,063**	**4.7**	**3.8**	⇩ -20%

Non-Elective Length of Stay

Directorate	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Discharges in the last month	Average length of Stay 2018-19 YTD	Average length of Stay 2019-20 YTD	Variance
Acute Medicine	2.5	2.5	2.7	2.9	2.8	2.8	2.7	2.7	2.5	2.6	2.9	3.0	3.3	2,718	2.7	2.8	⇧ 5.40%
Cardiothoracic	8.8	7.7	8.8	7.6	9.7	11.7	10.2	12.3	9.1	11.2	8.1	10.9	8.5	164	8.6	10.0	⇧ 16%
Children's & Women	2.3	2.4	2.4	2.4	2.9	3.1	3.4	3.6	3.7	3.7	3.2	3.3	3.6	850	2.4	3.5	⇧ 44%
Neurosciences	8.8	9.6	9.8	10.8	13.5	9.3	9.5	11.9	6.8	9.9	10.5	8.6	11.0	227	9.4	9.7	⇧ 4%
Senior Health	7.6	8.7	11.4	12.5	11.1	11.2	12.7	12.6	10.2	12.6	10.6	17.9	19.2	54	9.7	13.7	⇧ 41%
Specialist Medicine	6.4	7.6	7.5	8.3	6.8	8.5	9.5	11.1	11.2	7.9	9.3	9.9	5.8	133	7.3	9.2	⇧ 27%
Surgery & Trauma	4.6	5.1	4.2	5.3	5.0	4.0	4.3	4.2	4.1	4.8	4.1	4.1	4.1	868	4.4	4.2	⇩ -4.6%
Therapeutics	12.0	9.8	21.1	12.3	25.3	11.3	11.0	22.5	23.0	14.1	7.6	12.6	24.4	30	11.2	16.4	⇧ 47%
Grand Total	**3.6**	**3.7**	**3.8**	**4.0**	**4.3**	**4.0**	**4.1**	**4.3**	**3.9**	**4.2**	**4.1**	**4.4**	**4.4**	**5,044**	**3.8**	**4.2**	⇧ 10%

Maternity

Definitions	Format	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Total number of women giving birth (per calendar day)	Number	14 per day	13.0	14.1	13.3	13.6	13.1	12.9	13.6	14.0	13.6	13.2	12.6	13.4	14.4
Caesarean sections (Total Emergency and Elective by Delivery date)	%	<28%	26.8%	27.5%	23.7%	29.2%	28.5%	31.4%	30.4%	25.9%	25.9%	25.9%	25.6%	27.4%	25.7%
% deliveries with Emergency C Section (including no Labour)	%	<8%	4.5%	3.1%	1.9%	4.5%	4.6%	3.7%	4.7%	2.8%	3.2%	3.9%	2.6%	5.2%	4.5%
% Time Carmen Suite closed	%	0%		0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	0.0%	6.7%	0.0%	4.8%	1.7%	19.4%
% of all births in which woman sustained a 3rd or 4th degree tear	%	<5%	2.0%	3.6%	1.5%	2.1%	1.4%	2.0%	1.5%	2.8%	1.2%	1.5%	3.3%	3.5%	3.8%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	%	<4%	2.0%	2.6%	2.7%	2.6%	1.9%	3.0%	2.7%	1.8%	2.0%	3.4%	2.1%	2.0%	2.2%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit	Number		8	9	10	12	6	8	10	9	12	7	6	9	5
Supernumerary Midwife in Labour Ward	%	>95%	95.2%	98.3%	100.0%	98.4%	96.4%	95.2%	96.7%	98.4%	98.3%	100.0%	96.8%	96.7%	96.8%
% women booked by 12 weeks and 6 days	%	90%	78.0%	84.4%	86.2%	84.7%	86.6%	87.3%	83.3%	86.6%	88.4%	85.3%	84.9%	81.5%	81.7%

Mortality and Readmission

Indicator Description	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Jun-19 Dr Foster did not update date for May	Aug 2018 to July 2019
Hospital Standardised Mortality Ratio (HSMR)	86.7	79.5	69.8	80.3	73.0	64.2	76.9	74.5	77.6	78.1	79.4	79.4	91.9	105.5	86.1
Hospital Standardised Mortality Ratio Weekend Emergency	78.2	97.6	79.5	72.2	62.7	82.4	113.3	79.1	74.6	85.2	82.9	82.9	91.3	113	90.4
Hospital Standardised Mortality Ratio Weekday Emergency	87.1	82.5	67.6	78.1	68.4	60.1	64.9	78.2	79.4	74.1	76.3	76.3	91.5	100.4	84.2

Indicator Description	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Summary Hospital Mortality Indicator (SHMI)	0.82	0.82	0.82	0.82	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.81	0.81	0.81
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	8.20%	8.20%	7.0%	8.9%	8.3%	7.6%	8.2%	7.2%	8.2%	7.9%	8.0%	7.0%	8.3%	9.3%

Patient Safety

Indicator Description	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Number of Never Events in Month	0	2	0	0	1	0	0	1	0	0	1	0	0	1
Number of SIs where Medication is a significant factor	0	1	1	0	0	0	0	0	0	0	0	0	0	0
Number of Serious Incidents	=<8 month	5	6	6	6	6	4	3	7	7	2	4	1	3
Serious Incidents - per 1000 bed days	N/A	0.20	0.26	0.26	0.25	0.27	0.16	0.13	0.29	0.30	0.08	0.17	0.04	0.12
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.1%	95.0%	95.6%	95.9%	96.5%	96.0%	96.1%	96.1%	94.6%	95.4%	95.3%	96.0%	96.8%
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.3%	97.7%	97.6%	98.4%	98.6%	98.3%	98.3%	98.9%	98.0%	97.8%	98.7%	98.2%	98.3%
Percentage of patients who have a VTE risk assessment	95%	96.0%	96.2%	95.5%	95.9%	95.7%	95.5%	87.8%	88.2%	87.6%	93.8%	93.8%	93.9%	94.0%
Number of Patient Falls	N/A	181	173	148	128	147	135	143	135	133	123	158	142	131
Falls (Moderate and Above Severity)	N/A	1	3	1	3	1	2	2	2	1	0	3	0	2
Number of patient falls- per 1000 bed days	N/A	7.40	7.50	6.32	5.31	6.57	5.38	6.08	5.63	5.75	4.99	6.58	6.03	5.25
Acquired Category 2 Pressure Ulcers	N/A	12	25	13	10	16	6	4	17	20	10	15	15	13
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.49	1.08	0.56	0.42	0.72	0.24	0.17	0.71	0.86	0.41	0.63	0.64	0.52
Acquired Category 3 Pressure Ulcers		1	3	7	7	4	11	8	5	8	8	2	3	3
Acquired Category 3 Pressure Ulcers per 1000 bed days		0.04	0.13	0.30	0.29	0.18	0.44	0.34	0.21	0.35	0.32	0.08	0.13	0.12
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Complaints

Indicator Description	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Complaints Received		90	88	78	92	84	101	108	102	96	96	88	81	88
% of Complaints responses to within 25 working days	85%	76%	75%	78%	66%	55%	80%	72%	79%	78%	95%	100%	100%	100%
% of Complaints responses to within 40 working days	95%	60%	63%	48%	30%	64%	44%	56%	46%	57%	72%	96%	100%	100%
% of Complaints responses to within 60 working days	95%	100%	None Due	None Due	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PALS Received		416	353	252	369	334	280	249	247	218	177	259	232	316

Patient Priorities

Indicator Description	Threshold/Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Number of 2222 calls / 1000 adult ordinary IP admissions		9.8	9.4	11.3	11.0	11.1	8.8	7.1	8.9	10.2	12.3	8.6	7.8	7.8
Number of Cardiac Arrests / 1000 adult ordinary IP admissions (to become avoidable cardiac arrests)		0.7	3.4	2.6	3.8	3.3	2.8	4.0	2.8	1.8	3.6	0.9	1.8	1.2
% of patients in ED with Red Flag sepsis receiving antibiotics within an hour (adults)	90%	91.4%	95.3%	93.5%	94.5%	93.2%	88.3%	90.6%	91.4%	93.5%	87.2%	83.4%	90.3%	86.4%
Compliance with appropriate response to EWS (adults)	100%	92.4%	92.0%	93.3%	95.8%	87.3%	89.6%	92.7%	94.2%	92.9%	90.6%	93.9%	87.6%	86.8%
Resuscitation BLS	85%	70.5%	70.3%	69.8%	70.5%	71.5%	74.1%	76.2%	75.2%	76.0%	75.5%	75.9%	76.4%	77.8%
Resuscitation ILS	85%	64.3%	66.3%	68.5%	70.2%	69.3%	71.3%	72.1%	72.7%	72.0%	72.5%	69.2%	67.9%	67.7%
Resuscitation ALS	85%	27.1%	40.4%	51.2%	64.2%	67.0%	70.4%	72.7%	73.0%	73.5%	74.8%	59.1%	62.7%	64.4%

Indicator Description	Threshold/Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	79.5%	80.8%	83.4%	83.9%	86.3%	88.6%	89.8%	91.8%	90.8%	92.2%	92.1%	90.5%	89.6%
Mental Capacity Act & Deprivation of Liberties - Level 2	85%				21.7%	32.2%	42.0%	53.2%	62.9%	70.9%	74.3%	73.0%	72.7%	72.2%
%-age Staff knowledge of Mental Capacity Act - Fully Compliant							76.7%	100.0%	85.0%	75.0%	76.9%	100.0%	90.5%	94.7%
Staff knowledge of Mental Capacity Act - Number of staff interviewed							30	15	20	12	13	8	21	19
Total Datix incidents reported in month		1,345	1,366	1,174	1,333	1,215	1,208	1,096	1,329	1,332	1,413	1,544	1,463	1,459
Monthly % of incidents low and no harm								Delayed Not yet available						
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%							100.0%	92.0%	100.0%	97.0%	93.0%	data two months in arrears	
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above	100%	64%	66%	78%	67%	62%	Compliance timeframe changed from 10 working days to 20 working days							

Emergency Flow

Indicator Description	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
4 Hour Operating Standard	95%	90.1%	85.5%	85.6%	84.2%	82.2%	83.1%	85.4%	86.5%	87.0%	86.4%	83.3%	82.3%	83.2%
Patients Waiting in ED for over 12 hours following DTA	0	0	1	2	0	0	1	1	0	1	2	3	1	4
Admitted patients with a length of stay 7 Days or Greater		287	294	291	315	321	315	298	301	290	314	302	315	320
Ambulance Handover - % under 15 minutes	100%	42.5%	37.4%	37.0%	33.9%	33.0%	33.0%	35.1%	35.2%	36.0%	32.9%	32.4%	31.1%	31.3%
Ambulance Handover - % under 15 minutes (London Average)	100%	47.4%	46.5%	44.7%	41.6%	43.1%	45.4%	43.5%	44.4%	42.3%	43.9%	45.0%	44.7%	41.7%
Ambulance Handover - number of patients not handed over within 30 minutes	0	111	138	135	145	87	94	76	112	119	134	171	163	176
Ambulance Handover - % under 30 minutes	100%	94.5%	93.0%	93.6%	92.3%	95.1%	93.6%	95.5%	94.3%	93.5%	92.9%	90.8%	90.8%	90.2%
Ambulance Handover - % under 30 minutes (London Average)	100%	92.2%	91.5%	90.5%	88.2%	90.3%	92.7%	91.7%	92.2%	90.6%	92.4%	92.3%	92.0%	89.6%
Ambulance Handover - number over 60 minutes	0	0	3	1	13	6	8	6	0	4	2	1	4	11

Diagnostics

Indicator Description	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
6 Week Diagnostic Performance	1%	0.2%	0.5%	0.6%	0.5%	0.3%	0.5%	1.6%	0.7%	0.4%	0.95%	0.96%	0.92%	3.32%
6 Week Diagnostic Breaches	N/A	18	39	37	41	24	40	115	59	31	74	74	75	300
6 Week Diagnostic Waiting List Size	N/A	7,593	7,322	6,652	7,649	7,754	7,622	7,247	8,274	7,992	7,772	7,737	8,153	9,025

Indicator Description	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
MRI	1%	0.2%	0.3%	0.6%	0.4%	0.6%	0.1%	0.3%	0.3%	0.0%	0.0%	0.0%	0.1%	0.0%
CT	1%	0.2%	0.1%	0.7%	0.6%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Non Obstetric Ultrasound	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	1.0%	0.1%	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%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Audiology Assessments	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Echocardiography	1%	0.0%	0.0%	0.0%	0.8%	0.4%	4.3%	12.1%	4.2%	1.0%	9.0%	4.7%	7.3%	36.1%
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%	20.0%
Peripheral Neurophysiology	1%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.3%	0.5%
Sleep Studies	1%	0.0%	7.7%	2.4%	1.1%	0.8%	2.7%	4.6%	4.8%	1.4%	1.0%	0.9%	4.0%	3.0%
Urodynamics	1%	14.6%	10.2%	8.5%	16.3%	14.0%	0.0%	5.7%	0.0%	0.0%	2.9%	4.9%	0.0%	9.5%
Colonoscopy	1%	0.7%	3.0%	0.0%	2.9%	1.0%	0.0%	1.0%	0.6%	0.6%	0.9%	0.3%	0.4%	1.8%
Flexi Sigmoidoscopy	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	0.6%	2.0%	1.4%	1.9%	3.0%
Cystoscopy	1%	3.0%	4.5%	5.4%	3.2%	0.0%	1.9%	3.2%	6.4%	2.6%	3.0%	2.6%	0.0%	3.0%
Gastroscopy	1%	0.0%	0.0%	0.6%	1.4%	0.6%	1.8%	2.1%	2.3%	3.1%	3.7%	2.8%	1.6%	3.0%

Data tables

On the Day Cancellations

Indicator Description	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Number of on the Day Cancellations		52	53	60	86	73	49	45	69	69	54	38	46	53
Number of on the Day cancellations re-booked within 28 Days		50	52	58	86	71	47	42	68	69	54	38	45	52
% of Patients re-booked within 28 Days	100%	96.2%	98.1%	96.7%	100.0%	97.3%	95.9%	93.3%	98.6%	100.0%	100.0%	100.0%	97.8%	98.1%

Cancer

Indicator Description	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	No of Patients
Cancer 14 Day Standard	93%	95.5%	96.3%	95.9%	96.6%	94.4%	93.3%	94.4%	92.4%	90.2%	92.5%	95.6%	95.4%	93.8%	1,514
Cancer 14 Day Standard Breast Symptomatic	93%	97.9%	97.1%	95.4%	96.9%	97.4%	94.6%	94.7%	94.4%	94.9%	93.2%	94.9%	93.0%	94.3%	194
Cancer 31 Day Diagnosis to Treatment	96%	99.0%	99.1%	96.5%	98.2%	97.4%	98.4%	98.1%	96.2%	96.9%	96.0%	97.0%	98.5%	97.4%	189
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	100.0%	96.9%	96.6%	94.6%	97.9%	94.4%	96.2%	100.0%	95.7%	96.7%	100.0%	100.0%	100.0%	32
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90
Cancer 62 Day Referral to Treatment Standard	85%	80.6%	87.8%	88.1%	94.8%	86.2%	77.8%	85.0%	75.6%	71.4%	85.8%	92.7%	87.1%	87.6%	68.5
Cancer 62 Day Referral to Treatment Screening	90%	94.1%	91.8%	93.2%	82.0%	88.7%	70.5%	76.6%	87.7%	96.5%	93.8%	97.4%	100.0%	100.0%	24

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2.3

Meeting Title:	Trust Board		
Date:	28 November 2019	**Agenda No**	2.3
Report Title:	Emergency Care Update: Recovery actions being taken through the Trust's Emergency Care Delivery Board		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Ellis Pullinger, Chief Operating Officer		
Presented for:	Note		
Executive Summary:	The Trust continues to experience significant pressure in its performance against the emergency care four hour standard in October (the reporting month for this Board meeting) and into November to date. Of note is that the Trust reported an 8% gap between its October performance trajectory of 91.3% and its delivered performance of 83.25%. This paper provides an update to Board on specific actions that the Trust's internal Emergency Care Delivery Board (ECDB) is doing right now to get performance back to its month by month trajectory as the required expectation. For clarity, the Trust's trajectory for December 2019 is 87%. In this context, the Board has asked to see how specific recovery actions will translate to a 4% improvement (assuming a current run rate of circa 83% as taken across the September and October reported months' against the four hour standard). The Finance and Investment Committee will review the full action plan from the weekly St George's Emergency Care Delivery Board, and received the first such report at its November meeting. As a result, this paper will deliberately highlight for the Board the key priority actions that will support emergency care flow in the short term. The Finance and Investment Committee has also asked to receive a separate report on how the Trust has responded to each of the recommendations from the September and October 2019 Emergency Care Improvement Support Team (ECIST) report. This paper, by definition, is very focussed on performance improvement. As a result it refers to actions that are designed to improve patient flow and, in turn, percentage improvements against the standard. It is important to make the point that this is ultimately about patient care and making the explicit link that this performance standard is an evidenced quality measure.		
Recommendation:	The Board is asked to note this report and the priority actions of the Emergency Care Delivery Board (ECDB) to deliver the Trust's four hour internal trajectory for December 2019.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person. Right care, right place, right time.		
CQC Theme:	Safe, Effective, Responsive, Well-led		
Single Oversight Framework Theme:	Operational Performance, Leadership and Improvement, Quality of Care		
Implications			
Risk:	Emergency Care Performance is on the Divisional risk register		
Legal/Regulatory:	NHS Operating Standard		
Resources:	N/A		
Previously Considered by:	Finance and Investment Committee	**Date**	21.11.19
Appendices:	N/A		

Emergency Care Update
Trust Board, 28 November 2019

1.0 PURPOSE

1.1 This paper provides an update to Board on specific actions that the Trust's internal Emergency Care Delivery Board (ECDB) is doing right now to get performance back to its month by month trajectory as the required expectation. For clarity, the Trust's trajectory for December 2019 is 87%. In this context, the Board has asked to see how specific recovery actions will translate to a 4% improvement (assuming a current run rate of circa 83% as taken across the September and October reported months' against the four hour standard).

