St George's University Hospitals NHS Foundation Trust

Council of Governors Meeting

Date and Time: Wednesday, 19 February 2020, 15:00-18:00
Venue: Hyde Park Room, 1st Floor, Lanesborough Wing

Time	Item	Subject	Lead	Action	Format
1.0	**OPENING ADMINISTRATION**				
15.00	**1.1**	**Welcome and Apologies**	Chairman	-	Oral
	1.2	**Declarations of Interest**	All	Assure	Report
	1.3	**Minutes of Meeting - 17 December 2019**	Chairman	Approve	Report
	1.4	**Action Log and Matters Arising**	All	Review	Report
15:10	**1.5**	**Key Issues**	Chairman	-	Oral
2.0	**TRUST UPDATES**				
15:20	**2.1**	**Strategy Development:** • **Digital Strategy** • **Outpatient Strategy**	CSO/CIO	Review	Report
16:00	**2.2**	**Quality Priorities Update and Quality Accounts Planning**	DQGC	Assure/ Approve	Report
16:15	**2.3**	**Care Quality Commission Inspection Report - Action Plan**	DQGC	Note	Report
3.0	**MEMBERSHIP & ENGAGEMENT**				
16:25	**3.1**	**Membership Engagement Committee Report**	Committee Chair	Review	Report
16:45	**3.2**	**Governor Election Report**	CCAO	Discuss	Report
4.0	**GOVERNANCE**				
16:55	**4.1**	**Nominations & Remuneration Committee Report**	Chairman	Review	Report
17:05	**4.2**	**Proposed Revision to Trust Constitution relating to the Trust Board**	Chairman	Approve	Report
17:10	**4.3**	**Effectiveness Review Action Plan and Proposed Forward Plan**	CCAO	Discuss/ Approve	Report
5.0	**ACCOUNTABILITY**				
17:20	**5.1**	**Overview from Non-Executive Directors**	NEDs	Assure	Oral
6.0	**CLOSING ADMINISTRATION**				
17:50	**6.1**	**Any Other Business**	All	-	Oral
	6.2	**Reflections on meeting**	All	-	Oral
18.00	**CLOSE**				
Date and Time of Next Meeting: 5 May 2020, 15:00 – 18:00					

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Council of Governors Meeting

Council of Governors Purpose:	The general duty of the Council of Governors and of each Governor 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.

Membership and Those in Attendance		
Members	**Designation**	**Abbreviation**
Gillian Norton	Trust Chairman	Chairman
Nasir Akhtar	Public Governor, Merton	NA
Afzal Ashraf	Public Governor, Wandsworth	AA
Mia Bayles	Public Governor, Rest of England	MB
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB
Val Collington	Appointed Governor, Kingston University	VC
Nick de Bellaigue	Public Governor, Wandsworth	NDB
Anneke de Boer	Public Governor, Merton	ADB
Jenni Doman	Staff Governor, non-clinical	JD
Sandhya Drew	Public Governor, Rest of England	SD
Frances Gibson	Appointed Governor, St George's University	FG
John Hallmark	Public Governor, Wandsworth	JH
Hilary Harland	Public Governor, Merton	HH
Marlene Johnson	Staff Governor, Nursing & Midwifery	MJ
Basheer Khan	Public Governor, Wandsworth	BK
Nasir Javed Khan	Public Governor, Merton	NJK
Rebecca Lanning	Appointed Governor, Merton Council	RL
Doulla Manolas	Public Governor, Wandsworth	DM
Sarah McDermott	Appointed Governor, Wandsworth Council	SM
Richard Mycroft	Public Governor, South West Lambeth	RM
Sangeeta Patel	Appointed Governor, Merton & Wandsworth CCG	SP
Damien Quinn	Public Governor, Rest of England	DQ
Donald Roy	Appointed Governor, Healthwatch Wandsworth	DR
Stephen Sambrook	Public Governor, Rest of England	SS
Anup Sharma	Staff Governor, Medical and Dental	AS
Ataul Qadir Tahir	Public Governor, Wandsworth	AQT
Bassey Williams	Staff Governor, Allied Health Professionals	BW
In Attendance		
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Tamara Croud	Head of Corporate Governance & Board Secretary	HCG-BS
Secretariat		
Richard Coxon	Membership & Engagement Manager (Minutes)	MEM
Quorum:	*The quorum for any meeting of the Committee shall be at least one third of the Governors present.*	

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Minutes of the Meeting of the Council of Governors
17 December 2019, 15:00-18:00, GVR2.19, 2nd Floor, Grosvenor Wing

Name	Title	Initials
Gillian Norton	Trust Chairman	Chairman
Mia Bayles	Public Governor, Rest of England	MB
Nick de Bellaigue	Public Governor, Wandsworth	NDB
Anneke de Boer	Public Governor, Merton	ADB
Val Collington	Appointed Governor, Kingston University	VC
Jenni Doman	Staff Governor, Non-Clinical	JM
Frances Gibson	Appointed Governor, St George's University	FG
John Hallmark	Public Governor, Wandsworth	JH
Hilary Harland	Public Governor, Merton	HH
Kathryn Harrison	Public Governor, Rest of England	KH
Rebecca Lanning	Appointed Governor, Merton Council	RL
Doulla Manolas	Public Governor, Wandsworth	DM
Sarah McDermott	Appointed Governor, Wandsworth Council	SMD
Richard Mycroft	Public Governor, SW Lambeth (Lead Governor)	RM
Dr Sangeeta Patel	Appointed Governor, Merton & Wandsworth CCG	DSP
Simon Price	Public Governor, Wandsworth	SP
Donald Roy	Appointed Governor, Healthwatch Wandsworth	DR
Stephen Sambrook	Public Governor, Rest of England	SS
Anup Sharma	Staff Governor, Medical & Dental	AS
Khaled Simmons	Public Governor, Merton	KS
Bassey Williams	Staff Governor, Allied Health Professionals	BW
In Attendance		
Ann Beasley	Non-Executive Director	AB-NED
Sarah Wilton	Non-Executive Director	SW-NED
Tim Wright	Non-Executive Director	TW-NED
Jacqueline Totterdell	Chief Executive Officer (items 1-2.2)	CEO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Richard Jennings	Chief Medical Officer (Items 2.2.1 and 2.2.3)	CMO
Sarah James	Associate Director of Workforce & Education (item 2.2.1 only)	ADWE
Observers		
Tamara Croud	Interim Assistant Trust Secretary	IATS
Laura Ward	Development Programme Manager, NHS Providers	
Maisie Jenkins	Programme Administrator, NHS Providers	
Apologies		
Alfredo Benedicto	Appointed Governor, Healthwatch Merton	AB
Stephen Collier	Non-Executive Director	SC-NED
Marlene Johnson	Staff Governor, Nursing & Midwifery	MJ
Derek McKee	Public Governor, Wandsworth	DMK
Damian Quinn	Public Governor, Rest of England	DQ
Secretariat		
Richard Coxon	Membership & Engagement Manager	MEM

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		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome and Apologies** The Chairman welcomed everyone to the meeting and noted the apologies as set out above.	
1.2	**Declarations of Interest** There were no new declarations of interests reported.	
1.3	**Minutes of the meeting held on 22 October 2019** The minutes of the meeting held on 22 October 2019 were approved as a true record subject to the following amendments: • Page 7, item 1.3, paragraph 3, 1st sentence – Remove the words 'and asked whether this could be considered as a form of electoral fraud'; and • Page 9, item 5.1, paragraph 3 – Amended sentence to read 'raised a concern that the proposals were not sufficiently ambitious'.	
1.4	**Action Log and Matters Arising** The Council reviewed the action log and agreed that the following actions could be closed with the items added to the Council's forward work plan: • **Action COG.22.05.19/03** – The Council had requested a presentation on Getting it Right First Time (GIRFT) and Model Hospital: A briefing from the Chief Medical Officer would be integrated into the programme of Council workshops for 2020/21 • **Action COG.17.07.19/03** – The Council had requested a Volunteer Update: A briefing on the new volunteer strategy would be integrated into the programme of Council workshops for 2020/21 once agreed • **Action COG.22.10.19/02** – The Council had requested a briefing on the Research Strategy: The Associate Medical Director for Research would provide a detailed presentation on research as part of the programme of Council workshops in 2020/21 The following action could be closed because it was scheduled to be presented to the February 2020 Council meeting: • **Action COG.17.07.19/02** – The update on Information Technology would be delivered as part of the planned item on the draft digital strategy 2020-24 The following actions were on the agenda for discussion and therefore could be closed: • **Action COG.22.10.19/01** - Chief Executive's update on staff engagement and culture change programme • **Action COG.22.10.19/03** - Council of Governor Effectiveness	
1.5	**Key Issues** <u>Care Quality Commission Inspection Report</u> The Chairman reported that on 18 December 2019 the Care Quality Commission (CQC) would publish the report of its inspection of the Trust which had been carried out between July and September 2019. The CQC report maintained the Trust's overall rating of *'requires improvement'* but recommended to NHS Improvement (NHSI) that Trust be taken out of 'quality special measures'. The CQC report included some very positive improvements across the Trust especially in relation to services for children and young people which were now rated 'outstanding' and there had been other notable improvements across other areas. The Trust was now developing the action plan to	

		Action
	respond to the two requirement notices and would, in parallel, develop a wider plan to address the must and should do recommendations. The Council reflected that the results from the CQC inspection were positive for the Trust and for its patients and would go some way towards boosting staff morale. Overall, it was an important step forward for the hospital and demonstration of the progress that had been made in recent years. The Council also noted that whilst the Trust had been in 'quality special measures' it had received some financial and other support. This package would now be revised as part of NHSI's consideration of the CQC's recommendation that the Trust be taken out of quality special measures. <u>'Chairman-in-Common' Role Update</u> The Chairman provided an update on her role as 'Chairman-in-Common' at St George's University Hospitals NHS Foundation Trust and Epsom & St Helier University Hospitals NHS Trust (ESTH). She reported that it had been a busy couple of months since taking on the ESTH role on 1 October 2019, but she was enjoying the challenge and had successfully managed both roles by balancing the time she spends at each organisation. The Board had considered and authorised the existence of a conflict of interest and agreed how this would be managed going forward. It was also noted that this type of appointment across more than one provider was increasingly common in the NHS, and more 'Chairs–in-Common' appointments would likely be announced as the NHS moved further towards closer collaboration and integration. The Chairman reiterated her comments at the previous Council meeting that there were significant potential benefits to patients from the two organisations working together and what, while it was early days, the opportunities for greater collaboration were clear. <u>Governor Elections 2020 Update</u> The CCAO reported that the nominations process for the 2020 Governor Elections had closed on 13 December 2019. All seats would be contested with the following number of candidates nominating themselves for in the respective constituencies: • Public - Merton (1-year term) – 2 candidates • Public - Merton (3-year term) – 7 candidates • Rest of England – 5 candidates • Wandsworth – 14 candidates • Staff - Non-Clinical – 3 candidates Eligible members would be able to vote for their preferred candidates when the ballot opened on 7 January 2020. The voting process would close on 30 January 2020 and the results would be published on 31 January 2019 on the Trust's website. Successful Governors would commence their terms of office on 1 February 2020. Induction arrangements for newly elected governors were being planned ahead of the next meeting of the Council of Governors on 19 February 2020.	
2.0	**TRUST UPDTES**	
2.1	**Staff Engagement** The CEO provided the Council with an update on the work she was leading on improving organisational culture, and she noted the following: • The Trust was looking at different ways to engage with staff and improve the organisation's culture; • A key starting point was to ensure that the Trust had in place the right leadership that would nurture a culture that delivered high quality services, compassionate care and continuous improvement;	

		Action
	• Staff were already engaged in shaping this work. The recruitment campaign to find 15-20 staff culture champions to join the CEO and other senior leaders was underway. The culture champions would help in the discovery phase to identify what was working well and where improvement was needed. Thirty members of staff had applied to date. The CEO reported that she was ensuring that the staff who were involved in this work represented a diagonal 'cross slice' of the organisation, bringing in representatives at different levels of seniority from across the Trust; • The framework of the programme had already been used successfully by circa 60 NHS organisations. NHS Improvement (NHSI) was providing support to the Trust. The Trust had also engaged dedicated support from Tom Kenward, Programme Director: Organisational Development, Leadership and Culture; and • The discovery (diagnostics) phase was expected to take circa six months with the programme taking over two years to embed the cultural change. In discussion the Council raised and noted the following key points: • Some of the key themes arising from the NHS Staff Survey included, leadership, bullying and harassment and Black, Asian and Minority Ethnic staff feeling disenfranchised. • In response to a query from HH about the recurring themes from the Trust's NHS Staff Survey, the CEO reported this programme of work would sit alongside other initiatives such as implementing the actions from the Staff Engagement Plan, Directors' staff question time and the provision of coaching to divisional leaders. These would support the Trust in making a real step change. It was hoped the impact of these initiatives would be reflected in future staff surveys but these activities would inevitably take some time and transforming culture was, by definition a long-term piece of work. The programme of work was also being led by the CEO which was reflective of the commitment and dedication to make the necessary changes from the top of the organisation. • In response to NB's query, the CEO advised that there were robust mechanisms in place to performance manage underperforming staff members including where issues related to leadership performance. It was, however, important that the Trust provided the right level of support and development opportunities to staff members to ensure they had the right leadership skills and tools to lead in the 'St George's Way'. • The Trust would also to do more to ensure that all staff felt respected and supported. • Whilst agency staff did not participate in the NHS Staff Survey they would benefit and participate as much as practicable in the culture work. The CEO also noted that with many agency staff moving into substantive or bank roles the Trust would be able to better capture intelligence from these staff groups. The Council noted the update from the CEO on the culture work programme.	

		Action
2.2	**STRATEGY UPDATE**	
2.2.1	**Education Strategy** The Council welcomed the CMO and the ADWE to the meeting. The CMO outlined the key elements in the developing Education Strategy for 2020-2024. The strategy would be considered by the Board in February 2020 subject to taking on the views of the Council. The following key points were reported: • The proposed vision in the draft strategy was linked to the Trust's key education priorities and those in the workforce strategy. • The Trust wanted to be a learning organisation and would invest in: – Educating the current workforce now and in the future using highly skilled educators and technological advances. – Ensuring there would be protected time for all staff to develop and progress in ways that supported fulfilling career development and assures patient safety. – Leading South West London as an innovative and high quality education partner for staff and patients in order to make the Trust an employer of choice in the area. In response to queries raised by the Council the following key points were noted: • Whilst the Trust worked closely with St George's University of London it was recognised that more could be done collaboratively for the mutual benefit of both organisations' future employees. The Trust also worked with other educational institutions such as Kingston University. • Where the Trust had encountered challenges with specific services, particularly where the issues related to the learning environment, Health Education England had, in discussions with the Trust, withdrawn doctors in training as had been the case in recent years in cardiac surgery and vascular surgery. • The Trust was now making use of the apprenticeship levy and staff across the Trust were thinking of innovative ways to use the allocation through roles including nurse practitioners, advanced clinical practitioners and supporting administrators. It was, however, noted that more work was needed in this area. • The Trust was working hard to ensure all staff were supported to undertake the professional development required, for example doctors routinely required circa 50 hours of CPD training each year as part of their professional development and this formed part of their annual appraisal process. The Council noted the key elements in the developing Education for 2019-2020 which would be considered by the Board in February 2020 subject to prior review by the Workforce & Education Committee.	
2.2.2	**Quality & Safety Strategy** The CMO outlined the key elements of the new draft Quality & Safety Strategy for the Trust. The strategy would be considered by the Board in January 2020 subject to taking on the views of the Council and review by the Quality and Safety Committee. The CMO reported the following: • The Trust's quality and safety performance was much improved. The Trust would use the intelligence from the latest CQC report to drive further improvement.	

		Action
	• The Trust's Quality and Safety Strategy would also be framed by the national NHS Patient Safety Strategy, which had been published in July 2019, and the national work around Serious Incidents details of which were expected to be published in the coming months. • The proposed quality and safety priorities for 2020-24 were: – Minimising avoidable harm across our organisation, utilising the developments in technology and embedding further, robust quality, learning and governance processes. – Improving outcomes for patients through timely diagnosis, exceptional care and treatment. – Offering patients an excellent experience through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients. – Developing further our approach to improving staff experience, enabling staff to feel valued, supported, and equipped to deliver high quality safe care. – Providing equitable access to patients we serve, proactively reaching out to system partners in our communities to achieve this – Being at the forefront of providing and developing pioneering and leading edge treatments for today and in the future. • These proposed priorities had been triangulated with the priorities in the quality account, intelligence from the ward accreditation programme and quality improvement initiatives across the Trust. This level of triangulation provided the Trust with a robust assurance mechanism and ensured that the strategy was informed effectively to give focus to key areas of quality development and focus on reducing avoidable harm. • The Trust had a low mortality rate in comparison to the national average and its work would be further strengthened by the implementation of the Medical Examiner's Office (MEO) with Dr Nigel Kennea having been appointed as the lead Medical Examiner. The MEO would further support the Trust's system of learning from deaths in addition to benefiting bereaved families and patients. • The Trust had prioritised estates works which had a direct impact on patient and staff safety. The Board was also closely scrutinising estates issues through its Finance & Investment Committee (Estates) meetings each month. The Council noted the key elements in the draft Quality & Safety Strategy for 2019-2020 which would be approved by the Board in January 2020 subject to endorsement by the Quality & Safety Committee.	
3.0	**GOVERNANCE**	
3.1	**Council of Governors Effectiveness Review 2019-20** The CCAO presented the results of the Council of Governors Effectiveness Review 2019-20 and reported the following: • All Governors were invited to participate in the effectiveness review, as were the Non-Executive Directors and CCAO as the Executive responsible for providing support to the Council. • The response rate was high with 25 out of the 30 individuals eligible to participate having responded, resulting in a response rate of 83%. The following key points were raised in discussion:	

		Action
	• Respondents to the survey either agreed or strongly agreed that there was a clear understanding of the role of Governors and of the Council collectively. • A majority of respondents agreed that the Trust supports Governors in their role and supports the role of the Council of Governors as a whole. • It was agreed that a programme of site visits would be organised for Governors over the course of the year and would align with the proposed informal Governor briefing sessions planned for 2020-21. • Some of the results and responses from the review reflected the need for Governors to understand the importance of engaging more widely than attending Council meetings only. Further, it was important that regular review of Governors attendance was undertaken and where governors missed more than two consecutive meetings this needed to be addressed in line with the Trust's Constitution. • Options for improving governors' understanding of the role, attendance at Council meetings and widening engagement included: – Reviewing the Governor's Code of Code to ensure that there was clarity on attendance at Council meetings and improving transparency on attendance by publishing the Governor Attendance Register at each meeting. – Developing the standard proforma for Governors to share salient information regarding their attendance and observations of Board Committee meetings and other engagement activities with Council members. – Developing an effective induction programme for new governors and ensuring that incoming governors understood the time commitment required. It was important that Governors were able to give effect to their roles and it would therefore be useful to benchmark the Council's activities with other organisations. • The Care Quality Commission had reflected on the level of engagement of the Council of Governors. It was clear they felt there was a risk of the Council seeking to hold executive directors to account for the performance of the Board, rather than the Non- Executive Directors. It was also clear that the CQC inspectors had, to some degree, been surprised by the extent of Governors' access to Board and Committee meetings. The Council considered that such opportunities enabled Governors to discharge their statutory duties in respect of the Board. **The Council noted that the effectiveness review, the key actions to address feedback from review and that the CCAO would present an updated report at the next meeting of the Council.**	**CCAO**
4.0	**ACCOUNTABILITY**	
4.1	**Overview from Non-Executive Directors (NEDs):** **<u>Ann Beasley (AB-NED), Finance & Investment Committee</u>** AB-NED provided an overview from the Finance & Investment Committee (FIC) which had met twice since the last Council meeting. Financial performance was in line with plan however the Trust would not achieve its year-end forecast as a result of non-achievement of the savings target and an adverse run rate. The NEDs were deeply disappointed by this position and had robustly challenged the proposed recovery plans and emphasised the importance of delivering any revised forecast. The Trust had identified a number of actions to get back on plan but it was unlikely the Trust would recovery the position in line with the original plan of £3m deficit at year-end. Key	

		Action
	implications included the Trust remaining in financial special measures and not meeting its agreed control total, and as a result not benefiting from the full allocation of Provider Sustainability Fund (PSF) it might otherwise have been able to access. A discussion ensued about the culture in the organisation and the disconnect between quality actions and budgetary implications in clinical areas. It was important that all staff, clinical and non-clinical, understood that without effective financial control and grip the Trust could not continue to deliver high quality services and care to its patients. It was suggested that the Trust may benefit from external support. AB-NED advised that the financial management team at the Trust was very strong but the crux of the issue related to staff being held to account and owning their budgets. It was questioned whether with a sick leave cost of circa £20m per annum, the Trust was robustly tackling this area of spend. It was, however, reported that the Trust's sickness levels were lower and/or on par with other organisations. It was also noted that it would be useful to give the Council a briefing on workforce and the sickness levels. The Trust's theatre productivity remained challenged as did the Emergency Department performance. The Trust had brought in consultants but it was evident that the actions from those reviews had not been adequately embedded. There was insufficient time to hear from Tim Wright on the Quality and Safety Committee so the Council agreed this this would be deferred to the next meeting on the 19 February 2020. **It was agreed that the CCAO would arrange for the Chief People Officer to provide an update on workforce and sickness absence as part of the Council's forward work programme for 2020/21.**	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Any Other Business** KH reported that this was her last Council meeting as she would not be standing for re-election. The Chairman thanked her on behalf of the Council for her significant contribution to the Trust both as a public governor for the rest of England and as Lead Governor for a number of years, and wished her the very best for the future.	
5.2	**Reflections on meeting** Due to time constraints, there were no reflections on the meeting. The Chairman closed the meeting by thanking everyone for their comments and wishing everyone a Happy Christmas. The meeting closed at 18:00.	
	Date of next Meeting: 19 February 2020, 15:00 – 18:00	

Council of Governors Action Log - February 2020

Action Ref	Section	Action	Due	Lead	Commentary	Status
COG.17.12.19/01	Council of Governors Effectiveness Review 2019-20	The Council noted that the effectiveness review, the key actions to address feedback from review and that the CCAO would present an updated report at the next meeting of the Council.	19.12.19	CCAO	On agenda under item 3.3.	PROPOSED FOR CLOSURE
COG.17.12.19/02	Workforce and Sickness	It was agreed that the CCAO would arrange for a suitable time to for the Chief People Officer to provide an update on workforce and sickness.	05.05.20	CCAO	Not yet due	OPEN

2.1

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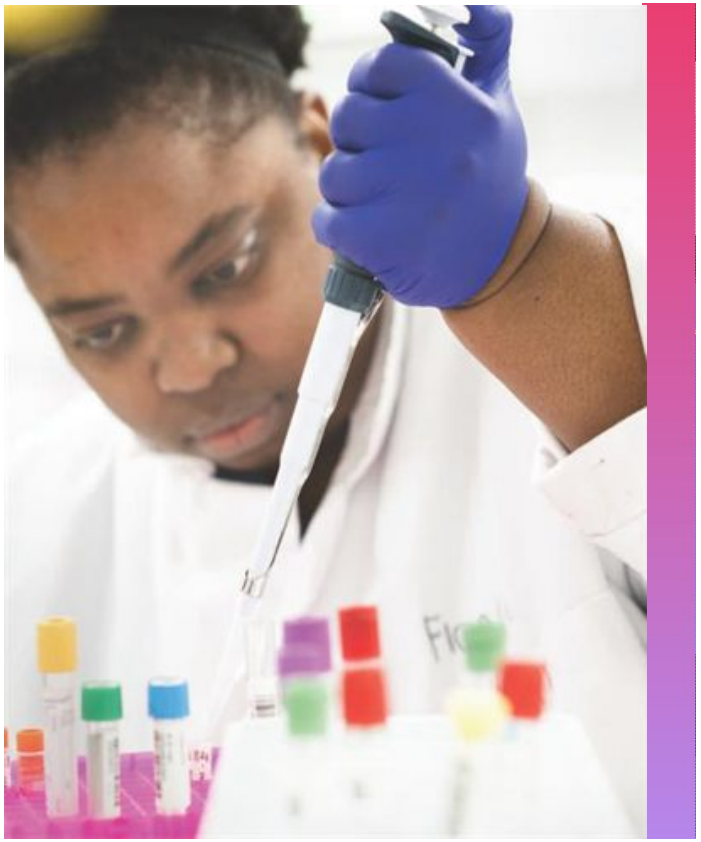
Digital Strategy 2020 – 2024



February 2020

Introduction & purpose

The Trust is currently developing a five-year digital strategy, due to be signed off by the Board at the end of February 2020.

Council of Governors is asked for views on the emerging strategy ahead of it going to Board.

Engaging with our staff and patients

In developing this strategy, we:

- Drew on messages we heard as part of developing the Trust's overarching five-year strategy, when we engaged with more than 500 staff and patients
- Undertook additional focused staff and public events with around 40 attendees
- Undertook a survey of our staff, receiving over 100 responses

The feedback we received helped shape our plans for the future.

Our staff and patients want us to improve our ICT

In developing this strategy, we drew on messages we heard as part of developing the Trust's overarching five-year strategy, when we engaged with more than 500 staff and patients. We also undertook additional focused staff and public events with around 40 attendees, and undertook a survey of our staff, receiving over 100 responses. Key messages included:

Public

- **Engaging with patients in different ways** (e.g. by text re appointments, or by phone/skype for consultations, one-stop-shop appointments).
- **Enabling clinicians to work together differently** (e.g. accessing patient data from other providers, using skype for MDTs)
- **Infrastructure** (slow computers, patchy WiFi, standardisation across different Trust sites)

Staff

- **Infrastructure** (aging hardware, WiFi, slow computers)
- **Business intelligence** (improving reporting, use of data for performance, use of data for research)
- **Supporting better/more efficient working:** (electronic systems to track patients, specimens, equipment; electronic systems for prescribing drugs/patient notes; use of tablets/mobile devices; using technology in training); electronic management of clinic rooms/booking
- **Importance of working collaboratively with partners and other trusts** (including on improving/simplifying electronic referral, sharing data,
- **Internal communication** (new intranet)
- **Clinical Systems** (better integration, new ways of communicating with patients e.g. via patient portals, apps)

ICT staff

- **Infrastructure**
- **New models of care for patients** (e.g. one-stop-shop, use of videoconferencing for patients with long-term conditions)
- **Single open system** – where consultants, GPs have all the patients' clinical history and when patients visit a hospital or GP they can see all the patients' clinical information
- **Supporting staff** (e.g. Working voice recognition, more use of handheld and tablet devices)

Digital Strategy, 2020 - 2024

Outstanding care every time

National and local ambitions rely on ICT

Both the national long-term plan for the NHS, and St George's own overarching strategy for the next five years, have significant implications for the Trust's digital strategy:

National long term plan	Sets out ambitions for 'digitally enabled care', with priorities being: empowering people, supporting health and care professionals, improving population health, and improving clinical efficiency and safety.
St George's strategy	Will rely on ICT improvements to: improve efficiency, improve quality of care (e.g. via interoperable clinical systems), support estates improvement, make the Trust a better place to work, enable new models of care (e.g. virtual consultations), enable closer collaboration with the wider NHS (e.g. through appropriate sharing of patient information), support research (e.g. by enabling researchers to access appropriate data)

Digital Strategy, 2020 - 2024

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

Strengths

- **Staff capability / capacity**: having moved away from heavily outsourced approach, growing capability/capacity in IT department
- **Range of newly installed systems**: e.g. shift from paper to electronic systems in inpatient & some outpatient areas; establishment of SWL Health Information Exchange. Benefits are likely to be felt over course of coming five years as these systems are embedded.