2.0 CONTEXT

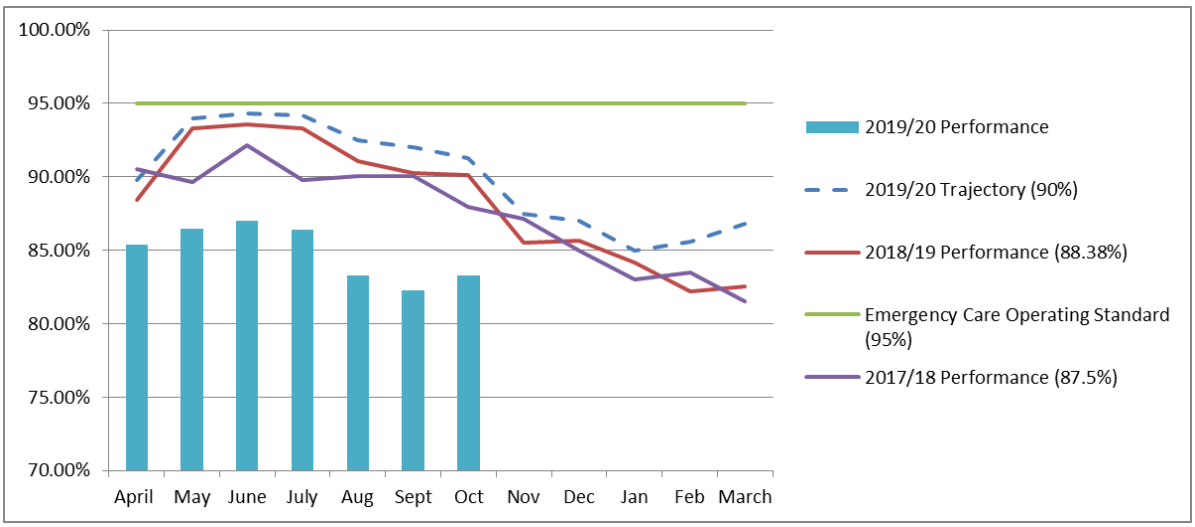
2.1 The Trust continues to experience significant pressure in its performance against the emergency care four hour standard in October (the reporting month for this Board meeting) and into November to date. Of note is that the Trust reported an 8% gap between its October performance trajectory of 91.3% and its delivered performance of 83.25%.

2.2 Performance for 2019/20 year to date is at 84.50% (as of the 17th November 2019)

- Admitted performance is running at circa 57% against the Trust trajectory of 80% year to date.
- Non-admitted performance is running at circa 81% against the Trust trajectory (and national requirement) of 98% year to date.

The chart (Fig1) below outlines current performance against the Trust trajectory as at the end of October 2019.

Fig 1. Emergency Care Performance against Trust Trajectory for the Four Hour Emergency Care Standard 2019/20



Emergency Care Performance year on year

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
2019/20 Trajectory (90%)	89.80%	94.00%	94.30%	94.20%	92.50%	92.00%	91.30%	87.50%	87.00%	85.00%	85.60%	86.80%
2019/20 Performance	85.36%	86.48%	87.00%	86.37%	83.30%	82.29%	83.25%					
2018/19 Performance (88.38%)	88.41%	93.31%	93.59%	93.28%	91.09%	90.26%	90.11%	85.49%	85.64%	84.15%	82.23%	82.51%
Admitted Performance	56.82%	61.77%	56.63%	55.74%	49.87%	51.30%	50.48%					
Non-Admitted Performance	88.98%	88.51%	90.71%	89.50%	87.08%	85.43%	86.94%					
Emergency Care Operating Standard (95%)	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
2017/18 Performance (87.5%)	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	87.97%	87.17%	84.99%	83.02%	83.52%	81.50%

3.0 ACTIONS

3.1 The first objective is to close the gap on current levels of four hour operating performance versus the agreed Trust trajectory. For December 2019 this equates to a 4% improvement in performance (working on the current baseline of 83%) to a figure of 87%. To put this objective into context, it is important to draw the Board's attention to the latest London position for the week ending the 17th November 2019. In this report, only three out the sixteen reporting London Trusts' delivered over 85% in this one week snapshot. However, while accepting the pressure felt across the London system, the Board is reminded that in December 2017 and 2018 the Trust delivered 85% so we have the ability to improve and, indeed, do better for our patients.

3.2 The overview of priority, targeted actions from the work of the weekly St George's ECDB to deliver this improvement in the Trust trajectory are listed below. This is not the exhaustive list of the work underway – it is written to draw the Board's attention to the key actions only that can make an impact in the short term. Where appropriate, please also note that each action is consistent with the highest priority recommendations from the recent ECIST.

- **Patient Flow through the Trust (Access/Discharge)**
  Objective: Stretch target of 3% improvement in the December 2019 Four Hour Operating Performance standard. There are two priority actions to support the delivery of this objective:

  1. Reduction in patients with a length of stay over 21 days
  The Trust is running at a mean of 140 patients with a length of stay of over 21 days. This equates to 17% of the total general and adult bed stock of the Trust. Each 1% reduction in the percentage of patients that are 21 days or longer, gives a 0.6% Type 1 performance improvement. This ECDB workstream will target a reduction of 40 patients in this cohort (i.e. delivering on the existing commitment to return the Trust's ambition of having no more than 100 such patients at any one time. One of the key step changes in this action (as of w/c 18th November) has been to invite both Wandsworth and Social Service teams into the established Trust long length of stay meetings (starting with the Medicine Division) in order to prioritise (and predict) appropriate system wide actions for each patient. This additional management support from our local Social Services partners is mirrored by increased Trust clinical and operational management presence in this meeting.

The Trust's SPC chart analysis shows that a mean reduction of 40 patients waiting over 21 days would support an improvement of type 1 performance of 5%. Therefore if the action plan brings the Trust back to the ambition level of no more than 100 patients, the overall Trust performance (all other things being equal) could improve by 3%.

2. Perfect Site Operations Process Week

The perfect process week will be undertaken in the w/c 25th November. ECIST recommend that site operations meetings should be more action focused with clear action owners and timescales allocated to actions. This will target specific 'push and pull' patient flow actions. Emergency Department (ED) Escalation Policy (to be read in conjunction with the Trust's Full Capacity Protocol). ECIST recommended a redefinition of the roles and responsibilities of the ED Consultant and Nurse in charge plus getting back to the basics of holding (consistently) two hourly safety huddles in the ED department. Other actions from this escalation policy will be trialled as part of the perfect site process week.

- **Emergency Care Processes (including Urgent Care Waits and Direct Access to Ambulatory Units)**

  Objective: Target of 1% improvement in the December 2019 Four Hour Operating Performance standard (potential for up to 3% improvement in future months). There are two priority actions to support the delivery of this objective:

1. Reducing crowding in ED

   The ECDB actions on the Urgent Care Centre (UCC) part of ED, plus the implementation of the interprofessional standards of clinical care are focused on reducing 'crowding' and improving the patient experience in the department. For the Board's benefit, examples of what is included in this workstream include the redirection of GP accepted work from ED to the medical and surgical ambulatory units within the Trust plus the introduction of senior decision making in the first assessment of patients entering ED. The NHS Econometrics work tells each Trust that:

   a) adding one more patient in the ED queue increases the probability of breaching the standard by 0.25%.
   b) the actions on UCC and on the interprofessional standards is a commitment to return to having no more than 70 patients in the department at any one time during the 11am to 10pm time period
   c) The Trust is currently averaging circa 80 patients during this time period. A return to running at an average of no more than 70 patients could bring a potential full benefit of a further 2.5% improvement in performance. At this stage, the objective is to aim for this workstream to contribute a proportion of the 1% improvement in December.

2. Optimal medical staffing rota management in ED

   This is an ECDB workstream and is one of the highest priority recommendations from ECIST. The analysis from NHS Econometrics work tells acute providers:

   A 10% increase in the proportion of actual medical workforce compared to planned medical workforce decreases the probability of breaching the four hour standard by 1%. The ECDB Trust workstream to change the rotas / review staffing model is a commitment to align doctor capacity to ED demand.

The newly appointed Clinical Director for ED is leading on this piece of work in conjunction with Medical Staffing to ensure any rota changes are enacted appropriately and in line with both contractual and working time directives.

Mental Health (ED presentations)

Objective: Target of 0.5% improvement in the December 2019 Four Hour Operating Performance standard.

The Trust sees around 4 patients per day who are referred to mental health services who breach the four hour standard. The ECDB workstream actions for mental health is a commitment to half this number and, if successful, would give a 0.5% performance improvement overall. The Board is asked to note that based on current levels of performance, this opportunity would be seen as an upside to the 4% improvement in the December trajectory (and as referenced in the first two priority workstreams already referenced in this paper.)

4.0 IMPLICATIONS

Risks

4.1 Performance against the Four Hour Operating standard is an established Trust risk

Legal Regulatory

4.2 NHS constitutional standard

Resources

4.3 N/A

Equality & Diversity

4.4 N/A

5.0 NEXT STEPS

5.1 The Trust Executive and Finance and Investment Committee to receive a report on progress with each of the ECIST recommendations in Q.4 2019/20

6.0 RECOMMENDATION

6.1 The Board is asked to note this report and the priority actions of the Emergency Care Delivery Board (ECDB) to deliver the Trust's four hour internal trajectory for December 2019.

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2.4

Meeting Title:	Trust Board		
Date:	28 November 2019	**Agenda No**	**2.4**
Report Title:	Cardiac Surgery Service Update		
Lead Director/ Manager:	Richard Jennings, Chief Medical Officer		
Report Author:	Phil Lunn, Interim General Manager - Specialist Medicine and Cardiac, Vascular & Thoracic Surgery		
Presented for:	Assurance		
Executive Summary:	This report provides an update to the Board on the sources of assurance, internal and external, regarding the safety of the Cardiac Surgery Service and the on-going steps being taken to improve quality within the Service, following the National Institute for Cardiovascular Outcomes Research (NICOR) safety alerts in June 2017 and April 2018 and the findings of the independent report by Professor Bewick (July 2018). This report focuses particularly on the update on the actions taken in response to the recommendations of the Bewick Report (July 2018).		
Recommendation:	The Board is asked to discuss and take assurance from the update on progress and key performance indicators in Cardiac Surgery, and the update on the action plan arising from the Bewick Report. The report was also considered by the Quality & Safety Committee on 21 November 2019.		
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:	National Adult Cardiac Surgery Audit (NACSA) outcomes data, as published by National Institute for Cardiovascular Outcomes Research (NICOR).		
Equality and Diversity:	N/A		
Previously Considered by:	Quality & Safety Committee	**Date**	21/11/2019
Appendices:	Appendix 1: Update on progress against the Bewick Report Recommendations (July 2018)		

CARDIAC SURGERY SERVICE UPDATE

1.0 PURPOSE

1.1 To provide an update to the Board on the progress being made with Cardiac Surgery since the paper received by the Board in October 2019.

2.0 BACKGROUND

2.1 This report provides an update to the Board on the sources of assurance, internal and external, regarding the safety of the Cardiac Surgery Service and the on-going steps being taken to improve quality within the Service, following the National Institute for Cardiovascular Outcomes Research (NICOR) safety alerts in June 2017 and April 2018 and the findings of the independent report by Professor Bewick (July 2018).

3.0 SAFETY UPDATE

3.1 Internal assurance: Cardiac Surgery monthly dashboard summary

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

In accordance with the Trust's Standard Operating Procedure for post-operative deaths in Cardiac Surgery all deaths are being considered at the Trust's Serious Incident Declaration Meeting (SIDM). Also in accordance with the Trust's Standard Operating Procedure, all decision making by the SIDM and investigations relating to post-operative deaths within Cardiac Surgery are independently reviewed by an independent Cardiac Surgery expert at another Trust in South London.

4.0 EXTERNAL GOVERNANCE: UPDATE

The Trust continues to meet regularly with NHSE/I and the CQC and other regional and local stakeholders to provide assurance on the safety of the service and the improvements being made.

5.0 EXTERNAL MORTALITY REVIEW

The External Mortality Review commissioned by NHS E/I is continuing its work, and the panel will publish its final report once complete.

6.0 RISK REGISTER

Since the last Board paper there has been no change in the Cardiac Surgery Risk Ratings.

8.0 UPDATE ON PROGRESS AGAINST THE BEWICK REPORT RECOMMENDATIONS

The Bewick Report recommendations (July 2018) and an updated position against these actions is set out in Appendix 1.

9.0 RECOMMENDATIONS

The Board is asked to discuss and take assurance from the update on progress and key performance indicators in Cardiac Surgery, and the update on the action plan arising from the Bewick Report.

Appendix 1: Update of actions taken in response to the Bewick Report Recommendations (July 2018)

	Recommendation	Update
1	The current consultant cardiac surgical team membership is incompatible and requires restructuring with some urgency.	See update under Recommendation 2 and 4.
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.	Cardiac Surgery now has sufficient capacity to run a "Consultant of the Week" system, an appropriate on-call rota, to populate a theatre template of 10 all day lists, give all surgeons adequate access to theatre and allows for subspecialisation. These changes are now all in place. There are two mitral surgeons and two surgeons doing major aortic surgery.
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.	See update under Recommendation 2 and 4.
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.	Mr Steve Livesey was appointed as Associate Medical Director (AMD) for Cardiac Surgery and Consultant Cardiac Surgeon in December 2018. This was initially a secondment, but Mr Livesey joined the Trust full-time in May 2019. Mr Livesey is a senior surgeon having been a Consultant in Southampton for 30 years and is an internationally respected mitral surgeon.
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.	The immediate requirement to produce a succession plan was appropriate at the point prior to which Mr Livesey was appointed to his current role. Mr Livesey has since been appointed as clinical lead for the service (and Associate Medical Director) on a permanent basis, so removing the need to succession plan in the short—medium term.

	Recommendation	Update
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.	We are continuing to work with neighbouring Trusts to identify training opportunities for junior doctors. We also remain in close contact with Health Education England.
7	Pathway leadership role. To complement the role of CGL which concentrates on the operational and governance issues of the unit a new role supporting development of a 'total pathway of care' model, encouraging multi-speciality team working across pre-, peri-and post-operative care. We see this as an essential step in promoting more critical analysis and safer care for all patients, but particularly those in 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.	The AMD for Cardiac Surgery currently provides dedicated pathway leadership. The introduction of the "Consultant of the Week" system has seen significant improvements -– having one consultant working across Cardiothoracic ICU (CTITU) and the wards, reviewing every patient twice a day has ensured smooth and efficient communication between intensivists and surgeons. On being transferred from CTICU to the ward, patients are currently reviewed by a CTICU nurse to ensure appropriate progress. The Trust has prioritised investment in a new critical care outreach team, which will go live in December 2019. This will similarly improve pathways and communication between the ward and CTICU. The Trust has also appointed a Case Management Team comprising five highly experienced nurses. They manage the pre-operative pathways ensuring that elective patients have an appropriate, timely and efficient work up prior to surgery. They also manage the urgent, inter-hospital transfer pathway with the "Consultant of the Week" to ensure efficient and timely transfer of patients requiring urgent surgery. They bring both these pathways together by co-ordinating the planning of operating lists. All patients are discussed at the daily MDT; this is co-ordinated by the Case Management Team.
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.	The unit does not have surgeons with mixed cardiac and thoracic practice any longer. This change was made immediately after receiving the Bewick report in July 2018 – and has remained established practice since then.
9	Sustainability of the unit. Develop senior ambassadorial roles. The cardiac surgery service is under considerable scrutiny and suffering reputational harm. The most senior clinicians (and new leaders as they	The AMD has taken on the ambassadorial role and visited all units which refer patients to St George's. The Clinical Governance Lead is able to deputise as required. The St George's unit is currently operating on approximately 750 patients per annum – and our hope and expectation is that this number will rise

	Recommendation	Update
	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.	as the unit continues to stabilise.
10	Unit project manager, to support the expansion of consultant numbers and to develop a unit strategy the Trust should employ suitable project support.	The Trust supports this proposal and has appointed a Cardiac Surgery Project Manager to co-ordinate all the projects which have been set up to improve the cardiac surgery service at St George's.
11	Cardiac institute. There is already cooperation between cardiologists and vascular surgeons across South London. There has been some reluctance to include cardiac surgery into the process. This should be revisited and, supported by lead clinicians and an executive director sponsor, lines of communication opened up with GST to commence meaningful negotiations.	The three Trusts in South London that provide a cardiac surgery service (SGUH, GSST and KCH) are in the early stages of discussion about ways in which they may work more closely together in the future.
12	Technical advice to improve patient safety. The report gave practical steps to assist surgical and associated specialities in improving clinical outcomes around the following areas listed below (12a-f).	
a	Minimising 'return to theatre'	***i. Make it a standing agenda item for discussion at M&M/audit meetings.*** This action is complete. ***ii. Develop a zero tolerance rule of needing to reopen for bleeding. Meticulous care with haemostasis. It should not just be left to a junior SpR to close chests at the end of operations. It should be supervised by the***

	Recommendation	Update
		consultant, certainly until outcomes are better. This advice has been taken. The resternotomy rate for bleeding is shown in the cardiac surgery dashboard attached. ***iii. Take as long as necessary to secure haemostasis. We detected an underlying pressure to "get on with the next case". This has to be suppressed***. This is accepted and is being actioned. ***iv. Use the thrombo-elastogram routinely to inform need for blood products.*** This is in place routinely. ***v. Timely intervention for recognised post-operative bleeding. Don't sit on blood trickling into the drains. Reopen the chest before the patient becomes haemodynamically compromised and it becomes an emergency*** There is a protocol in place for managing post-operative bleeding. ***vi. Develop a culture of zero tolerance of imperfect surgery.*** The AMD has worked closely with cardiac surgery colleagues to enhance and maintain high standards for procedures undertaken within the unit. ***vii. Re-do surgery is hazardous and is not to be belittled. Low thresholds to CT scan or any other appropriate diagnostic assessment to identify, for example, adherence of right ventricle or aorta to sternum.*** This advice is accepted and is part of the routine practice of the unit.
b	Minimising renal injury	***i. Renal injury after cardiac surgery reflects a period of low cardiac output and/or inadequate perfusion pressure. Blood loss and hypovolaemia is an avoidable cause.*** This advice is accepted. We have a renal risk preoperative assessment protocol in place and a management of low urine output protocol in place on CTICU. ***ii. Myocardial injury during bypass – either inadequate coronary perfusion pressure or inattention to myocardial preservation during aortic cross clamp periods will cause myocardial damage as will unnecessarily long cross clamp periods. A collaborative culture should be developed between***

	Recommendation	Update
		surgeons, anaesthetists and perfusionist's to minimise myocardial injury during surgery. This advice is accepted. Over-reliance on retrograde cardioplegia is understood and warm cardioplegia is no longer used. ***iii. Recognition of low cardiac output/haemodynamic compromise during the postoperative period is important. Optimising a patient's condition at an early stage is important in limiting its occurrence. This requires experienced input at all times. We strongly recommend that the Trust insists on either consultant intensivist rostered presence until 22.30h, or a late evening (e.g. 2200 – 2400h) consultant ward round being factored into consultant intensivist job plans. This would not only improve care for cardiac patients but would also improve the standard of care for other patients in the ICU. For similar reasons I would insist on the availability of a second consultant intensivist to cover busy times of day e.g. the mornings on weekends and public holidays.*** This is in place and plans to recruit more senior "junior staff" to CTICU are in place.
c	Minimising infection	***i. The trust has already made improvements in the frequency of surgical site infections and this is recognised. The input of the infection control team is important in this regard. Meticulous attention to operating theatre discipline, patient education, attention to wound care, removing unnecessary venous cannula or replacing time-expired cannula, and insistence on good hand hygiene are all examples of factors to consider when minimizing SSI. These are all features of a well-run hospital***. The wound infection rate is extremely low. We have not seen a deep sternal wound infection in 2019.
d	Outcome monitoring.	***i. The role and function of the M&M process needs to be more comprehensive. Surgeons (and anaesthetic/intensivists) need to be more engaged in morbidity issues*** The M&M regularly monitors • VLAD plots • unexpected long ITU stay, • unexpected long cross clamp time

	Recommendation	Update
		ii. 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 See response to recommendation 14 below.
e	MDT process	All patients are discussed at the daily MDT. These meetings are minuted and each patient's MDT discussion is stored in the patient's electronic record.
f	Joined up approach to discharge and readmission to ITU	***i. Improve communication on discharge from ITU to ward through improved handover and documentation and use of EMR across the system.*** The Trust has fully rolled out a new electronic patient record system (ICLIP) at both Tooting and Queen Mary's sites. CTICU, cardiology and surgical wards are all using iClip for medical records and prescribing. The discharge policy from CTICU includes phone call to Surgical team. The Nurse in Charge on Benjamin Weir ward continues to review potential discharges on CTICU before they are sent to the ward. ***ii. Improve engagement with surgeons during ITU stay and agree discharge planning toward early.*** The cardiac surgical consultant of the week currently reviews cardiac surgical patients on CTICU daily with the CTICU consultant. This includes a daily discharge planning discussion. The CTICU SpR also carries out a 22.30 ward round with the ICU SpR. ***iii. Avoid inappropriate discharge (e.g. an SI where a patient with no underlying rhythm, sent to ward with temporary pacing wires unknown to the ward staff). Regardless of nursing "failures" on the ward this is not acceptable practice.*** Discharge criteria from ICU have been reviewed and updated as part of ITU SOP review set out below. The SOP now includes underlying rhythm compatible with an adequate Cardiac output.
g	Standard operating policies for theatres to reduce unnecessary and time consuming variation of practice	***i. Improve routine consultant presence during evenings in line with ICS guidelines. Mandate 2 x ward rounds per day by consultants – which there are. For a 21 bedded unit there should either be a planned consultant presence until 10pm in job plans, or there should be a planned late evening ward round done in person by a consultant (this is in the context of many***

	Recommendation	Update
		resident trainees being junior, who may not have adequate experience of cardiac surgery and cardiology problems). There have always been 2 consultant ward rounds per day and this has not changed. Consultant presence meets all required Guidelines for the Provision of Intensive Care Services V2 (GPICS2) criteria and job plans have been altered to include predictable on-call until 21:00 plus 3 hours of unpredictable on-call after this. In the context of the volume and complexity of surgery that was being done, this was considered to be more than adequate. Should volume and complexity increase again, the consultant body will reconsider staying later. The consultant body also recognise the following recommendation in GPICS2 around Consultant staffing "*Rotas for consultants and resident staff must be cognisant of fatigue and the risk of burnout*" ***ii. Specialist input should be requested early in the deteriorating patient e.g. failure to request cardiology to manage a post-op tachy-arrhythmia resulting in an avoidable death.*** Escalation criteria have been reviewed and strengthened and emphasise early escalation to both Cardiothoracic Intensive Care Unit (CTICU) consultant level and external specialist teams. ***iii. Review comprehensively ITU SOP's (P15 of ICU quality report shows risk adjusted mortality to be above average – sailing very close to 2SD line for much of reporting period. – and look at risk adjusted mortality funnel plot on P13 of quality paper – looking at other "similar" units presented as darker blue dots in comparison to St G)*** The unit mortality has been comfortably in the expected range since this report was published. When making comparison with "similar" units, it should be recognised that there are significant differences between these units and CTICU. These relate to the amount of acute cardiology and "General" ICU admissions that we take, which is far higher than dedicated post-op cardiac surgical units considered by Intensive Care National Audit and Research Centre (ICNARC) as similar to St George's. A comprehensive programme of reviewing and updating all ICU SOPs is well underway, and began with SOPs that directly influence cardiac surgery patients. A new electronic platform, Clinibee, is the planned repository for these to enable easy access. This is in use in other units in the South London Critical Care Network.

	Recommendation	Update
13	Improved data entry unsatisfactory at present. 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. If SGH do not play by the same rules as other units, they are doing themselves a disservice (in reality probably very minor effect on outcome data). 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 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.	The 'Dendrite' System is in place: https://www.e-dendrite.com/database-registries Data is entered by the appropriate staff member at each stage of the patient journey, e.g., the pre-assessment nurse enters data during pre-assessment, the registrar / consultant enters operative data, the perfusionist enters perfusion data etc. This is then validated against the patient record by the data manager. The department is planning to appoint a data manager for cardiology. The two will cross-cover each other's roles.
14	Outcome monitoring. We have found little evidence of on-going 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. 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.	Outcome data is reviewed regularly by the AMD and presented monthly at the Cardiac Surgery Integrated Governance Meeting where it is a standing item on the agenda. The Clinical Governance lead will deputise in the absence of the AMD. These meetings occur on a rolling half-day each month and no non-emergency clinical activity is undertaken at this time. The meetings are well attended and detailed minutes are taken. Both unit and individual VLAD plots are reviewed. This does not seem to be causing any difficulties and it encourages transparency and open discussion. All post-operative deaths and any significant morbidities are discussed at this meeting. An audit programme is in place and these audits are also discussed. A review by NHSE and NHSI staff in February 2019 identified that there was an improved focus on morbidity as well as mortality at Cardiac Surgery M&M meetings.

	Recommendation	Update
		Moreover, the system of reviewing potential serious incidents in the Trust has undergone significant changes since the publication of the Bewick report. All potentially Serious Incidents are reviewed at a weekly Serious Incident Decision Meeting (SIDM) which is chaired by the Chief Medical Officer and attended by the Chief Nurse, the Associate Medical Director for Clinical Governance and Quality Governance lead. The meeting is informed by a Rapid Response Report – completed by the senior clinician involved in the care of the patient and by a Structured Judgement Review, compiled by a senior clinician in the Trust. This clinician is drawn from an unrelated specialty; this has replaced the system in place prior to the Bewick report where the review was undertaken by a clinician from the same specialty. Currently, any decision made by SIDM on the care of a cardiac surgery patient is sent for review by a senior surgeon at a neighbouring Trust.
15	Pooling patients with decision on appropriate allocation at the MDT, led by 'surgeon of the week'.	All patients are discussed at the daily MDT and are allocated as appropriate. A formal pooling system has not been introduced at this stage. Many of the cardiologists who refer patients from other Trusts to Cardiac Surgery at St George's have not yet worked with a pooling system, and are accustomed to referring into our service through long-established mechanisms with named surgeons. However, we will continue to keep this under review.

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3.1

Meeting Title:	**Trust Board**		
Date:	28 November 2019	**Agenda No**	**3.1**
Report Title:	**Finance and Investment Committee (Core) report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 21st November 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

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3.1

Finance and Investment Committee (Core) – November 2019

The Committee met on 21 November and in addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on 5 Year Financial Planning and an SWLP report.

Committee members discussed the BAF risks on finance and IT. A review of financial risk noted a change in the function risk 'Managing Income & Expenditure in line with budget' to a '25'. The Committee noted encouraging performance on metrics reported in the IQPR (including RTT and Cancer Targets). However, targets were not met in Diagnostics and Emergency Flow. The Committee also noted the reduction in Theatre Productivity levels. Agency Expenditure was noted as continuing to be above the internal cap. The Committee discussed actions being undertaken to improve the current financial performance in view of the forecasted year end position. **The Committee wishes to bring the following items to the Board's attention:**

1.1 Finance Risks – the Chief Financial Officer (CFO) gave an update on financial risks. He noted the intention to increase the functional risk 'Managing Income & Expenditure in line with budget' to the maximum score of '25', due to the forecasted year end position.

1.2 ICT Risks – the Chief Information Officer (CIO) noted that there were no material changes to the ICT risks and a task finish group was in place to look at the problems associated with the QMH deployment of iClip.

1.3 Activity – the Chief Transformation Officer (CTO) updated the Committee on the reduction in Theatre Productivity levels, particularly with the average cases per session. The Committee expressed disappointment at the lack of sustained progress following previous improvement groups and were frustrated that senior resources were required to intervene in order to improve productivity.

1.4 Cancer Update – the Trust has met all 7 standards in September. The Committee was encouraged by this information.

1.5 RTT Update – the Trust has exceeded its RTT incomplete trajectory in September with a performance of 86.1% against a target of 85.8%, which includes QMH for the first time following the Patient Administration System migration. The 52 week performance was higher than trajectory in September, at six 52 week waiters compared to a target of five.

1.6 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard is currently at 84.50%, which is under the Trust's commitment of a 90% delivery in 2019/20. The Committee were concerned at the continued deterioration in performance. The Chief Operating Officer (COO) noted the actions in place to improve performance. This included a Perfect Site Process Week to look at the site operations.

1.7 Agency Performance – the Chief People Officer (CPO) outlined some of the challenges in Agency expenditure that continues in October. The Committee discussed the work underway to ensure the external agency cap was not breached for the financial year. The CPO noted some of the positive performance metrics, for example flu vaccination and staff survey progress.

1.8 Financial Performance – the Deputy CFO (DCFO) noted performance to date at Month 7 was in line with plan showing a £33.2m Pre-PSF/FRF/MRET deficit.

1.9 Financial Forecast – the DCFO provided an update for the Committee on the Trust's financial forecast, which had not materially changed. The Committee expressed deep disappointment at the forecast year end Pre-PSF/FRF/MRET variance of £13m to plan. The CFO updated the Committee on the introduction of weekly financial recovery meetings, which have Executive leads, and improvements should be seen in Month 8. The Committee discussed methods for improving financial performance and the role of management to drive these changes. The Committee requested the Executive team consider the actions required to deliver a balanced financial position.

1.10 5 Year Planning Update – the Director of Financial Planning (DFP) introduced the Committee to the paper providing a final update on the STP submission, which was submitted in November. The SWL position is showing a material gap to the system control total.

1.11 SWLP report – the DCFO introduced an update to the committee on SWLP. The Committee welcomed this update.

2.0 Recommendation

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

Ann Beasley
Finance & Investment Committee Chair,
November 2019

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3.2

Meeting Title:	**Trust Board**		
Date:	25 November 2019	**Agenda No**	**3.2**
Report Title:	**Finance and Investment Committee (Estates) Report**		
Lead Director/ Manager:	Tim Wright, Lead Non-Executive Director, Estates		
Report Author:	Tim Wright, Lead Non-Executive Director, Estates		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 21 November 2019.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

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3.2

Finance and Investment Committee (Estates) – November 2019

This Part 2 FIC meeting has been set up on a monthly basis to provide more comprehensive assurance on Estates risks in the Trust. It should be noted that the November meeting was shortened as the Part 1 (Core) FIC meeting had been extended to allow more time to discuss the Trust's financial position.

The November FIC E meeting was constructive and helpful, at which members received updates from the Assistant Directors (ADs) of Estates on their respective domains. In addition, the committee received papers on overall Estates risk, the progress of the HV and LV (High Voltage and Low Voltage) Infrastructure Project and a report on Health and Safety. Committee members praised the good quality of papers produced and thanked the Estates team for their continued efforts in challenging circumstances, noting that progress was being made.

The Committee welcomed updates from the ADs that included information on the Mitie contract, the Non-Emergency Patient Transport contract, the Procure 22 (P22) Project, and a recent HSE inspection visit.

The Committee wishes to bring the following items to the Board's attention:

1.1 Risk Review - the Chief Financial Officer (CFO) began the meeting by introducing a paper on overall Estates BAF risks. He noted no major changes to individual or strategic risks and the committee noted that we now have a helpful and complete dashboard on overall Estates risk position. Discussion focused on the two key areas of Fire and Water (both with risk scores of 20) and the plans to reduce theses to 15/16 in the near future. Progress has been made in both areas with the water risk improving particularly in terms of infection control. The key issue with respect to fire is around compartmentalisation which was highlighted as a key focus of the P22 capital programme.

1.2 AE Report HV and LV Infrastructure Project - It was noted that progress remained slow but that additional temporary resource had been recruited to support delivery of this Project. It was recognised that the installation of additional medical equipment (particularly MRI scanners) would add significantly to the Trust's current electricity requirement potentially exceeding the capacity that is currently available from the grid. Upgrading the local supply infrastructure will be expensive and the Trust will explore options to share costs with neighbouring organisations (eg Local Council).

1.3 External Health and Safety Governance Review – Matura Health were commissioned to assess the Trust's Health and Safety arrangements and the report was summarised for the committee. 48 recommendations were made, 11 classified as "urgent" and a response and action plan is being developed. It was agreed that good Health & Safety governance needs to be instilled across the organisation and clear performance indicators developed that are accessible to the Trust Board.

1.4 AD Report – Divisional Overview - the Deputy Director of Estates & Facilities (DDE&F) highlighted improvements in current staffing KPI's, particularly vacancy turnover and sickness management. The financial pressure of scoping large scale capital Projects from the existing Capital Budget was also highlighted.

1.5 AD Report – Capital Projects - the Assistant Director of Capital Projects (ADCP) introduced an update on Capital Projects. The P22 Programme continues to progress with detailed costings now received for individual Programme Projects and a £10 million budget approved by TEC. Confidence remains high that the budgeted programme can be delivered by FY end and the impact upon hospital operation of disruptive works are being worked through. Progress on the Cath Labs Project remains slow and the major work is now expected to commence in March/ April once the infrastructure alterations have been signed off by the PFI Provider.

1.6 AD Report - Estates - the Assistant Director of Estates (ADE) introduced a paper on current performance, highlighting the absence across disciplines of accurate as-built documentation which hampers the Estates Team's operations. 10 operating theatres do not currently have a satisfactory UPS (Uninterrupted Power Supply) and whilst procedures and contingencies are in place a detailed survey is underway and consultation with clinical leads to ascertain what is required. Some concerns were expressed over recent increase in backlog of reactive maintenance caused by the focus on statutory compliance. Resourcing levels are under review.

1.7 AD Report - Facilities - the DDE&F introduced a paper which included an update on Non-Emergency patient transport, confirming that the tender documents had been released. An update on Mitie Contract Performance was given with improvement noted in clinical areas, whilst some issues in public areas require resolving.

1.8 AD Report- Medical Physics & Clinical Engineering – The Assistant Director of Medical Physics and Clinical Engineering (ADMPCE) presented a summary on statutory compliance noting that there are no areas of non-compliance although in some areas full compliance can only be achieved with cooperation with other Trusts. We now have a detailed breakdown of maintenance priorities for medical equipment. It was noted that 11% of current equipment is flagged as overdue for maintenance however the team have a clear view of item criticality and are working through the backlog. An interesting graphic showing the expected end life of current equipment was reviewed and the potential productivity gains that could be realised through new equipment discussed.

1.9 AD Report- Health & Safety –The AD Health & Safety (ADHS) had previously discussed the external Health and Safety Report. It was noted in this abridged section that the HSE visit in November had confirmed that significant progress had been made and the Inspector had granted an extension in recognition of the extent of the task being remedied. It was concluded that this should be viewed as a positive, rather than a missed deadline, as extensions are rarely afforded.

A water leak from the fire hydrant main which occurred on 6 November was discussed and an investigation to understand the root cause is underway.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Estates) on 21 November 2019 for information and assurance.