Opportunities

- **South West London-wide working:** e.g. opportunities to enable clinicians across SWL to access relevant patient data from other providers; opportunities from economies of scale (joint procurement; SWL-wide approach to information management); population health management approaches
- **New ways of interacting with patients** : e.g. consultations between patients and clinicians by video, greater use of mobile devices, use of apps to help patients manage their own health, with significant quality and financial benefits.
- **New ways of working:** e.g. greater use of virtual MDTs, use of machine learning, technology to enable home working, voice recognition: with significant quality, financial, estates and workforce benefits.

Weaknesses

- **Capability/capacity:** Trust recently moved away from heavily outsourced approach; still building right mix of capability/capacity in IT department. Trust not 'informatics/IT-savvy' as an organisation
- **Infrastructure:** ageing infrastructure, sometimes no longer supported, with limited capacity
- **Clinical systems:** raft of specialist systems are not interoperable, leading to inefficiencies and safety risks
- **Non-clinical systems**: email system has limited capacity and is not secure. Full functionality of Microsoft Office not being used. Systems used by corporate teams (HR, finance, estates etc) often old & unsupported, do not support SWL-wide working, and do not interact with clinical systems.
- **Communications & telephony:** limited virtual MDT working, and fragmented use of apps for communication between clinicians. Ownership of/responsibility for equipment unclear. Old switchboard system with high risk to business continuity. Old intranet.
- **Data collection / information management:** data collection still partly paper-based. IM primarily focused on monitoring 'what has happened internally' rather than future /benchmarking vs others. Reactive approach to data quality, often responding to commissioner challenge. Datawarehouse not built to deal with volume of data now available and does not link to database in real time.
- **Access to capital:** likely to be a key constraining factor in coming years

Threats

- **Cyber security:** a key national concern and the biggest growth area in criminal activity.
- **Tertiary networks:** risk that if the Trust's systems do not support appropriate sharing of information/referrals with tertiary networks (Surrey, Sussex, Cancer Alliance) that work could come under threat

Outstanding care every time

Our vision for 2024 is for staff and patients to have access to the digital technology and information they need, when and where they need it.

To deliver on that vision, we will pursue three strategic priorities:

1. Robust infrastructure	• We will upgrade our IT infrastructure and telephony systems • We will upgrade and renew the systems that underpin clinical and non-clinical work within the Trust, and ensure the different systems we use increasingly operate as one • We will strengthen our systems and processes for cyber-security
2. New models of care for our patients	• We will use information technology to interact with our patients differently (phone, online, video), sparing them trips to hospital wherever possible • Our approach to business intelligence will be proactive, outward-looking, and focused on enabling future improvement of our services
3. New ways of working for our staff	• We will enable our clinicians to access the information they need from other NHS providers at the point of contact with a patient • We will complete the shift from paper-based to efficient and effective electronic clinical systems • We will enable our staff to do more work remotely • We will use the latest technology and systems to help staff work efficiently and effectively – including making use of big data and AI

Digital Strategy, 2020 - 2024

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NHS
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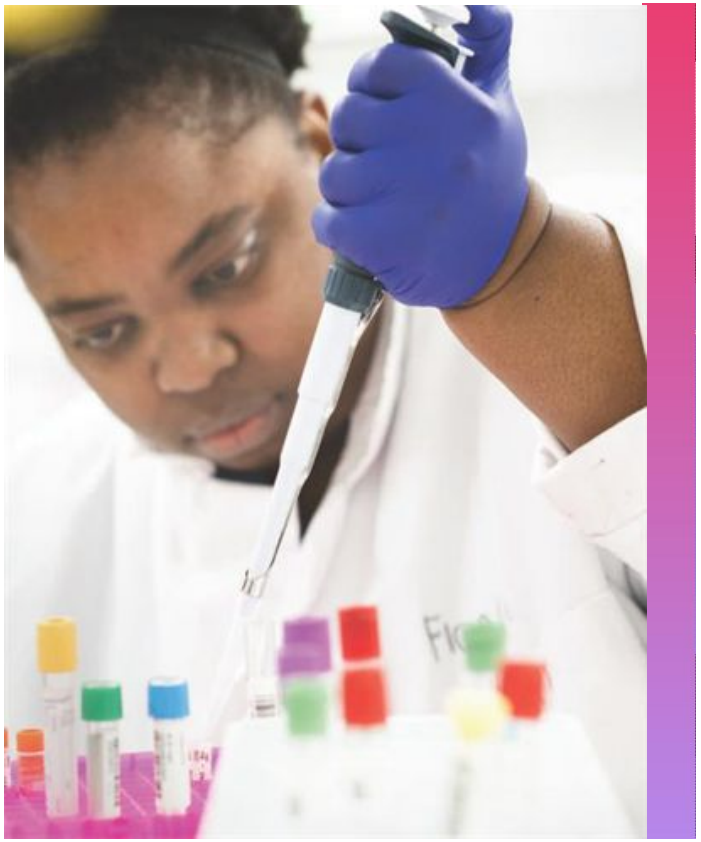
Outpatient strategy



Council of Governors, February 2020

Introduction & purpose

The Trust is currently developing a five-year outpatient strategy, due to be signed off by the Board at the end of February 2020.

Council of Governors is asked for views on the emerging strategy ahead of it going to Board.

Our stakeholders want us to change our outpatient offer

In developing the vision for outpatient services agreed by Board in July 2019, we engaged with staff, patients and partners

- To help develop the Trust's five-year strategy, over 30 care groups undertook a SWOT analysis and presented their strategic vision to the Board. Many included a focus on the future of outpatient services
- A stakeholder event was held in November 2018 on the future of outpatient services, attended by approximately 80 Trust staff and external stakeholders (e.g. commissioners, patient representatives)
- As part of the development of the Trust's clinical strategy, a series of 26 engagement events were held for staff, patients and partners, with over 500 participants. A number of key themes related to outpatient transformation.

Key messages were that our stakeholders (staff, patients and partners) want us to…

- Make better use of technology (e.g. virtual clinics, patient-managed apps, patient portals),
- Provide more care in different settings (particularly in collaboration with primary care, or virtually);
- Streamline pathways (e.g. one-stop clinics, rapid access, collaboration with primary care, group outpatient sessions),
- Provide care through a different skill mix, with less reliance on consultants (e.g. through greater use of allied health professionals, physician associates, consultant nurses);

… but staff also talked about:

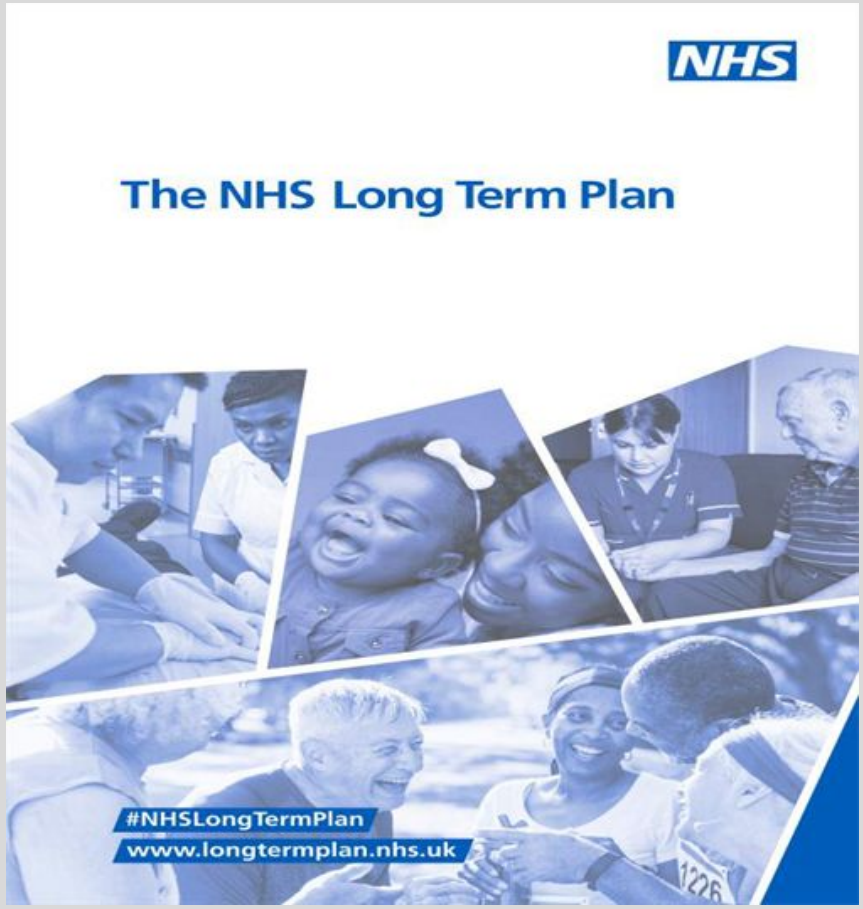
- Taking a menu-based approach to transformation rather than a 'one-size-fits-all' approach – with some services more suited to virtual working than others, greater scope for a different workforce mix in some than others, etc.;
- Anxiety about the Trust's ability to dedicate management capacity to implementing change in the context of operational pressures, our IT capability to deliver some of the changes envisioned, the capacity of the corporate outpatient department, and the need for investment in some cases.

The NHS Long-Term Plan calls for a major redesign

The NHS Long Term Plan, published in early 2019, set out a commitment that **"digitally-enabled primary and outpatient care will go mainstream across the NHS".**

The Long Term Plan says that:

- "hospital outpatient visits have nearly doubled over the past decade from 54 to 94 million, at a cost of £8 billion a year."
- "the traditional model of outpatients is outdated and unsustainable."
- "In some hospitals patients are already benefitting from the redesign of outpatient services. These include better support to GPs to avoid the need for a hospital referral, online booking systems, appointments closer to home, alternatives to traditional appointments where appropriate including digital appointments and avoiding patients having to travel to unnecessary appointments. This is better for patients, supports more productive use of consultant time and enables the capacity of outpatient clinics to be used more efficiently."
- "Outpatient services will be fundamentally redesigned…. so that **over the next five years patients will be able to avoid up to a third of face-to-face outpatient visits**, removing the need for up to 30 million outpatient visits a year. This will save patients time and inconvenience, will free up significant medical and nursing time, will allow current outpatient teams to work differently, and will avoid spending an extra £1.1 billion a year on additional outpatient visits were current trends simply to continue. These resources will instead be used to invest in faster, modern diagnostics and other needed capacity."
- "Reforms to the payment system will move funding away from activity-based payments and ensure a majority of funding is population based"



We have agreed a vision for outpatient services

The Trust's vision for outpatient services, agreed at Board in July 2019, is for **outpatient services that fit around our patients' lives, using the latest technology**

In terms of the care our patients experience, that means….

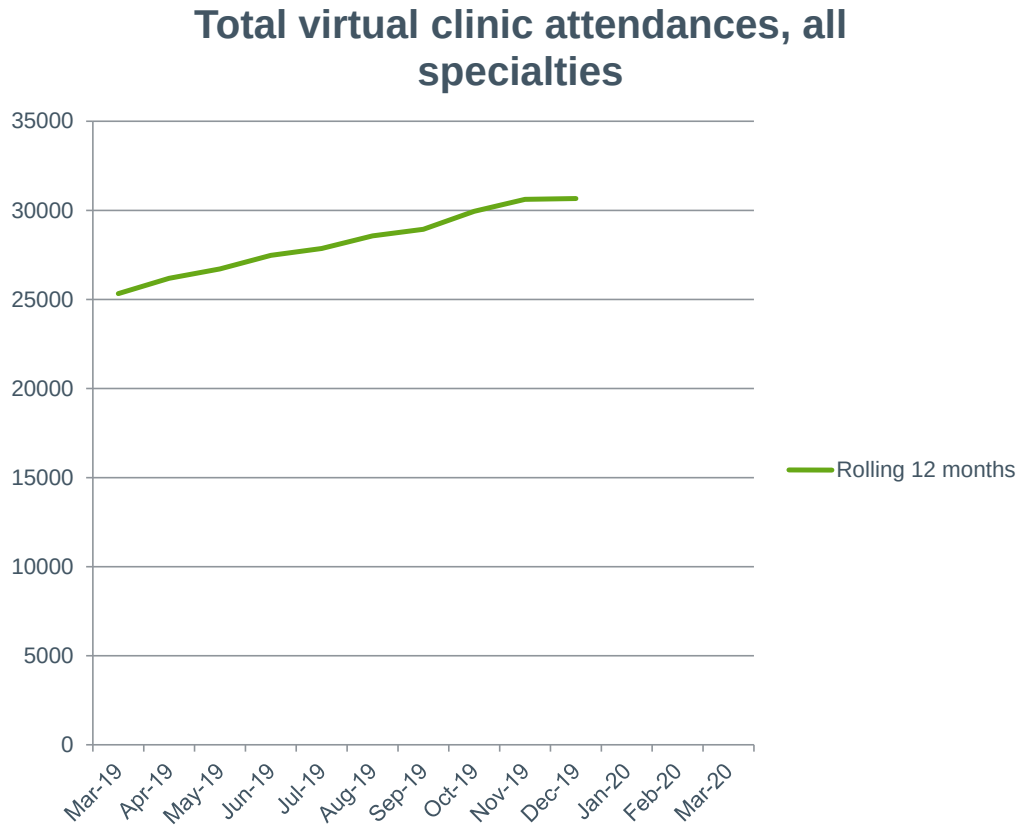
Patients' valuable time is treated with respect:	• *Patients' assessment, diagnosis, treatment and care is coordinated into a single attendance as far as possible.* • *Patients with multiple comorbidities (e.g. older people with multiple long-term conditions) are able to access joint clinics.* • *Patients are admitted for their surgery on the day where possible, at the right time, and with all pre-operative work completed in advance.*
Care is delivered closer to home.	• *Patients have the information and tools they need to manage their own health and care.* • *GPs have timely access to all of the information and tools that they need to support patient care within primary care as far as possible, including advice and guidance from St George's staff.* • *Patients who do not need to come to hospital receive their care virtually (e.g. by video, phone, letter or via a portal).*
Care is delivered when patients need it.	• *Patients with ongoing or urgent needs are able to access the right clinical expertise when they need it.* • *Patients can choose the date and time of their appointments*

We have agreed a vision for outpatient services (2)

For the Trust, this vision should also mean:

Freeing up space and workforce	• *Provision of more virtual clinics, better use of the non-consultant workforce (allied health professionals, specialist nurses, associate physicians), and supporting more patients to be cared for at home/in primary care, freeing up space and workforce to develop and grow more innovative, specialist treatments for the people of south west London and beyond, enabling us to be responsive to changing patient demand.*
Improving our estate	• *Greater use of virtual clinics, and rationalisation of what is provided where, supports improvement to the physical environment that patients and staff experience.*
Better use of resources	• *our workforce is deployed in a way that gets maximum patient benefit from every taxpayer pound we spend. Technology supports clinicians to review patient cases more efficiently (e.g. through virtual clinics, patient apps).*

We have started making those changes, but need to accelerate



- The Trust has already piloted/introduced some new models of outpatient care, such as the gastroenterology clinical assessment service (CAS) or open access follow-ups in some surgical specialties
- These have brought benefits to patients and given the organisation a set of models and experience to build on.
- The volume of virtual clinics that the Trust provides has been steadily growing to c. 30,000 a year at present.
- However, to deliver the scale of ambition set out in the national NHS Long Term Plan (33% reduction in the c. 600,000 face-to-face appointments the Trust provides each year) will require a significant acceleration of pace.

Outpatient Strategy, 2020 - 2024

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We will put in place the key enablers for change

For instance, we need to

- Ensure **leadership** at all levels (corporate, clinical, managerial) is able to prioritise this agenda in the context of a large number of competing priorities
- Support our staff with the **culture change** that new ways of working will require
- Put in place the **IT systems** to enable these changes (e.g. rolling out iClip across outpatient services)
- Make sure our **corporate outpatient department** is able to support new ways of working
- Ensure that the **financial implications** of change for each specialty are understood and supported
- Provide **change management resource** to drive delivery

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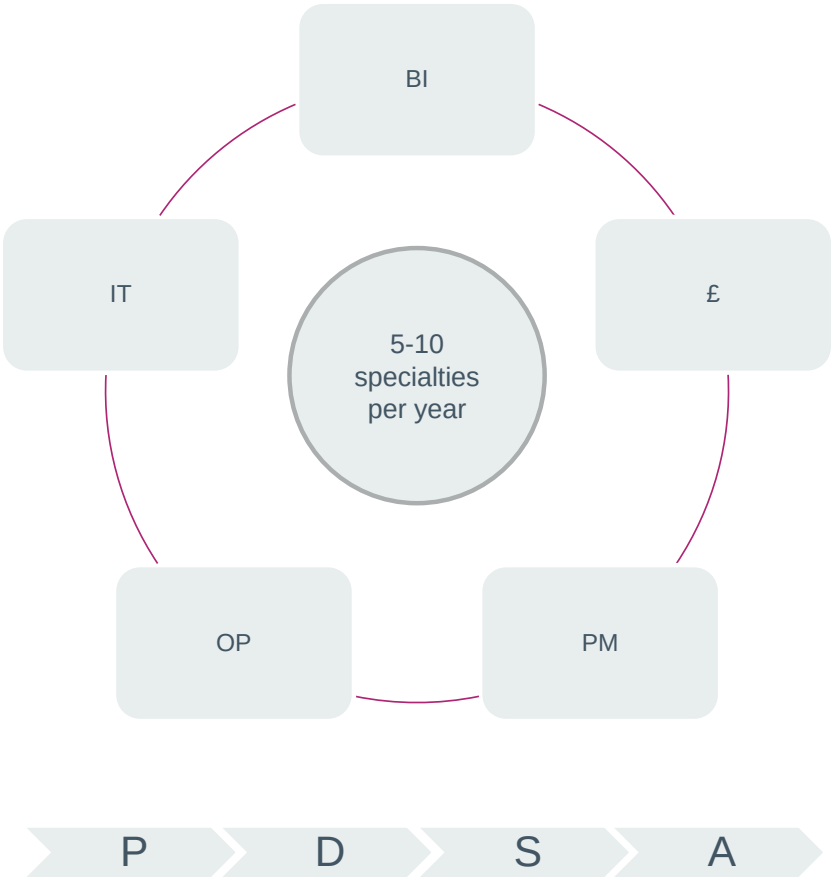
We will adopt a specialty-based approach to change



- We will provide more intensive support to 5-10 specialties per year, to help them change their outpatient model through a Plan, Do, Study, Act (PDSA) cycle
- Specialties will be prioritised on the basis of the opportunity for change (e.g. in terms of patient experience, or productivity) and readiness to deliver.
- Each specialty supported will be expected to identify clinical and managerial leads, with dedicated time to deliver the project
- Dedicated change management resource will be attached to the specialty – including to ensure appropriate clinical & patient engagement
- The corporate outpatient department will be involved from the beginning, helping design and deliver new pathways
- Corporate departments will identify named individuals to work with each specialty supported, 'ring fencing' their time to work on the project. For instance, a specialty might be supported by business intelligence in mapping out outpatient activity and identifying opportunities, developing trajectories and monitoring progress. Dedicated IT time might be required to help the specialty understand potential IT solutions available, to configure iClip at specialty level to support the changes envisaged, or to train staff once that configuration is complete. Finance staff might support the service to understand the financial impact of the proposed changes, or ensure any contracting issues are resolved.

Outpatient Strategy, 2020 - 2024

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Each specialty will adopt changes from a ‘menu’ of options

Each specialty will be supported to choose from a ‘menu’ of options, as appropriate for their service. The menu is based on projects already undertaken at the Trust, and on guidance published by NHS England.

Menu of options	Examples
1. Self-care	Knee workshops for patients with osteoarthritis, helping more patients manage their own condition
2. Improve referrals	Consultants offering advice to GPs considering a referral, reducing the number referred to hospital
3. Enhanced triage	Gastroenterology consultants reviewing referrals virtually, and discharging patients straight away where applicable / ordering necessary tests before seeing them
4. Alternative services	First Contact Practitioner service offers patients with back/joint pain contact with a physiotherapist directly rather than waiting to see a GP or being referred to hospital
5. Different kinds of appointment	
a) One stop shops	‘one stop shop’ appointments for patients to undergo a number of diagnostics/tests on the same day, or for patients with multiple co-morbidities to see more than one specialist on the same day
b) Via alternative media	Video consultations
6. Different kinds of follow-up	
a) Open access	Open access follow-up, where patients can request a follow-up if they want one (e.g. following minor surgery)
b) Via alternative media	Phone follow-up clinics for patients who have had prostate surgery

We will work closely with system partners to deliver change

The successful transformation of outpatient services will rely not just on the Trust, but on our partners in primary care (e.g. making changes in referral practice) and commissioners.

We will therefore adopt a collaborative, place-based approach to transformation, working closely with our partners across Wandsworth and Merton. We will pool resource via virtual teams that straddle the Trust and CCG, and oversee the programme of work via joint governance.

In some places, there may be ways we can deliver greater benefits for our patients, at greater pace, by collaborating across South West London (for instance, by procuring common IT solutions once, or designing a single model of care in one specialty where there is appetite to do so across the region). In such cases we will collaborate with partners across South West London, taking a systematic approach to identifying opportunities for regional joint working.

The pace of change will accelerate over time

Once the Trust has put in place the key enablers for change (such as the roll-out of iClip for outpatient services, and the restructure of the corporate outpatient department), it will be able to accelerate progress. The more specialties are supported through change, the more quickly the Trust will be able to support others to follow suit, creating a snowball effect.

We therefore expect the growth in new models of care, and the reduction in face-to-face activity, to start at a relatively modest pace and accelerate over time, delivering a 33% reduction in face-to-face activity within five years (in line with the national NHS plan).

We will prioritise delivering improvements in quality and waiting times, with cost savings following later

Delivering outpatient services differently should lead to better experience for those patients able to use services differently, with fewer unnecessary trips to hospital. The changes we are pursuing should also release capacity (e.g. if enhanced triage leads to fewer patients being sent to hospital, or if a clinician can deliver more phone-based follow-ups per clinic than face-to-face) – and this should enable the Trust to improving waiting times.

Ultimately, if these changes release capacity they could also enable the Trust to reduce costs (e.g. by reducing the amount of space we need to deliver outpatient services). But this will only be possible once the volume of face-to-face activity is significantly reduced, and once reductions in waiting times have been delivered.

Our first priority will therefore be to improve patient experience and waiting times, with cost reductions potentially following in later years.

We will implement this strategy via the annual business planning process

Each year, the Trust will incorporate into its annual business plan for the year ahead:

- An identified set of specialties to be supported to deliver new models of outpatient care
- The resources required to support those specialties
- A clear trajectory for the changes in face-to-face and ‘virtual’ activity that will deliver

Progress in delivering against these annual plans will then be monitored and reported to Board on a regular basis.

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St George's University Hospitals NHS Foundation Trust

2.2

Meeting Title:	**Council of Governors**		
Date:	**19 February 2020**	**Agenda No**	**2.2**
Report Title:	**Quality account priorities update and quality account planning**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control**		
Report Author:	**Alison Benincasa, Director of Quality Governance and Compliance**		
Presented for:	**Assurance**		
Executive Summary:	**Introduction** The Trust is required to publish a quality account each year. The quality account is an important way for providers to report on quality and show improvements in the services they deliver to local communities. It helps Trusts to improve public accountability for the quality of care provided. The quality account is a document in its own right. NHS England and NHS Improvement also require all NHS Foundation trusts to produce a quality report as part of the Trust annual report. Our quality account will also serve as the quality report within the Trust annual report. As part of the development of its quality account the Trust is required to engage with its Council of governors and other key stakeholders to actively seek input into its development. **Progress against quality account priorities 2019-20** An update on the progress made with the quality account priorities 2019-20 is shown at slides 10 and 17-18. The report highlights that one of the nine quality account priorities was completed (improved performance in complaints response times) and significant progress has been made across the remaining eight. Whilst progress has been made it is recognised that more focus is required to ensure our quality account priorities are fully embedded across the Trust to ensure the outcomes are achieved. **Proposed quality account priorities 2020-21** The proposed quality account priorities for 2020-21 are outlined at slide 12, including the rationale for inclusion (and are in line with year 1 of our Quality and safety Strategy 2019-24). **Governor selection of one local indicator for external audit** External auditors (Grant Thornton) are required to provide external assurance for quality reports on two mandated indicators and on one local indicator selected by governors. The two mandated indicators for the Trust are: 1. Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge 2. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period Governors are required to select one local indicator for audit based auditable indicators in the quality report. To help with this selection a list of possible indicators has been provided at slide 14.		

	Annex Slides 16-22 to provide additional information for the quality account including the set of core national quality indicators, the timetable for development of the quality account and information relating to the wider quality agenda in the Trust.		
Recommendation:	1. Note the progress made with reference to the quality account priorities 2019-20 2. Agree the quality account priorities for 2020-21 and/ or make recommendations for change 3. Select one local quality indicator for external audit		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person		
CQC Theme:	Safe, Effective, Responsive, Caring and Well led		
Single Oversight Framework Theme:	1. Quality of Care (safe, effective, caring, responsive) 2. Leadership and Improvement Capability (well-led)		
Implications			
Risk:	Failure to deliver the quality account in line with legislation will result in reputational damage, loss of confidence in the organisation, and perceived failure of leadership		
Legal/Regulatory:	The Health Act 2009 The NHS (Quality Accounts) Amendment Regulations 2017 ('the quality account regulation')		
Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	N/A	**Date**	
Appendices:	Appendix 1 – Quality Account		

2.2

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Quality Account

Council of Governors

19 February 2020

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Purpose of the session

- Update on progress against the quality account priorities 2019-20
- Discuss and agree the quality account priorities 2020-21
- Discuss selection of the local quality indicator for external audit

Introduction

There are ***two specific pieces of legislation*** governing NHS healthcare providers (Foundation Trusts) to publish a ***quality account*** each year: The Health Act 2009; and The NHS (Quality Accounts) Amendment Regulations 2017 ('the quality account regulations').

The quality account is an important way for providers to ***report on quality and show improvements*** in the services they deliver to local communities. It helps Trusts to ***improve public accountability*** for the quality of care provided.