Tim Wright
Lead Non-Executive Director, Estates
November 2019

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3.3

Meeting Title:	**TRUST BOARD**		
Date:	**28 November 2019**	**Agenda No.**	**3.3**
Report Title:	**Finance Report (Month 07) 2019/20**		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer/Deputy Chief Executive Officer		
Report Author:	Tom Shearer, Deputy Chief Financial Officer Michael Armour, Head of Finance – Reporting		
Presented for:	Update		
Executive Summary:	The Trust has reported a deficit to date in M7 of £33.2m which is equal to the Pre-Public Sustainability Funding/Financial Recovery Funding/Marginal Rate Emergency Tariff (PSF/FRF/MRET) plan. Within the position, income is favourable to plan by £1.5m, and expenditure is overspent by £1.5m. Cost Improvement Plan (CIP) performance to date is £16.8m which is in line with plan. The Trust has recognised £16.5m of PSF/FRF/MRET funding year-to-date (YTD) to Month 7 in line with plan. The Trust also recognised £0.5m of prior year PSF as discussed at the Finance & Investment Committee in June.		
Recommendation:	The Board is asked to note the Trust's financial performance to M7.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Finance and Investment Committee	Date	21/11/2019
Appendices:	N/A		

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3.3

Financial Report Month 07 (October 2019)

Trust Board

Andrew Grimshaw
Chief Finance Officer

28th November 2019

Executive Summary – Month 07 (October)

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The Trust is reporting a Pre-PSF/MRET/FRF deficit of £33.2m** at the end of October, which is **on plan**. Within the position, income is favourable to plan by £1.5m, and expenditure is overspent by £1.5m. **M07 YTD PSF/MRET/FRF income of £16.5m** in the plan has **been achieved** in the Year-to-date position. **£3.9m of this is MRET which is expected to be received in all scenarios, and the remaining £12.6m has been achieved** as the Trust is delivering the Pre-PSF/MRET/FRF plan. **£0.5m of Prior Year PSF** is included in the position following a re-allocation of the General PSF after finalisation of annual accounts.	On plan	On plan
Income	Income is reported at £1.5m favourable to plan year to date. SLA income is £3.9m over plan, mainly due to decreased Challenges and excluded Drugs and Devices which are offset in non-pay. Non-SLA income is £2.3m adverse to plan, which is mainly owing to shortfalls in Pharmacy and Pathology income, both of which are offset by lower costs.	£1.5m Fav to plan	£0.7m Adv to plan
Expenditure	Expenditure is £1.5m adverse to plan year to date in October. This is caused by Non-Pay adverse variance of £1.2m, related to pass-through income, and Pay adverse variance of £0.4m across all clinical staff groups.	£1.5m Adv to plan	£0.7m Fav to plan
CIP	The Trust planned to deliver £16.8m of CIPs by the end of October. To date, £16.8m of CIPs have been delivered; which is on plan. Income actions of £3.4m and Expenditure reductions of £13.4m have impacted on the position. A £2.6m gap remains in Green schemes identified against the £45.8m target.	On plan	On plan
Capital	Capital expenditure of £25.6m has been incurred year to date. This is to plan. The current month YTD position is £25.6m and the previous month YTD position is £22.4m.	£25.6m To plan	£22.4m To plan
Cash	At the end of Month 7, the Trust's cash balance was £3.8m. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.	£0.8m Fav to plan	On plan
Use of Resources (UOR)	At the end of October, the Trust's UOR score was 4 as per plan.	UOR score 4	UOR score 4

Financial Report Month 07 (October 2019)
St George's University Hospitals NHS Foundation Trust

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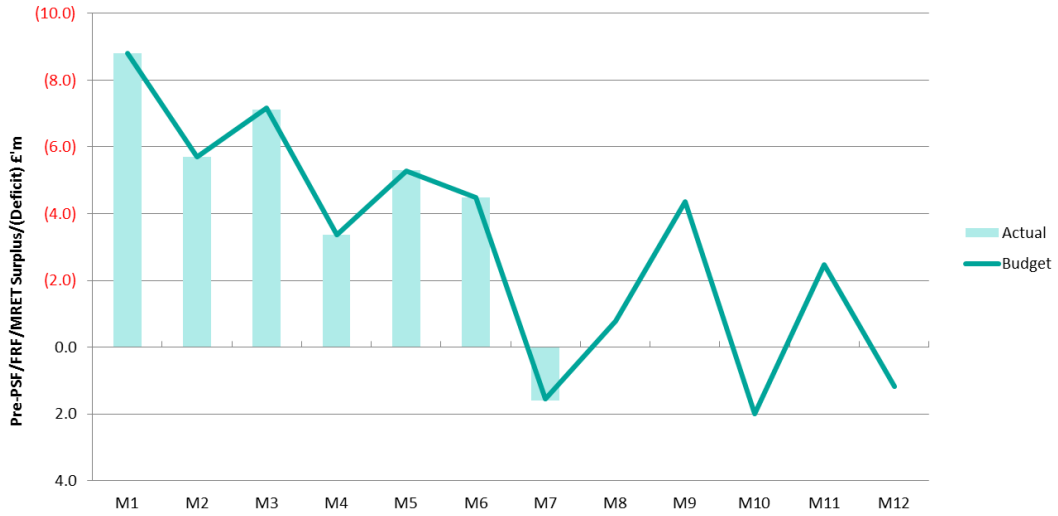
Contents

1. Month 07 Financial Performance

			Full Year Budget (£m)	M7 Budget (£m)	M7 Actual (£m)	M7 Variance (£m)	M7 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF/FRF/MRET	**Income**	SLA Income	678.3	59.0	60.8	1.8	3.1%	393.8	397.6	3.9	1.0%
		Other Income	159.0	13.4	13.8	0.4	3.0%	93.4	91.1	(2.3)	(2.5%)
	Income Total		**837.3**	**72.4**	**74.6**	**2.2**	**3.1%**	**487.2**	**488.7**	**1.5**	**0.3%**
	Expenditure	Pay	(532.6)	(43.0)	(44.1)	(1.1)	(2.5%)	(317.4)	(317.8)	(0.4)	(0.1%)
		Non Pay	(306.6)	(24.8)	(25.9)	(1.1)	(4.4%)	(182.1)	(183.5)	(1.4)	(0.8%)
	Expenditure Total		**(839.2)**	**(67.9)**	**(70.1)**	**(2.2)**	**(3.2%)**	**(499.5)**	**(501.3)**	**(1.7)**	**(0.3%)**
	Post Ebitda		(35.8)	(3.0)	(3.0)	(0.0)	(0.2%)	(20.9)	(20.7)	0.2	1.1%
Pre-PSF/FRF/MRET Total			**(37.7)**	**1.6**	**1.6**	**0.0**	**2.3%**	**(33.3)**	**(33.2)**	**0.0**	**0.1%**
PSF/FRF/MRET			34.7	3.4	3.4	0.0	0.0 %	16.5	16.5	0.0	0.0 %
Total			**(3.0)**	**4.9**	**5.0**	**0.0**	**(0.7%)**	**(16.7)**	**(16.7)**	**0.0**	**0.2%**
Prior Year PSF			0.0	0.0	0.0	0.0	0.0 %	0.0	0.5	0.5	0.0 %
Grand Total			**(3.0)**	**4.9**	**5.0**	**0.0**	**(0.7%)**	**(16.7)**	**(16.2)**	**0.5**	**3.2%**



Trust Overview

- Overall the Trust is reporting a Pre-PSF deficit of £33.2m at the end of Month 07, which is on plan.
- **SLA Income** is £3.9m ahead of plan, after adjustment for block contract values. There remains a large level of estimation within the M07 income position due to delays in coding in some specialties.
- **Other income** is £2.3m under plan, which is owing to Pharmacy services income, and Pathology income, both of which are offset by reduced cost.
- **Pay** is £0.4m overspent across all clinical staff groups.
- **Non-pay** is £1.2m overspent, mainly related to pass-through income.
- **PSF/FRF/MRET Income** is on plan at M07 YTD, at £16.5m. The Trust has met the pre-PSF control total target of a £33.3m deficit.
- **Prior Year PSF** of £0.5m is included in the position. This is the trust's element of the Post Accounts PSF adjustment for 2018/19.
- **CIP delivery** of £16.8m is on plan. Delivery to plan is:
  - Non-pay £0.5m favourable
  - Income on plan
  - Pay £0.5m adverse

Financial Report Month 07 (October 2019)
St George's University Hospitals NHS Foundation Trust

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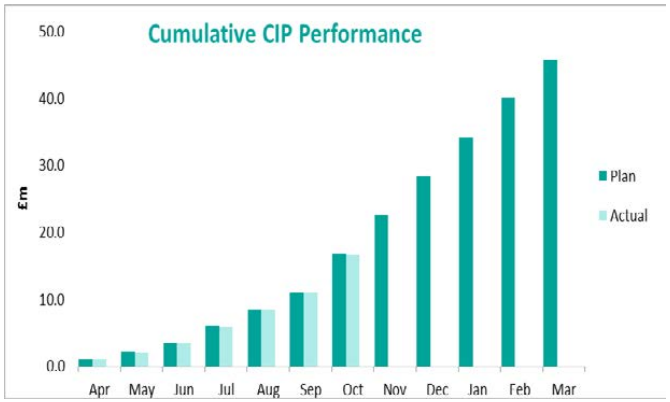
2. CIP Performance M07



YTD (£ m)			
Category	**Plan**	**Act**	**Variance**
Income	3.4	3.4	(0.0)
Pay	8.6	8.1	(0.5)
Non Pay	4.8	5.3	0.5
Total	**16.8**	**16.8**	**(0.0)**

2019/20 (£ m)			
Category	**Plan**	**Green Schemes**	**Variance**
Income	9.4	9.3	(0.1)
Pay	23.4	17.8	(5.6)
Non Pay	13.0	16.1	3.1
Total	**45.8**	**43.2**	**(2.6)**

CIP Delivery and Variance

- CIP delivery at the end of M7 is on track compared to plan
- Green schemes now total £43.2m, which is 93% of the £45.8m target
- This includes £10m of non-recurrent support

CIPs at Risk / Under Delivery

- The CIP delivery profile stepped up at M7, with a £2.6m gap remaining to the Green target

CIP Pipeline / Mitigations

- Deep dives with each division has resulted in the following action to mitigate the under delivery risks as follows:
  - Corporate, Estate and Facilities delivery risk mitigation actions of £2m has now been confirmed
  - Clinical divisions action to improve Green schemes by £1m has been confirmed
  - Clinical divisions action to translate £5m pipeline schemes to Green through the remainder of the year to mitigate the delivery risk
  - £3m relates to procurement schemes and this is a key area of focus through the Financial Recovery meetings and recently established non-pay/ procurement steering group
- The Financial Recovery programme is starting to provide the grip and control needed to support divisions with delivery and an update of the forecast impact will be provided to FIC following the latest round of meetings.

Financial Report Month 07 (October 2019)
St George's University Hospitals NHS Foundation Trust

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3. Balance Sheet as at Month 07

Balance Sheet	Mar-19 Audited Account (£m)	Revised Y/E Plan 31.3.2020	M07 YTD Revised Plan (£m)	M07YTD Actual (£m)	M07 YTD Variance to Plan (£m)
Fixed assets	**390.5**	**408.8**	**393.2**	**401.9**	**8.7**
Stock	7.8	6.5	6.5	7.9	1.4
Debtors	101.9	84.2	91.7	89.0	(2.7)
Cash	3.2	3.0	3.0	3.8	0.8
Creditors	(122.4)	(86.5)	(94.3)	(111.6)	(17.3)
Capital creditors	(4.3)	(3.6)	(15.4)	(16.3)	(0.9)
PDC div creditor	0.0	0.0	0.0	0.8	0.8
Int payable creditor	(1.2)	(1.2)	(1.2)	(1.8)	(0.6)
Provisions< 1 year	(0.5)	(0.4)	(0.4)	(0.4)	0.0
Borrowings< 1 year	(57.6)	(82.5)	(73.3)	(162.4)	(89.1)
Net current assets/-liabilities	**(73.1)**	**(80.5)**	**(83.4)**	**(191.0)**	**(107.6)**
Provisions> 1 year	(1.0)	0.0	0.0	(0.8)	(0.8)
Borrowings> 1 year	(284.3)	(299.3)	(295.1)	(194.6)	100.5
Long-term liabilities	**(285.3)**	**(299.3)**	**(295.1)**	**(195.4)**	**99.7**
Net assets	**32.1**	**29.0**	**14.7**	**15.5**	**0.8**
Taxpayer's equity					
Public Dividend Capital	133.4	133.4	133.4	133.4	0.0
Retained Earnings	(213.4)	(216.5)	(230.7)	(230.0)	0.7
Revaluation Reserve	110.9	110.9	110.9	110.9	0.0
Other reserves	1.2	1.2	1.2	1.2	0.0
Total taxpayer's equity	**32.1**	**29.0**	**14.8**	**15.5**	**0.7**

M07 YTD Balance Sheet

- **The previous slide explains the variance between the previous and the revised plan, in this slide we are using the revised YTD plan as a comparison to YTD actual.**
- Fixed assets are £8.7m higher than the plan. This includes depreciation charges and capital spend to month 7 .
- Stock is £1.4m higher than plan, mainly due to an increase in pharmacy area.
- Debtors is £2.7m better than plan in month and has reduced by £12.9m from March 2019. Target reduction of £ 18m by year end is being actively pursued.
- The cash position is £0.8m higher than planned. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.
- Creditors are £17.3m higher than plan in month. However have been reduced by £10.8m since March 2019.
- Capital creditors are £0.9m higher than the plan. This is an accruals for commitments to October.
- £17.4m of capital loan was received as at October subject to an interest rate of 1.55%. The Trust has requested drawdown of capital loan in November of £1.9m with the same interest rate as in October.
- The Trust requested and received working capital loan of £11.6m in April and May to fund the current year deficit as per submitted plan. This has been reduced to £2m with payments made to benefit from interest rate payments. No loan has been requested was since June.
- The deficit financing borrowings are subject to an interest rate 3.5%

4. Month 07 YTD Analysis of Cash Movement

	M07 YTD Plan £m	M07 YTD Actual £m	YTD Variance £m
Opening Cash balance	**3.2**	**3.2**	**(0.0)**
Income and expenditure deficit	(17.2)	(16.5)	0.7
Depreciation	14.3	14.3	0.0
Interest payable	6.0	7.1	1.1
PDC dividend	0.0	0.0	0.0
Other non-cash items	(0.1)	(0.1)	0.0
Operating deficit	**3.0**	**4.8**	**1.8**
Change in stock	(1.6)	(0.2)	1.4
Change in debtors	20.1	17.4	(2.7)
Change in creditors	(33.1)	(15.8)	17.3
Net change in working capital	**(14.6)**	**1.4**	**16.0**
Capital spend (excl leases)	(13.7)	(13.1)	0.6
Interest paid	(6.4)	(6.4)	0.0
PDC dividend paid/refund	0.0	0.0	0.0
Other	(0.3)	(0.3)	0.0
Investing activities	**(20.4)**	**(19.8)**	**0.6**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	19.6	2.0	(17.6)
Capital loans	17.4	17.4	0.0
Loan/finance lease repayments	(5.2)	(5.2)	0.0
Cash balance 30.09.19	**3.0**	**3.8**	**0.8**

M01-M07 YTD cash movement

- The cumulative M7 I&E deficit is £16.5m, £0.7m better than plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £16.5m, depreciation (£14.3m) does not impact cash. The charges for interest payable (£7.1m) and are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating surplus" of £4.8m.
- The operating deficit variance from plan is £1.8m.
- Working capital is better than plan by £16.0m. This favourable variance comprises of £2.7m lower on debtors and £17.3m better on creditors. The change of stock level is £1.4m better than the plan.
- The Trust has borrowed £11.6m to fund the YTD deficit and repaid £9.6m.
- The Trust has received £17.4m for capital loan. The working capital borrowing is £17.6 lower than the YTD plan. The Trust has requested a drawdown of capital loan in November of £1.9m with an interest rate of 1.55%. Although the Trust can borrow up to £27.3m, however due to the phasing of the I&E at month 7, we have not requested any loans since June. The Trust would have had to repay any excess as the maximum loan cannot exceed £12.8 at the yearend.

October cash position

- The Trust achieved a cash balance of £3.8m on 30 October 2019, £0.8m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 15 week cash flow submitted last month.

Financial Report Month 07 (October 2019)
St George's University Hospitals NHS Foundation Trust

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5. Capital budget and expenditure at M07

- The Trust's funded capital expenditure budget for 2019/20 is £47.489m.
- The Trust has incurred capital expenditure of £25.642m in the first seven months of the year. This spend is against a capital plan of £25.642m but the spend includes a spend to plan accrual of £9.297m for commitments.

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M07 YTD)	Actual (M07 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	1
Agency rating	1	2
SCORE BEFORE OVERRIDES		3
SCORE AFTER OVERRIDES		4

Basis of the scoring mechanism

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

Commentary

- 1 represents the best score, with 4 being the worst.
- At the end of October, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating", "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in the first 3 categories, owing to adverse cash and I&E performance.
- The "agency rating" score of 2 is owing to additional agency costs that have meant the Trust has exceeded its agency ceiling to date (otherwise a '1' would have been scored). The internal Trust cap of £15.0m is lower than the external cap of £20.5m.
- The distance from plan score is worked out as the actual % YTD I&E deficit (3.30%) minus planned % YTD I&E deficit (3.30%). This value is 0.00% which generates a score of 1.

Overrides

- The Trust's score is based on the average of the 5 metrics which generates a score of 3.
- However a number of overrides exist which may change this score.
- As the Trust is currently in financial special measures, the Trust score deteriorates to a 4 automatically.

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St George's University Hospitals NHS Foundation Trust

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4.1

Meeting Title:	Trust Board		
Date:	28 November 2019	**Agenda No**	**4.1**
Report Title:	Workforce Strategy 2019-2024 (Draft)		
Lead Director	Harbhajan Brar, Chief People Officer		
Report Author:	Sarah Brewer, Head of Business Planning		
Presented for:	Approval/Discussion		
Executive Summary:	The workforce strategy 2019-2024 is one of a number of supporting strategies being developed by the Trust in order to support deliver of the ambitions set out in the Trust Strategy 2019-2024. The development of the workforce strategy has been informed and shaped by engagement with staff, patients and the public and via working group with representatives from professional staff groups. Given the breadth of issues, challenges and opportunities facing the workforce now and in the future, the strategy has focussed on a smaller number of key priorities areas which are within the Trust's gift to deliver and have the potential to deliver the biggest impact in the shorted timescales. These are: • Retention • Supply • New Roles However, in order to deliver on these priorities, the Trust will need to build on its Organisational Development Programme to ensure the right culture, values and leadership capability is in place. The actions identified will require investment - either in terms of finances or capacity - this will be identified and agreed through the annual business planning process. Due to the timing of the Workforce & Education Committee (WEC) and the Trust Board, this strategy is going directly to the Trust Board for approval. This strategy will be formally tabled at the December WEC, where more detailed discussions about the three priorities will take place.		
Recommendation:	The Trust Board is asked to: • Note that this strategy has not been discussed at WEC due to timing of the Committee; • Review the proposed Workforce Strategy 2019-2024 and in particular the priorities which have been identified for action; • Approve the Workforce Strategy 2019-2024; and • Note the leadership responsibilities that will be required to support the change in culture to support new ways of working.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future		

	4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today 7.		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring:** staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date:**	20/11/2019
Appendices:	A. Workforce Strategy 2019-2024 B. Equalities Impact Assessment		

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4.1

Workforce Strategy 2019-2024

1.0 Introduction

1.1 The Workforce Strategy 2019-2024 is one of a number of supporting strategies the Trust is developing in order to support delivery of the ambitions set out in the Trust Strategy 2019-2024.

1.2 Having a workforce equipped to help us deliver these priorities will require us to think beyond traditional roles and workforce models.

1.3 The strategy for the future workforce also needs to reflect the challenges and opportunity of the external environment such as the NHS Long Term Plan and the South West London Strategic Health Partnership and Acute Provider Collaborative.

1.4 An Equalities Impact Assessment (EQiA) has been carried out for this strategy and this is attached as an appendix.

2.0 Approach to developing the workforce strategy

2.1. The strategy has been developed through engagement with staff, patient and the public. This has involved bottom-up engagement via a working group comprising representation from the following staff group:

- Nursing and midwifery
- Allied Health Professionals
- Advanced Clinical Practitioners
- Physician Associates
- Pharmacists
- Healthcare Scientists
- Medical
- Clerical and Administration
- Divisions
- Partnership Forum

2.2 This group has identified the current and future challenges, opportunities and solutions for their staff groups and have been considered in developing the strategy. The list of stakeholders engaged in developing the strategy is set out in annex 1.

2.3 Through this work a number of issues and challenges have been identified for specific staff groups. However, there a number of challenges and opportunities identified common to all staff groups.

2.4 This strategy aims to identify those areas which require specific focus or bespoke solutions together with those areas where a corporate or Trust wide approach is the most appropriate solution across all staff groups.

3.0 Identifying the Priorities for the Workforce Strategy

31. Given the number of challenges and opportunities identified, the strategy for the next 5 years recognises that the Trust will not be able to deliver action across all of these all at once and

therefore needs to identify those areas which are within our gift to deliver and have the potential to deliver the biggest impact in the shorted timescales.