The quality account is a document in its own right. NHS England and NHS Improvement also require all NHS Foundation trusts to produce a quality report as part of the Trust annual report. Our ***quality account*** will also serve as the ***quality report*** within the ***Trust annual report.***

Our quality account priorities 2019-20: three quality themes

As required by the quality account regulations we categorised each quality account priority under one of ***three quality themes*** below:

1. ***Patient safety:*** having the right systems and staff in place to minimize the risk of harm to our patients and, if things do go wrong, to be open and learn from our mistakes

2. ***Patient experience*****:** meeting our patients' emotional as well as physical needs

3. ***Clinical effectiveness:*** providing the highest quality care, with world class outcomes whilst also being efficient and cost effective

Our quality account priorities 2019-20: Improving Patient Safety

In line with the quality account regulations the Trust identified three quality priorities for improving patient safety:

- ***Treatment escalation plans:*** we will ensure that all non-elective adult inpatients have a treatment escalation plan (TEP) in place within 24 hours of admission

- ***Identification, protection and care of patients who lack mental capacity to make certain decisions:*** we will demonstrate through audit of healthcare records that patients who lack mental capacity are identified promptly, and have proper protection and care. We will achieve compliance with our training targets for MCA training

- ***Recognising the deteriorating patient:*** we will identify deteriorating patients early and so reduce the number of cardiac arrests compared with the 2018/19 baseline. We will improve the outcomes in our audits on appropriate response to the National Early Warning Score (NEWS2)

Our quality account priorities 2019-20: Improving Patient Experience

In line with the quality account regulations the Trust identified three quality priorities for improving patient experience:

- ***Provide a responsive, high quality complaints service:*** we will achieve our targets for responding to complaints by the end of September 2019

- ***Build a patient partnership structure to enable patients to be involved in improvement work from the earliest stage:*** we will deliver year one of the strategy and develop the strategy for the next three years

- ***Improve immediate feedback from patients through the Friends and Family Test (FFT) by increasing response rates for both inpatient and outpatient services:*** we will achieve a response rate of at least 20% by the end of 2019-20 for both inpatient and outpatient services and the emergency department

Our quality account priorities 2019-20: Improving Effectiveness and Outcomes

In line with the quality account regulations the Trust identified three quality priorities for improving effectiveness and outcomes:

- ***Improve services for people with mental health needs who are in an acute healthcare setting:*** we will demonstrate through audit of healthcare records that patients' mental health needs have been met when they are receiving care from our acute services

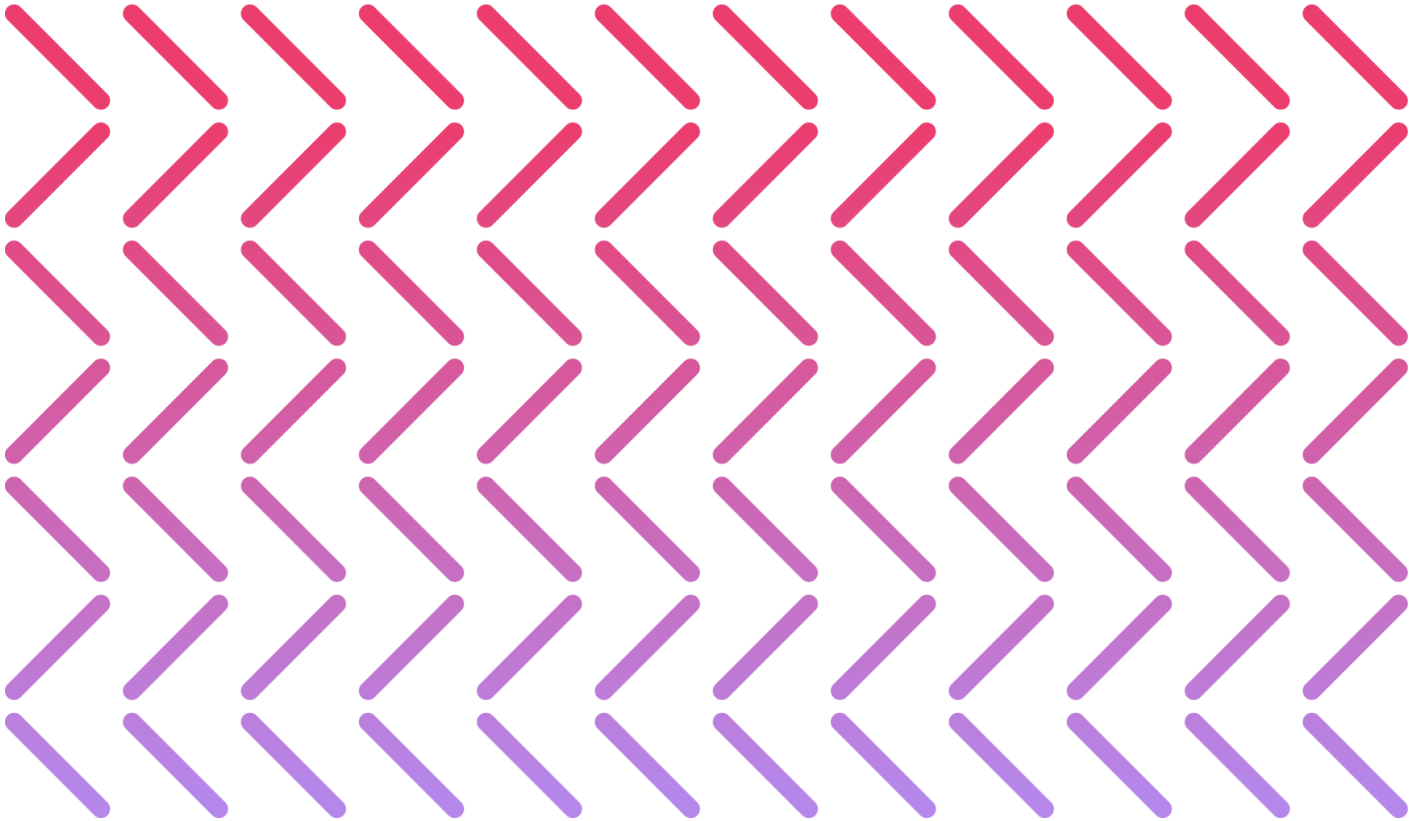
- ***Improve the effectiveness of our discharge process ensuring that patients are equipped with the information they need to manage their health and that they know how to access appropriate support:*** we will see an improvement in the response to these questions on our local patient surveys and in the national patient survey 2019

- ***Improvement review of clinical governance:*** we will carry out a review of our clinical governance processes throughout the trust to ensure they support the delivery of safe, high quality care

2.2

Quality Account Priorities 2019-20

Progress to date and remaining issues



Our quality account priorities 2019-20: High level progress to date

Improving Patient Safety	RAG	Recommended for inclusion in 2020-21
Implement treatment escalation plans	A	√
Identify, protect and care of patients who lack mental capacity	A	√
Recognise and respond to the deteriorating patient	A	√
Improving Patient Experience		
Provide a responsive, high quality complaints service	G	Revised focus
Build a patient partnership structure	A	Revised focus
Improve immediate feedback from patients through the Friends and Family Test (FFT)	A	Revised focus
Improving Effectiveness and Outcomes		
Improve services for people with mental health needs who are in an acute healthcare setting	A	Revised focus
Improve the effectiveness of our discharge process	A	√ Under patient experience
Improve clinical governance	A	Revised focus

See Annex slides 17 and 18 for further detail

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2.2

Proposed Quality Account Priorities 2020-21

Action for the Council of Governors

1. Do you support these quality priorities?

2. Are there any areas missing?

Proposed quality account priorities 2020-21: For inclusion in Quality Account 2019-20*

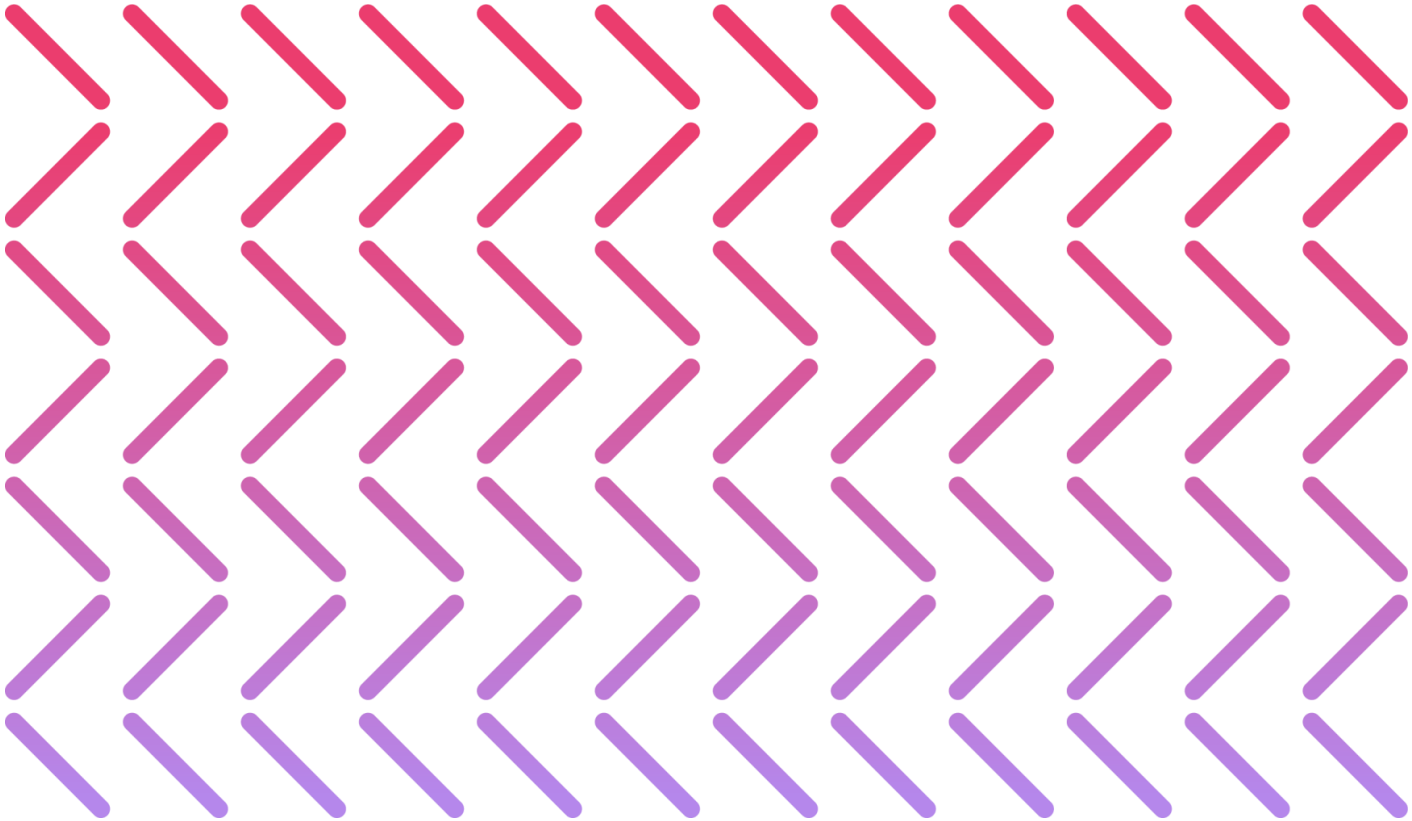
***These are also in line with year 1 of our Quality and Safety Strategy 2019-24**

Quality Priority 2020-21	Comment/ Rational for Inclusion	Link to corporate objective 20-21 and Quality and Safety Strategic priority 2019-24
Improving patient safety		
1.All non-elective adult patients will have treatment escalation plans within 24 hours of admission **2.**Patients who lack mental capacity will have proper protection and care and all patients will be supported to give consent for their treatment * 3.Inpatients who deteriorate will be recognised and treated promptly **4.**Implement and embed processes to ensure we learn from deaths	It is proposed to roll-over these priorities from 2019-20 into 2020/21 with a slight amendment to one (2) and introduce one new priority (4) - this is because whilst progress has been made to deliver the priorities in the current year, it is recognised that more focus is required to ensure these are fully embedded across the Trust to ensure the outcomes are achieved *The current priority regarding mental capacity has been expanded to include 'consent' as this was one of the recommendations from the CQC report	**Treat the patient, treat the person** **Reduce harm to patients**
Improving patient experience		
5.Monitor and review feedback to ensure continual improvement so we provide patients with an excellent experience through their journey with us 6.Develop a plan, working with our system partners, to ensure we provide patients with an equitable experience particularly patients from vulnerable groups 7.Improve patient flow particularly with reference to improved discharge processes	These are key priorities for the quality and safety strategy which will be a focus for 2020-21 and build on the quality priorities in the quality account 2019-20	**Treat the patient, treat the person** **Provide patients with an excellent experience** **Provide patients with an equity of access and quality**
Improving effectiveness and outcomes		
8.Through our leadership of the SWLSTG-SGUH Mental Health reference group we will develop an approach to diabetes to integrate physical and mental health across the Trust and wider health system 9.We will work to embed a culture where governance of quality, safety and learning is embraced across the organisation 10.Patients will not wait long for treatment	These are key priorities for the quality and safety strategy which will be a focus for 2020-21 and build on the quality priorities in the quality account 2019-20 8.This is one objective of the SWLSTG-SGUH Mental Health reference group and is aimed at tackling health inequalities of 'lost years' for people with severe mental illness. 9 & 10 This is a follow-up to the current corporate objective 2019-20 which relates to the clinical governance review approved at Trust Board in December 2019. The emphasis in 2020-21 will be to ensure the action plan to deliver the recommendations of the review is implemented consistently across the organisation. This is a priority of the Quality and Safety Strategy 11.The Trust's responsibility to meet the constitutional standards around emergency, cancer, diagnostic and elective (RTT) care are a given and tracked through the monthly performance process, up to and including, Trust Board. The quality priority is to now aim to deliver these standards (against agreed trajectories for each standard) against GIRFT and Model Hospital benchmarking	**Treat the patient, treat the person** **Provide patients with an equity of access and quality** **Embed a quality, safety and learning culture**

Local indicator for external audit

Action for Council of Governors

1. Selection of one local indicator for audit



Governor selection of the local indicator for external audit

(Audit will be undertaken by Grant Thorton)

Last year, due to NHSI guidance, Governors were advised to select SHIMI (Summary Hospital-level Mortality Indicator) as the local indicator for external audit. The indicators below are those that were reported in the quality report and are therefore auditable.

1. **Mortality:** value and banding of the Summary Hospital-level Mortality Indicator (SHIMI) for the Trust and percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust

2. **Patient reported outcome measures (PROMs) scores:** groin hernia surgery; varicose vein surgery; hip replacement surgery; and knee replacement surgery
   (NOTE: The Trust performs only a small number of knee and hip replacements (complex) and the majority of routine cases are referred to the South West London Elective Orthopaedic Centre. This indicator is not recommended for audit).

3. **Readmission within 28 days of discharge:** percentage of patients readmitted within 28 days shown by age 0 to14 and 15 or over

4. **Patient experience:** our score for the five questions in the national inpatient survey relating to responsiveness and personal care

5. **Staff recommendation to friends and family:** percentage of staff employed by the trust who would recommend the Trust as a provider of care to their family and friends

6. **Venous thromboembolism (VTE):** percentage of patients admitted who were at risk of VTE

7. **Infection control:** rate per 1000,000 bed days of reported C. *difficile* cases for patients aged 2 and over

8. **Patient safety incidents:** number and rate of patient safety incidents reported within the Trust and the number and percentage that resulted in severe harm

9. **Provide a responsive high quality complaints service:** percentage performance against Trust response targets

10. **Maximum waiting time of 62 days from urgent referral to first treatment for all cancers:** percentage of cancer patients treated within 62 days of urgent GP referral and percentage of patients treated within 62 days from screening referral

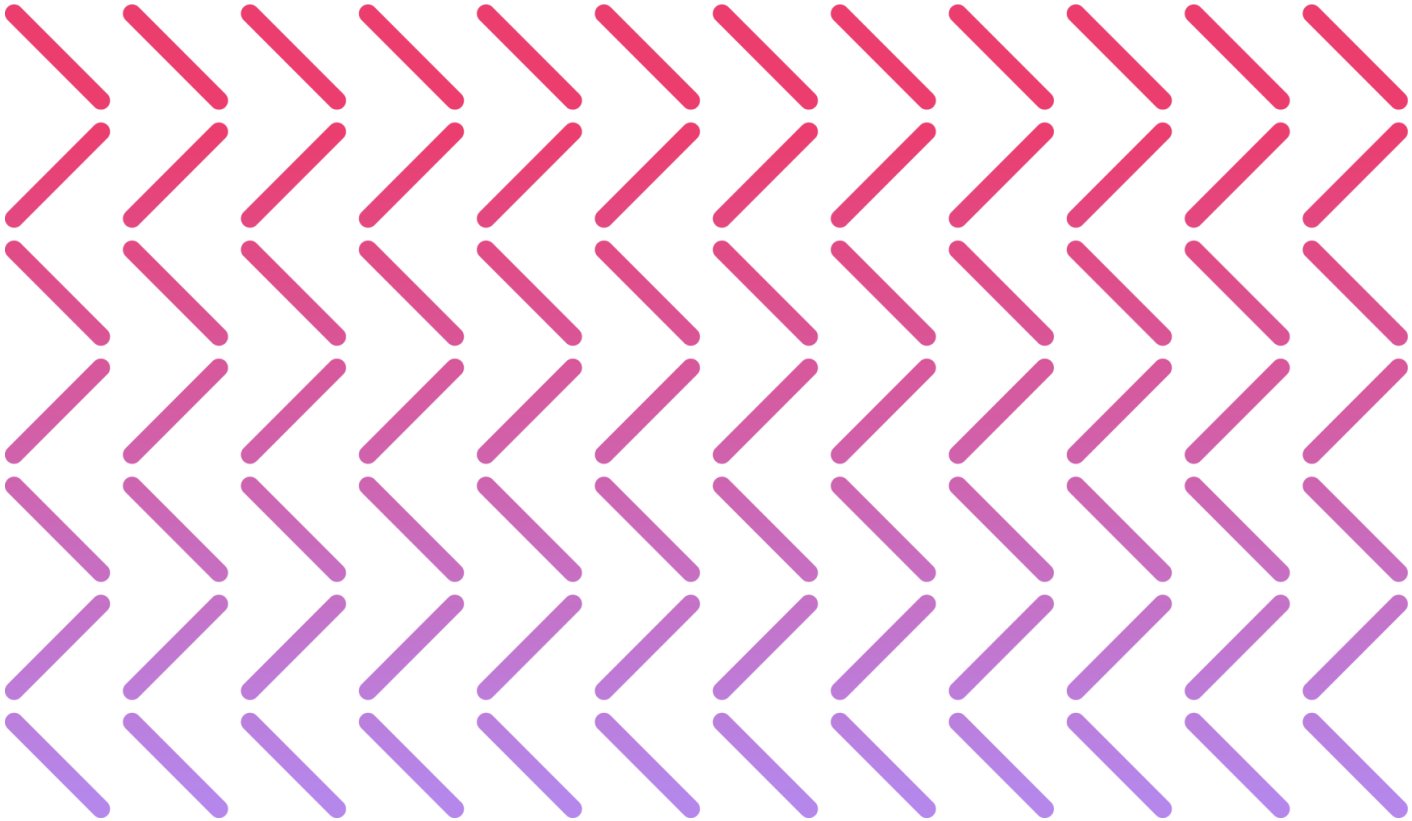
The two mandated indicators for external audit

The two indicators for external audit year ended 31 March 2019 consisted of number 1 and 3 outlined below.

This year the Trust is required to select from the list below in order (i.e. if 1 and 2 are both reportable then those should be selected). Therefore, as both are reportable, the **Trust is mandated to select indicators 1 and 2.**

Mandated indicators: NHS foundation trusts providing acute services
1. Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
2. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
3. Maximum waiting time of 62 days from urgent referral to first treatment for all cancers
4. Emergency readmissions within 28 days of discharge from hospital

ANNEX

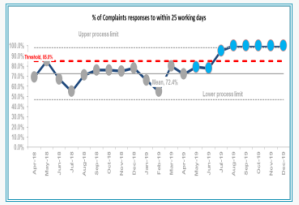


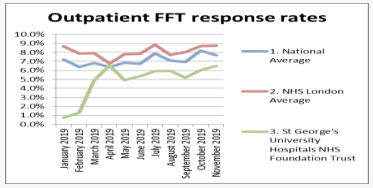
Our quality account priorities 2019-20: Detailed progress to date and remaining issues

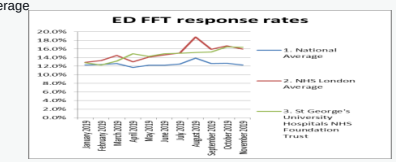
QUALITY ACCOUNT PRIORITY 2019-20	OVERALL PROGRESS TO DATE	REMAINING ISSUES & SAMPLE KPIs
IMPROVING PATIENT SAFETY		
1.Emergency patients will have treatment escalation plans (TEP) within 24 hours of admission	• Treatment Escalation Plan developed (paper format) and implementation commenced • Electronic Treatment Escalation Plan built in test domain of iClip (electronic patient records) • Baseline audit undertaken	• Trust wide roll out of iClip TEP at pace supported by education and training of staff • Test domain re-launch before approval • Revise Key Performance Indicators to improve performance monitoring
2.Patients who lack mental capacity will have proper protection and care	• Developed staff reference cards – information and guidance at a glance to support staff making evidence based treatment decisions on a range of key topics e.g. Mental Capacity Assessment and Depravation of Liberty assessment, safeguarding children and adults • Established a working group for the development of standard documentation of Mental Capacity –Assessment and Best Interest Decisions • Developed draft standardised documentation for assessment of mental capacity and best interest decision making • Developed South West London audit/ staff knowledge survey to understand the baseline knowledge in our staff groups, benchmark our position with other trusts and assess the impact of our level 1 and 2 training programmes • Developed level 2 training to extend the learning at level 1 • Completed a training needs analysis to identify staff required to complete level 1 and 2. • Implemented 2 levels of MCA awareness training on the e-learning platform • Achieved compliance with level 1 training and saw improvement in level 2 • Staff knowledge regarding MCA/DoLs is incorporated into the ward/department accreditation system. This is a pulse check each month based on a small sample of staff. These results are reported as part of the IQPR to the Board. In addition to this a staff knowledge audit has been developed in collaboration with partners across SW London. This will be launched in Q4 • In support of the continued need to improve practice for MCA and DoLs in the Trust a new post of Lead for MCA has been created and appointed to on the 10 January 2020	• Test documentation on iClip (electronic patient records) • Develop iClip training and support for staff • Revise Key Performance Indicators to improve performance monitoring • Implement South West London audit/ staff knowledge survey to support continual improvement • Increase focus on achieving 85% training performance for all staff groups across all divisions Table 1: Staff training compliance MCA level 1 and 2 by division and staff group
3.Inpatients who deteriorate will be recognised and treated promptly	• The updated national early warning score assessment process (NEWS2) implemented in iClip • Critical care outreach team launched December 2019 • Focus on achieving 85% training compliance across all staff groups for all resuscitation modules	• Easy view access to observations • Completion of recruitment to critical care outreach team • Revise KPIs to improve performance monitoring • Trajectory for compliance against 85% Resus training performance not met due to high level of on the day non-attendance and increase focus on achieving 85% compliance for all staff groups across all divisions

Area	Level 1	Level 2
Trust	89.6%	74.6%
Medcard	88%	74%
SNCT	94%	67%
CWDT	87%	82%
Corporate	88%	63%
Estates and Facilities	90%	-NA
Add Prof Scientific and Technical	93%	88%
Additional Clinical Services	89%	63%
Administrative and Clerical	89%	80%
AHP	91%	92%
Estates and Ancillary	91%	-NA-
Health Care Scientists	93%	100%
Medical and Dental	80%	54%
Nursing and Midwifery	89%	88%

	IMPROVING PATIENT EXPERIENCE	REMAINING ISSUES & SAMPLE KPIs
4.Provide a responsive, high quality complaints service	• Restructured the complaints service to bring in senior staff resource • Our response rates for complaints has been above the 85% response target for all categories since August 2019 and 100% for all categories since September 2019	• Increase the focus on learning from complaints and shared learning across the Trust • Improve the monitoring of the completion of improvement actions Figure 1: Complaints response times compliance performance April 2018 – December 2019
5.Build a patient partnership structure to enable patients to be involved in improvement work from the earliest stage	For the first year of the Patient Partnership and Experience Group (PPEG) objectives were set within two broad areas - improving our ability to obtain a diverse range of patient feedback and creating new communication channels explaining the work of PPEG. The following progress has been made: • Reviewed PPEG with revised terms of reference and action plan for delivery against the two broad areas • Developed a toolkit for staff setting up a user group and considering how to effectively involve patients • Participated in key service development within ED, Pharmacy, Cancer, Maternity and Outpatients • Participated in recruitment of staff within Patient Experience team • Supported the development of user groups for dermatology and urology • Worked on the PPEG website • Developed the PPEG Charter • Contributed to Trust Strategies, including the Quality and Safety Strategy (which incorporates Patient Experience)	We will continue to maintain our focus on improving patient experience as one of our seven strategic priorities in our Quality and Safety Strategy 2019-24: We will **provide patients with an excellent experience** through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients Figure 2: Inpatient FFT responses compared with National and London average
6.Improve immediate feedback from patients through the Friends and Family Test (FFT) by increasing response rates for both inpatient and outpatient services	The Trust established a target of 20% response rate for FFT across all services. In order to achieve this the following actions were taken: • Weekly automated report to the matrons, Heads of Nursing and DDNG detailing the number of responses achieved each week and how this equates as a percentage based on the average number of discharges per ward • Replacement of broken tablets across wards and departments and issuing of individual tablets to matrons and Heads of Nursing to support with audit • Implementation of patient survey including FFT on the Trust	







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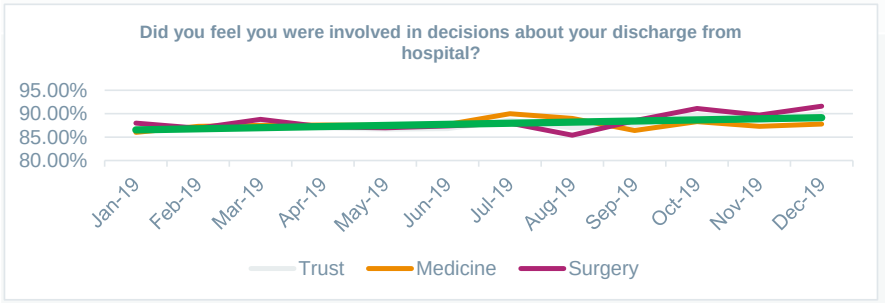
Our quality account priorities 2019-20: Detailed progress to date and remaining issues

Quality account priority 2019-20	Overall progress to date	
	IMPROVING EFFECTIVENESS AND OUTCOMES	**REMAINING ISSUES & SAMPLE KPIs**
7.Improve services for people with mental health needs who are in an acute healthcare setting	• Established a joint Mental Health Reference Group between St Georges Mental Health Trust and St Georges NHS FT • Delivered Foundations of Psychological Care course to all new Healthcare assistants within St Georges • Delivered training to all newly qualified band 5 nurses on the principles of mental health • Two mental health nurses included in Emergency Department nursing establishment • Agreed a standard operating policy for the documentation of assessments completed by the psychiatric liaison team • Reviewed leadership capacity and developed a new role: Head of Nursing for Mental Health	• Establish a mental health delivery group to improve governance around mental health within St Georges • Complete a business case if required for the newly developed Head of Nursing for Mental Health • Complete a training needs analysis for staff specific to mental health, including a joint training agreement between ST Georges and the Mental Health Trust. • Review the service level agreement for the provision of psychiatric liaison services at St Georges
8.Improve the effectiveness of our discharge process ensuring that patients are equipped with the information they need to manage their health and that they know how to access appropriate support	• Review of patient experience of discharge through the departure lounge by Healthwatch • Established long length of stay meetings within Medicine and Cardiovascular to help facilitate discharges of complex patients • Incorporated Red to Green reporting on iClip	 Figure 5: Patient involvement in discharge planning There is an upward trend in our patients reporting involvement in their discharge arrangements. NB: Children's services have been included in the overall trust data due to the low number of respondents.
9.Improvement review of clinical governance	• Completed two external governance reviews of morbidity and mortality monitoring and capacity of clinical governance structures • Developed an action plan to capture the recommendations from the two external reviews and commenced implementation • Developed a business case for investment • Took a paper to the Trust Board outlining the investment required to strengthen governance processes and secured additional investment for staff resources to strengthen governance processes, circa £0.75M • Scoped a third external review to assess the effectiveness of quality and safety reporting and monitoring through the existing meeting structures up to the Quality and Safety Committee and to the Board	• Increase pace of delivery against review recommendations e.g. recruit to the enhanced governance team structures and mortality monitoring meeting coordinators • Undertake third external review and implement agreed recommendations • Undertake internal audit of risk management processes with subject matter expert input from NHSI/E and implement agreed recommendations

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National core set of quality account indicators: will also be reported in our quality account 2019-20

In 2012 a statutory core set of quality indicators came into effect. All Trusts are required to report their performance against these indicators, of which there are eight for acute trusts, in the same format with the aim of making it possible for the reader to compare performance across similar organisations. For each indicator our performance will be reported in our quality account together with the national average and the performance of the best and worst performing trusts.

1. **Mortality:** value and banding of the Summary Hospital-level Mortality Indicator (SHIMI) for the Trust and percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust
2. **Patient reported outcome measures (PROMs) scores:** groin hernia surgery; varicose vein surgery; hip replacement surgery; and knee replacement surgery
3. **Readmission within 28 days of discharge:** percentage of patients 0 to14 and 15 or over
4. **Patient experience:** our score for the five questions in the national inpatient survey relating to responsiveness and personal care
5. **Staff recommendation to friends and family:** percentage of staff employed by the trust who would recommend the Trust as a provider of care to their family and friends
6. **Venous thromboembolism (VTE):** percentage of patients admitted who were at risk of VTE
7. **Infection control:** rate per 1000,000 bed days of reported C. *difficile* cases for patients aged 2 and over
8. **Patient safety incidents:** number and rate of patient safety incidents reported within the Trust and the number and percentage that resulted in severe harm

Quality and Safety Strategy 2019-24: Strategic priorities set against quality account three themes

IMPROVING PATIENT SAFETY

- We will **minimise avoidable harm across** our organisation, utilising the developments in technology, reducing unwarranted variation and embedding further, robust quality assurance and learning processes
- We will **embed a culture** in which **quality, safety and learning** is embraced across the organisation, and is supported by robust systems of safety governance

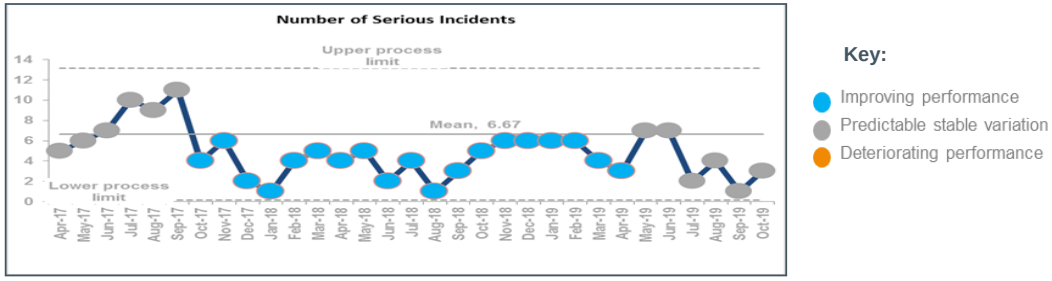
IMPROVING PATIENT EXPERIENCE

- We will **provide patients with an excellent experience** through their journey with us, monitoring and acting on feedback to ensure continual improvements in the areas that matter the most to our patients
- We will improve **staff experience**, enabling staff to feel valued, supported, and equipped to deliver high quality safe care and improve their work via quality improvement methodology

IMPROVING EFFECTIVENESS AND OUTCOMES

- We will **improve outcomes for patients** through timely diagnosis, exceptional care and treatment and by working with our partners to ensure we contribute to developing the whole pathways of care for our patients
- We will **provide patients with an equity of access and quality** by proactively improving access and care for vulnerable groups
- We will be at the forefront of **providing and developing pioneering and leading edge treatments** for today and for the future

Progress against our Quality Improvement Programme 2019-20

Priorities 2019-20	Key progress to date	Remaining areas to address
Our clinical priorities		
Emergency patients will have treatment escalation plans (TEP) within 24 hours of admission	• Treatment Escalation Plan developed (paper format) and implementation commenced • Electronic Treatment Escalation Plan built in test domain of iClip (electronic patient records)	• Trust wide roll out of iClip TEP at pace supported by education and training of staff
Patients who lack mental capacity will have proper protection and care	• Developed staff reference cards – information and guidance at a glance to support staff making evidence based treatment decisions on a range of key topics e.g. Mental Capacity Assessment and Depravation of Liberty assessment, safeguarding children and adults • Achieved compliance with level 1 training and saw improvement in level 2 • Developed South West London audit/ staff knowledge survey to understand the baseline knowledge in our staff groups, benchmark our position with other trusts and assess the impact of our level 1 and 2 training programmes	• Improve and sustain compliance in level 1 and level 2 training • Implement South West London audit/ staff knowledge survey to inform targeted training and support
Inpatients who deteriorate will be recognised and treated promptly	• The updated national early warning score assessment process (NEWS2) implemented in iClip • Critical Care Outreach team launched December 2019 to improve quality of care provision and patient outcomes • Improved compliance across all staff groups for the 3 resuscitation modules. However, the Trust target of 85% compliance was not met, as of January 2020 Trust performance was 73.6%	• Completion of recruitment to critical care outreach team • Improve and sustain compliance in resuscitation training modules • Provide on-going training and education of our clinical staff • Explore further IT solutions for patient observations
Our non-clinical priority		
We will map, standardise, support and improve our departmental-level governance of quality, safety and learning	• Completed 2 external governance reviews • Developed an action plan to capture the recommendations and commenced implementation • Investment secured for additional staff to strengthen governance processes • The number of serious incidents has reduced from in 2019/20 and the general trend over the last 2 years has been a significant reduction (see figure 1 below) Figure 1. Number of Serious Incidents 2017-2019  	• Increase pace of delivery against review recommendations e.g. recruit to the enhanced governance team structures and mortality monitoring meeting coordinators • Review and embed optimal governance reporting systems from ward/ department to board

Annual report 2019/20: Indicative timetable (1 of 2)

2019/20 Indicative timetable		
Date	**Governance group**	**Action**
21 January	Audit Committee	Approve plan and timetable for production and submission of Annual Report and Accounts 2019/20.
		Agree accounting policies
23 January	Finance and Investment Committee	Approve year-end timetable and agree accounting policies
19 February	Council of Governors	Draft quality priorities presented to Council of Governors. Council of Governors agree quality indicator for scrutiny by the External Auditors.
25 February	Quality and Safety Committee	Draft quality priorities presented to the Quality and Safety Committee for consideration.
10 April	External auditors	First draft Annual Report sent to External Auditors.
15 April	Audit Committee	Draft financial position considered by Audit Committee
		First draft Annual Report considered by Audit Committee
		First draft Quality Account considered by Audit Committee
23 April	Finance and Investment Committee	Draft financial position considered by FIC
23 April	Quality and Safety Committee	First draft of Quality Account considered by Quality and Safety Committee.
24 April	External consultation	Start of consultation with commissioners, Healthwatch, and Overview and Scrutiny Committees on Quality Account.
24 April (tbc)	NHS Improvement	Draft accounts submitted to NHSI

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Annual report 2019/20: Indicative timetable (2 of 2)

2019/20 Indicative timetable		
Date	**Governance group**	**Action**
27 April (tbc)	External Auditors	External Auditors begin audit
10 May (tbc)	External Auditors	External Auditors finish audit
14 May	Audit Committee	Annual Report and Accounts workshop (Committee members and Executive leads only).
18 May	Audit Committee	Proposed final draft Quality Account submitted to Audit Committee for approval as part of final draft ARA.
21 May	Trust Board	Extraordinary Trust Board meeting to consider and approve Annual Report and Accounts, including Quality Account.
29 May (confirmed)	NHS Improvement	Deadline for submission of Annual Report and Accounts (inc. Quality Account) to NHSI
29 June (tbc)	NHS Choices	Quality Account published on NHS Choices.
16 July (tbc)	Parliament	Full Annual Report and Accounts 2018/19 laid before Parliament.
September	Annual Members' Meeting	Annual Accounts presented to AMM.

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St George's University Hospitals NHS Foundation Trust

2.3

Meeting Title:	**Council of Governors**		
Date:	**19 February 2020**	**Agenda No**	**2.3**
Report Title:	**CQC Inspection Report December 2019**		
Lead Director/ Manager:	**Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control** **Richard Jennings, Chief Medical Officer**		
Report Author:	**Alison Benincasa, Director of Quality Governance and Compliance**		
Presented for:	**Noting**		
Executive Summary:	The purpose of this report is for the Group to formally receive the CQC Inspection Report 2019. The CQC inspection was conducted between July and September 2019, five of our eight core services were assessed (Urgent and Emergency Care, Medical Care, Surgery, Children and Young People and Outpatients) including an assessment of Trust leadership (well led). Surgery was rated as good overall and services for Children and Young people were rated as outstanding (see page 17 of the report for detail about other core services). The CQC confirmed the overall rating for the Trust as ***Requires Improvement*** and has recommended to NHSI/E that the Trust is removed from Quality Special Measures. The Trust received two requirement notices (MUST dos), see appendix 2 for the detailed improvement action plan which was submitted to the CQC on 16 January 2020. **MUST do's – Trust wide** • Make sure all patient records are stored securely, completed accurately and kept confidential • Make sure consent is correctly recorded in patients notes in line with best practice The Trust was informed of forty-four further issues across six service areas where the Trust should make improvement: **SHOULD do's – Urgent and Emergency care** • Complete all documentation correctly, including fluid balance charts, pain scales and Glasgow Coma Scales • Check that all equipment is clean, safe for use, and appropriate checklists completed • Improve the BAME knowledge and support within the department • Display information about how to raise a concern in all patient areas • Ensure all medicines correctly prescribed and administered • Ensure all patients have necessary risk assessments completed and documented, and that these are updated **SHOULD do's – Medical Care** • Continue work to improve vacancy, sickness and turnover rates amongst nursing staff • Continue work to improve completion rates of mandatory training amongst medical staff		

- Improve the consistency of completion of patient records including risk assessments and reach out to me forms
- Improve the recording of actions taken when fridge temperatures are out of range
- Continue with plans to improve the catheter laboratory to provide a safe service for patients and staff
- Reduce the number of patient-moves at night
- Improve the referral to treat time (RTT) in the five specialities where they fell below the England average

SHOULD do's – Surgery

- Continue work to improve vacancy, sickness and turnover rates amongst nursing staff
- Continue work to improve the environment across the surgical division
- Continue work to improve completion rates of mandatory training amongst medical staff
- Continue work to improve appraisal rates for staff across the surgical division
- Consider further ways to improve staff wellbeing in light of staffing shortages
- Update and ensure staff have access to the deteriorating patient policy
- Ensure all locum medical complete a full local induction
- Continue work to improve waiting times from referral to treatment and arrangements to admit, treat and discharge patients to bring them in line with national standards

SHOULD do's – Surgery at QMH (day case unit)

- Have a policy in place for seeing paediatric patients
- Improve staff awareness on learning from incidents
- Ensure records are stored securely
- Update and ensure staff have access to the deteriorating patient policy
- Continue to work to improve nurse staffing levels
- Ensure relevant learning from audits is shared across both sites and ensure data is consistently collected for audits and action plans completed where necessary
- Work to improve staff appraisal rates
- Ensure consent form documentation is fully completed
- Ensure senior staff are clear of who has overall responsibility and oversight of surgery (day case) at Queen Mary's Hospital
- Ensure risk registers are completed with up to date information

SHOULD do's – Children and Young People

- Continue work to improve completion of nursing staff annual appraisals
- Continue work to improve the amount of staff qualified in speciality working within the neonatal unit and paediatric intensive care
- Continue work to improve completion rates of mandatory training amongst medical staff
- Consider further ways to improve staff engagement, well-being and address concerns highlighted in staff survey
- Continue with recruitment and retention strategies to reduce vacancy, turnover and sickness rates
- Consider how to avoid mixed sex breaches
- Continue with the planned refurbishment to make the premises suitable for modern day healthcare

	SHOULD do's – Outpatients • Consider an effective process for quality improvement and risk management • Improve its local audit programme and review national audit outcomes to improve patient outcomes • Complete infection prevention and control audits regularly and take action to address concerns including risks associated with the environment for decontamination of naso-endoscopes were embedded in practice • Improve staff compliance with mandatory training, including information governance safeguarding level three and resuscitation • Provide adequate seating facilities in clinics, to ensure patients and relatives have enough seating areas • Develop systems and processes which enable the trust to determine the quality and performance of its outpatients department		
Recommendation:	1. Formally receive the CQC Inspection Report 2019 2. Note the Trust action plan to address the two requirement notices (MUST dos) was submitted to the CQC on 16 January 2019 3. Note the **a** Trust wide action plan to address all improvement actions is currently under development		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person		
CQC Theme:	Safe, Effective, Responsive, Caring and Well led		
Single Oversight Framework Theme:	1. Quality of Care (safe, effective, caring, responsive) 2. Leadership and Improvement Capability (well-led)		
Implications			
Risk:	Failure to deliver quality improvements in line with the expectations of the CQC will result in reputational damage, loss of confidence in the organisation, and perceived failure of leadership		
Legal/Regulatory:	Level of compliance with CQC key lines of enquiry		
Resources:	N/A		
Equality and Diversity:	No issues to consider		
Previously Considered by:	Trust Executive Committee Quality and Safety Committee Trust Board Patient Safety and Quality Board	**Date**	22.01.2020 23.01.2020 30.01.2020 19.02.2020
Appendices:	Appendix 1 - CQC Inspection Report 2019 Appendix 2 - CQC Requirement Action Plan (MUST dos)		

St George's University Hospitals NHS Foundation Trust

Inspection report

St Georges Hospital
Blackshaw Road, Tooting
London
SW17 0QT
Tel: 02086721255
www.stgeorges.nhs.uk

Date of inspection visit: 17 July to 5 Sept 2019
Date of publication: This is auto-populated when the report is published

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**
Use of resources rating for this trust	**Requires improvement**

Summary of findings

Combined quality and resource rating for this trust

Requires improvement

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Background to the trust

St George's University Hospitals NHS Foundation Trust is a teaching trust with two hospital locations; St George's Hospital, Tooting, and Queen Mary's Hospital, Roehampton.

The main acute site is St George's Hospital, which provides general and specialist services including PPCI, HASU and Major Trauma Centre and has an emergency department. Queen Mary's Hospital does not have an emergency department, but it does have a Minor Injuries Unit.

St George's University Hospitals NHS Foundation Trust has 1,083 beds; 995 at St George's and 88 at Queen Mary's. The beds at St George's Hospital comprise of 871 general and acute, 67 maternity, 57 critical care. The beds at Queen Mary's Hospital comprise of 46 for people with limb amputations who require neurorehabilitation and 42 for sub-acute care, treatment and rehabilitation of older people. The hospitals are both in the London Borough of Wandsworth. The lead clinical commissioning group is Wandsworth, who co-ordinates the commissioning activities on behalf of the other local clinical commissioning groups such as Merton and Lambeth.

The trust serves a population of 1.3 million across south west London. Several services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation, also cover significant populations from Surrey and Sussex, totalling around 3.5 million people.

The number of staff employed by the trust as of May 2019 was 8,932 staff.

The trust was had been in Quality Special Measures since November 2016 and Financial Special Measures since April 2017.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

➔ ➔

What this trust does

St George's University Hospitals NHS Foundation Trust provides acute district general and specialist services to the whole population of south west London and more specialist services for the population of Surrey and Sussex. St George's Hospital in Tooting is the only trust location which provides accident and emergency department services.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Summary of findings

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected St George's Hospital and Queen Mary's Hospital. At St George's Hospital, we inspected the core services of urgent and emergency services, medical care, surgery, services for children and young people and outpatients, as part of our continual checks on the safety and quality of healthcare services.

At Queen Mary's Hospital, we inspected surgery.

We selected the services for inclusion in this inspection based on those that were rated 'requires improvement' as a result of our findings at the previous inspection carried out in March 2018. Intelligence information we held on these areas indicated the need for re-inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed; Is this organisation well-led?

What we found

Our overall findings indicated that many areas made improvements. Of the services inspected, one was rated as outstanding, one was rated good and four were rated as requires improvement.

Overall, we rated safe, effective, responsive and well-led as requires improvement. We rated caring as good. We rated both St George's Hospital and Queen Mary's Hospital as requires improvement.

The trust was in special measures for both quality and finance. The trust was meeting the 62-day cancer standard and the two-week standard, but not meeting the accident and emergency four hour wait target. The trust returned to reporting Referral to Treatment (RTT) data for the St George's Hospital site to NHS England/Improvement in January 2019, after a two-year suspension. The trust was not meeting this standard, though it was meeting the trajectory it had agreed with NHS England/Improvement for this standard.

We found the urgent and emergency services at St George's Hospital remained as requires improvement. Effective and well-led improved from requires improvement to good. Caring remained as good. Safe and responsive remained as requires improvement.

Medical care at St George's Hospital remained as requires improvement. Caring remained as good. Safe and effective remained requires improvement. Responsive and well-led decreased from good to requires improvement.

Surgery at St George's Hospital improved to good. Safe and effective improved from requires improvement to good. Caring and well-led remained as good. Responsive remained as requires improvement.

Services for children and young people improved to outstanding. Caring and responsive improved from good to outstanding. Safe and well-led improved from requires improvement to good. Effective remained as good.

Outpatients at St George's Hospital remained as requires improvement. Safe improved from requires improvement to good. Caring remained as good. Responsive remained as requires improvement. Well-led improved from inadequate to requires improvement. We did not rate effective.

Summary of findings

Surgery at Queen Mary's Hospital remained as requires improvement. Safe improved from requires improvement to good. Effective and well-led remained as requires improvement. Caring remained as good. Responsive reduced from good to requires improvement.

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good. We rated one of the trust's 12 core services across two locations as outstanding, three as good, six as requires improvement and two were not rated. In rating the trust, we took into account the current ratings of the five services not inspected this time.
- We rated well-led for the trust overall as requires improvement.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Medical care and children and young people services did not always have enough staff with the right qualifications, skills, training and experience. However, there were mitigations in place to keep patients safe from avoidable harm.
- **Records were not always stored securely.** In the emergency department, casualty cards were unsecured in the cubicles in majors. In surgery at St George's Hospital, some patient identifiable information and do not resuscitate forms were in folders that were not marked as confidential. In the day care unit at Queen Mary's Hospital, some records were left in persons unlocked cabinets during the day. This meant records were accessible to unauthorised persons.
- Services provided mandatory training in key skills to all staff, however, not all staff had completed them.
- **Services did not always control infection risk well.** We saw examples of staff not washing their hands between patient contact.
- **Services were dealing with an ageing estate which at times was a risk to patient safety.** The trust had taken some actions to control the risk, such as filters on taps to prevent legionnaires disease and the pipework was flushed regularly to prevent leaks, but this was an ongoing challenge.

However:

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse, and they knew how to apply it.
- **Staff completed risk assessments for each patient swiftly.** They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.
- **Services managed patient safety incidents well**. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave people who used services and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- **Some policies were out of date.** This meant that staff did not have access to the most up to date evidence-based practice.
- The number of staff who received an annual appraisal was below the trust target in many wards and departments.

Summary of findings

- **Staff did not always monitor the effectiveness of care and treatment and did not always use audit findings to make improvements and achieve good outcomes for patients.** For example, on the medical care wards, not all patients had a pain score recorded in their records, which meant staff were not able to see whether a patient's pain score had changed after administering analgesia. However, wards used the results of their accreditation scheme to drive improvement.
- **Staff did not always record consent in patients' records.** We saw some examples in surgery at Queen Mary's Hospital, of forms not completed in full and inconsistent recording which meant staff were not sure correct consent for treatment had been obtained.
- **Not all patients had a pain score recorded in their records.** Some staff told us they did not use a pain score tool for patients and no score was recorded in their records. This meant staff were not able to see whether a patient's pain score had changed.

However:

- **Services provided care and treatment based on national guidance and evidence-based practice.** For example, they followed guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons
- **Staff gave patients enough food and drink to meet their needs and improve their health.** They used special feeding and hydration techniques when necessary. Services made adjustments for patients' religious, cultural and other needs.
- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.** They supported each other to provide good care.
- **Staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.** They used agreed personalised measures that limited patients' liberty.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- **People were not able to access services in a timely way**. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- **Referral to treatment (RTT) data for non-admitted pathways was worse than the England overall performance.** However, the trust only returned to reporting on referral to treatment data for St George's Hospital in January 2019.
- The trust was not meeting the emergency department national standard to admit, treat or discharge patients within four-hours.

Summary of findings

- **The trust did not always meet their threshold for 'did not attend' rates.** However, leaders discussed 'did not attend' rates at meetings and measures to improve them were considered, including texting and making phone calls to patients, prior to their appointment. .
- The average length of stay for medical elective patients was higher than the England average.
- Facilities and premises were designed for the services delivered. However, there were limitations on space within clinics and waiting areas, in the outpatients' department at St George's Hospital.

However:

- **Services planned and provided care in a way that met the needs of local people and the communities served.** They also worked with others in the wider system and local organisations to plan care.
- **Services were inclusive and took account of patients' individual needs and preferences.** Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- **Services treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.** However, there was a lack of patient information displayed in some areas, on how to raise a concern.

Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

- **Most leaders had the skills and abilities to run their services.** However, we had concerns that there was insufficient oversight and management of issues in surgery at Queen Mary's Hospital, and the outpatient department at St George's Hospital.
- Some frontline clinical and non-clinical OPD staff were unaware of their services strategy document and were not involved in the development of the services strategy.
- Some black, Asian and minority ethnic (BAME) were not aware of the equality network they could join.
- **Some leaders did not operate effective governance processes and not all staff at all levels were clear about their roles and accountabilities.** For example, there was no clarity of who had overall responsibility and oversight of surgery at Queen Mary's Hospital, and some senior staff in the outpatient department at St George's Hospital, could not tell us their responsibility for the development of the service.
- Some staff and middle grade managers were not aware of what was on their department's risk register and arrangements for managing risks were not always clear.

However:

- Leaders collaborated with partner organisations to help improve services for patients.
- **Staff were committed to continually learning and improving services.** They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.
- Leaders were visible and approachable in services for patients and staff.

We rated use of resources as requires improvement because:

The trust does not consistently manage its resources to allow it to meet its financial obligations on a sustainable basis and to deliver high quality care.

Please see the separate use of resources report for details of the assessment. The report is published on our website at www.cqc.org.uk/provider/rj7/reports.

Summary of findings

Combined quality and resource

Our combined rating of quality and resource is requires improvement because:

- We rated safe, effective, responsive, and well-led as requires improvement; and caring as good;
- We took into account the current ratings of the five services across the two locations not inspected this time.
- We rated six services across the trust as requires improvement.
- We rated one service as outstanding.
- We rated three services as good.
- We did not rate two services.
- The overall ratings for each of the trust's acute locations remained the same.
- The trust was rated requires improvement for use of resources.

See guidance note 7 then replace this text with your report content. (if required)…

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice at St George's Hospital.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found 42 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued two requirement notices to the trust. Our action related to breaches of two legal requirements in the emergency department and medical care services at St George's Hospital.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will check that the trust takes the necessary action to improve it services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

We found examples of outstanding practice in the emergency department:

Summary of findings

- The emergency department had an extensive research programme in progress. Staff were encouraged to participate in the research programme. We saw that trained nurses were able to rotate through the programme for 6-month periods.
- The 'hot lab' in the emergency department was able to produce a full blood count within minutes. This could have a significant benefit when treating patients with certain conditions and reduce the use of unnecessary broad-spectrum antibiotics. This also benefitted patients as they were able to go home rather than being admitted or having to wait in the emergency department.
- The emergency department were also able to test for influenza within the department. This had a significant benefit as patients were able to be tested for 'flu' quickly. This reduced the use of unnecessary anti-viral medicines, as well as reduced the amount of patients being isolated unnecessarily. This also benefitted patients as they were able to go home rather than being admitted or having to wait in the emergency department.
- We saw the use of the sepsis REDS score being used in the adults' emergency department. This was an innovative sepsis specific scoring tool that had been developed by one of the emergency department consultants as part of the newly developed emergency department pathway for patients suspected as having sepsis. The REDS score helped give guidance to clinicians in managing the septic patient and allowed for early escalation to intensive care if necessary.

We found examples of outstanding practice in surgery at St George's Hospital:

- In February 2019, the trauma and orthopaedic team became the first in the UK and second in the world to use a new type of tibial nail in surgery.
- The service had developed an innovative programme called 'Get Set 4 Surgery' to help patients prepare for having an operation and understand what would happen at each stage of their journey, from surgical assessment to discharge and recovery at home. The service had been recognised for this innovative practice through an award from Healthy London Partnership.

We found examples of outstanding practice in the children and young people service:

- The service had implemented situation awareness for everyone (SAFE) safety huddles in paediatrics. Aimed to improve outcomes for acutely unwell children on paediatric wards and reduce variation in service delivery quality. Used in the safety huddle to improve situational awareness and facilitate improved communication.
- The trust had implemented the reducing harm by keeping mothers and babies together programme. This was part of the national Avoiding Term Admissions into Neonatal units' programme. This promotes all maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so.
- On the paediatric intensive care unit had introduced weekly "Druggle" rounds which reviewed medicine prescribing errors with support from pharmacy.
- Introduction of coffee mornings on Wednesdays for parents with babies on the paediatric intensive care unit.
- There was quarterly joint paediatric medicine, paediatric emergency department and paediatric intensive care clinical governance meetings, where joint audits and quality improvement projects were presented.
- Weekly safeguarding teaching sessions were undertaken. These were led by the safeguarding responsible doctor. These were open to all but were mainly attended by doctors and medical students. The sessions included a variety of safeguarding subjects and any past of current safeguarding cases.