3.2 This was recognised during the Board seminar on the 2nd October, where Board members gave a clear steer that the strategy needs to be focussed around a smaller number of priority areas and build from that. The areas identified by the Board were:

- Retention
- Supply
- New roles

3.3 These three areas are individual but also very much over-lap, and identifying solutions in one area will for part of the solution in another. In addition, in mapping the themes identified during the work being done with the staff groups to these three priority areas, it is clear that there is much synergy between these.

3.4 The specific areas that have been identified within these three priorities have been informed through the work done with the professional staff groups who have identified the range of potential solutions which have been considered. This will hopefully provide staff re-assurance that they have been listened to and can see the Trust committing to take action on the issues they have raised during the engagement activities.

3.5 The strategy also recognises that any improvement and to change traditional ways of working will require the organisation to have the right culture and values and the leadership capability and capacity to support change. Therefore driving forward the Trust Organisational Development programme will be fundamental to delivering the ambitions in the strategy.

4.0 Implementing the Workforce Strategy – points to note

4.1 Specific areas of action have been identified for each of the priorities in the strategy which will form part of year on year implementation plans and will form part annual business planning.

4.2 Delivering the priorities set out in the strategy will require the leadership within the Trust to support new ways of working, manage the balance between operational delivery and staff development and also identify investment required to take forward specific initiatives.

Particular examples include:

- Maximising the opportunity of new roles – investment in these roles will potentially require ‘double running’ costs whilst staff are being trained. In addition, in order for the huge potential of these roles to be fully realised, the Trust needs to proactively consider these alongside/instead of traditional roles

- Flexible working – our strategy will take a fresh look at our flexible working policy to ensure it gives staff real opportunities to have work/quality of life balance. This will require manages to adopt creative approaches to finding solutions to support flexible working and not let ‘operational issues’ always to be a barrier

5.0 Recommendations

The Trust Board is asked to:

- Note that this strategy has not been discussed at WEC due to timing of the Committee;
- Review the proposed Workforce Strategy 2019-2024 and in particular the priorities which have been identified for action;
- Approve the Workforce Strategy 2019-2024; and
- Note the leadership responsibilities that will be required to support the change in culture to support new ways of working.

Annex 1 - Stakeholder Engagement

The following groups were engaged in developing the workforce strategy

Stakeholder	How have contributed
Staff Groups: • Allied Health Professionals • Advanced Clinical Practitioners • Physician Associates • Nursing and Midwifery • Pharmacists • Healthcare Scientists • Medical • Clerical and Administration • Divisional representation	3 workshops have been held between July – October with representation from each of the staff groups listed and together they have contributed to: • Scoping the workforce strategy • Identify current, future challenges for their relevant staff group • Identifying potential solutions • Review and testing of the emerging strategy
Partnership Forum	Presentation 17th September and 19th November
Trust Board	Board Seminar 2nd October
Trust staff	Staff engagement event 28th October
Public and Patient Groups	Engagement event 21st October
Council of Governors	Presentation at the 22nd October meting
Workforce and Engagement Committee	Standing item on WEC agenda and focussed discussion 10th October meeting Draft strategy shared with the Chair for comment

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4.1

Workforce Strategy 2019-2024

November 2019

Contents

Introduction

It is our ambition to have sustainable and fulfilled workforce which is empowered to deliver outstanding care, every time. The workforce is a crucial enabler to help us deliver the priorities and ambitions set out in the Trust Strategy for 2019 – 2024. Delivering the priorities within the Trust Strategy will not only require us to build on what is great about working at St George's but will require a fresh look at our workforce models and to ensure the culture and values of the organisation enable us to attract, nurture and retain our most valuable resource – our people.

This workforce strategy sets out the ambitions for the future workforce recognising the challenges that we face now and in the future.

It harness the opportunities for new ways of working and new workforce models to help shape the future.

It identifies areas where we will prioritise our efforts to ensure we can address the challenges and maximise the opportunities to build a sustainable workforce.

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Engaging with our staff and patients

In developing this strategy we have engaged with a range of staff, patient and the public. The detail in the strategy has been informed through bottom-up engagement with professional staff groups via a working group comprising of representative from the follow staff groups:

- Midwifery and Nursing
- Physician Associates
- Allied Health Professionals
- Advanced Clinical Practitioners
- Healthcare Scientists
- Pharmacists
- Medical
- Administrative & Clerical (includes ancillary and estates)
- Divisions
- Partnership Forum

What our staff said …….

‘Staff need protected time for learning’

‘Flexible working could help retention’

‘Career pathways should be available to all staff’

‘Support bank staff through training so that they we can better distribute workload across the Trust’

‘More rotations especially newly qualified staff to improve their skills practicing in different areas of the Trust’

What our patients and the public said……

‘Patents need to understand new roles and who ‘seeing’ them’

‘St George’s needs to be a good place to work’

‘Staff are trained and developed and professionally qualified with excellent people skills’

‘Look to Further Education as part of the workforce pipeline’

The feedback we received helped shape our plans for the future, but we will continue to engage with our staff to support implementation

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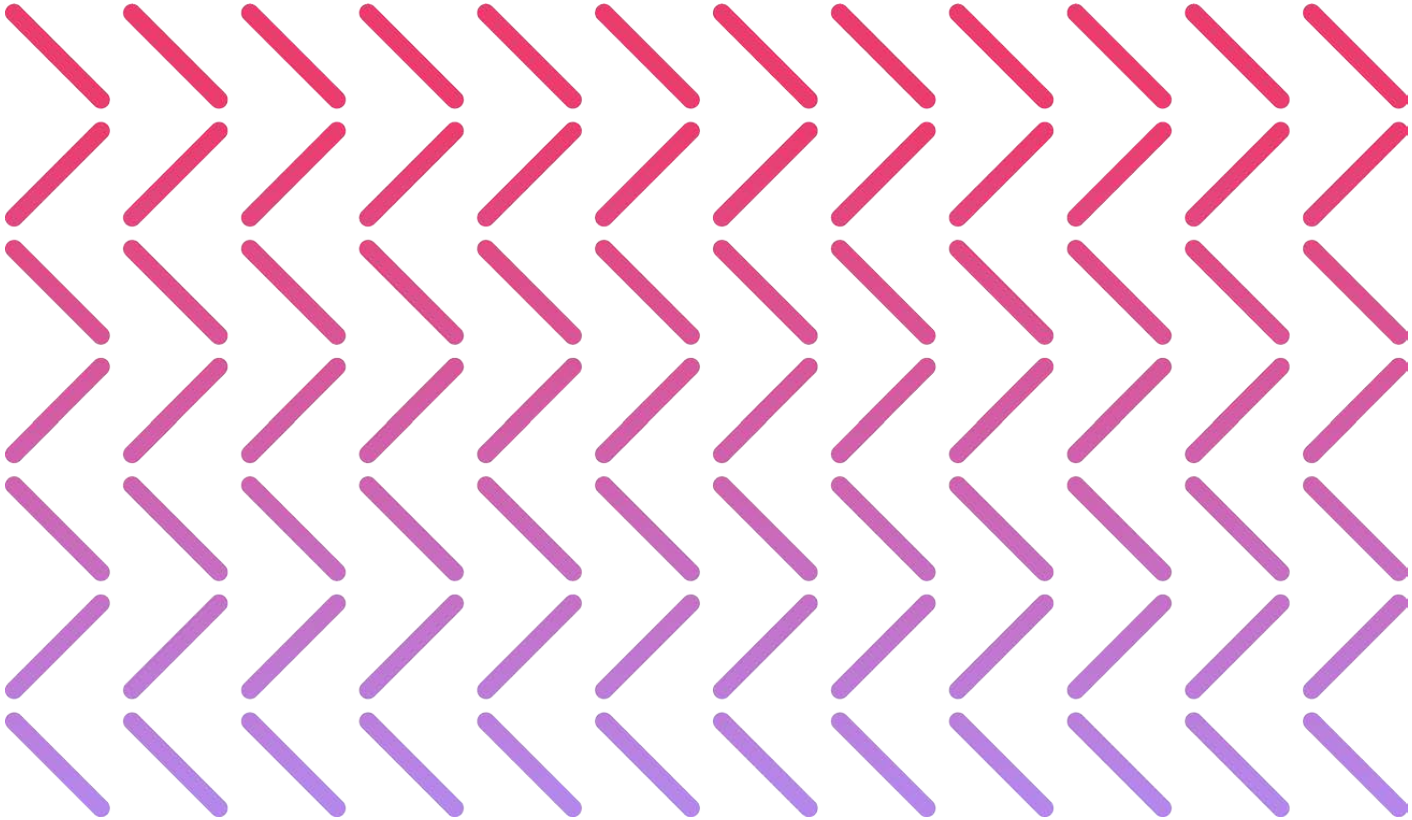
Workforce Strategy 2019-2024

Where we have come from, and where we are now



St George's – where we are now

St George's is committed to being an employer of choice, offering an excellent working and development environment, with staff dedicated to providing outstanding care every time and recognises that the key quality and financial objectives can only be achieved through the contribution of a well-led, engaged and efficient workforce.

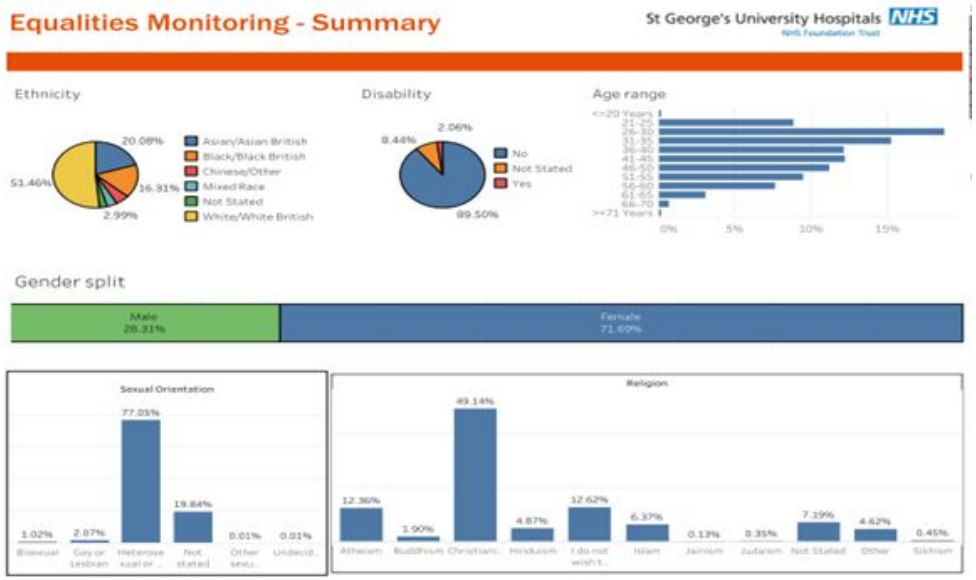
What makes St. George's a great place to work?

The Trust is dedicated to providing opportunities for staff to engage, learn new skills, and to receive one to one support and guidance such as coaching, mentoring via its employee assistant programmes (EAP). It strives to provide opportunities for staff to learn more about quality improvement through our Quality Improvement Academy. There is a range of health and well-being initiatives that are made available to staff across all our sites, and online health and wellbeing resources that can be accessed at any time.

The Trust invests in continuous professional and personal development for all staff by offering in-house and externally commissioned development programmes. The Trust continues to work closely with Health Education England, and Higher and Further Education Institutions to explore new ways to support the development of a competent, capable and caring current and future workforce, for example its state of the art SIM (simulation) Centre.

Champion Team St George's is one of the Trust strategic objectives and has a raft of initiatives to make the organisation a great place to work where staff feel engaged and valued and have opportunities to flourish in their chosen careers.

Our BAME workforce represents over 48% of staff and this is something we need to celebrate and build upon



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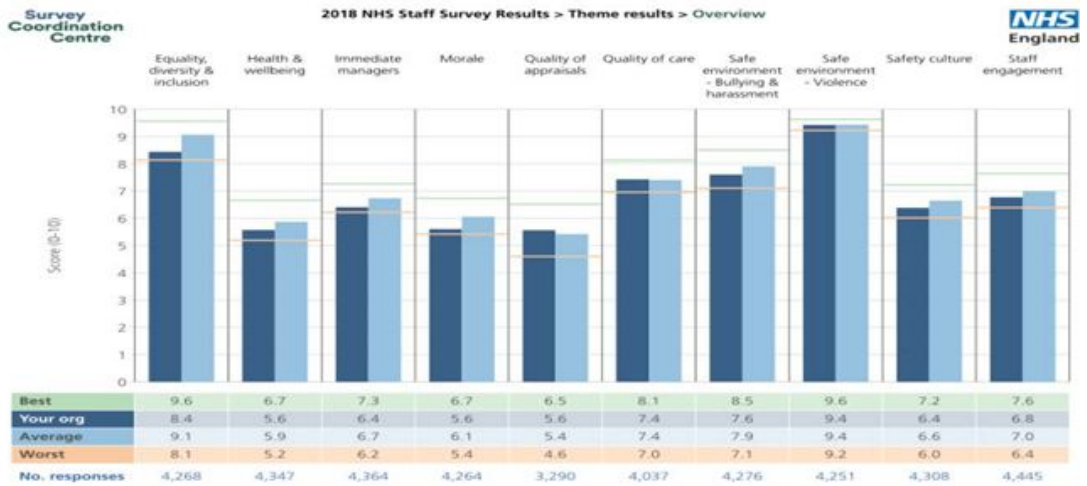
St George's – where we are now



However, as an organisation we have our challenges:

Staff Survey – results for 2018/19 show that:

- Levels of bullying and harassment are not acceptable
- Not enough staff are getting annual appraisals
- Staff feel they are not supported in their career progression
- Diversity and Inclusion is not where it should be

Fragile future workforce – age profile of the workforce:

As an organisation we have an ageing workforce (as highlighted in the analysis set out in slide 9) – this means we are potentially facing a retirement 'cliff edge' when much of our workforce may be eligible for retirement at the same time and therefore we will need to think and work differently, for example utilising retire and return initiatives, as well as embracing flexible working.

Shortage of supply in key areas

There are a number of key roles, not just doctors and nursing, where there are national or even international shortages and we have to find innovative solutions to address these.

Strategic Workforce Risks

We have a number of strategic risk relating to HR and Organisational Development. These include:

Culture – there is a risk that we are unable to make a shift in culture such that staff feel engaged, empowered and safe to raise concerns
Diversity and Inclusion – there is a risk that we are not seen as diverse and inclusive employers by our staff
Bullying and Harassment – there is a risk that we are unable to sufficiently address issues of bullying and harassment
Recruitment and Retention – there is a risk that we are unable to recruit, train and retain an engaged and effective workforce
New ways of working – there is a risk we are unable to deliver new and innovative ways of working to deliver the Trust's clinical strategy

Where we are now – a snap shot

HR KPI Metrics

St George's University Hospitals NHS
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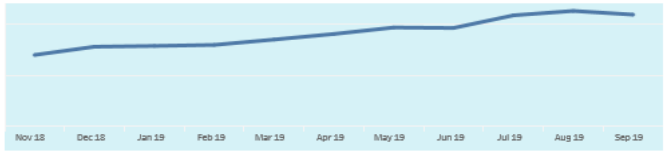
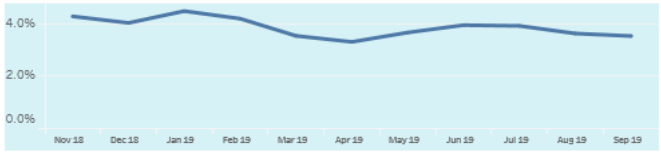
	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Establishment FTE	5,437.37	5,440.30	5,460.02	5,496.24	5,495.08	5,502.90	5,502.75	5,514.33	5,513.87	5,566.41	5,555.72	5,560.73
Staff in Post FTE	5,047.73	5,063.07	5,037.21	5,066.54	5,059.76	5,038.10	5,007.63	4,983.11	4,985.14	4,963.55	4,929.98	4,954.64
Vacant FTE	389.64	377.23	422.81	429.70	435.32	464.80	495.12	531.22	528.73	602.86	625.74	606.09
Vacancy %	7.17%	6.93%	7.74%	7.82%	7.92%	8.45%	9.00%	9.63%	9.59%	10.83%	11.26%	10.90%
Headcount	5,454	5,475	5,451	5,481	5,476	5,449	5,417	5,387	5,383	5,357	5,315	5,338
Sickness %	4.07%	4.26%	4.01%	4.46%	4.17%	3.51%	3.28%	3.64%	3.92%	3.89%	3.60%	3.51%
Non-medical Appra..	73.54%	74.90%	74.99%	74.02%	73.51%	72.02%	73.42%	73.43%	75.17%	74.34%	71.81%	69.85%
Medical Appraisal								84.12%	84.03%	82.73%	85.19%	83.63%
Stability %	83.13%	82.50%	82.25%	83.21%	83.28%	83.19%	81.82%	81.35%	81.65%	81.25%	80.96%	81.04%
Turnover %	16.91%	17.59%	17.51%	17.55%	17.48%	18.05%	17.72%	18.43%	18.65%	18.66%	18.84%	19.03%

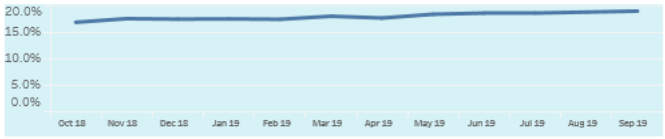
Vacancy %



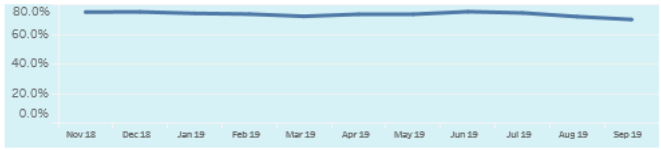
Sickness %



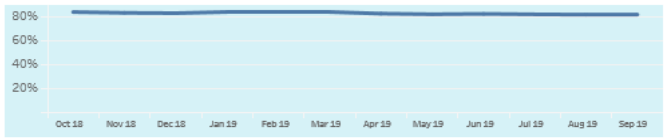
Turnover %



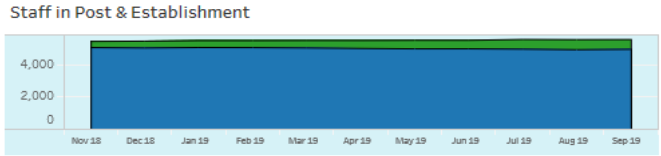
Non-Medical Appraisal



Stability %



Staff in Post & Establishment



What this is telling us:

- That our turnover is stubbornly holding at around 18%
- Whilst we have made inroads in getting our vacancy numbers down from where they were two years ago, we may need to think differently about how we fill our posts – possibly looking at new roles