Summary of findings

- The trust was in the process rolling out a new scheme to provide every primary and secondary school with an emergency asthma kit, which was believed to be the first initiative of its kind in London. The scheme, which was in conjunction with the Wandsworth and Merton Children's Asthma Board, was devised to ensure that all state schools in Wandsworth and Merton had an emergency asthma kit available in line with the Department of Health guidelines and as part of a drive to improve asthma awareness and education.
- Parents were given a pager by theatre staff when they had left their child in theatre for an operation. When the patient was in recovery and awake theatre staff called the pager to notify the parent to come back to the theatre as their child was in recovery.
- On the neonatal unit, there was a weekly parent meeting on a Wednesday led by either Consultant, Matron/Senior nurse/Family-care Coordinator.

Areas for improvement

Action the trust MUST take to improve

- Make sure all patient records are stored securely, completed accurately and kept confidential.
- Make sure consent is correctly recorded in patients notes in line with best practice.

Action the trust SHOULD take to improve

In the emergency department:

- Complete all documentation correctly, including fluid balance charts, pain scales and Glasgow Coma Scales.
- Check that all equipment is clean, safe for use, and appropriate checklists completed.
- Improve the BAME knowledge and support within the department.
- Display information about how to raise a concern in all patient areas.

In medical care:

- Continue work to improve vacancy, sickness and turnover rates amongst nursing staff.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Improve the recording of actions taken when fridge temperatures are out of range.
- Continue with plans to improve the catheter laboratory to provide a safe service for patients and staff.
- Reduce the number of patient-moves at night.
- Improve the referral to treat time (RTT) in the five specialities where they fell below the England average.

In surgery at St George's Hospital:

- Continue work to improve vacancy, sickness and turnover rates amongst nursing staff.
- Continue work to improve the environment across the surgical division.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Continue work to improve appraisal rates for staff across the surgical division.
- Consider further ways to improve staff wellbeing in light of staffing shortages.

Summary of findings

- Update and ensure staff have access to the deteriorating patient policy.
- Ensure all locum medical staff complete a full local induction.

In surgery at Queen Mary's Hospital:

- Have a policy in place for seeing paediatric patients in the day case unit.
- Improve staff awareness on learning from incidents.
- Ensure records are stored securely.
- Update and ensure staff have access to the deteriorating patient policy.
- Continue to work to improve nurse staffing levels.
- Ensure relevant learning from audits is shared across both sites and ensure data is consistently collected for audits and action plans completed where necessary.
- Work to improve staff appraisal rates.
- Ensure consent form documentation is fully completed.
- Ensure senior staff are clear of who has overall responsibility and oversight of surgery at Queen Mary's Hospital.
- Ensure risk registers are completed with up to date information.

In services for children and young people:

- Continue work to improve completion of nursing staff annual appraisals.
- Continue work to improve the amount of staff qualified in speciality working within the neonatal unit and paediatric intensive care.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Consider further ways to improve staff engagement, well-being and address concerns highlighted in staff survey.
- Continue with recruitment and retention strategies to reduce vacancy, turnover and sickness rates.
- Consider how to avoid mixed sex breaches.
- Continue with the planned refurbishment to make the premises suitable for modern day healthcare.

In the outpatients' department:

- Consider an effective process for quality improvement and risk management.
- Improve its local audit programme and review national audit outcomes to improve patient outcomes.
- Complete infection prevention and control audits regularly and take action to address concerns including risks associated with the environment for decontamination of naso-endoscopes were embedded in practice.
- Improve staff compliance with mandatory training, including information governance safeguarding level three (3) and resuscitation.
- Provide adequate seating facilities in clinics, to ensure patients and relatives have enough seating areas.
- Develop systems and processes which enable the trust to determine the quality and performance of its outpatients' department.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust stayed the same. We rated well-led as requires improvement because:

The trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. There was a stable executive team in post who were all focused on improving care for patients and the financial position within the trust and the commitment and abilities to tackle the challenges within the trust.

Each of the executive directors had a team to provide them support and oversight of their portfolio, and on the whole, these provided the support required to move forward the strategy and objectives within the trust.

There were good working relationships between the executive and non-executive directors, at board and through subcommittees. The chair and chief executive had a strong working relationship.

There were positive working relationships with partners in the system. A number of executives had lead roles within the system. This would be strengthened through the appointment of the trust chair as the chair of a nearby trust, which occurred shortly after our inspection.

The trust had a clear vision and set of values with quality and sustainability as the top priorities. How the trust set out to achieve the vision was entitled the St George's Way. The board had a clear commitment to the vision. Although not all staff were able to clearly articulate it, board members were optimistic that all staff would get to the point where they "live and breathe" the vision of Outstanding Care Every Time and that this would be embedded.

The trust's clinical strategy was entitled 'Delivering outstanding care, every time: Our strategy for 2019-2024. The strategy was published in April 2019 and aimed to achieve its goals through four priorities: strong foundations; excellent local services; closer collaboration; and leading specialist healthcare. The strategy had been developed with the involvement of staff and clinical teams. The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. Supporting strategies were being developed and planned for publication later in the 2019/20 business year, with timescales agreed by the trust Board. Without these supporting strategies in place, the trust's ability to effectively and systematically achieve the organisational priorities and deliver good quality care could be hampered.

Culturally, there had been much progress within the trust. However, there were still areas for improvement, which the trust had identified. These included:

- Continuing work on addressing bullying and harassment within the trust.
- Embedding and ensuring that there were clear objectives for, and awareness of, equality and diversity networks.
- Promoting equality and diversity in staff's day to day work and when looking at opportunities for career progression for BAME staff.
- Building improved relationships with trades unions.
- Supporting leaders and managers throughout the organisation through a development programme.
- Developing a clear organisation development strategy.

Summary of findings

The board were sighted on most of these areas and were developing programmes to support this. There was a real focus on providing good quality patient care articulated by the board and across the trust, with improvements seen in core services.

There were systems in place to support staff to speak up, with a Freedom to Speak Up Guardian and Guardian of Safe Working Hours in place and there was board oversight of this. The board was sighted on the fact that there were areas of the trust that people did not feel confident to speak up and had asked that the Speak Up service to pull together a strategy to overcome this. The Freedom to Speak up Guardian was line managed by the Listening into Action Lead, who sat within the human resources directorate. Whilst the Freedom to Speak up Guardian had direct access to the Chief People Officer, there was an agreement that individual cases were not be discussed with him.

It was also notable that the trust had learnt from challenges in team dynamics within areas of the trust. We saw evidence that they had taken action to resolve difficulties in team dynamics relating to leadership and relationships amongst senior staff in an area. Mediation and organisational development support had been arranged swiftly to help to resolve these issues.

The trust had governance structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Although further embedding of these structures were needed.

There was a board assurance framework in place which had been reviewed. It identified the strategic risks and provided assurance to the board, of the trust awareness of those strategic risks and had a plan to address them. However, it was long and not as user friendly as it could have been, with a presentational disconnect between the risk and mitigations or assurance statements.

Neither the board nor the trust executive committee (TEC), reviewed the whole board assurance framework all at once, but leaders were sighted and recognised that this needed to happen. The trust's executive governance structures were at differing stages of development and ensuring these were fully implemented and embedded was essential for the board to be able to gain assurance and oversight.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed.

Non-executive and executive directors were clear about their areas of responsibility. There was good working in board subcommittees. Non-executives and executives undertook walkabouts and were visible within the organisation.

Governors were actively engaged in the operation of the trust. The trust reported good working relationships with governors. Governors were able to attend both parts of the board meeting and all sub-committees. Governors were clear that their role was to hold non-executives to account. However, there was potential for governors to be too close to the operational decision-making process, which could lead to them seeking to hold executive directors, rather than non-executive directors to account.

There were arrangements in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'. The corporate risk register included divisional risks, which had a risk level of 10 and above. The corporate risk register was reviewed by all executive directors who attended the risk management executive, which was a sub-group of the trust executive committee (TEC). However, two-thirds of the risks on the corporate risk register, had not moved or had got worse over the two years prior to our inspection. This implied the controls or mitigation were not having the maximum effect.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems.

Summary of findings

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. At the time of the inspection, several important performance targets were not being achieved by the trust. These included the 4-hour emergency access target and referral to treatment. However, the trust had performed well against diagnostics and had achieved this target over the past 12 months. In May 2019, the trust's performance was 99.30% against a national median of 97.23%. This placed the trust in the first (best) quartile nationally. It was worth noting that the trust was utilising Statistical Process Control charts in its board reporting and this was to be commended as good practice and would allow the board to focus on areas of variation.

The trust had faced challenges for several years and had an agreed control total of £3m deficit for the 2019/20 financial year. To meet this target, the trust needed to achieve £45.8m in savings. They had achieved significant savings in the previous year. At the time of the inspection, the trust was forecasting achieving its financial position, but the savings programme was weighted towards the second half of the year and the whole value was not yet identified.

At month three for the financial year 2019/20, the trust was forecasting achieving the year end plan and it was the view of the chief financial officer, chair of the finance and investment committee and chief executive that it would be achieved, despite the risks.

Where cost improvements were taking place, there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Where cost improvements were taking place, we saw they did not compromise patient care.

Leaders used meeting agendas to address quality and sustainability sufficiently at all levels across the trust. Staff said they had access to all necessary information and were encouraged to challenge its reliability.

The trust had a structured and systematic approach to engaging with people who used services, those close to them and their representatives. The patient engagement strategy was launched in 2018. This strategy set out the steps the trust planned to take to engage patients, listen to their views, and act upon them. The strategy was developed with input from patients and staff. The trust had a long history of engaging with patients and had active groups for maternity, kidney and renal patients. There was a patient, partnership and engagement group.

The trust sought to actively engage with people and staff in a range of equality groups. Staff engagement by the trust had been improving, but board members recognised that they had a long way to go, before changing the culture in the organisation. The trust published its staff engagement plan in November 2017, in response to feedback from staff. Following the inspection, the trust informed us that the 2017 engagement plan was a two-year plan and a refreshed staff engagement plan was approved by the trust board in September 2019.

The staff engagement plan identified three target areas to be improved:

- Improve overall staff engagement
- Address bullying and harassment
- Improve equality and diversity

There were organisational systems to support improvement and innovation work. The trust had made improvements since our last inspection which had been systematic. The ward accreditation system had been embedded with most staff groups. Staff knew what the standards and expectations were through the ward accreditation programme. The programme had been both supportive and a good mechanism for holding people to account. There was also a quality improvement academy and staff had received training in improvement methodologies and used standard tools and methods. The director of quality improvement told us of plans to embed quality improvement principles into the organisation. There was a quality improvement team which engaged with staff to inform them about the quality improvement methodology 'The St George's Way'.

Summary of findings

The trust, being a teaching hospital, also had a significant research and innovation base which was evident throughout.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
St George's Hospital	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019
Queen Mary's Hospital	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019
Overall trust	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for St George's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Requires improvement → ← Dec 2019
Medical care (including older people's care)	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Good → ← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement → ← Dec 2019
Surgery	Good ↑ Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Good → ← Dec 2019	Good ↑ Dec 2019
Critical care	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Maternity	Good Nov 2016	Outstanding Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Services for children and young people	Good ↑ Dec 2019	Good → ← Dec 2019	Outstanding ↑ Dec 2019	Outstanding ↑ Dec 2019	Good ↑ Dec 2019	Outstanding ↑↑ Dec 2019
End of life care	Requires improvement Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Requires improvement Nov 2016
Outpatients	Good ↑ Dec 2019	Not rated	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement → ← Dec 2019
Overall*	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Queen Mary's Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good ↑ Dec 2019	Requires improvement →← Dec 2019	Good →← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019
Outpatients	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Overall*	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Good →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019	Requires improvement →← Dec 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

St George's Hospital (Tooting)

Blackshaw Road
Tooting
London
SW17 0QT
Tel: 02086721255
www.stgeorges.nhs.uk

Key facts and figures

St George's Hospital is located in Tooting, London and managed by St George's University Hospitals NHS Foundation NHS Trust. The hospital serves a population of around 1.3 million people in South West London, with services commissioned by Wandsworth, Merton and Lambeth Clinical Commissioning Groups.

The hospital has 995 beds, including 51 children's beds.

St George's Hospital operates 24 hours per day and has an accident and emergency department and a major trauma centre. The hospital provides acute hospital services and specialist care for the most complex of injuries and illnesses, including trauma, surgery, neurology, cardiothoracic medicine, renal transplantation, cancer care and stroke.

In 2018/19, St Georges Hospital had 159,912 emergency attendances, 160,199 admissions (includes maternity) and 683,210 outpatient attendances.

During the inspection, we spoke with over 81 patients, over 24 relatives and over 180 members of staff from various disciplines. We reviewed over 62 sets of patient records. We observed care being delivered and attended safety briefings and handovers.

Summary of services at St George's Hospital (Tooting)

Requires improvement ➔➔

Our rating of services stayed the same. We rated them as requires improvement because:

- Staff did not always complete and update risk assessments for each patient. Documentation in patient files was inconsistent and not always completed; and in medical care, consent forms were not always completed in full.
- Some services did not keep detailed records of patients' care and treatment. Some records were not clear, up-to-date, stored securely or easily available to staff providing care.
- Some services did not control infection risks well. Some staff did not use equipment and control measures to protect patients, themselves and others from infection. Some areas of the emergency department were not visibly clean.
- Some facilities and premises were not always ideal and in need of modernising or refurbishment. For example, some of the departments and wards were excessively hot in the summer months due to lack of air conditioning.

Summary of findings

- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. The number of nursing staff who had received an annual appraisal was below the trust target in many wards and departments.
- People could not always access the service when they needed it and did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- Not all risks on some risk registers were completed thoroughly.
- Services provided mandatory training in key skills to all staff, however, not all staff had completed the training required.

However;

- Staff had training in key skills and understood how to protect patients from abuse. Services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve services.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Services planned care to meet the needs of local people and took account of patients' individual needs.
- In children and young people services, staff found innovative ways to enable children and young people to manage their own health and care when they could and to maintain independence as much as possible.
- Most services had enough staff to care for patients and keep them safe, despite there being vacancies in many areas.
- The trust scored highly in the Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade A in latest audit.

Urgent and emergency services

Requires improvement 

Key facts and figures

St George's Hospital provides urgent and emergency care services which are open 24 hours a day, 365 days per year. The hospital provides services to the local populations within south west London including the London boroughs of Wandsworth, Merton, Lambeth. St George's emergency department (ED) is a major trauma receiving unit for emergency adult, paediatric and maternity patients.

From February 2018 to January 2019 there were 167,547 attendances. Of these 33,112 were children and young people under the age of 17 years.

Patients present to the department by walking into the reception area, arriving by ambulance via a dedicated ambulance-only entrance or by the Helicopter Emergency Medical Service (HEMS). Patients transporting themselves to the department were seen by a streaming nurse who would triage them.

The ED had different areas where patients were treated depending on their acuity including majors, resuscitation area, clinical decision unit (CDU), and the urgent care centre (UCC). There was a separated paediatric ED with its own waiting area.

During this inspection we spoke with over 35 members of staff from a range of clinical and non-clinical roles and of varying grades. We spoke with 30 patients and 10 relatives. We reviewed 45 patient records, including 10 related to children and young people. We made observations and looked at documentary information accessible within the department and provided by the trust.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. Some areas of the emergency department were not visibly clean.
- Staff did not always complete risk assessments for each patient swiftly. They did not remove or minimised risks and did not update the assessments.
- Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date, stored securely and easily available to all staff providing care.
- The service did not use systems and processes to safely prescribe, administer, record and store medicines.
- People could not always access the service when they needed it and did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Patients did not receive treatment within agreed timeframes and national targets.
- It was not easy for people to give feedback and raise concerns about care received. There was a lack of patient information displayed in public areas on how to raise a concern. This was something we found on the previous inspection.
- Not all staff understood the service's vision and values, and how to apply them in their work.

However:

Urgent and emergency services

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Is the service safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection. Cleaning records were not always up-to-date and did not demonstrate that all areas were cleaned regularly. Not all equipment was labelled to show when it was last cleaned. Some areas of the emergency department were not visibly clean. The department participated in monthly hand hygiene audits. The department scored 80.4%, which is below the trust target of 95%.
- Staff did not complete risk assessments for each patient swiftly. They did not remove or minimised risks and did not update the assessments. Patients who had presented to hospital having had a fall did not always have a falls risk assessment completed. The risk of the patients having another fall while in the department had not been assessed. Staff did not always complete Waterlow assessments for frail patients who had been in the department for more than 6 hours. Patients had not been assessed for risk of developing pressure ulcers.
- Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date, stored securely and easily available to all staff providing care. Pain assessments, falls risk assessments, pressure ulcer risk assessments and fluid balance charts were not always completed. During our last inspection we found that medical notes were not being stored securely. On this inspection we found that this was still the case. Medical notes which included patient identifiable information and confidential medical information were stored in unsecure folder holders in cubicle areas.
- The service did not use systems and processes to safely prescribe, administer, record and store medicines and there were inconsistences using the electronic drug charts. Staff in the emergency department were unable to prescribe or administer medicines using electronic drug charts as they had not yet been trained in its use. Patients who had been prescribed medication electronically by specialist teams did not have these administered as emergency department staff could not use the electronic prescriptions.

However:

- The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Urgent and emergency services

- The service mostly had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They mostly used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Urgent and emergency services

Is the service responsive?

Requires improvement  

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when they needed it and did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From June 2018 to May 2019 the trust failed to meet the standard. From June 2018 to May 2019 performance worsened from 94% to 86%.
- Patients did not receive treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard in any month from April 2018 to March 2019.
- It was not easy for people to give feedback and raise concerns about care received. There was a lack of patient information displayed in public areas on how to raise a concern. This was something we found on the previous inspection.

However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Urgent and emergency services

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However:

- Not all staff were aware of the department's vision and strategy. Staff were aware of the trust's vision and strategy, but most were not aware of the emergency department's vision and strategy.
- Staff had little knowledge of the BAME network. Neither BAME and non BAME staff were able to tell us if the department had a BAME network. Staff were not aware of the BAME support available in either the department or the trust.

Outstanding practice

- The ED had an extensive research programme in progress. Staff were encouraged to participate in the research programme. We saw that trained nurses were able to rotate through the programme for 6-month periods.
- The 'hot lab' in the ED was able to produce a full blood count within minutes. This could have a significant benefit when treating patients with certain conditions and reduce the use of unnecessary broad-spectrum antibiotics. This also benefitted patients as they were able to go home rather than being admitted or having to wait in the ED.
- The ED were also able to test for influenza within the department. This had a significant benefit as patients were able to be tested for 'flu' quickly. This reduced the use of unnecessary antiviral medicines, as well as reduced the number of patients being isolated unnecessarily. This also benefitted patients as they were able to go home rather than being admitted or having to wait in the ED.
- We saw the use of the sepsis REDS score being used in the adults ED. This was an innovative sepsis specific scoring tool that had been developed by one of the ED consultants as part of the newly developed ED pathway for patients suspected as having sepsis. The REDS score helped give guidance to clinicians in managing the septic patient and allowed for early escalation to intensive care if necessary.

Areas for improvement

The service MUST:

- Ensure all patients records are stored securely.

The service SHOULD:

- Ensure all documentation is correctly completed including fluid balance charts, pain scales and Glasgow Coma Scales.
- Ensure all equipment is clean, safe for use, and appropriate checklists completed.
- Improve the BAME knowledge and support within the department.
- Ensure information about how to raise a concern is displayed in all patient areas.

Urgent and emergency services

- Ensure all medicines are correctly prescribed and administered.
- Ensure all patients have necessary risk assessments completed and documented, and that these are updated.

Medical care (including older people's care)

Requires improvement 

Key facts and figures

The Acute and General Medicine service provides a range of general and specialist inpatient, ambulatory and outpatient care. Adult patients are admitted via the Acute Medical Unit except for some specialist pathways.

The inpatient aspect of specialist medical services including gastroenterology, respiratory, diabetes and endocrinology are delivered by dual-accredited specialist teams with oversight from the Inpatient Medicine care group.

The hospital provided tertiary service provision for intestinal failure, nutrition, hepatology, weaning/acute-domiciliary ventilation and lymphoedema.

Inpatient beds:

- AMU 51 inpatient beds
- General Medicine 112 inpatient beds

The trust had 43,385 medical admissions from February 2018 to January 2019. Emergency admissions accounted for 18,602 (38.4%), 3,005 (6.2%) were elective, and the remaining 26,778 (55.3%) were day case.

During our inspection we visited the following wards: Allingham, Amyand, Belgrave, Caesar Hawkins, Champneys, Charles Pumphrey Unit, Dalby, Gordon Smith, Kent, Marnham, Richmond, Rodney Smith, Trevor Howell And William Drummond. We spoke with approximately 50 members of staff including nursing and medical staff of all grades, allied health professionals such as occupational therapists, healthcare assistants, housekeeping and catering staff, and managers. We spoke with 25 patients and their relatives. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff however not all staff had completed it. Medical staff in the division did not meet the trust target for most mandatory training and safeguarding training modules.
- Staff did not always complete and update risk assessments for each patient. Documentation in patient files was inconsistent and not always completed, and consent forms were not always completed in full.
- The service did not always have enough staff, including nurses and doctors, with the right qualifications, skills, training and staff told us this was a potential risk to patient safety.
- Records of patients' care and treatment were not always stored securely or easily available to all staff providing care. Electronic records were not always accessible in a timely manner and paper records were not always securely stored. We saw paper records that included patient identifiable information and do not resuscitate forms accessible in folders and were not secure or marked as confidential.
- The service did not always coordinate between pharmacy and ward staff use systems and processes to safely store medicines. We found examples of fridge temperature recordings consistently higher than the recommended temperature and ward staff were not clear what action had been taken. Staff could not be sure the medicines was safe to use.

Medical care (including older people's care)

- The catheter laboratory had aging equipment that needed replacing and two beds had been decommissioned as a result. There was a risk of further equipment failure and a temporary mobile catheter laboratory had been commissioned by the trust. The trust is a designated heart attack centre. Following the inspection, the trust advised us that a business case for the provision of equipment was approved by the board in September 2019.
- Patients were at a higher risk of readmission following discharge when compared to the national average. The risk of readmission for both elective and non-elective treatment was higher than the national average in two of the top three specialities by number of admissions.
- The service did not encourage black, Asian and minority ethnic (BAME) to join the staff BAME network where they could seek support. Staff we talked to were not aware of the network and senior staff were not able to direct us to information on the intranet for staff to access.

However:

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The division had worked hard to reduce the number or patient falls. We saw examples of initiatives such as "bay watch", where a designated member of staff always remained in a bay to assist patients and patients were provided with socks with grip to prevent slips. All staff we talked to had a good awareness of initiatives and why they were important.
- The trust scored highly in the Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade A in latest audit.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Is the service safe?

Requires improvement ● ➔➔

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff did not always complete and update risk assessments for each patient. Documentation in patient files was inconsistent and not always completed in full. During our inspection we saw examples of risk assessments being completed, partially completed or not at all.
- Records of patients' care and treatment were not always stored securely or easily available to all staff providing care. Electronic records were not always accessible in a timely manner and paper records were not always securely stored. We saw paper records that included patient identifiable information and do not resuscitate forms accessible in folders and were not secure or marked as confidential.
- The service provided mandatory training in key skills to all staff however not all staff had completed it. Medical staff in the division did not meet the trust target for most mandatory training and safeguarding training modules. No staff group met the trust target for lifesaving training and staff told us this training had been difficult to access.

Medical care (including older people's care)

- The service did not always have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. For nurses, the vacancy, turnover and sickness rate continued to be higher than the trust target and 19% of hours set to be filled by bank or agency staff were unfilled. On the days we visited, we saw wards where the planned number of staff was not filled.
- The service did not always coordinate between pharmacy and ward staff or use systems and processes to safely store medicines. We found examples of fridge temperature recordings consistently higher than the recommended temperature and ward staff were not clear what action had been taken. Staff could not be sure the medicines was safe to use.
- The service did not always control infection risk well. We saw example of staff not washing their hands between patient contact and this was reflected in one ward's hand hygiene score for June 2019 of 88.1%.
- The trust and division were dealing with an ageing estate which at times was a risk to patient safety. The trust had taken some actions to control the risk, such as filters on taps to prevent legionnaires disease and the pipework was flushed regularly to prevent leaks, but this was an ongoing problem.

However:

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support. Staff told us there was an open and honest culture and they were encouraged by their managers to report incidents and staff were able to give us examples of when duty of candour had been applied.
- Dalby ward was refurbished and opened in December 2018 to provide a safe, dementia friendly environment for patients. Comfort cooling, an air-cooling system, was installed so the bays did not reach high temperatures and the exit and entry system was designed to allow patients to walk freely around the ward without the risk of them leaving unattended.
- The division had worked hard to reduce the number or patient falls. We saw examples of initiatives such as "bay watch", where a designated member of staff always remained in a bay to assist patients and patients were provided with socks with grip to prevent slips. All staff we talked to had a good awareness of initiatives and why they were important.

Is the service effective?

Requires improvement → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not always record consent appropriately. We saw examples of forms not completed in full and inconsistent recording which meant staff were not sure correct consent for treatment had been gained.
- Not all patients had a pain score recorded in their records. Staff we talked to told us they did not use a pain score tool for patients that could articulate their pain and no score was recorded in their notes. This meant staff were not able to see whether a patient's pain score had changed.
- Patients were at a higher risk of readmission following discharge when compared to the national average. The risk of readmission for both elective and non-elective treatment was higher than the national average in two of the top three specialities by number of admissions. This had not improved since our last inspection.

Medical care (including older people's care)

- Not all staff received an appraisal of their work. The trust set a target of 90% of staff to receive an annual appraisal and the division did not meet this target for any staff group. This had not improved since our last inspection.
- The division did not meet the seven-day clinical standards target in all specialities. Access to Magnetic resonance imaging (MRI) was limited and four medical specialities were not compliant at the weekend.
- We saw a deprivation of liberty safeguards (DoLS) application that had no expiry or review date recorded.

However:

- Staff gave patients enough food and drink to meet their needs and improve their health and we saw staff encouraging patients to drink in hot weather.
- Following the National Diabetes Inpatient Audit 2017, the division had secured funding for a specialist inpatients diabetes teams to work with ward staff, supporting them to provide safe care for diabetic patients.
- The trust scored highly in the Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade A in latest audit.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Patients told us that staff were caring and this was consistent across all wards we visited.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Patients, relatives and staff could access multi faith, multi denomination, chaplaincy services.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. We saw staff having conversations with patients and relatives about their care, treatment and prognosis. This was delivered with compassion and patients and relatives were able to ask questions.
- We saw examples of compliments from patients displayed in the wards we visited, thanking staff for the care they received.

However:

- The response rate for the Friends and Family test on some wards was less than five per month and meant a score was not recorded as the sample was too low.

Is the service responsive?

Requires improvement ↓

Our rating of responsive went down. We rated it as requires improvement because:

Medical care (including older people's care)

- Five medical specialities were below the England average for admitted referral to treatment time (RTT). The worst performing speciality was cardiology which was 34% below the England average of 81.1% patients seen within 18 weeks.
- The average length of stay for medical elective patients was 8.6 days which was higher than the England average of 5.9 days.
- Elective work was placed early in the day which did not account for emergency patients and reduced patient flow through the hospital.
- We saw blank "reach out to me" forms use to record patient's personal preference and we were not assured these were consistently completed.
- There were 572 patient moves at night within the division. The three wards with the highest number of moves were Belgrave (102), Kent (57) and Trevor Howell (45). Night moves after 10.30pm are not in line with best practice.

However:

- The service planned took account of patients' individual needs. Dalby ward was refurbished to meet the needs of patients living with dementia and Heberden ward was undergoing refurbishment to a similar standard.
- Ambulatory care had been introduced in two areas of the hospital to improve the number of patients that were treated and reduce the number or patients admitted to a ward.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Staff gave us examples of complaints they dealt with and knew how to escalate concerns when needed.
- The service used the butterfly scheme to identify patients living with dementia and those with suspected delirium. This was a discrete way for staff to easily identify patients that needed additional support.

Is the service well-led?

Requires improvement  

Our rating of well-led went down. We rated it as requires improvement because:

- Staff could not provide examples of a change in practice following an incident, complaint or action taken after open conversations with senior management.
- Not all staff we talked to were aware of the vision and strategy was for the trust or the ward they worked on. Four nurses we talked to did not know what the vision and strategy was and were not aware a new strategy had been launched in April 2019.
- Not all low risks on the divisional risk register had met the action due date or been updated for over 12 months.
- The trust had recently established a group for black, Asian and minority ethnic (BAME) staff to network and seek support. However, staff we spoke with were not aware of the network and senior staff were not able to direct us to information on the intranet for staff to access.
- Four staff networks had recently been established, BAME, Disability and Wellbeing, LGBTQ+ and women's. They had not yet set their objectives and staff were not able to locate information on the intranet.
- Not all wards used GREATix to celebrate compliments about their staff. GREATix was a trust wide system where staff could nominate other staff members, recognising excellence. The trust recorded 152 GREATix submissions in medical care between March 2017 and November 2019.

Medical care (including older people's care)

However:

- The leaders of the service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders told us about their aim to improve the elderly care service which considered the increasing numbers of this patient group.
- Staff felt respected, supported and valued and were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. All staff we talked to told us there was an open reporting culture and they were encouraged to report incidents.
- Leaders operated effective governance processes, and staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service.
- All staff were committed to continually learning and improving services and leaders encouraged innovation.

Areas for improvement

The service MUST:

- Make sure all patient records are stored securely, completed accurately and kept confidential.
- Make sure consent is correctly recorded in patients notes in line with best practice.

The service SHOULD:

- Continue work to improve vacancy, sickness and turnover rates amongst nursing staff.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Improve the consistency of completed patient records including risk assessments and reach out to me forms.
- Improve the recording of actions taken when fridge temperatures are out of range.
- Continue with plans to improve the catheter laboratory to provide a safe service for patients and staff.
- Reduce the number of patient moves at night.
- Improve the referral to treat time (RTT) in the five specialities where they fell below the England average.

Surgery

Good ↑

Key facts and figures

The surgery service at St George's Hospital Tooting includes a wide variety of surgical disciplines and is a tertiary hub for South West London and Surrey, covering major trauma, complex cardiology and the hyper-acute stroke unit. The trust had 29,700 surgical admissions from February 2018 to January 2019. Emergency admissions accounted for 10,838 (36.5%), 11,078 (37.3%) were day case, and the remaining 7,784 (26.2%) were elective.

During our inspection we visited the following wards: Benjamin Weir, Brodie, Caroline, Champneys, Chelsden, Florence Nightingale, Gray, Gunning, Holdsworth, Keate, McKissock and Vernon. We also visited a selection of theatres, the Surgical Admissions Lounge and the Nye Bevan Unit. We spoke with approximately 40 members of staff including nursing and medical staff of all grades, allied health professionals such as occupational therapists, healthcare assistants, housekeeping and catering staff, and managers. We spoke with 10 patients and their relatives. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Summary of this service

Our rating of this service improved. We rated it as good because:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and took account of patients' individual needs.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The design of the environment did not always follow national guidance. Many ward areas were cluttered with equipment at various points throughout the day (for example, when receiving orders). However, leaders and housekeeping staff we spoke to confirmed there was a transformation programme underway to improve this.
- Vacancy, turnover and sickness rates amongst nursing staff did not meet the trust's target, although the service was taking action to address this.

Surgery

- From April 2018 to March 2019, 75.3% of required staff in surgery at St George's Hospital received an appraisal compared to the trust target of 90%. This meant the trust could not be assured that all staff received an appraisal of their work performance.
- People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not line with national standards.

Is the service safe?

Good 

Our rating of safe improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure most staff completed it. Where there were areas of lower compliance, leaders oversaw action plans to encourage improvement.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

However:

- The design of the environment did not always follow national guidance. Many ward areas were cluttered with equipment at various points throughout the day (for example, when receiving orders). However, leaders and housekeeping staff we spoke to confirmed there was a transformation programme underway to improve this.
- Vacancy, turnover and sickness rates amongst nursing staff did not meet the trust target. Despite this the service was taking action to address this, and we did not observe any impact upon patient safety as a result.

Is the service effective?

Good 

Surgery

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However:

- Managers did not always appraise staff's work performance regularly. From April 2018 to March 2019, 75.3% of required staff in surgery at St George's Hospital received an appraisal compared to the trust's target of 90%. This meant the trust could not be assured that all staff received an appraisal of their work performance.

Is the service caring?

Good ➔➔

Our rating of caring CHOOSE A PHRASE. We rated it as CHOOSE A RATING because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

Surgery

- People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not line with national standards. From January 2019 to April 2019, the trust's referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average. Therefore, this had a negative impact on our rating for responsive. Despite this, leaders described ongoing work to improve this.
- From February 2018 to January 2019 the average length of stay for patients having elective surgery at St George's Hospital (Tooting) was 4.2 days, which was worse than the England average of 3.9 days.
- The service treated concerns and complaints seriously but did not always investigate them in a timely way. The trust took an average of 27 days to investigate and close complaints. This was not in line with their complaints policy, which states complaints should be closed within 25 working days.

However:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. For example, the service had also developed an innovative programme called 'Get Set 4 Surgery' to help patients prepare for having an operation and understand what would happen at each stage of their journey.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were approachable in the service for patients and staff.
- Leaders had taken action to improve all aspects of the leadership and culture of the cardiac surgery service.
- The service was developing a vision for what it wanted to achieve and a strategy to turn aspirations into action, developed with all relevant stakeholders.
- Most staff we spoke with felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service collected reliable data and analysed it.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Surgery

Outstanding practice

- In February 2019, the trauma and orthopaedic team became the first in the UK and second in the world to use a new type of tibial nail in surgery.
- The service had developed an innovative programme called 'Get Set 4 Surgery' to help patients prepare for having an operation and understand what would happen at each stage of their journey, from surgical assessment to discharge and recovery at home. The service had been recognised for this innovative practice through an award from Healthy London Partnership.

Areas for improvement

The service SHOULD:

- Continue work to improve vacancy, sickness and turnover rates amongst nursing staff.
- Continue work to improve the environment across the surgical division.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Continue work to improve appraisal rates for staff across the surgical division.
- Update and ensure staff have access to the deteriorating patient policy.
- Ensure all locum medical staff complete a full local induction.
- Continue work to improve waiting times from referral to treatment and arrangements to admit, treat and discharge patients to bring them in to line with national standards.

Services for children and young people

Outstanding ☆ ↑↑

Key facts and figures

The trust provides specialist children's services and an integrated mix of tertiary care and specialist services as a regional centre for Wandsworth, South West London and further afield.

There is a comprehensive range of specialist services in both medical and surgical specialties cared for over three wards. These are supported by paediatric intensive care, the neonatal unit and neonatal intensive care.

There is a children's community nursing team and clinical nurse specialists who are supported by play specialists and child psychology services. Psychology is the scientific study of the human mind and its functions.

The trust has a consultant-led rapid referral service for GPs to contact their paediatricians (doctors specially trained to care and treat children) to help reduce pressures on the emergency department by diverting appropriate patients to the paediatric ambulatory unit (Blue- Sky).

Surgical services cover all aspects of paediatric surgery (excluding cardiac) including minimally invasive techniques. The department is the designated lead paediatric surgery centre for South West London and Surrey.

The hospital has 101 inpatient paediatric beds:

- Frederick Hewitt Ward: 17 beds
- Pinckney Ward: 15 beds
- Nicholls Ward: 19 beds
- Paediatric intensive care unit (PICU): 12 beds
- Neonatal unit: 38 beds

In addition, there are 15 beds on Jungle Ward, the paediatric day case unit.

During our inspection, we spoke with more than 20 members of staff including consultants, doctors, nurses, play specialists and domestic staff. We spoke to 14 parents, and three children and young people who were using the service at the time of our inspection. We observed care and treatment and looked at seven patient records and seven medication charts.

Summary of this service

Our rating of this service improved. We rated it as outstanding because:

- The Children's service had made significant improvements in safeguarding training and supervision, meeting the individual needs of children and young people, reduction of surgical site infections, improved outcomes in the National Diabetes audit, management of risks, maintaining dignity and respect, meeting guidelines for consultants to review patients within 14 hours of admission and the leadership of the service. Many of the issues identified in our previous inspection had been addressed or there were effective plans to address.
- The service had enough staff to care for children and young people to keep them safe. However, some departments were still heavily reliant on bank and agency staff, but a successful recruitment campaign meant this would be addressed. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well. Although the staff qualified in speciality on the neonatal unit and paediatric intensive care unit

Services for children and young people

did not meet the national guidelines, it had improved since our last inspection. The service controlled infection risks well. Staff assessed risks to children and young people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff recognised and respected the totality of the needs of children, young people and their families. They always took their personal, cultural, social and religious needs into account, and found innovative ways to meet them.
- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from people who used the service, those close to them and stakeholders was always very positive about the way staff treated people.
- Staff found innovative ways to enable children and young people to manage their own health and care when they could and to maintain independence as much as possible.
- There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs.
- The service planned care to meet the needs of local children and young people and took account of their individual needs and made it easy for them to give feedback. Children and young people could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. A Children's Strategy Priorities was awaiting final ratification, some staff had knowledge of this. Staff understood the service's values, and how to apply them in their work. Staff felt more respected, supported and valued since our last inspection. Morale was still low in some areas but improving. Staff were focused on the needs of children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children and young people and the community, to plan and manage services. All staff were committed to improving services continually.

However:

- The neonatal unit was not still meeting British Association of Paediatric Medicine staffing standards for units providing neonatal intensive care. The standards require 70% of nurses to be qualified in the specialty. However, this had improved since our last inspection; 58% were now qualified, compared to 40% at the time of the last inspection. The paediatric intensive care unit was still not meeting national standards requiring 70% of nurses to be qualified in the speciality. However, this had improved since our last inspection and 63% were now qualified, compared to 61% at the time of our last inspection. The service had a tangible plan to ensure this standard was met within the next 12 months.
- The number of nursing staff who had received an annual appraisal was below the trust target in many wards and departments. Across the whole service 72% of nursing staff had received and appraisal which (trust target 95%).

Services for children and young people

- There were still high level of staffing vacancies on the neonatal unit and paediatric wards, which meant the service had high use of agency and bank staff. Agency staff were not able to carry out all the procedures undertaken by permanent staff. Staffing levels on the inpatient wards had been increased following an establishment review, although the trust still did not have enough staff of the right qualifications, skills, and training. Due to a recent successful recruitment programme the service would be over established with nurses in September 2019.
- Some facilities and premises were not always ideal and in need of modernising or refurbishment, but we didn't observe this having an adverse effect on the care patients received. For example, some of the departments and wards were excessively hot in the summer months due to lack of air conditioning.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.
- The service was mostly meeting guidelines for consultants to review patients within 14 hours of admission. This was an improvement since our last inspection.
- We found a thorough risk assessment had been undertaken on Jungle ward in relation to the amount of space in between the beds and the risks mitigated. There had been no incidents reported in relation to the bed space. This was identified as an area of concern during the last inspection.
- The service provided mandatory training in key skills to all staff. The majority of staff had received up-to-date mandatory, statutory and clinical training.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had the correct level of training on how to recognise and report abuse, and they knew how to apply it. Staff received safeguarding supervision regularly this was an improvement since our last inspection.
- The service controlled infection risk well. Staff adhered to infection prevention and control practice and kept equipment, and the premises clean. They used control measures to prevent the spread of infection.
- Staff completed and updated risk assessments for each child or young person. They kept clear records and asked for support when necessary. Staff used the Paediatric Observation Priority Score tool to observe children and young people. Staff had training on when to escalate and to refer appropriately for medical help. Staff used the World Health Organisation checklist for surgical practice and operations. This ensured safety for children and young people.
- Staff kept detailed records of care and treatment of children and young people. Records were clear, up-to-date, and easily available to all staff providing care.
- The service followed best practice when prescribing, administering, and recording medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However:

Services for children and young people

- There were still high level of staffing vacancies on the neonatal unit and paediatric wards, which meant the service had high use of agency and bank staff. Agency staff were not able to carry out all the procedures undertaken by permanent staff. Staffing levels on the inpatient wards had been increased following an establishment review, although the trust still did not have enough staff of the right qualifications, skills, and training. Due to a recent successful recruitment programme the service would be over established with nurses in September 2019.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.
- The service targeted and took a proactive approach to health promotion and prevention of ill-health, and they use every contact with people to do so. The trust was in the process rolling out a new scheme to provide every primary and secondary school with an emergency asthma kit, which was believed to be the first initiative of its kind in London. The scheme, which was in conjunction with the Wandsworth and Merton Children's Asthma Board, was devised to ensure that all state schools in Wandsworth and Merton had an emergency asthma kit available in line with the Department of Health and Social Care guidelines and as part of a drive to improve asthma awareness and education.
- The service participated in relevant national clinical audits. Outcomes for children and young people were positive, consistent and generally met or exceeded expectations, such as national standards.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service had developed a comprehensive action plan to address performance in the 2016 National Paediatric Diabetic audit. The 2017 National Paediatric Diabetic audit showed improved performance.
- Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored children and young people regularly to see if they were in pain. They supported those unable to communicate using assessment tools and gave additional pain relief to ease pain.
- Staff of different kinds worked together as a team to benefit children and young people. Doctors, nurses, play specialists and other healthcare professionals supported each other to provide good care. There was a strong focus on multidisciplinary team work with specialists to improve outcomes for children and young people.
- Key services were available seven days a week to support timely care for children, young people and their families. The only exception to this was availability of MRI scans out of hours.
- Staff gave children, young people and their families practical support and advice to lead healthier lives.
- Staff understood how and when to assess whether a child or young person had the capacity to make decisions.

However:

- The number of nursing staff who had received an annual appraisal was below the trust target in many wards and departments. Across the whole service, 72% of nursing staff had received and appraisal which (trust target 95%).

Services for children and young people

- The neonatal unit was not still meeting British Association of Paediatric Medicine staffing standards for units providing neonatal intensive care. The standards require 70% of nurses to be qualified in the specialty. However, this had improved since our last inspection; 58% were now qualified, compared to 40% at the time of the last inspection. The paediatric intensive care unit was still not meeting national standards requiring 70% of nurses to be qualified in the speciality. However, this had improved since our last inspection and 63% were now qualified, compared to 61% at the time of our last inspection. The service had a tangible plan to ensure this standard was met within the next 12 months.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Feedback from people who used the service, those close to them and stakeholders was always very positive about the way staff treated people.
- The anti-ligature bay on Frederick Hewitt Ward, maintained the privacy and dignity of children and young people. During the last inspection, this was not that case, as curtains were transparent.
- Staff recognised and respected the totality of the needs of children, young people and their families. They always took their personal, cultural, social and religious needs into account, and found innovative ways to meet them. We observed staff taking into account a child's religious needs into account, only female staff cared for the child.
- Staff involved children, young people and those close to them in decisions about their care and treatment. Parents were made to feel welcome and involved in their child or young persons care and were able to stay with them.
- Staff provided emotional support to children, young people and their families to minimise their distress. The emotional and social needs of children, young people and those close to them were seen as being as important as their physical needs. A parent told us how the service had provided counselling for a year after their baby was born due to provide support at a very difficult time.
- Staff were fully committed to working in partnership with children, young people and their families and making this a reality for each person. Staff showed determination and creativity to overcome obstacles to delivering care. Play specialists supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach. Play specialists worked with children and young people who attended regularly for intravenous (into a vein) injections to develop coping techniques to enable them to have the cannula inserted without the support of a play specialist.
- Staff recognised that children, young people and their families needed access to, and links with, their advocacy and support networks in the community and they supported them to do this. For example, the service could access Redthread to provide support to young victims of crime. Redthread is a youth work charity aiming to support and enable young people in south London to lead healthy, safe and happy lives.
- Staff found innovative ways to enable children, young people and their families to manage their own health and care when they could and to maintain independence as much as possible. Staff gave basic life support training to parents of children at risk of becoming very unwell at home. Parents were also given training in more advanced skills such as tracheostomy care to enable children to be cared for at home. A tracheostomy is an opening created at the front of the neck, so a tube can be inserted into the windpipe to help breathing.

Services for children and young people

- Staff were exceptional in enabling people to remain independent. Staff encouraged and supported children and young people to attend the school within the hospital when they felt well enough. Play specialists took time to find out what the interests and hobbies were of children and young people and found ways of pursuing these whilst in hospital.
- Staff were discreet and responsive when caring for children young people and families. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff were skilled in communicating with children and young people.
- Staff always empowered children, young people and their families to have a voice and to realise their potential. For example, on the neonatal unit, there was a weekly parent meeting on a Wednesday led by either a consultant, matron, sister/ or family-care co-ordinator. Presentations included common neonatal medical conditions such as jaundice, prematurity and nutrition. These were followed by discussions and questions.

Is the service responsive?

Outstanding ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The hospital delivered a broad range of services for children and young people, including a number of highly specialist paediatric services. The service took into consideration the holistic needs of children, young people and their families. Services were planned in a manner to limit the disruption to children and young people's education.
- The service had developed pathways with referring hospitals to ensure patients received the correct care and treatment quickly. For example, Jungle ward had set up a plastic surgery pathway.
- The services provided were flexible, provide informed choice and ensured continuity of care. Children and young people with cancer had their care planned and coordinated by the hospital. The service worked in partnership with local hospitals, children's community nursing teams and GP's to provide 'care closer to home' for children and young people with cancer and their families during and following their treatment
- The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Children and young people had access to same day and next day clinics. GPs could obtain advice from paediatricians via a hotline. The service had specific pathways which could be assessed to prevent unnecessary attendance to the emergency department. For example, there was a pathway for new born babies with jaundice or that were failing to gain weight.
- The service ensured that play services were an integral part of the service to ensure psychological need were met. The hospital play team provided a very comprehensive programme of play support to children across all paediatric clinical areas. The variety of play support ensured that children and young people understood the strange environment and unpleasant procedures so that the risk of harm from hospitalisation was mitigated.
- It was easy for children, young people and their families to give feedback and raise concerns about care received and the service encouraged it. The service treated concerns and complaints seriously, investigated them promptly and thoroughly, and included children, young people and their families in the process. The service shared lessons learned with all staff in the service and more widely
- Children, young people and their families had access to interpreting services so that they were kept fully informed.

Services for children and young people

- The service organised an interpreter during the inspection so that a parent could give feedback to us about the care their child had received. The feedback was positive, and they felt they had been involved in their child's care and treatment and were kept informed with the use of an interpreter.
- The hospital school was rated as 'outstanding' by Ofsted and teachers at the school provided educational and learning support to children and young people across the hospital.
- Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities.
- The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which was accessible and promoted equality. For example, the development of transitional services had been identified as a key strategic objective by the service to ensure the needs of these young people were met.
- Children, young people and their family's individual needs and preferences were central to the delivery of tailored services. The service held a Safari Club every Saturday morning on Jungle Ward. The sessions were designed to introduce children and their families to the hospital and ward environment and meet some of the staff who will be looking after them when they attend hospital for surgery. The sessions involved the opportunity to try on hospital gowns, theatre masks and see cannulas. The play specialist facilitated this in a fun, engaging way that helped to alleviate anxiety for both the children and their families. Parents were also invited to share any concerns or fears they or their child had a head of surgery so that this can be addressed on the day.
- Jungle Ward had a variety of entertainers, magicians, singers, balloonists, musicians and therapy dogs who visited to entertain and amuse children.
- Play specialists produced photo albums of the different stages a child would go through when they had an operation. They used these to show the child and explain what was happening at each stage.

However:

- Some facilities and premises were not always ideal and in need of modernising or refurbishment, but we didn't observe this having an adverse effect on the care patients received. For example, some of the departments and wards were excessively hot in the summer months due to lack of air conditioning.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good because:

- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The governance structure had been strengthened since our last inspection. Regular multi-disciplinary, directorate departmental governance meetings were undertaken.
- There were improved governance processes, responses to staff feedback, development a strategy and improvements made since our last inspection.
- There was a new directorate leadership team since our inspection. The Head of Nursing for Children's services had been in post since March 2019. Staff were positive about the new leadership team and especially the positive impact of the Head of Nursing.

Services for children and young people

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, this was awaiting final ratification from the trust board. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- Most staff felt respected, supported and valued. Bullying and harassment was identified as a problem in the 2019 staff survey. No staff reported feeling bullied or harassed to us during the inspection. Staff reported that morale had been low due to staffing issues and a very hard winter period. All staff we spoke to were optimistic about the future of the service and that “they were moving in the right direction”. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. The trust had a Quality Improvement Academy as part of this the service had a quality improvement programme which included more than 50 different innovations.

Outstanding practice

- The service had implemented situation awareness for everyone (SAFE) safety huddles in paediatrics. Aimed to improve outcomes for acutely unwell children on paediatric wards and reduce variation in service delivery quality. Used in the safety huddle to improve situational awareness and facilitate improved communication.
- The trust had implemented the reducing harm by keeping mothers and babies together programme. This was part of the national Avoiding Term Admissions into Neonatal units’ programme. Which promotes all maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so.
- On the paediatric intensive care unit had introduced weekly “Druggle” rounds which reviewed medicine prescribing errors with support from pharmacy.
- Introduction of coffee mornings on Wednesdays for parents with babies on the paediatric intensive care unit.
- There was quarterly joint paediatric medicine, paediatric emergency department and paediatric intensive care clinical governance meetings, where joint audits and quality improvement projects were presented.
- Weekly safeguarding teaching sessions were undertaken. These were led by the safeguarding responsible doctor. These were open to all but were mainly attended by doctors and medical students. The sessions included a variety of safeguarding subjects and any past of current safeguarding cases.

Services for children and young people

- The trust was in the process rolling out a new scheme to provide every primary and secondary school with an emergency asthma kit, which was believed to be the first initiative of its kind in London. The scheme, which was in conjunction with the Wandsworth and Merton Children's Asthma Board, was devised to ensure that all state schools in Wandsworth and Merton had an emergency asthma kit available in line with the Department of Health guidelines and as part of a drive to improve asthma awareness and education.
- Parents were given a pager by theatre staff when they had left their child in theatre for an operation. When the patient was in recovery and awake theatre staff called the pager to notify the parent to come back to the theatre as their child was in recovery.
- On the neonatal unit, there was a weekly parent meeting on a Wednesday led by either Consultant, Matron/Senior nurse/Family-care Coordinator.

Areas for improvement

The service SHOULD:

- Continue work to improve completion of nursing staff annual appraisals.
- Continue work to improve the amount of staff qualified in speciality working within the neonatal unit and paediatric intensive care.
- Continue work to improve completion rates of mandatory training amongst medical staff.
- Consider further ways to improve staff engagement, well-being and address concerns highlighted in staff survey.
- Continue with recruitment and retention strategies to reduce vacancy, turnover and sickness rates.
- Consider how to avoid mixed sex breaches.
- Continue with the planned refurbishment to make the premises suitable for modern day healthcare.

Outpatients

Requires improvement 

Key facts and figures

Outpatient services at St Georges Hospital Tooting is provided in several locations within the main hospital and in different locations within the London borough of Wandsworth.

The trust provides outpatient services for a range of specialties including general outpatients; medical, surgery, cardio-thoracic surgery, transplant, diagnosis and pre and post-operative assessment, women and children's services, ophthalmology, ear, nose and throat (ENT), dental and oral surgery, trauma and orthopaedics, pain, rheumatology, stroke, elderly care, haematology/oncology, breast care, therapy services, audiology, podiatry and paediatrics. The trust has a range of specialist neurology clinics, including memory, motor neurone disease (MND) and infusion services.

More than 1000 clinics are held every week and around 1,049,437 patients attend each year for outpatient consultations and treatment. The trust had 857,157 first and follow up outpatient appointments from February 2018 to January 2019.

Outpatient clinics are supported by multidisciplinary teams including doctors, nurses, healthcare assistants and allied health professionals. Allied health professionals such as audiologists, orthoptists, therapists and specialist nurses run outpatient clinics alongside medical teams.

We visited a range of clinics in all the outpatient areas. We spoke with 25 staff including nursing, medical, physiologists, senior staff and administrative staff. We met with 15 patients and relatives who shared their views and experiences of the outpatient service. We observed how people were being cared for and reviewed 12 care/treatment records.

We also reviewed national data and performance information about the trust, and a range of policies, procedures and other documents relating to the operational of the outpatients' department.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The trust returned to reporting on their referral to treatment time (RTT) data for the St George's Hospital site. However, this reporting was still in its early days. This meant the outpatient department could not yet be fully assured that all patients had received their appointments.
- The trust's target for completion of mandatory training was not achieved in some areas.
- Staff did not always audit practice regularly to check whether they had made improvements for patients care and treatments.
- Systems to monitor the effectiveness of care and treatment were not embedded in the service.
- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. Appraisal rates for some staff groups working in the outpatient services were below the trust target.
- Most staff and middle grade managers were not aware of what was on their department's risk register.
- Not all risks on the risk register had associated actions, a date for review or a date by which actions to be completed and the risk owner.

Outpatients

- There was not always a registered nurse available to manage the outpatients' clinic, some clinics were managed by healthcare assistants as compared to qualified nurses, however all clinics had a registered nurse oversight.
- We uncovered issues with heavy workloads for some key staff and a lack of senior staff support in some areas of the outpatients' department.