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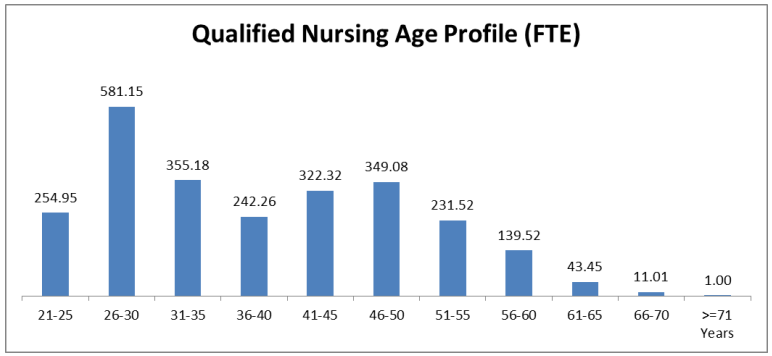
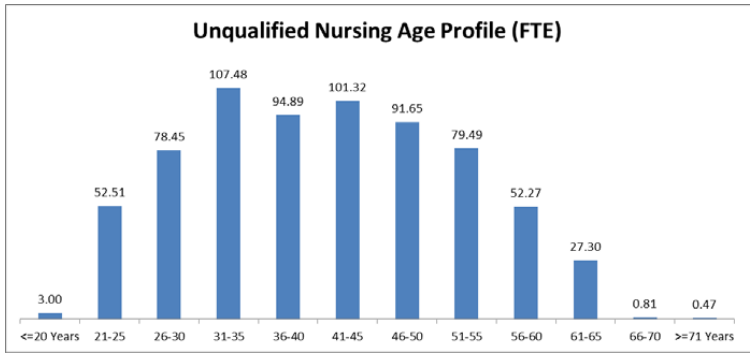
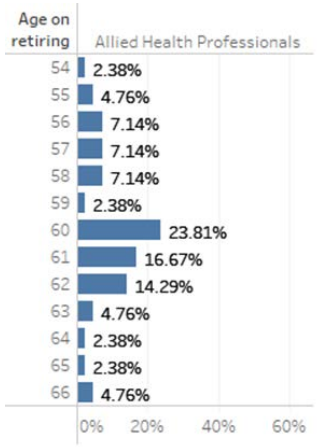
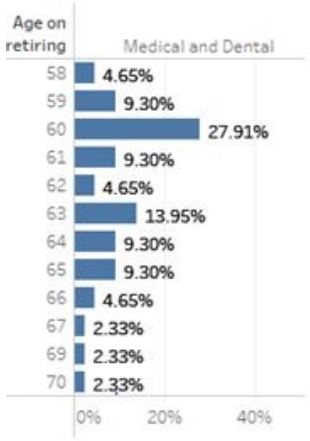
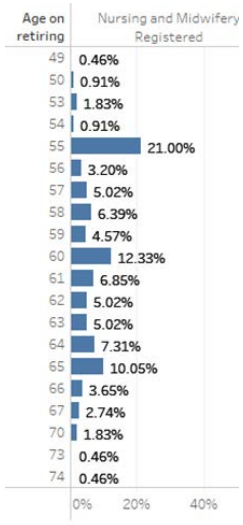
Where we are now – a snap shot











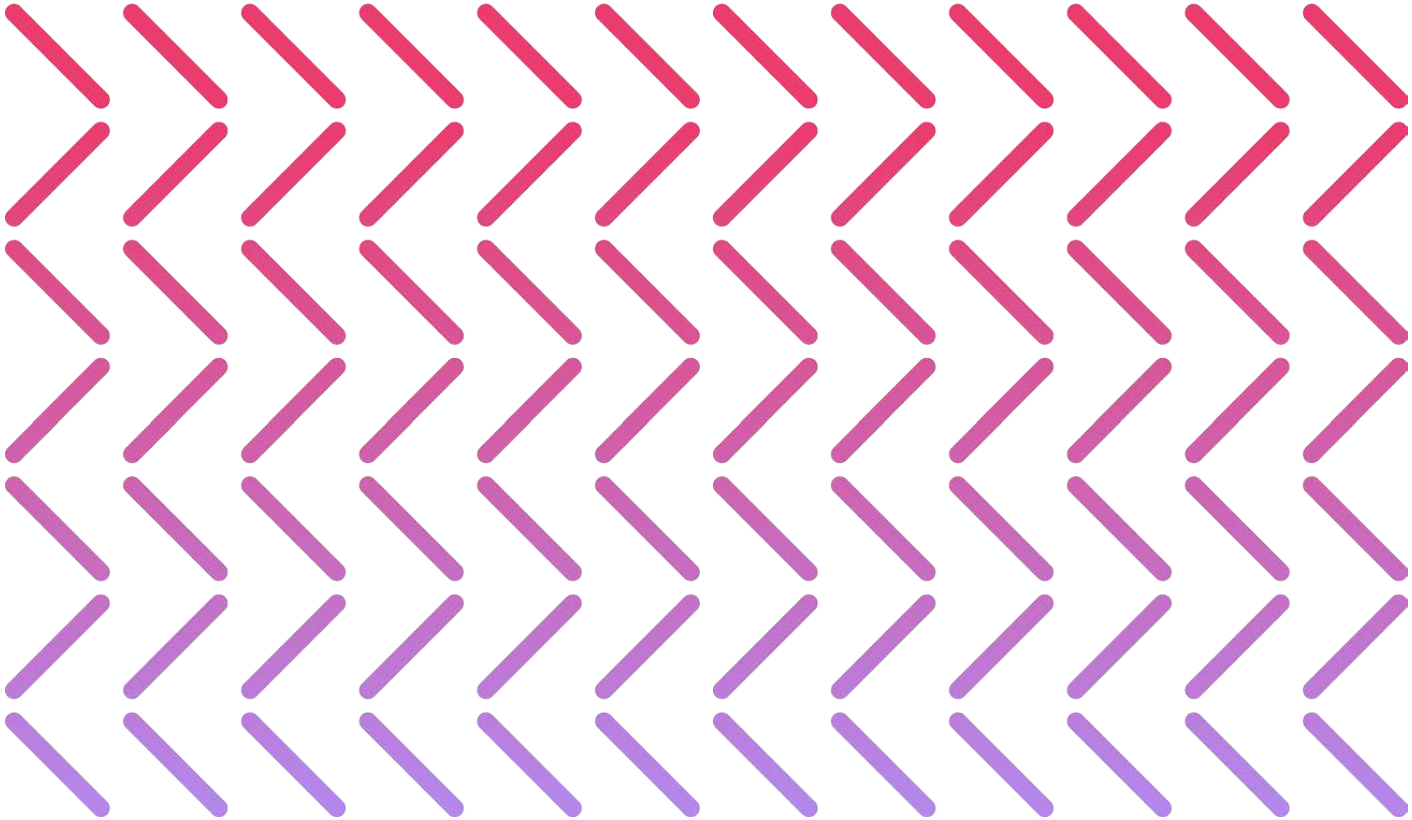
What this is telling us:

- Around 28% of our nursing staff are at an age when they might be considering retirement
- This combined with the short supply of new nursing staff is a threat to our future nursing workforce

Outstanding care every time

Workforce Strategy 2019-2024

Key drivers



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External Strategic Environment

The challenges facing the NHS in England are evolving.

We have an ageing population, many living with multiple long term conditions and the way we are living our lives is also changing meaning that more younger members of the population are accessing health services. All of this is putting increased demand on the NHS.

In response to this, the NHS published the **Long Term Plan** in 2019 which sets out the priorities for NHS for the next 10 years.

Much of this relies on re-designing care pathways and delivering care in a different way:

- Integrated local care systems
- Stronger network of GPs and community services
- Radically transformed outpatient services
- Avoiding hospital admittance
- Specific commitments relating to a range of priority areas such as cancer, stroke, children's services and maternity

Success in delivering this ambitious 10 year plan requires the NHS to re-think traditional workforce models and to develop a sustainable and flexible workforce of the future…..

The draft **NHS People Plan** has been published and this sets out the six overarching priorities for the workforce of the future:

1. The NHS will be a great place to work
2. All staff will be proud and committed to work for the NHS, so much so, that they will stay within the NHS system
3. There will be a big change in how we increase the NHS workforce so we are confident of a home grown excess of staff who represent the communities they serve
4. We will innovate to ensure the types of teams, career and job roles exist to support demographic changes, care model changes and integration
5. The experience of staff and patients alike will be transformed by utilisation of current and new technological advances, such as AI, and the use of data which will reduce unnecessary variation and increase productivity.
6. We will re-balance workforce leadership between the NHS ALBs and local employers, enabling more impactful local action on workforce issues

External Strategic Environment

Health Education England (HEE)

Immediate priorities for Health Education England in order to support the NHS Long Term plan are to:

- Developing an on line workforce platform (eWorkforce) which enables all providers to create future demand forecasts
- Supporting STP/ICS to build their workforce plans focusing on five key enablers of:-
    - Supply
    - Up-skilling
    - New roles
    - New ways of working and
    - Leadership

South West London Context

The SWL STP is developing a collaborative workforce strategy, setting out how partners can work together to meet the workforce needs of the local health system. A number of joint working opportunities have already been identified but further collaborative working will be essential if we are to maximise the workforce we have across our region particularly as we move towards an Integrated Care System.

Current joint projects include:
- Jobs that Care – a board game used to promote healthcare as a career to school children
- Apprenticeship Co-ordinator
- Self Rostering Toolkit

Acute Provider Collaborative
The Acute Provider Collaborative (APC) is also working on a number of key collaborative projects that will enable the four acute hospitals to provide and integrated approach to the services we provide for our staff.

Initiatives underway include:
- Creating agreed clinical pathways between the 4 Trusts which will help to address some of the more difficult to fill clinical roles.
- Collaborative staff bank
- Shared pay-roll
- Collaborative recruitment ‘hub’
- Integrated OH service

Internal Strategic Environment

St George's Clinical Strategy 2019-2024

The Trust published it's **Clinical Strategy 2019-2024** in April 2019 and this set out the clinical priorities for the next five years. Having a workforce equipped to help up realise the ambitions set out in this strategy will require us to think beyond the traditional roles and workforce models.

Engagement carried out as part of the clinical strategy development identified the following workforce issues :

- Junior doctor challenges
- Increases in nursing and nursing associates workforce required
- Alternative workforce models required
- Different skill mix required
- Greater role for wider healthcare staff, new roles
- Pre-post operative nursing
- Maximise the role of and investment in Advanced Clinical Practitioners
- Shortages in certain areas e.g. sonographers, diagnostics/radiography, cardiac technicians, therapists
- More robust management models
- Uncertainty on the future EU workforce supply

Finance and Quality Special Measures

St George's University Hospitals NHS Foundation Trust has experienced a number of years of financial, operational, quality and leadership challenges. The Trust remains in Financial and Quality Special Measures (FSM and QSM), and whilst challenges remain, the Trust has seen a number of areas of improvement and has an ambition to build on these, taking our workforce with us, to continue our improvement journey during 2019/20 and beyond.

The Trust has achieved an improved CQC rating following a full inspection in 2018 and the Quality Improvement Plan sets out our ambition to achieve a rating of 'good' and on to 'outstanding'. The Trust's Quality Improvement Academy, set up in the summer of 2018, will play a key role in ensuring the Trust creates the right conditions for long term success.

Having a sustainable and engaged workforce is fundamental to achieving these ambitions

Champion Team St Georges.

This is one of the Trust's Corporate Priorities for 2019/20 and as part of this has put in place a number of initiatives to support St George's to be a great place to work. This includes:
The Trust's Leadership Academy has put in place the building blocks of collaborative and compassionate leadership - an OD strategy is to be developed to embed the learning into day to day practice.
We have adopted a zero tolerance policy on harassment and bullying and are now actively implementing our Diversity and Inclusion Strategy

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We face a range of strengths, weaknesses, opportunities, & threats – which drive where we go next

Strengths
- Brand Team St George's
- Co-location of SGUH and SGUL - education and training opportunities
- Diversity of the workforce
- Major trauma centre
- Considered 'local' hospital
- Potential of the local workforce
- Research opportunities

Weaknesses
- Financially constrained environment
- Retention and recruitment
- No clear OD strategy
- Staff survey results are poor which does not help our reputation
- Lack of career pathways for some non-medical staff groups
- Lack of organisational senior leadership and governance for some roles e.g. AHP's PA, ACP
- No clear career pathway for some roles
- Capacity to release staff for training and development

Opportunities
- Further collaboration with SWL STP the Acute Provider Collaborative
- NHS People Plan
- Greater use of international recruitment
- Development of different roles
- Improved profile to support ' employee of choice'
- Links to University - opportunity to develop more 'in-house' training /courses with the university, cost effective, accredited
- Our research strategy - increased research opportunities will attract talent
- Tapping into the potential local workforce of the future
- Apprenticeships

Threats
- Brexit – uncertainty over future reliance of supply of EU staff
- Constraints on supply
- An older workforce – retirement 'cliff-edge'
- Scaling back of HEE funding
- Financial position of the Trust
- Pay competition with greater use of recruitment and retention 'incentives' in the sector
- Cost of living in London
- Pensions and impact on retention

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Frontline Staff Feedback Informing the Strategy

Direct engagement with a range of staff groups have helped to inform the workforce challenges that need to be addressed through this strategy

Midwifery and Nursing	Allied Health Professionals	Advanced Clinical Practitioners	Physician Associates
Challenges: • Recruitment & retention • Age of workforce • Funding for ACP and HE • Work/life balance • Changes to preceptorship • Reduction in student numbers • Lack of mental health nurses • Career pathways	**Challenges:** • National/international shortage of some professions • Reduction in number qualifying due to grant loss • Retaining a skilled workforce due to reduction in HEE funding • Apprenticeship scheme creating pressure on workforce to train	**Challenges:** • Rota gaps – use of bank/agency • Recruitment & retention • Lack of understanding of the ACP role and different job titles • Career progression and support for trainees • Future funding for ACP posts • Leadership development	**Challenges:** • Retention – losing the best PAs to other Trusts • No clear senior leadership and lack of governance • Ability to get the right medical workload to be able to recertify • Not operating to their potential • Professional development
Opportunities/Solutions: • Nursing associate roles • Accreditation of in-house training • Flexible retire and return options • Embracing new roles as part of a mixed workforce to support care	**Opportunities/Solutions:** • Return schemes, flexible working & retirement options • Protected time for CP (built into job planning) • Recruitment – from overseas as well as potential local workforce of the future • In-house training, accreditation schemes, mentorships	**Opportunities/Solutions:** • Development of ACP workforce where there are gaps in rota • Potential for productivity gains – ACP attractive career step in otherwise hard to recruit posts • Maximise scope of practice • Degree level apprenticeship levy to support clinical development	**Opportunities/Solutions:** • Clear clinical lead for PAs • St George's has the leading number of PAs in the UK – PR opportunity • Strengthen support for newly appointed PAs • Clear governance framework • Raising profile of the PA role to medical staff

Frontline Staff Feedback Informing the Strategy

Direct engagement with a range of staff group have helped to inform the workforce challenges that need to be addressed through this strategy

Pharmacists	Healthcare Scientists	Medical	Clerical and Administration *
Challenges: • Retention of staff once qualified IPs and ACP Pharmacists • Reduced funding for IP/ACP from HEE in 2020 - may impact succession planning • Qualified IPs / ACPs not getting opportunity to practice - not enough consideration of benefit of these roles	**Challenges:** • Diverse workforce covering many disciplines • National/international shortage of some professions • Brexit – Pathology recruit from Portugal • Capacity/protected time to train staff • HEE funding cuts	**Challenges:** • Junior doctor shortages • Work/life balance • Government policy incentivising in some areas causing shortages in others • Short rotation for junior doctors • Highly competitive market in London • Timescales for recruitment process • Money spent on locums	**Challenges:** • Recruitment and retention • Career pathways • Turning words into practice in the workforce space • Investment in training and development • Competition for key posts across SWL and differential pay • Reliance on interims in hard to recruit post
Opportunities/Solutions: • Trust wide approach to consider IP /ACP 'ready 'pharmacists for other roles e.g freeing up medical staff • Opportunities to work with PCNs to provide clinical pharmacist capacity that is required	**Opportunities/Solutions:** • Return to practice schemes • Apprenticeships for school leavers • Expand in-house training • Opportunity to develop HCS to deliver some roles currently done by medical/nursing staff • Protected time for CP (built into job planning)	**Opportunities/Solutions:** • Clear clinical lead for PAs • St George's has the leading number of PAs in the UK – PR opportunity • Strengthen support for newly appointed PAs • Clear governance framework • Raising profile of the PA role to medical staff	**Opportunities/Solutions:** • Establish career pathways to support retention • Recruitment incentives for key posts • Resources to support learning and development • Better succession planning

Workforce Strategy 2029-2024

* Includes ancillary and estates staff

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The Strategic Issues – common themes across all staff groups

The input from individual staff groups has identified a number of key themes of focus which are common to all groups and are areas for this strategy to consider

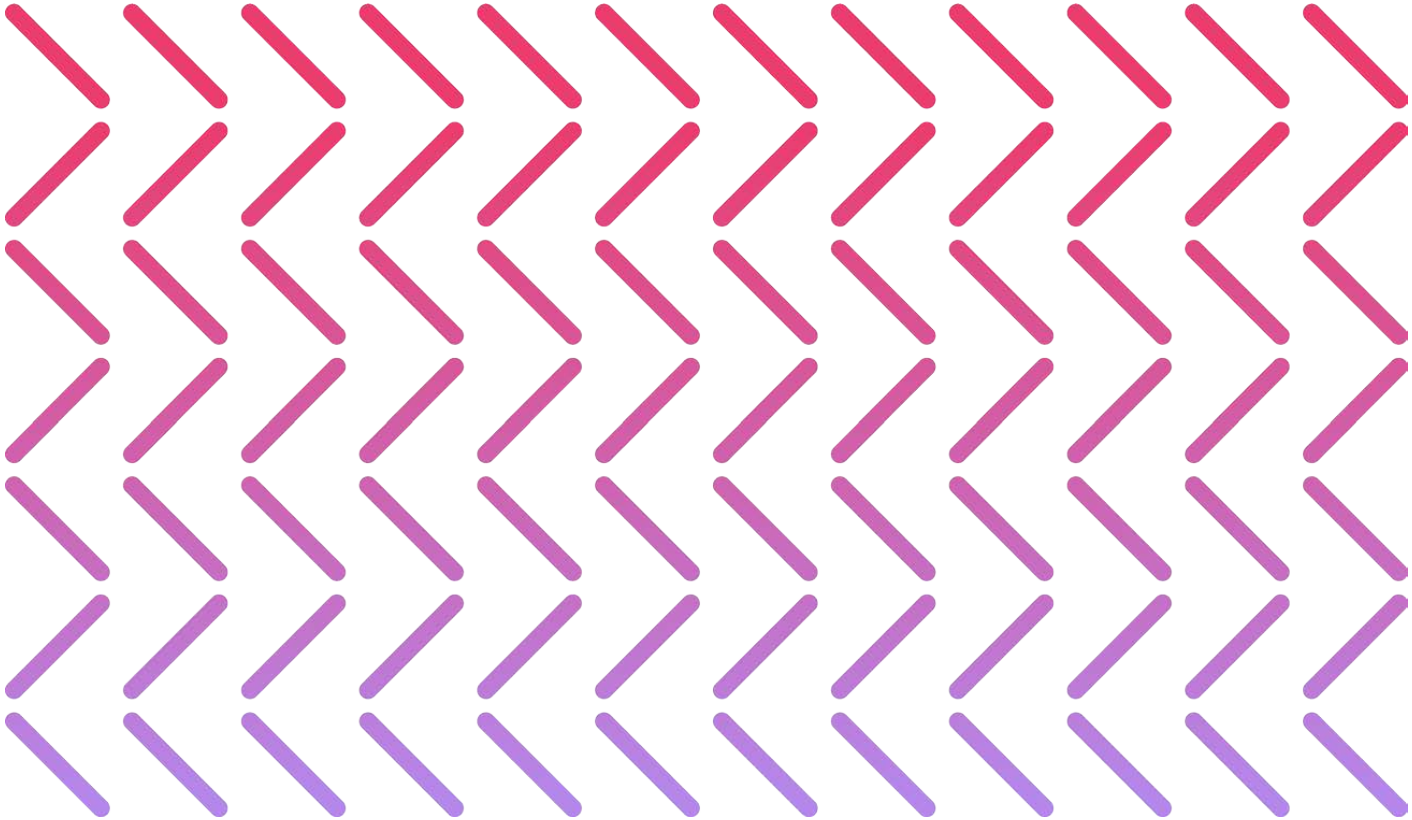
- Recruitment and Retention
- Leadership Development
- Maximising potential of new roles
- Flexible working – work/life balance
- New ways of working
- Career pathways and CPD opportunities
- Age profile of current workforce
- Future proofing and succession planning
- Culture
- Funding
- Financial sustainable solutions
- National shortage of medical and nursing staff
- Maximising the skills of current staff

Workforce Strategy 2019-2024

Our vision for 2024

‘To have a sustainable and fulfilled workforce which is empowered to deliver outstanding care, every time’

How we will get there



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Objectives of the Workforce Strategy

Building on the engagement and feedback we have had in developing this strategy and looking at the analysis of our current workforce and future trends, these have been identified as the key objectives that our future workforce strategy must achieve:

OBJECTIVE	WHY IT IS IMPORTANT
Maximising the opportunities of new roles	New roles such as Advanced Clinical Practitioners and Physician Associates must play a significant role in supporting the medical workforce, for example addressing the gaps in junior doctor rotas. They can undertake many of the clinical duties traditionally carried out by junior doctors. These roles also support career development pathways for senior HCPs and can significantly improve quality of care and patient experience
Attracting and retaining talented people particularly in hard to recruit to roles	Most of our staff groups have identified challenges with recruiting to certain posts and retaining good people . The reasons for this are varied and many, and the impact is significant on those teams that are struggling for example with rota gaps etc. Finding sustainable recruitment and retention solutions to these issues is fundamental to the organisation being able to deliver our quality, clinical and financial ambitions
Ensure all roles have clear career pathways and staff have opportunity to progress	Evidence has shown that we lose high quality and talented members of staff due to the lack of obvious career pathways in particular roles or the lack of support or capacity to fully commit to learning and developing opportunities . This is one of the key areas to address if we are to improve on both recruitment and retention
Meeting the needs of a modern workforce- flexible working, work/life balance	Many people, even the most career orientated, have ambitions for their lifestyle beyond the workplace. Given the pressures associated with many roles, many people chose to leave their chosen profession due to work-life/'quality of life' balance not being met. We need to re-think our cultural approach to flexible working and recognise this means different things to different people
Creating a workplace where all staff feel valued and respected	Our staff survey results have indicated that we haven't quite got this right. We have a very dedicated and hard working staff who often go the extra mile for their patients and their colleagues. This good will can easily be undermined if staff do not feel valued and respected. We need to create the right psychological/Health and Well-Being environment for this to flourish.
We have leaders who empower their staff and we create compassionate leaders of the future	Great leadership is the bedrock of any organisation and in challenging times compassionate leadership is even more important to ensure staff are supported and guided in the right way that empowers them to be at their best.. We need to focus attention at all levels of the organisation and ensure we develop and grow both our current and future leaders

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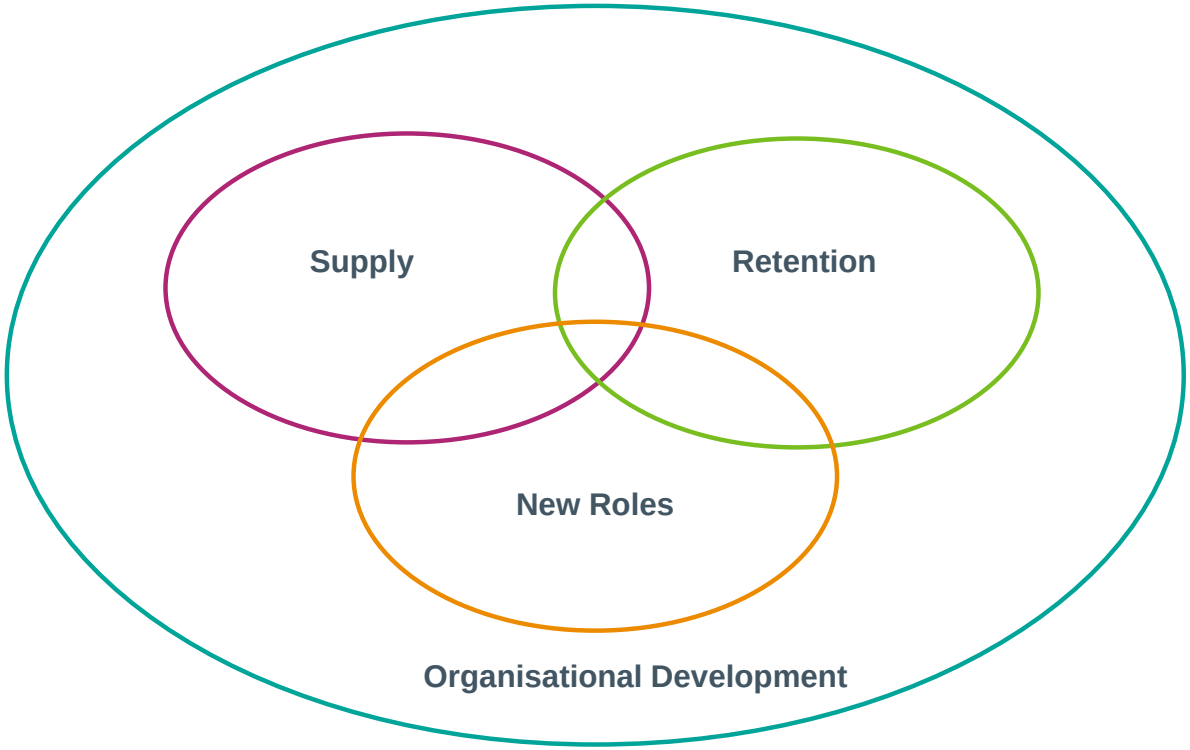
Priorities for Action

In developing this strategy, we have identified a wide range of challenges, issues and opportunities which we need to be able to address to ensure we have the right workforce that is both flexible and sustainable.

However, we recognise that we cannot tackle everything in one go. We therefore have to prioritise those actions that we thing that are within our gift to deliver and those that will have the biggest immediate impact.

We have identified three main priorities that will be the focus of our workforce strategy over the next 4-5 years. This does not however mean that we will not continue to address the other areas of focus.



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Our priorities for action on retention

As a Trust we have made some significant inroads in reducing our overall vacancy levels to around 10%, however our staff turnover remains doggedly high at around 17%. There are a number of areas we can focus in on to better understand why people leave and to put actions in place to improve our retention rates.

As part of our strategy on **retention** we will:

- Better **understand why our staff leave** and to put into place strategies to specifically address these
- Look at what flexibilities we have as a Foundation Trust around the **use of recruitment and retention premia** – ideally in a SWL collaborative way
- Put in to place **clear career pathways** for our staff including non-medical staff and ensure that our staff have 'protected time' for learning
- Ensure every member of staff has proper **development (PDR) conversations**
- Ensure we have a clear **understanding of where our talent lies** and what plans we have in place around succession
- Ensure that we have good **career coaching** and career conversations
- Address **grievances in a timely** and compassionate manner
- Maximise the **skills and capabilities of our current staff** and support them to contribute to clinical care as much as they can by operating at the top of their licence
- Ensure that the **culture of the organisation** is one that encourages people to want to stay and also recommend St George's as a great place to work
- Provide a **flexible working environment** which reflects a modern workforce and also supports people to realise their life as well as career ambitions

Our priorities for action on supply

The issue of supply has been raised by a range of staff groups we have engaged with during the development of this strategy. This tells us that supply issues are not just limited to medical and nursing staff . In may areas there are national and international shortages. We need to better understand where we have supply issues, the root cause of these and target out activities in these areas accordingly. We also need to build on and learn from where we have developed successful recruitment campaigns, such as in nursing for which we were awarded a national accolade for our approach to this.

As part our strategy on **supply** we will::

- Understand where we can **grow our own** future workforce, including reaching out to schools and colleges
- To look at if there are **new and innovative roles** we can develop to fill as part of a new workforce model
- Maximise the opportunities of the **apprenticeships** and better use our apprenticeship levy
- Work with our **local education providers** (FE and HE) to help us develop the local workforce of the future, focussing particularly on those roles which are in short supply or are hard to recruit to
- Maximise opportunities for wider **collaboration across South West London** in terms of recruitment initiatives but also explore the potential of shared roles across Trusts in certain specialisms
- Tap into **international recruitment** campaigns
- Collaborate with **St George's University London** to support the development of training courses for those hard to fill and new roles
- Change the **perception and culture around 'bank staff**' to ensure they are embedded as part of the Team St George's
- Maximise our **reputation as a specialist tertiary centre** with excellent research opportunities to attract the best talent

Our priorities for action on maximising new roles

As a large acute provider our multi-disciplinary workforce is already benefiting from the contribution of 'new roles' such as Advanced Clinical Practitioner, Physicians Associates, Independent Prescribers. However our approach to recruitment, training and development and ensuring the potential of these roles is maximised is very inconsistent across the organisation. Developing a sustainable workforce for the future relies on us to take a more strategic approach to how we recruit, support and deploy these roles in all parts of the Trust.

As part our strategy on **maximising new roles** we will:

- Build on the work already being done on the development of a Trust wide **strategy for Advanced Clinical Practitioners** and expand this approach to other roles such as Physician Associates and Independent Prescribers
- Ensure that the role specification and **capabilities of these roles are widely understood** across the Trust to ensure their value can be maximised; this includes ensuring consistent job descriptions and job titles
- Adopt a **corporate wide approach to recruitment and training** of such roles as part of the sustainable clinical workforce models - this includes targeted **investment** to support transition from medical roles to advanced clinical practice roles in areas where this is the appropriate workforce solution
- Ensure the appropriate **senior leadership and governance** arrangements are in place to support staff in these roles

Organisational Development - Champion Team St George's

Organisational development underpins the ambitions set out in this strategy: success in developing a sustainable and flexible workforce, requires us to have the right culture and approach to organisational development to attract and retain the best.

We will continue to build on and deliver our organisational development programme and ensure this filters down to every level of the Trust to support our people deliver outstanding care every time

- **Organisational Culture**
- **Diversity and Inclusion**
- **Leadership & Development**
- **Living our Values**
- **Bullying and Harassment**
- **Freedom to Speak Up**

Delivering our workforce visions - approach to implementation

- Like the NHS as a whole, St George's is operating in a challenging financial environment
- We recognise that delivering this strategy will require dedicated time and investment, which will be reflected in annual business plans over the coming years
- In year 1 (2020/21) we will build on what we already have started and ensure that we maximise the opportunities e.g. PA's, ACP's for 'quick wins'
- Implementation plans will be produced for each of the three priority areas which will set out in detail the actions needed, clear targets, KPI's and an accountable owner
- The governance of the plans will rest with the Workforce and Education Committee (WEC) which reports into the Trust Board
- The operational delivery will be managed through the PMG through to TEC
- We will continue to engage with the working groups to drive and support implementation

EQUALITY IMPACT ASSESSMENT FORM

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Workforce Strategy 2019-2024	Strategy	Sarah Brewer, Head of Business Planning	New strategy	13 / 11 / 2019

1.1 Who is responsible for this service / function / policy?

Harbhajan Brar, Chief People Officer

1.2 Describe the purpose of the service / function / policy?

The purpose of the workforce strategy 2019-2024 is to set out how the Trust will ensure it has a workforce which is equipped to deliver the priorities set out in the Trust Strategy (2019-2024) and respond to the changing needs of the wider health system. The strategy identifies the key priority areas which will be the focus of action over the next 5 years to ensure the Trust has a sustainable future workforce model.

1.3 Are there any associated objectives?

The strategy has been drafted to be consistent and aligned with national priorities (e.g. the NHS Long Term Plan and draft people plan), local priorities (e.g. the SWL Health and Care Partnership and the Acute Provider Collaborative) and the and the Trust's vision (Outstanding Care, Every Time) and corporate priorities (Champion Team St George's)

Out of the strategy will be three key areas of focus for 2020/21.

1.4 What factors contribute or detract from achieving intended outcomes?

There are a range of factors which could contribute or detract from achieving the ambitions set out in the strategy. These include:

- Availability of investment (either by the Trust or through other organisations such as HEE)
- National/International challenges to workforce supply
- Changes to the commissioning and provider landscape
- Digital infrastructure
- Estates
- Management capability and capacity

1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights?

The proposed workforce strategy should have a positive impact on equalities. For example, the strategy:

- Outlines the Trust's ambition to become a model Diversity and Inclusion employer
- Commits to offering a flexible working environment to support staff achieve the work/quality of life balance they desire
- It commits to providing development opportunities for all roles within the Trust therefore provide all members of staff with the support they need to progress
- Commits the Trust to continue its work to tackle bullying and harassment
- Ensure that we look to all communities to help fill our key roles.

1.6 If yes, please describe current or planned activities to address the impact.

These positive impacts will be pursued through implementation of the strategy, which will be driven forward by individual workforce plans which will be reported to Trust Board.

1.7 Is there any scope for new measures which would promote equality?

As the Trust moves into implementing the workforce strategy, it may decide there is scope for new measures to further promote equality and through on-going engagement with staff groups who have contributed to developing the workforce strategy.

1.8 : What are your monitoring arrangements for this policy/ service

The impact of the key areas of focus will be monitored and reported to the Workforce and Education Committee

1.9 Equality Impact Rating [low, medium, high]

Low.

2.0. Please give you reasons for this rating

The proposed Trust Strategy should have a positive impact on equalities, as set out in this assessment. There will be further opportunities to ensure that this potential positive impact is delivered as the Trust moves into implementing the workforce strategy, and monitoring progress. The process of drawing up more detailed workforce implementation plans, and then monitoring progress against them, will also afford further opportunities to identify and prevent/mitigate any unintended negative impact on equalities.

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

4.2

Meeting Title:	**The Trust Board**		
Date:	28 November 2019	**Agenda No**	**4.2**
Report Title:	Fit and Proper Person Policy and Procedure		
Lead Director/ Manager:	Harbhajan Brar, Chief People Officer)		
Report Author:	Harbhajan Brar, Chief People Officer)		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Ratification		
Executive Summary:	The Fit and Proper Person Policy and Procedure ensures the Trust complies with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 5: Fit and Proper Persons Requirement (and as updated in January 2018). Regulation 5 was introduced as a direct response to the failings at Winterbourne View Hospital and the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust. The report recommended that a statutory fit and proper person's requirement be imposed on health service bodies. The Fit and Proper Person Policy and Procedure (FPPR) outlines the application of this test for new appointments and existing postholders. Where the Trust engages an interim at a senior level equivalent to the posts above, the same process FPPR test will apply whether they are employed or registered as an external worker. This policy and procedure applies to all Board appointments i.e. executive and non-executive directors. This includes permanent, interim and associate positions. Where an interim is sourced by an agency the recruitment agency will be made aware of the FPPR process and must confirm that they have undertaken the employment history and reference checks. Executive search companies will provide relevant evidence to the Trust to be retained on file. The Chief People Officer is responsible for ensuring compliance with the overall policy and providing the Board with appropriate assurance of that fact. The policy has been reviewed and updated to: • Ensure all CQC requirements are met • Reflect the current process for carrying out FPPR checks • Update job titles to reflect the current structure • Change the responsible officer for the policy to the Chief People Officer		
Recommendation:	The Board is asked to ratify this policy and procedure.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		

CQC Theme:	**Well led**: Meets the CQC requirements on good governance		
Single Oversight Framework Theme:			
Implications			
Risk:			
Legal/Regulatory:	The Fit and Proper Person Policy and Procedure ensures the Trust complies with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 5: Fit and Proper Persons Requirement (and as updated in January 2018).		
Resources:	N/A		
Previously Considered by:		**Date**	
Equality Impact Assessment:	Completed – Included in the Policy		
Appendices:	None.		

St George's University Hospitals NHS
NHS Foundation Trust

APPENDIX 1

Fit and Proper Person Policy and Procedure

The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This procedural document has been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individual differences and the results are shown in Appendix B.

Policy Profile			
Version:	1.1		
Author:	Chief People Officer		
Executive sponsor:	Chief People Officer		
Target audience:	**Board Members**		
Date issued:	November 2019		
Review date:	November 2022		
Consultation			
Key individuals and committees consulted:	Human Resources	**Dates**	November 2019
		Dates	
Approval			
Approval Committee:	The Executive Committee		
Date:	20 November 2019		
Ratification			
Ratification Committee:	Board		
Date:	28 November 2019		
Ratification Committee:	Board		
Date:			

Document History			
Version	**Date**	**Review date**	**Reason for change**
1.0	Sept 2016	Sept 2019	Created as a stand-alone policy

St George's University Hospitals NHS
NHS Foundation Trust

Contents

St George's University Hospitals NHS
NHS Foundation Trust

Executive Summary

To outline the procedure for ensuring that Board Level appointments are compliant with the Fit and Proper Persons test and the responsibilities for ensuring compliance.