However:

- The service provided mandatory training in key skills and most staff completed the training in line with the trust's target.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up to date, and generally available to all staff providing care.
- Medicines in outpatients were managed safely. Medicines and prescription pads were kept locked when not in use.
- Care and treatment were provided based on national guidance. Speciality clinics followed relevant national guidance and participated in national and local audits.
- People were treated with compassion, kindness, dignity and respect, when receiving care. Staff communicated with people in a way that supported them to understand their care and treatment.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- Staff kept appropriate records of patients' care and treatment. Records were clear, up to date, and generally available to all staff providing care.
- Medicines in outpatients were managed safely. Medicines and prescription pads were kept locked when not in use. The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

However:

Outpatients

- The trust's target for completion of mandatory training was not achieved in some areas.

Is the service effective?

Not sufficient evidence to rate

We do not rate effective

- The service provided care and treatment based on national guidance. Speciality clinics operating within the outpatient department followed relevant national guidance.
- The service made sure staff were competent for their roles. Staff that were new to the department had an appropriate induction and appraisal rates within outpatients were high.
- Staff gave patients enough food and drink, where appropriate, to meet their needs whilst in the outpatient department.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Nurses undertook a wide range of monthly audits recorded on the Trust RATE system. Remedial action plans were in place for improvements.

However;

- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. Appraisal rates for some staff groups working in the outpatient services were below the trust target.

Is the service caring?

Good →←

Our rating of caring stayed the same. We rated it as good because:

- Patients were treated with kindness, dignity and respect, when receiving care. Feedback from people who used the service, those who were close to them and other stakeholders, were positive about the way staff treated people.
- Doctors, nurses, healthcare assistants and allied health care staff provided compassionate and considerate care to patients. Staff introduced themselves and attempted to build a good rapport with patients.
- Staff throughout the department understood the need for emotional support. Patients and relatives felt that their emotional wellbeing was cared for.
- Staff included patients in their care and consultants explained things to them clearly in a way they could understand.

Is the service responsive?

Requires improvement →←

Outpatients

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Some people could not access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- The trust returned to reporting on their referral to treatment time (RTT) data for the St George's Hospital site. However, this reporting was still in its early days. This meant the outpatient department could not yet be fully assured that all patients had received their appointments.
- The RTT for non-admitted pathways was worse than the England overall performance. The latest figures showed 83.1% for the trust, as compared to the England average of 87% of patients had been treated within 18 weeks.
- The did not attend (DNA) rate for the hospital was slightly higher than the national average.

However:

- Trust performance for cancer waiting times was better than the operational standard and the national average in the most recent two quarters.
- The trust was performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral.
- Delays and cancellations were explained to people and the trust closely monitored clinics that were cancelled in less than six weeks with a view to reducing late cancellations and the impact these had on patients. Data showed that the proportion of cancelled clinics had reduced.
- There was evidence of learning and improvement from complaints. Complaints were responded to in line with the trust's complaints policy.
- The trust had a range of support teams available including dementia, learning disability and mental health liaison to meet patient's individual needs.
- There was access to face to face and telephone translation services and patient information leaflets could be accessed in languages other than English upon request.

Is the service well-led?

Requires improvement  

Our rating of well-led improved. We rated it as requires improvement because:

- The frontline clinical and non-clinical outpatients' department staff were unaware of the strategy document and were not involved in the development of the service strategy.
- Most staff and middle grade managers were not aware of what was on their departments risk register and arrangements for managing risks were not always clear.
- Not all risks on the risk register had associated actions, a date for review or a date by which actions to be completed and the risk owner.
- We were not fully assured that local governance arrangements were effective. For example; the knowledge about the risk register by staff and lack of local audits such as clinic waiting times and late starts.

However:

Outpatients

- There was a monthly OPD directorate governance meeting with representation from matrons, admin manager and service management. This meeting reported to divisional governance and management groups.
- The outpatient services had local leadership capacity and capability to deliver high-quality, sustainable care. We were told that matrons were supportive and visible within the department.
- The culture within the outpatient department was centred on the needs and experience of people who use the service and staff felt supported, respected and valued.
- The service had systems and processes in place to engage with patients, staff, the public and local organisations to plan and manage services. Patients had been involved in service improvement activities within the department.

Areas for improvement

The service SHOULD:

- Encourage an effective process for quality improvement and risk management.
- Improve its local audit programme and review national audit outcomes to improve patient outcomes.
- Encourage all eligible staff to be compliant with mandatory training, including information governance safeguarding level three (3) and resuscitation.
- Review whether there are adequate seating facilities in clinics, to ensure patients and relatives have enough seating areas.
- Developed systems and processes which enable the trust to determine the quality and performance of its outpatients' department.

Queen Mary's Hospital

Roehampton Lane
Roehampton
London
SW15 5PN
Tel: 02087253206
www.stgeorges.nhs.uk

Key facts and figures

Queen Mary's Hospital (QMH) provides services for adults and children and young people. The hospital offers more than 60 services, which are provided by St George's University Hospitals NHS Foundation Trust and other NHS trusts.

Services provided by Queen Mary's Hospital include outpatients (adults and children and young people), community inpatients, neurorehabilitation, limb fitting, burns dressing and dermatology, a day case unit which offers diagnostic service for endoscopy and urology. There are 88 inpatient beds and 10 day case beds.

There are two inpatient wards which provide sub-acute care, treatment and rehabilitation for older people and rehabilitation and support for adults who have had limb amputations.

The majority of services are provided on weekdays only with the inpatient wards open 24 hours a day, seven days a week.

In 2018/19, Queen Mary's Hospital had 17,063 attendances, 585 admissions and 89,337 outpatient attendances.

Summary of services at Queen Mary's Hospital

Requires improvement ● →←

Our rating of the service stayed the same. We rated it as requires improvement because:

- Leaders did not run services well using reliable information systems and did not always support staff to develop their skills. The leadership team were not clear of who had overall responsibility and oversight of surgery at Queen Mary's Hospital. Senior staff in the surgery department at Queen Mary's Hospital relied on the general manager for outpatients to send them performance data as they did not have access to the new electronic system.
- The service did not always manage learning from incidents well. Staff did not always collect safety information and use it to improve the service.
- Managers did not always monitor the effectiveness of the service. Key services were not available seven days a week.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- At the time of inspection, surgery at Queen Mary's Hospital was not reporting its RTT position.

However:

Summary of findings

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- During the previous inspection, staff were not fully complaint with the World Health Organisation (WHO) surgical safety checklist. However, on this inspection we did observe staff following the checklist.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care.

Surgery

Requires improvement 

Key facts and figures

The Day Case Unit (DCU) provides care for patients undergoing Endoscopic and Surgical procedures which are carried out under sedation, local anaesthesia and regional block. The unit consists of a first and second stage recovery, two endoscopy rooms, decontamination room and an operating theatre. The DCU provides diagnostic and surgical services in upper and lower gastroenterology, urology, plastic surgery, ophthalmology and podiatry. Procedures requiring general anaesthetic are not carried out on the unit and patients are normally discharged on the same day as the procedure.

The trust had 29,700 surgical admissions from February 2018 to January 2019. Emergency admissions accounted for 10,838 (36.5%), 11,078 (37.3%) were day case, and the remaining 7,784 (26.2%) were elective.

During our inspection we visited the surgery day case unit over three days. We then came back for another day and observed podiatry surgery in the day case unit. We spoke with approximately 35 members of staff including nursing and medical staff of all grades, allied health professionals, healthcare assistants, housekeeping staff and managers. We spoke with 13 patients and their relatives and checked 10 patient records. This was a routine inspection on a comprehensive basis. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Leaders did not run services well using reliable information systems and did not always support staff to develop their skills. The leadership team were not clear of who had overall responsibility and oversight of surgery at Queen Mary's Hospital. Senior staff in the surgery department at Queen Mary's Hospital relied on the general manager for outpatients to send them performance data as they did not have access to the new electronic system.
- The service did not always manage learning from incidents well. Staff did not always collect safety information and use it to improve the service.
- Managers did not always monitor the effectiveness of the service. Key services were not available seven days a week.
- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- At the time of inspection, surgery at Queen Mary's Hospital was not reporting its RTT position.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection.
- During the previous inspection, staff were not fully complaint with the World Health Organisation (WHO) surgical safety checklist. However, on this inspection we did observe staff following the checklist.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care.

Surgery

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff used equipment and control measures to protect patients, themselves and others from infection.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Nursing staff were meeting trust compliance rates for mandatory training in nine out of 10 modules.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

However:

- The day case unit treated a small number of paediatric patients and the trust was unable to provide written guidance or policies stating how to manage paediatric patients in this setting.
- Records were not always stored securely. Although records were kept in lockable cabinets behind reception, this was unlocked and open in the day, there were times when the reception staff would need to leave the desk. This left notes accessible to the unauthorised persons.
- The service did not always manage patient safety incidents well. Most of the staff we spoke with were unable to provide examples of learning from incidents when questioned.
- The nursing staff vacancy rate was 22% which was above the trust target of 9.6%. Staff sickness rate was 5.4% which was above the trust target of 3.4%.

Is the service effective?

Requires improvement →←

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- Although audits for Local Safety Standards for Invasive Procedures were carried out, data was not always submitted, and we did not observe action plans from the audit.
- British Association of Dermatology had recommendations put in place, however, it was unclear from the audit provided by the trust what the action plans were to implement the recommendations.
- Results and action plans from the national bowel screening audit were not presented to the staff at QMH. Staff told us they did not have the opportunity to attend clinical governance days as they were run at St George's Hospital and not QMH.

Surgery

- Staff did not always monitor the effectiveness of care and treatment. They did not always use the findings to make improvements and achieved good outcomes for patients.
- We observed some policies that were out of date and the previous report had recommended that all policies should be reviewed and updated in line with agreed timescales. This meant that staff did not have access to the most up to date evidence-based practice.
- Staff did not always follow national guidance to gain patients' consent. We observed gaps in documentation for consent forms and the consent policy was due for review in June 2019.
- Managers did not always appraise staff's work performance regularly. From April 2018 to March 2019 nursing and medical staff did not reach the trust target appraisal completion rate of 90%. Results showed a completion rate of 11.8% for nursing staff. However, on inspection, most the staff we spoke with had completed their appraisals.

However:

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- During the previous inspection, staff were not fully complaint with the World Health Organisation surgical safety checklist. However, on this inspection we did observe staff following the checklist.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. People told us that they felt that staff understood the emotional impact of their conditions.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.
- Staff had mechanisms in place to support patients who became distressed in an open environment, and to help maintain their privacy and dignity.

However:

- None of the patients we spoke with reported being asked for feedback on their care or being given a friends and family test questionnaire. We raised this with staff who knew there was an issue with the text system that was used to ask for feedback.
- Discussions about patient appointments could be heard in waiting areas.

Is the service responsive?

Requires improvement ↓

Surgery

Our rating of responsive went down. We rated it as requires improvement because:

- At the time of inspection, surgery at QMH was not reporting its RTT position. However, shadow reporting was being undertaken in readiness for return to reporting at QMH.
- QMH had a validation team that monitored the patient tracking list and checked if any patients had not met the 18-week referral to treatment time period. If QMH had breached the 18-week referral to treatment time, this was escalated to the general manager. However, data specific to surgery would be available once the new electronic system came into place.
- At the time of the inspection, the trust had not returned to reporting referral to treatment data at Queen Mary's Hospital but were shadow reporting.
- The trust did not always meet their threshold for did not attend rates from April 2018 to April 2019. They did have a did not attend rate team that phoned patients 72 hours in advance to check if they were attending surgery, however the text messaging reminder service was due to be implemented in September 2019.
- Staff were unable to provide details of any actions that had been implemented as a result of a complaint.
- We requested to see responses sent from complaints and action plans, but the trust did not provide us with information.

However:

- The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- Clinic letters contained information about transport, access, patient support and facilities. This included information such as support for patients with hearing impairments, assistance dogs, catering facilities and breast feeding and baby changing facilities.

Is the service well-led?

Requires improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Leaders did not have all the skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were approachable in the service for patients and staff.
- Leaders did not operate effective governance processes, throughout the service and with partner organisations. Not all staff at all levels were clear about their roles and accountabilities. There was no clarity of who had overall responsibility and oversight of surgery at Queen Mary's Hospital.
- The governance arrangements were not clearly explained due to the complexity of the leadership at Queen Mary's hospital. However, there was some oversight of governance via the monthly management and staff team meetings.
- The head of nursing from St. George's Hospital visited Queen Mary's Hospital weekly, however, some staff we spoke with commented that staff from St. George's Hospital were not visible.
- Leaders and teams did not always manage performance effectively. They did not always identify and escalate relevant risks and issues. The risks identified during the inspection did not reflect all the risks on the risk register. Career progression opportunities were limited for nursing staff in day case surgery.

Surgery

- Senior staff in the surgery department at Queen Mary's Hospital relied on the general manager for outpatients to send them performance data as they did not have access to the new electronic system.

However:

- Most staff we spoke with felt respected, supported and valued. They were focused on the needs of patients receiving care.
- Most of the staff we spoke with were aware of the trust's vision and strategy and if not, they were able to point to a board which displayed this information.

Areas for improvement

The service SHOULD:

- Have a policy in place for seeing paediatric patients in the day case unit.
- Improve staff awareness on learning from incidents.
- Ensure records are stored securely.
- Update and ensure staff have access to the deteriorating patient policy.
- Continue to work to improve nurse staffing levels.
- Ensure relevant learning from audits is shared across both sites and ensure data is consistently collected for audits and action plans completed where necessary.
- Work to improve staff appraisal rates.
- Ensure consent form documentation is fully completed.
- Ensure senior staff are clear of who has overall responsibility and oversight of surgery at Queen Mary's Hospital.
- Ensure risk registers are completed with up to date information.

This section is primarily information for the provider

2.3

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Our inspection team

Cath Campbell, Head of Hospital Inspection at CQC led this inspection. An executive reviewer, Anna Morgan, supported our inspection of well-led for the trust overall.

The team included one inspection manager, 11 inspectors, two assistant inspectors, and 12 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RJ7
Our reference	INS2-6341882901
Organisation Name	St George's University Hospitals NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Treatment of disease, disorder or injury Diagnostic procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent
	How the regulation was not being met:
	1. Consent forms were not always completed in full on some medical wards. Regulation 11

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

In line with the Obtaining Valid Consent for Treatment Policy the Trust uses standardised paper consent forms recommended by the Department of Health. The Trust will continue to use the recommended standardised consent forms downloaded from the DoH website:

- Consent form 1: Patient agreement to investigation or treatment
- Consent form 2: Parental agreement to investigation or treatment for a child or young person
- Consent form 3: Patient/ parental agreement to investigation or treatment (procedures where consciousness not impaired)
- Consent form 4: Form for adults who are unable to consent to investigation or treatment

To meet the regulation the Trust will complete the following actions:

Action	**By when**
Confirm a medical lead for consent supported by an identified nurse lead.	31.01.2020
Following the appointment of the medical lead and nurse lead for consent, a Task and Finish Group for consent will be established with representation	28.02.2020

from Clinical Directors and/or Care Group Leads to ensure divisional representation and ownership of actions and with support from the Chief Clinical Information Officer and Chief Nursing Information Officer. The Task and Finish Group will have responsibility to design, implement and analyse the Trust wide consent audit and specifically will: ➢ Review and revise existing consent audit template ➢ Agree audit methodology ➢ Agree audit schedule ➢ Develop and implement improvement action plan based on findings of baseline audit with support from Divisional Quality Improvement leads ➢ Develop KPI framework to monitor performance against a target of 100% ➢ Agree reporting framework to monitor performance to Patient Safety Quality Group, Quality and Safety Committee and Clinical Quality Review Group (external quality monitoring group chaired by the CCG) and Trust Executive Committee to Trust Board	
The medical lead for consent supported by the nurse lead will review and, where appropriate, update the Obtaining Valid Consent for Treatment Policy. The Policy will then be reviewed at the Patient Records Group ahead of going to the Patient Safety and Quality Group for ratification and will be supported by an agreed implementation plan and communication strategy.	31.03.2020
The Patient Records Group will review and, where appropriate, recommend updates to the information provided to new staff about consent requirements during the induction process.	31.03.2020
The monitoring of valid consent will be reinforced through the agreed audit schedule at ward rounds, safety huddles, matrons and ward manager checks and WHO checklist. Feedback from the audits will be provided to the multi-disciplinary team.	31.07.2020
We will investigate the opportunity to develop an electronic process for consent audit to facilitate improved reporting on the completeness of consent documentation through a single electronic enquiry rather than a manual review of individual patient records.	31.07.2020
Who is responsible for the action?	Richard Jennings, CMO
How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
To ensure that improvements are sustainable members of the Patient Records Group and the Task and Finish Group will be fully representative of the three divisions and of the multidisciplinary team to secure local ownership of the consent improvement agenda and the actions required.	

The KPIs which capture the level of performance will be included in the monthly ward and departmental posters for display and will be included in the Trust Integrated Quality and Performance Report. To further support sustainability the measures we will put in place to check this are that a repeat audit will be undertaken in Quarter 2 to establish the impact of the improvement action plan. The documentation of consent audit will form part of the Trust's annual audit calendar and will be completed on a quarterly basis. The findings of the on-going quarterly audit will be reported at Divisional Governance Boards to provide visibility of performance at service level and at the Patient Safety and Quality Group, reporting onwards to Trust Executive Committee, Quality and Safety Committee and the Trust Board. In addition, the quarterly thematic analysis of the learning from claims will be used to check for any issues about whether our patients are fully informed.	
Who is responsible?	Richard Jennings, Chief Medical Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
No additional resource required	
Date actions will be completed:	31 July 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
There is a risk that patient records do not accurately document the type of consent given for a procedure or treatment. To raise awareness of consent, posters and information for patients and carers/relatives about the need for consent are on display and available in clinical areas. All incidents relating to consent will be recorded on the Trust's risk management system Datix.

Completed by: (please print name(s) in full)	Alison Benincasa
Position(s):	Director of Quality Governance and Compliance
Date:	15 January 2020

Regulated activity(ies)	Regulation
Treatment of disease, disorder or injury Diagnostic procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance
	How the regulation was not being met:
	1. Patient records were not always stored securely, completed accurately and kept confidential in the emergency department and some medical wards. Regulation 17

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has a Quality Improvement Programme (QIP) to drive improvements in a number of areas. Part of the QIP focusses on improving the fundamentals of care though our ward and departmental accreditation scheme. We want to protect all our patients by ensuring patient records are stored safely and kept confidential in clinical areas and corporate areas, ensuring there is no opportunity for unauthorised access to patient records and that we know where patient records are at any one time. We also want to ensure that patient records are completed accurately.

To meet the regulation the Trust will complete the following actions:

Action	By when
Confirm a clinical lead for patient records	**COMPLETE**
The clinical lead for patient records will re-establish the Patient Records Group, which will report regularly through the Patient Safety Quality Group. The revised terms of reference will include issues relating to consent.	28.02.2020
The clinical lead for patient records, with support from the Chief Clinical Information Officer and Chief Nursing Information Officer, will establish a Task and Finish Group for governance of patient records with representation from Clinical Directors and/or care group leads to ensure divisional ownership to: ➢ Review and revise existing patient records audit template ➢ Agree methodology ➢ Agree audit schedule ➢ Develop and implement improvement action plan based on findings of baseline audit with support from Divisional Quality Improvement leads ➢ Develop KPI framework to monitor performance through spot-check audits of ED and medical wards and no moderate or above level incidents recorded on Datix	28.02.2020

➢ Agree reporting framework to monitor performance to Patient Safety Quality Group, Quality and Safety Committee and Clinical Quality Review Group (external quality monitoring group chaired by the CCG) and Trust Executive Committee to Trust Board	
The clinical lead for patient records will communicate with all staff to reinforce the need to ensure that records are securely stored. This will be supported by a ward and departmental poster campaign. Communication with all staff will continue on a quarterly basis.	28.02.2020
The Patient Records Group will review and, where appropriate, recommend updates to the information provided to new staff about patient record management during the induction process.	31.03.2020
The clinical lead for patient records will review and, where appropriate, update the Health Records Policy. The Health Records Policy will then be reviewed at the Patient Records Group ahead of going to the Patient Safety and Quality Group for ratification and agreement with reference to implementation and communication.	31.03.2020
The monitoring of safe storage and accurate completion of patient records will be reinforced through the agreed audit schedule at ward rounds, safety huddles, matron and ward manager checks. In addition, a safe storage of patient records audit will be developed and implemented on a quarterly basis. Feedback from the audits will be reported to the Patient Safety and Quality Group. The Patient Safety and Quality Group will report issues of concern to specific multi-disciplinary teams for attention.	31.12.2020

Who is responsible for the action?	Richard Jennings, Chief Medical Officer

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

As for improvements required to comply with Regulation 11 outlined above, the Trust will ensure that improvements are sustainable; members of the Patient Records Group and the Task and Finish Group will be fully representative of the three divisions and of the multidisciplinary team to secure local ownership of the actions needed to improve the governance of patient records.

The KPIs which capture the level of performance will be included in the monthly ward and departmental posters for display and will be included in the Trust Integrated Quality and Performance Report.

To further support sustainability the measures that we will put in place to check this are that a repeat audit will be undertaken in Quarter 2 to establish the impact of the improvement action plan. The patient records audit will form part of the Trust's annual audit calendar and will be completed on a quarterly basis. The findings of the on-going quarterly audit will be reported

at Divisional Governance Boards to provide visibility of performance at service level and at the Patient Safety and Quality Group, reporting onwards to Trust Executive Committee, Quality and Safety Committee and the Trust Board. The Trust is currently developing its Information Technology Strategy 2019-24 which will include our ambition to be a paperless organisation. As the Trust moves forward its strategic agenda we will also remain sighted on deliverable and sustainable electronic improvements.	
Who is responsible?	Richard Jennings, Chief Medical Officer
What resources (if any) are needed to implement the change(s) and are these resources available?	
No additional resource required	
Date actions will be completed:	31 December 2020

How will people who use the service(s) be affected by you not meeting this regulation until this date?
If we do not meet the regulation, there is a risk that information related to our patients may be inadvertently viewed by others. Incidents relating to patient records will be recorded to enable these incidents to be fully investigated and the learning shared and any actions taken forward by the relevant teams.

Completed by: (please print name(s) in full)	Alison Benincasa
Position(s):	Director of Quality Governance and Compliance
Date:	15 January 2020

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

3.1

Membership Engagement Committee Report

Richard Mycroft
Membership Engagement Committee Chair

19 February 2020

1. Introduction

Summary:

This report presents an update on the Membership and Engagement Committee meeting held on 28 January 2020. It sets out the discussions held and the outcome of the meeting.

Recommendation:

The Council of Governors is asked to note the update on the outcomes of the Membership and Engagement Committee meeting held on 28 January 2020.

2. Year One Membership Strategy Implementation Plan

At its meeting on the 28 January 2020, the Committee considered the Membership Strategy Year One implementation report. The Committee agreed that there had been good progress in delivery on the year one Membership Strategy Objectives and these were broadly on track with a few exceptions.

- **Health Talks** are planned for the year ahead and Governors are invited to introduce speakers to raise profile with members. These have been linked to the themed weeks. The outline programme for 2020-21 is attached at Appendix 1 with talks aligned with health awareness weeks where possible and to include non clinical topics.
- The implementation of the **three levels of membership** which was a key part of the Membership Strategy had now been completed on the membership database. The current members have been moved into one of the three levels based on their preferences when they became members. The three levels are; Be Informed (5,007 members), Be Engaged (6,693 members) and Be Involved (1,388 members). All new members can now choose on joining what level of engagement they want with the Trust and existing members can change their preferences at any time. Members have been notified of this and will be reminded periodically how they can change their preferences.
- **Staff Governors** engagement was discussed and a high level model for staff Governor engagement plan with staff Governors was discussed and to see what activities would be the most beneficial and practical. Some of the suggested activities include drop in sessions for staff in restaurant or in reception areas, presenting at staff induction and a presentation at senior leaders meeting.
- **Meet your Governor** sessions had been planned for 2020-21 at both St George's and Queen Mary's Hospital and other possible venues explored with Governors
- The first **Question Time Constituency Events** had been scheduled for the second week of March 2020 and the second set of events will take place in autumn 2020 if successful.

3. Question Time Constituency Events

The Committee heard that the Question Time Constituency events would be piloted in March 2020 in:

- South West Lambeth (Streatham Library) 9 March 2020
- Wandsworth (Earlsfield Library) 11 March 2020
- Merton (Raynes Park Library) 12 March 2020

The events would be marketed as *Question Time* to increase interest public and open the scope for wider engagement. It was noted *Question Time Constituency Events* also responds to the following year 1 objectives:

- *Develop model for governor communication with members tailored to Borough level*
- *Governor participation in new constituency level events.*

It was noted that these events would provide an opportunity for Governors to meet and engage with Members and people at Borough level and to promote and raise the profile of the work of the Trust and the Council of Governors.

It was noted that the events would be benchmarked for success if there were at least 20-30 attendees with good Governor representation at each (regardless of Constituency). It is hoped that there would be good engagement with members in the question and answer session with useful event evaluation through the feedback forms.

The Agenda is at Appendix 2.

4. Membership

Membership Engagement

The Committee received a presentation on the proposed programme for membership engagement following the Membership Strategy year one objectives. These were:

- Develop a model for Governor Communication with members tailored to borough level;
- Develop a programme of members talks and have a Governor
- Identify a range of key partners to work with and explore opportunities for joint work to help recruit new members.

It was noted that Governors have access to a wider network at borough level and in their communities. It was proposed that Governors provide the Trust with details of their local contacts and information about stakeholder events. It had been agreed that it was important to plug into the right local community networks. The Question Time Constituency Events were part of this along with the member talks programme and Meet your Governor events.

Analysis of Current Membership by Constituency

The Committee heard that there had not been a great deal of change in the membership numbers since the previous report in September 2019. Overall the number of new members had increased by 612 members (5% increase in membership) and it would appear that the increase had ben prompted by the Governor election.

Log of issues raised by Members to Governors

The Committee reviewed the latest update of the issues log raised by members to Governors to ensure Governors have an understanding of issues being raised. It was agreed that as more Governor engagement took place to capture more feedback from members this would help create a more dynamic document. This will continue to be updated and reviewed at every Committee meeting.