The Trust's policies set out the organisation's standards and intentions, and are written with the aim of being as clear and comprehensive as possible. However, we operate in a dynamic and evolving work environment and attention should be paid to the spirit of the policy as well as the letter. Policies by themselves cannot guarantee effective behaviour or the delivery of key objectives. While they are designed to support the Trust, and the people working within it, our success depends on continuous, high quality effort by everyone the policy covers, and alongside this policy you should read any guidance or supporting documentation that relates to this policy to help you do this.

Fit and Proper Persons Requirement (FPPR) Policy and Procedure

1. Scope

This policy and procedure applies to all Board appointments i.e. executive and non-executive directors. This includes permanent, interim and associate positions.

2. Purpose

The purpose of the procedure is to ensure the Trust complies with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement (and as updated in January 2018).

3. Introduction

Regulation 5 has been introduced as a direct response to the failings at Winterbourne View Hospital and the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory fit and proper person's requirement be imposed on health service bodies. This policy outlines the application of this test for new appointments and existing postholders. Where the Trust engages an interim at a senior level equivalent to the posts above, the same process FPPR test will apply whether they are employed or registered as an external worker.

Where an interim is sourced by an agency the recruitment agency will be made aware of the FPPR process and must confirm that they have undertaken the employment history and reference checks. Executive search companies will provide relevant evidence to the Trust to be retained on file.

4. Meeting the Requirements of Regulation 5

The introduction of the fit and proper person's requirements (FPPR) places the ultimate responsibility on the Chairman to discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the fitness test and do not meet any of the 'unfit' criteria. Further detail is provided in the CQC Guidance for NHS Bodies: Fit and Proper Persons: Directors, updated in January 2018, can be found at the CQC's website:

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-5-fit-proper-persons-directors

The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about Board directors available to CQC on request. Individuals who fall into the categories above must satisfy the Chairman that they:

- Are of good character
- Hold the required qualifications and have the competence, skills and experience required for the relevant office for which they're employed

- Are able, by reason of their physical and mental health, after any required reasonable adjustments if required, capable of properly performing their work.
- Can supply relevant information as required by schedule 3 of the act, ie documentation to support the FPPR.
- Not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).
- Are prohibited from holding the office in question under other laws such as the Companies Act or Charities Act.

In accordance with schedule 4 part 1 of the act a person is deemed “unfit” if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- The person is included in the children’s barred list or the adults’ barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland (an enhanced Disclosure and Barring Service test will be undertaken).
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

In accordance with part 2 of the Act a person will fail the good character test if:

- Has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.
- Has been erased, removed, struck off a register of professionals maintained by a regulator of health care of social work professionals

Members of the Board will not be able to commence in post unless the FPPR have been met. However, there may be exceptional circumstances where, in the interests of the efficient running of the organisation and/or to ensure that the requirements of our licence are fulfilled, a director may start work before all components the FPPR has been met. The Chairman is the responsible officer for making an informed decision regarding the course of action to be followed, and will confirm their authorisation for the Board member to start prior to the FPPR being met.

Please note commencement of appointment is subject to the expectation of the appointee successfully meeting the FPPR and if he or she does not then the appointment may be terminated with immediate effect.

Implementation of FPPR for Existing staff and On-going Fitness

5.1 Implementation

The NHS Employment Check standards apply to applications for NHS positions, including permanent staff, staff on fixed-term contracts, volunteers, students, trainees, contractors, highly mobile staff, temporary workers (including locum doctors), those working on a Trust bank, and other workers supplied by an agency. The checks are intended to provide assurances that staff working in the NHS are appropriately registered, qualified, experienced, and do not pose a risk to patients. NHS providers are required to show evidence of their compliance with these standards as part of the Care Quality Commission's regulatory framework.

The standards are:

- Identity Checks – reducing the risk of employing illegal workers and impersonators
- Right to Work in the UK check
- Professional Registration (where appropriate) and Qualification Checks
- Criminal Record and Barring Checks – reducing the risk of employing criminals
- Employment History and Reference Checks – reducing the risk of employing staff with unsuitable or unsatisfactory employment records
- Work Health Assessments – reducing the risk of employing staff that are not correctly immunised.

These checks will be conducted for all new Board Members, including where they are interim or associate positions.

In addition to the NHS pre-employment checks the following checks will be carried out:

- Search of insolvency and bankruptcy register
- Search of disqualified directors register
- The Director completes a self-declaration form (Annex A)
- An appropriate media and social media search is conducted

The process for assurance includes a check of personal files to ensure there is a complete employment history and where there are any gaps or omissions the post holder will be asked to provide a written explanation for this. Where the Trust has no record of mandatory qualifications or mandatory professional registration the individual will be asked to produce the original for inspection and verification.

If any issues arise as a result of any of process an interview may be conducted by the Chairman or their nominated Deputy (normally the Chief People Officer). Further documentary evidence may be required from the Director to support this process and should be provided on request.

This declaration and all associated documentation regarding the fit and proper persons test will be retained on the individual's personal file by the Chief People Officer for both Executive and Non-Executive Appointments

The Chairman will be notified of any issues of non–compliance and is the responsible officer for making an informed decision regarding the course of action to be followed.

5.2 On-going Fitness

The annual appraisal process will provide an opportunity to discuss continued "fitness", competence and how the post holder role displays the Trust values and behaviour standard including the leadership behaviour expected. The CEO will be responsible for appraising the

Executive Directors, whilst the Chairman will be responsible for appraising the Non-Executive Directors. The CEO will be appraised by the Chairman. The Chairman will be appraised through the agreed appraisal process, including where the Chairman is appointed by NHSI using their regulatory powers.

There is an annual requirement for post holders to complete a further form of declaration confirming that they continue to be a fit and proper person and declare any conflicts of interest. Confirmation of compliance will be published in the Trust's Annual Report. This will be undertaken in spring each year.

Individuals will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that this can be considered by the Trust using the Fit and Proper Persons Requirement Disclosure Form Existing post holders (Appendix A).

5.3 Concerns regarding an Individual's Continued FPPR Compliance

Where matters are raised that cause concerns relating to an individual being fit and proper to carry out their role the Chairman will address this in the most appropriate, relevant and proportionate way on a case by case basis. Where it is necessary to investigate or take action the Trust's current processes will apply using the Trust's capability process (managing performance or sickness absence), disciplinary procedure or afforded a similar process to this if the potential discontinuation could be due to 'some other substantial reason'. There may be occasions where the Trust would contact the regulator for advice or to discuss a case directly.

The Trust reserves the right to suspend a Director or restrict them from duties on full pay / emoluments (as applicable) to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of service users or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director with immediate effect, in line with the Trust's Disciplinary policy. Where an individual who is registered with a professional regulator (GMC, NMC etc.) no longer meets the fit and proper person's requirement the Trust must inform the regulator, and also take action to ensure the position is held by a person meeting the requirements. Directors may personally be accused and found guilty by a court of serious misconduct in respect of a range of already prescribed behaviours set out in legislation. Professional regulators may remove an individual from a register for breaches of codes of conduct.

Responsibilities

Responsibilities of the Chairman:
The CQC requires the Trust Chairman to:

- Confirm that the fitness of all new directors has been assessed in line with the regulations.
- Declare in writing that they are satisfied that they are fit and proper individuals for that role.

Responsibilities of Board Members:
Board members have a responsibility to comply with these requirements.

Responsibility of the Chief Executive:

The Chief Executive will request a search of the Insolvency and Bankruptcy Register and the Disqualified Directors Register should be conducted annually at the time of appraisal and the outcome recorded.

Responsibility of the Chief People Officer:
The Chief People Officer has responsibility for ensuring these checks are carried out for the Chief Executive, Executive Directors, the Chairman and Non-Executive Directors. The Chief People Officer will also have responsibility for ensuring compliance with the overall policy and providing the Board with appropriate assurance of that fact.

The Chief People Officer will retain the personal files for all the Board members.

Responsibility of the Associate Director of Communications
The Associate Director of Communications will have responsibility for ensuring the media and social media searches are carried out at the request of the Chief People Officer.

St George's University Hospitals NHS
NHS Foundation Trust

Appendix A

Fit and Proper Persons Test

Declaration Form

Objective

The Fit and Proper Persons Regulation came into force in March 2015. The aim of the regulation is to ensure that all Board level appointments of NHS Foundation Trusts have a process in place to ensure those individuals appointed are fit and proper to carry out their role. The test applies when a new director is appointed. This is known as Regulation 5. Regulation 5 is in addition to the existing general obligation for health service providers to ensure they employ individuals who are fit for the role and to demonstrate that 'nominated individuals' have necessary qualifications, skills and experience. This self-declaration form is to be completed by all new Directors.

Requirements

The requirements of the fit and proper persons test are set out below:

1. the individual is of good character,
2. the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,
3. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,
4. the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and
5. none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

Declaration

I understand the requirements of the Fit and Proper Persons Test identified above and I can confirm that I am not aware of any issues that would raise any concerns regarding my appointment. If I become aware of any issues that may raise concerns or that the Trust will need to consider, I will immediately inform the Trust of the relevant details.

Are there any issues that you would like to disclose:

Yes: ☐ No ☐

Signed ……
Date ……
Role ……

If you have any issues to declare please set these out below:

Signed……..

St George's University Hospitals NHS
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Appendix B

EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Fit and Proper Person Policy and Procedure	Governance	J McCullough	Now a stand-alone policy	November 2019

1.1 Who is responsible for this service / function / policy?
Chief People Officer

1.2 Describe the purpose of the service / function / policy? Who is it intended to benefit? What are the intended outcomes?

- The policy applies to all Board members including all interim and associate members of the Board.
- All Board members should be appointed through this process
- Providing greater clarity on the process for new appointments and the annual process
- Clarifying the accountabilities and in particular that the Chief People Officer is accountable for the overall process

1.3 Are there any associated objectives? E.g. National Service Frameworks, National Targets,
Strengthened policy put in place in line with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement (and as updated in January 2018).

1.4 What factors contribute or detract from achieving intended outcomes?
None

1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights? Details:
[see Screening Assessment Guidance]
No

1.6 If yes, please describe current or planned activities to address the impact.
No

1.7 Is there any scope for new measures which would promote equality?

1.8 What are your monitoring arrangements for this policy/ service

1.9 Equality Impact Rating [low, medium, high]- see guidance notes 3.1 above

Low

2.0. Please give you reasons for this rating

No impact on equality

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St George's University Hospitals NHS Foundation Trust

4.3

Meeting Title:	**Trust Board**		
Date:	**28 November 2019**	**Agenda No**	**4.3**
Report Title:	**Statement of Purpose**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	**Alison Benincasa, Director of Compliance and Quality Improvement**		
Presented for:	**Approval**		
Executive Summary:	All organisations registered with the CQC are required by law to have a Statement of Purpose: the document includes a standard set of information about Trust services. The Statement of Purpose must be approved by the Board. The Board received and approved a revised Statement of Purpose in June 2019 to reflect the transfer of Community Services out of the Trust. The Statement of Purpose at Appendix 1 was created using the CQC template. It has three parts: • Part 1 gives the legal status of the Trust and the contact details for service of documents; • Part 2 describes our aims in providing our services: the high level strategic aims for 2019-24 have been used as they describe our purpose in the long term; and • Part 3 gives details of each of our registered locations. For each location the regulated activities and services provided are listed. The service user groups, as defined by the CQC, are also given. **The Statement of Purpose has been updated following the transfer out of Offender Healthcare Services on 31 August 2019** The Statement of Purpose reflects this change to service provision and describes the services provided by the Trust.		
Recommendation:	The Board is asked to: • Approve the amendment to the Statement of Purpose and agree that it accurately reflects the services the Trust provides; and • Note the Statement of Purpose will be updated on the Trust website and HMP Wandsworth will be deregistered as a location with the CQC.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well led)		
Implications			
Risk:	N/A		

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Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	Trust Executive Committee	**Date**	27.11.2019
Appendices:	Appendix 1 - Statement of Purpose November 2019		

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Appendix 1

St George's University Hospitals NHS Foundation Trust

Statement of Purpose

Health and Social Care Act 2008

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Statement of purpose

Part 1

Name and legal status

Health and Social Care Act 2008, Regulation 12, schedule 3

The provider's business contact details, including address for service of notices and other documents, in accordance with Sections 93 and 94 of the Health and Social Care Act 2008

1. Provider's name and legal status							
Full name[1]	St George's University Hospitals NHS Foundation Trust						
CQC provider ID	RJ7						
Legal status[1]	Individual	☐	Partnership	☐	Organisation	☒	

2. Provider's address, including for service of notices and other documents	
Business address[2]	St George's Hospital Blackshaw Road Tooting
Town/city	London
County	
Post code	SW17 0QT
Business telephone	020 8725 1635
Electronic mail (email)	Jacqueline.totterdell@stgeorges.nhs.uk

Part 2

Aims and objectives

Our strategy for 2019 to 2024 supports our vision to provide outstanding care, every time, for patients, staff and the communities we serve. Our priorities for the next five years describe what we aim to achieve by providing the regulated activities at the locations described in part 3 of this statement of purpose

We have four priorities that drive what we do and influence the decisions we will take over the next five years. Our four priorities are:

- **Strong foundations:** To provide outstanding care, every time
- **Excellent local services:** To provide excellent local hospital services for the people of Wandsworth and Merton
- **Closer collaboration:** To work with others to provide health services for people across south west London
- **Leading specialist healthcare:** To provide specialist healthcare for the people of south west London, Surrey, Sussex and beyond

Part 3

Registered locations

St George's Hospital

Blackshaw Road
Tooting
London
SW17 0QT

020 8672 0007

At this location we provide services used by the whole population.

We provide the following regulated activities at this location:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies

Queen Mary's Hospital

Roehampton Lane
Roehampton
London
SW15 5PN

At this location we provide services used by children from 0 -18 and adults from 18 - 65+.

We provide the following regulated activities at this location:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury

The table below shows which of our services are provided at our two hospital sites.

Service	St George's Hospital		Queen Mary's Hospital	
	Inpatient	Outpatient	Inpatient	Outpatient
Amputee rehabilitation			Y	Y
Audiology		Y		Y
Breast Screening		Y		
Cancer Services	Y	Y		
Cardiac Surgery	Y	Y		
Cardiology	Y	Y		Y
Chest Medicine	Y	Y		
Clinical Genetics		Y		
Clinical Haematology	Y	Y		
Clinical Infection Unit	Y	Y		
Critical Care – Cardiothoracic ICU	Y			
Critical Care – General ICU	Y			
Critical Care – Neuro-sciences ICU	Y			
Dental • Paediatric • Restorative • Orthodontics	Y	Y		
Dermatology	Y	Y		Y
Diabetes/Endocrinology	Y	Y		
Dietetics	Y	Y		Y
Elderly Rehabilitation	Y	Y	Y	Y
Emergency Department		Y		
Endoscopy	Y	Y		Y
ENT	Y	Y		
Gastroenterology	Y	Y		
General Medicine	Y	Y		
General Surgery	Y	Y		
Gynaecology	Y	Y		
Hepatology	Y	Y		
HIV		Y		Y
Integrated Falls Service	Y	Y		
Interventional Radiology	Y			
Lymphodema	Y	Y		
Maxillofacial	Y	Y		
Minor injuries unit				Y
Neonatal ICU	Y			
Neuroradiology	Y	Y		
Neuro rehabilitation	Y		Y	Y

Neurosurgery	Y	Y		
Neurology	Y	Y		
Obstetrics	Y	Y		
Oncology	Y	Y		
Ophthalmology	Y	Y		
Orthotics				Y
Paediatric Intensive Care Unit	Y			
Paediatric Medicine	Y	Y		
Paediatric Oncology	Y	Y		
Paediatric Physiotherapy	Y	Y		
Paediatric Surgery	Y	Y		
Chronic Pain Service		Y		
Palliative Care	Y	Y		
Pharmacy	Y	Y		Y
Physiotherapy	Y	Y		Y
Plastic Surgery	Y	Y		
Podiatry		Y		Y
Radiology	Y	Y	Y	Y
Renal Medicine	Y	Y		
Rheumatology	Y	Y		
Senior Health	Y	Y		Y
Speech and Language Therapy	Y	Y		Y
Stroke	Y	Y		
Thoracic Surgery	Y	Y		
Trauma & Orthopaedics	Y	Y		
Urology	Y	Y		Y
Vascular Surgery	Y	Y		
Wheelchair Services				Y

Note: Pathology services are provided by South West London Pathology. This partnership was set up by local hospitals to provide a single, integrated pathology service across South West London.

St John's Therapy Centre

162 St John's Hill
Battersea
London
SW11 1SW

At this location we provide services used by adults from 18 – 65+ and children from 0 -18 as outpatients.

We also provide a day hospital service for residents of Wandsworth who are over 65 years of age. The Day Hospital provides an interim facility between acute and primary care settings

for this group of patients. They are able to access multidisciplinary assessment and support together with treatment and rehabilitation by therapists on individual and group basis.

We provide the following regulated activities at this location:

Diagnostic and screening procedures
We provide this through the following services:

- X-ray
- Phlebotomy

Treatment of disease, disorder or injury
We provide this regulated activity through outpatient services for the following specialties:

- Integrated falls service and bone health
- Dietetics
- Ear, nose and throat
- Audiology
- Gynaecology
- General medicine
- Nephrology
- Plastic surgery
- Rheumatology
- Paediatrics
- Physiotherapy
- Speech and language therapy

Nelson Health Centre

Kingston Road
Wimbledon Chase
London
SW20 8DB

The Nelson Health Centre is funded through a NHS Local Improvement Finance Trust (LIFT), the overall responsibility for the development lies with Community Health Partnerships (CHP), a limited company wholly owned by the Department of Health. Merton CCG commissions the clinical services provided within The Nelson Health Centre. We share this location with a number of other healthcare providers, the Nelson GP Practice; Nelson Pharmacy; Central London Community Healthcare; and South West London and St George's Mental Health NHS Trust.

At this location we provide outpatient services to the whole population.

We provide the following regulated activities:

Diagnostic and screening procedures
We provide this regulated activity through the following services:

- X-ray
- Ultrasound
- Endoscopy
- Cardiac tests such as Echo and ECG
- Phlebotomy

Treatment of disease, disorder or injury
We provide this regulated activity through outpatient services for the following specialties:

- Gynaecology
- General medicine
- General surgery
- Respiratory medicine
- Rheumatology
- Dermatology
- Trauma and orthopaedics
- Diabetes
- Cardiology
- Urology
- Colorectal surgery
- Gastroenterology

END