Appendix 1: Members Talks Programme – 2020/21

Date	Theme/topic	Purpose/Format	Venue	Presenters
20 April 2020, 2.30pm	Diabetes	Diabetes Type 2 Prevention week 20-26 April 2020	Lecture Theatre C, Ground Floor, Hunter Wing	Dr Arshia Panahloo, Consultant, Diabetes & Endocrinology
13 May 2020, 3pm	Dementia	Awareness of developments in the treatment of Dementia and how wards are made 'Dementia friendly' for patients. Dementia Awareness Week 11-17 May 2020	John Parker Lecture Theatre, Ground Floor, Atkinson Morley Wing	Dr Jeremy Isaacs, Consultant Neurologist
June 2020	Skin Cancer	Skin Cancer awareness month	TBC	Victoria Akras, Lead Dermatology Consultant
July 2020	Keeping your Spine Healthy	The consultant will advise on how an individual can keep their spine strong and healthy	TBC	Matthew Crocker, Consultant Neurosurgery
August 2020	24 Hours in A&E	Awaiting confirmation from Communications Team on timing – 3 members of staff to talk about their experiences of featuring in 24 Hours in A&E to tie in with new series	TBC	ED Patients and Staff
October 2020	Mental Health Network	Mental Health collaborative working across South West London (World Mental Health Day 10 October 2020)	TBC	Suzanne Marsello, Chief Strategy Officer
November 2020	Lung Cancer	Lung Cancer Awareness Month	TBC	TBC
January 2021	Quality – an overview of the Trust's Quality Priorities	What is a quality service? How is it measured and evaluated? Attendees will be asked to help choose quality indicators.	TBC	Alison Benincasa, Director of Quality Governance and Compliance
February 2021	Cancer Services	World Cancer Day – 4 February 2021	TBC	TBC
March 2021	Tinnitus	The consultant will advise what is Tinnitus and how the symptoms can be mitigated.	TBC	TBC

Appendix 2. Question Time Constituency Events

The timings and format for the events will follow:

Agenda

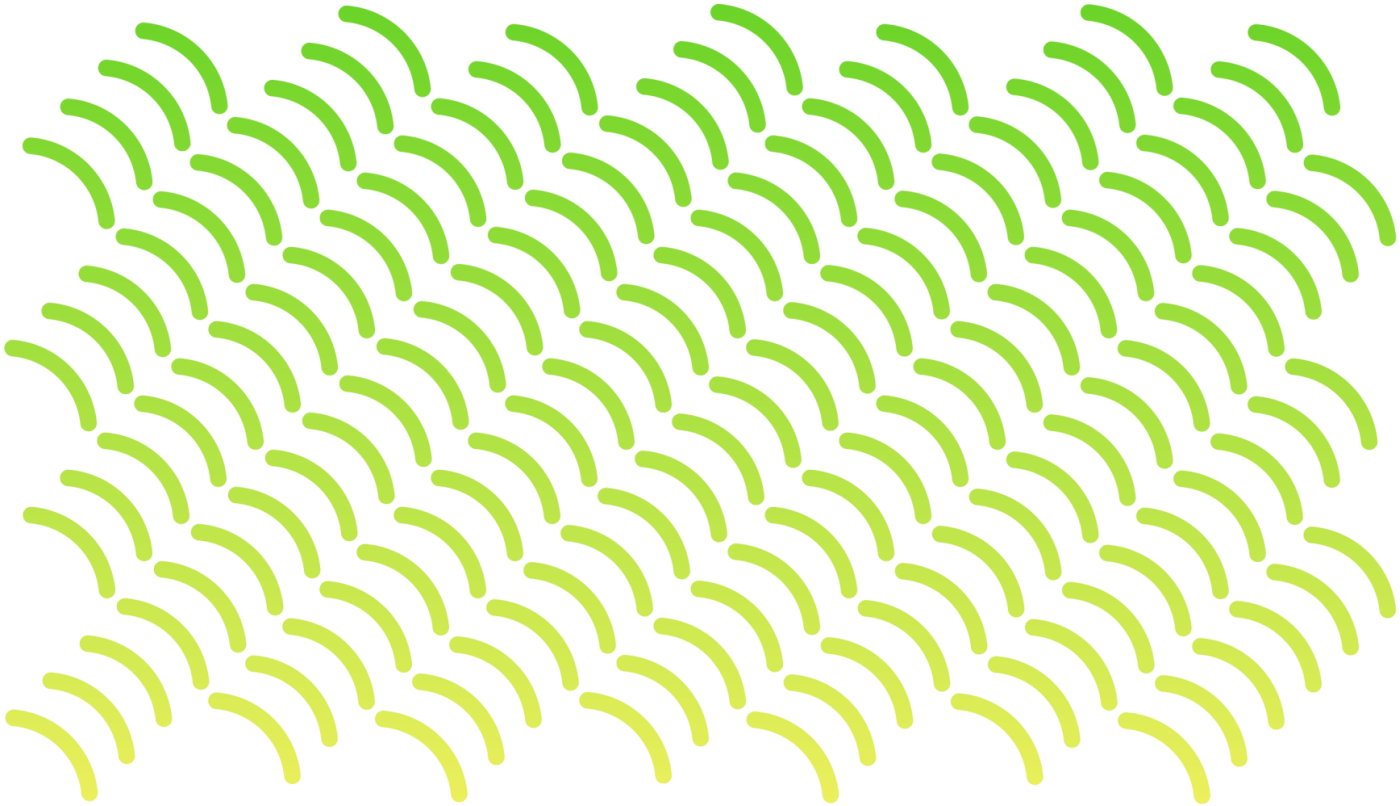
17:30-17:45* – Refreshments and networking

17:45-18:00 – Welcome and Introductions (Governor Lead)

18:00-18:15 – Highlights from Trust (Trust Executive)

18:15-19:00 – Question and Answer session from Trust Executive and Governor panel

* *The Earlsfield Library event will start at 18:00*



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3.2

Governor Election Report 2020

Stephen Jones
Chief Corporate Affairs Officer

19 February 2020

Introduction and context

Purpose

This paper provides an update on the Governor elections that ended on 30 January 2020 and considers ways in which we can strengthen our approach to Governor elections in the next election cycle later this year.

Background and Context

A total of nine seats on the Council of Governors were contested in the January 2020 elections:

- three in Wandsworth (three year term)
- two in Merton (three year term)
- one in Merton (one year term)
- two in the Rest of England (three year term)
- one Non-Clinical staff governor (three year term)

Recommendation

The Council is asked to note the update on the January 2020 elections and the learning which would be used to improve the election process for 2021 Governor Elections.

Election Process and Timetable

- The Council of Governors considered the election process at its meetings on the 17 July 2019 and 22 October 2019.
- The election process started in November 2019 and closed on 30 January 2020.
- Civica Election Services (formerly Electoral Reform Services) was appointed as the independent Returning Officer.
- The timetable for the election was in line with the timeframe set out in the Trust's Constitution.
- Nominations opened on 25 November 2019 and Closed 13 December 2019.
- Voting started on 07 January 2020 and closed 30 January 2020.
- Trust organised information sessions for people to hear about the role before they put themselves forward:
  - x3 Informal Sessions in September 2019 (2-5 people attending)
  - One Governor Awareness Session December 2019 (15-20 attending)
- Elections publicised in various ways including:
  - Trust Website and social media channels
  - Posters around the Trust and sent to community stakeholders
  - Regular messages to staff through internal communications and in the stakeholder newsletter – The Brief

Election Results 2020

We are pleased to welcome new and re-elected Governors

Merton – Public Governor three-year term:

Nasir Akhtar

Nasir Javed Khan

Merton – Public Governor one-year term:

Anneke de Boer

Wandsworth – Public Governor three-year term:

Ataul Qadir Tahir

Afzal Ashraf

Basheer Khan

Rest of England – Public Governor three-year term:

Stephen Sambrook

Shandhya Drew

Non-Clinical Staff Governor three-year term:

Non clinical
Jenni Doman

And sadly say good by to long standing governors.. Khalid Simmons (Merton) and Simon Price (Wandsworth)

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Election Results 2020

- First election since 2015 that all seats contested
- More members stood for election with 32 candidates (9 in Merton; 14 in Wandsworth; 5 in Rest of England and 3 for Non-Clinical staff) compared with 18 in 2018
- The table below shows that the turnout is broadly similar to previous elections. There is significantly lower turnout in Rest of England unsurprisingly and very positive levels of engagement and turnout for staff for first contested staff election.

Constituency	Number of seats	Eligible Voters (2020)	Votes Cast (2020)	Eligible Voters (2018)	Votes Cast (2018)	Eligible Voters (2017)	Votes Cast (2017)
Wandsworth	Three	**4,133**	**463 (11.2%)**	**4,126**	**389 (9.4%)**	**3,978**	**334 (8.4%)**
Merton	• Two – 3 year term • One – 1 year (2020 only)	**3,419**	**415 (12.1%)**	**3,134**	**418 (13.3%)**	**2,983**	**290 (9.7%)**
Rest of England	Two	**4,949**	**287 (5.8%)**	**4,832**	**Uncontested**	**4,506**	**284 (6.3%)**
Staff (Non-Clinical)	One	**1,976**	**597 (30.2%)**	**1,834**	**Uncontested**	**1,874**	**Uncontested**

Inducting New Governors

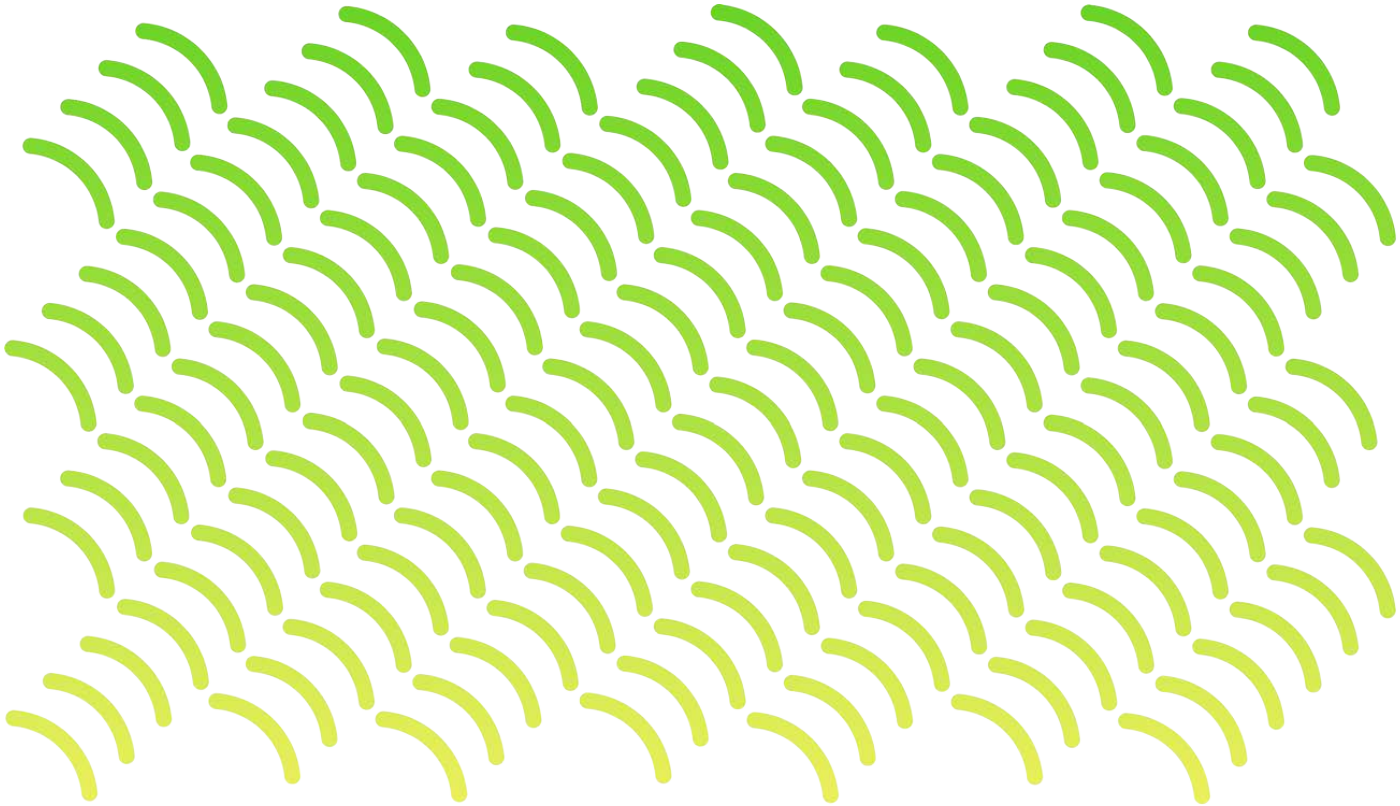
- There is a robust introduction process for new governors which include:
  - Governor Induction Session – 11 February 2020
    - Welcome - Trust Chairman
    - Governor Involvement & Engagement – Lead Governor
    - Trust Governance Structure & Corporate Governance in NHS – Chief Corporate Affairs Officer
    - Overview of the Trust/Strategy/Operations etc – Acting Chief Executive Officer
  - Offer NHS Providers Core Governor Training comprising:
    - an understanding of the structure of the NHS and the governor's role within this context
    - knowledge of the statutory role and associated duties
    - an understanding of public accountability and local ownership
    - an understanding of NHS finance
    - the skills to hold the board to account.
  - Offer New Governors Opportunity to on Trust Corporate Induction every Monday
  - Provide reference resources – Trust Constitution, Code of Conduct, Guide to being a Governor
  - Provided with schedule of Meetings
  - Offer to have orientation of main sites conducted by the Membership & Engagement Manager

Next Steps and Planning for 2021 Elections

Date	Activity
Late Spring 2020	• Start Promoting Forthcoming Elections through all media channels and at events.
Summer 2020	• Host series of Governor Awareness Sessions
September 2020	• Launch of timetable for elections at Annual Members Meeting 2020
	• Road show of Local Stakeholders Events – Fresher's Fayre etc.
	• Promotion through The Brief, website, local networks and social media
	• Open Nominations
October 2020	• Final Governor Awareness Session before Nominations Close
	• Nominations Close
November 2020	• Voting Opens
	• Voting Close (end November)
December 2020 – January 2021	• Formal Induction Session and Begin Induction programme
	• Observe Council of Governors Meeting, Board Meetings (Public), Membership & Engagement Committee
01 February 2021	• Start Role

Governor Planning for 2021 Elections -

Constituency	Number of seats
Merton - Public	• Two seats
Wandsworth - Public	• Two seats
Rest of England - Public	• Two seats
Allied Health Professional and other clinical and technical staff	• One seat
Nursing and Midwifery	• One seat
Medical and Dental	• One seat



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4.1

Meeting Title:	**Council of Governors**		
Date:	19 February 2020	**Agenda No**	**4.1**
Report Title:	**Report of the Governors' Nominations and Remuneration Committee**		
Lead Director	Gillian Norton, Chairman		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approval		
Executive Summary:	This report updates the Council of Governors on the meeting of the Governors' Nominations and Remuneration Committee held on 11 February 2019. The Committee considered new guidance issued to Trusts by NHS England and NHS Improvement in relation to: • The remuneration of NHS provider Chairs and Non-Executive Directors • The appraisal process for NHS provider Chairs • The competency framework for NHS Chairs The Committee noted the guidance and considered the implications of this for the Council's approach to the appointment and re-appointment of non-executive Board members and for the upcoming appraisal of the Chairman, the outcomes of which will be considered, along with those of the non-executive directors, at the Committee's next meeting on 28 April 2020.		
Recommendation:	The Council is asked to: i. Note the update from the Committee; ii. Note the new requirements relating to process for conducting appraisals of NHS provider Chairs and the new competency framework; iii. Note the requirements relating to the remuneration of Trust Chairs and Non-Executive Directors and the fact that the Committee will consider this again at its next meeting following further engagement with NHS England and NHS Improvement. iv. Approve the amended policy for the appraisal of the Chairman and Non-Executive Directors set out at Appendix 4.		
Supports			
Trust Strategic Objective:	Build a better St. George's		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	As set out in the paper		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

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4.1

Report of the Governors' Nominations and Remuneration Committee

Report of the meeting held on 11 February 2020

Stephen Jones
Chief Corporate Affairs Officer

19 February 2020

1. Introduction

Purpose and context

i. Purpose

This paper updates the Council of Governors on the meeting of the Governors' Nominations and Remuneration Committee held on 11 February 2020.

ii. Background and context

The Committee met to discuss new national guidance from NHS England and NHS Improvement regarding:

- the remuneration of NHS provider chairs and non-executive directors
- the process for conducting appraisals of NHS provider chairs
- the competency framework for NHS provider chairs

The new guidance has implications for how the Council of Governors decide upon the remuneration of the Chairman and other non-executive directors, particularly at the point of appointment or re-appointment and the degree of flexibility the Council have in setting remuneration rates. The guidance also prescribes a process for conducting appraisals of the Chairman, which requires some minor changes to the Trust's current processes.

iii. Reference documents

The new structure for remuneration, framework on NHS provider chair appraisals and the competency framework for provider chairs are available to download here:

- Structure for remuneration: https://improvement.nhs.uk/documents/6110/Chair_and_NED_Remuneration_Structure_1nov.pdf
- Appraisal framework: https://improvement.nhs.uk/documents/6107/Provider_Chair_Appraisal_Framework_1nov.pdf
- Competency framework: https://improvement.nhs.uk/documents/6103/Provider_Chair_Development_Framework_1nov.pdf

2. The new remuneration structure for Chairs and Non-Executive Directors (1 of 2)

The Committee reviewed the key features of the new structure for the remuneration of NHS provider chairs and non-executive directors and considered the implications of this for the Trust.

The Committee heard that the new structure for chair and non-executive director remuneration being introduced by NHS England and NHS Improvement sought to put in place arrangements that would apply equally to NHS trusts and NHS foundation trusts, and to all new appointments and re-appointments. The Committee noted that the published structure acknowledged the responsibilities of Councils of Governors of foundation trusts to set remuneration for Chairs and NEDs locally, and allowed foundation trusts the ability to opt out of the structure "*on a comply or explain"* basis.

Under the new structure, a new single uniform annual rate of £13,000 per year was being introduced for all non-executive directors, regardless of whether the organisation was an NHS Trust or an NHS foundation trust. There would be local discretion to award supplementary payments of up to £2,000 per year in recognition of designated additional responsibilities (such as chairing of Committees or undertaking the role of Senior Independent Director). Under the guidance, when those additional responsibilities ceased, remuneration levels revert to £13,000 p.a.

Any supplementary payments may only be made to two non-executives in smaller trusts (annual turnover of up to £500m) and three non-executives in larger trusts (annual turnover above £500m).

For Chairs, remuneration levels will be linked to the size of the trust, measured in terms of annual turnover, and the complexity of the role. Lower, median and upper quartiles of remuneration would be established and would be applied on the basis of the complexity of the role and the experience of the chair. For example, upper quartile remuneration would be more likely in an organisation that was regarded as "*challenged*".

The new structure will be implemented by April 2022. NHSE&I have clarified that no Chair or NED should receive a reduction in remuneration during their current terms of office.

A summary of the key features of the new structure is set out in Appendix 1.

2. The new remuneration structure for Chairs and Non-Executive Directors (2 of 2)

The Committee noted that, at present, all substantive non-executive directors at the Trust receive remuneration of £14,000 per year and that this is a uniform rate across all of the NEDs and that there is no system of supplementary remuneration for additional responsibilities. The Committee recognised that the changes would not impact on the remuneration of the NEDs in their current terms of office, but that the Trust would be expected to implement the new levels in the course of any appointment or reappointment. For current NEDs, this would involve a £1,000 reduction in current basis remuneration, albeit up to three could receive supplementary remuneration of up to £2,000 for addition responsibilities.

While the Committee recognised that the sums involved were relatively minor, it was concerned that implementing such a structure would create inequality in remuneration among the NED membership of the Board and ran counter to the culture of equality of endeavour the Chairman valued. The Committee considered that all of the NEDs invested considerably more time fulfilling their NED duties at the Trust than was set out in their role descriptions and that the time commitment of a NED at St George's was often considerably more than in other NHS organisations.

In principle, the Committee agreed that in the event that it was necessary to introduce a system of supplementary remuneration based on additional responsibilities, that supplementary remuneration should be made to the Chairs of the Quality and Safety Committee (QSC) and the Finance and Investment Committee (FIC), as well as to the Chair of the Audit Committee. While this was in no way to discount the additional responsibilities taken on by the other NEDs, QSC and FIC were critical monthly Committees for Trust currently in special measures, and the Audit Committee had a key role in providing assurance on governance and control.

The Committee nonetheless had significant reservations about implementing such a model and agreed that the Trust should explore with NHS England and NHS Improvement the extent to which it would be possible to retain uniformity in remuneration across the substantive NED cohort on the Board. It recognised that deviations from the new structure were permitted on a comply or explain basis, and agreed to consider the matter further at its next meeting.

In relation to the Chairman's remuneration, the Committee recognised that the current remuneration of the Chairman was already at the median point for a Trust of this size and that no changes would be necessary at this time. It noted that this retained some flexibility to increase the level at the point at which the Trust exited special measures in the event the Council of Governors considered this appropriate as it had previously signalled.

3. The new framework for conducting appraisals of NHS provider chairs

The Committee heard that the stated aims of the new guidance were to establish “a standard framework within which annual appraisals for provider chairs are applied and managed” and “to ensure that the annual appraisal is a valuable and valued undertaking that provides an honest and objective assessment of a chair’s impact and effectiveness, while enabling potential support and development needs to be recognised and fully considered”.

The Committee considered the new process and noted that the current process the Trust had in place closely reflected the new requirements and that only minor changes would be needed to bring this into line with the new framework. The Committee observed that the key changes related principally to the use of the new competency framework for chairs, which supersedes the framework we currently have in place, and the requirement to share the outcomes of the process with NHSE&I. The latter requirement – particularly where NHSE&I indicate a desire to moderate the outcomes of the review – could potentially have an impact on the timings for concluding the review. A comparison between the new requirements of the framework and the Trust’s current approach is set out in Appendix 2.

In terms of multi-source feedback, the Committee heard that the process would remain largely unchanged though the specific questions asked of internal and external stakeholders would need to reflect the core competencies of the new NHS provider chair competency framework (see Appendix 3).

The Committee reflected that the new framework was largely silent on the role of the Council of Governors. Despite this, it agreed to retain the current steps of the appraisal process whereby:

- The outcomes of the Chairman’s appraisal are presented to the Governors’ Nominations and Remuneration Committee for information by the Senior Independent Director, and the Non-Executive Directors’ appraisals by the Chairman.

- A high level summary report on the appraisals is presented to the Council of Governors confirming that the process has been undertaken and highlighting the key outcomes.

The Committee agreed to a series of consequential amendments to the Trust’s current policy on Chairman and NED appraisals to bring it into line with the new requirements. The updated policy is set out at Appendix 4 and the Committee agreed to recommend this for approval by the Council of Governors.

4. Recommendations

The Council of Governors is asked to:

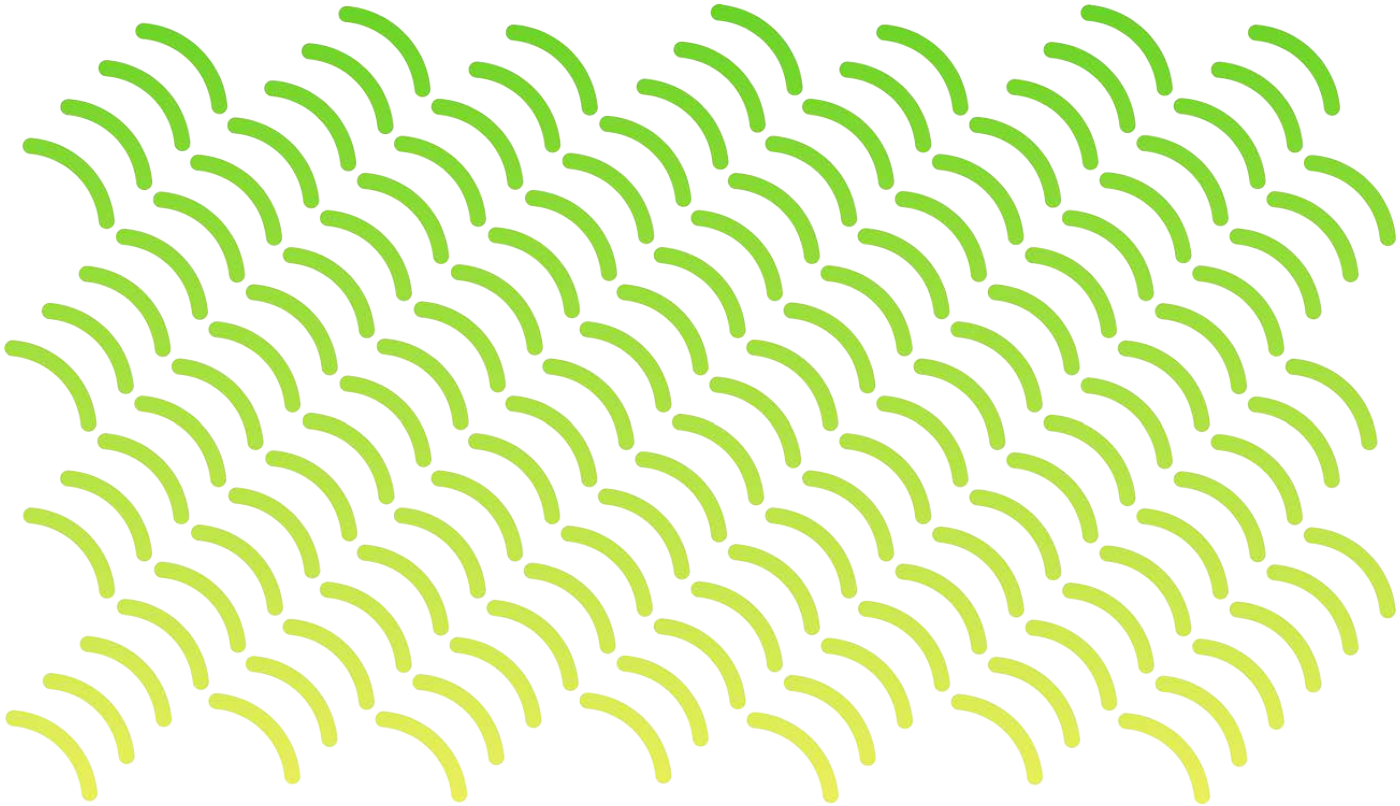
- Note the update from the Committee;
- Note the new requirements relating to process for conducting appraisals of NHS provider Chairs and the new competency framework;
- Note the requirements relating to the remuneration of Trust Chairs and Non-Executive Directors and the fact that the Committee will consider this again at its next meeting following further engagement with NHS England and NHS Improvement.
- Approve the amended policy for the appraisal of the Chairman and Non-Executive Directors set out at Appendix 4.

Appendices 1-3:

Appendix 1: The new structure for remuneration of Chairs and Non-Executive Directors

Appendix 2: The new framework for conducting appraisals of NHS provider chairs

Appendix 3: The new competency framework for NHS provider chairs



Appendix 1: The new structure for remuneration of Chair and Non-Executives

Key features of the new structure

The new structure for chair and non-executive director remuneration being introduced by NHS England and NHS Improvement seeks to put in place arrangements that would apply equally to NHS trusts and NHS foundation trusts, and to all new appointments and re-appointments. The published structure acknowledges the responsibilities of Councils of Governors of foundation trusts to set remuneration for Chairs and NEDs locally. It also recognises to freedom of FTs to opt out of the structure, "*on a comply or explain"* basis.

The remuneration structure is informed by the "market rate" of chair and non-executive director remuneration based on a 2018 survey by NHS Improvement of the of NHS foundation trusts.

- ***Non-executive directors:***
    - Introduction of a single uniform annual rate of £13,000 per year
    - Local discretion to award supplementary payments of up to £2,000 per year in recognition of designated additional responsibilities (such as chairing Committees, undertaking the role of Senior Independent Director)
    - When additional responsibilities cease, remuneration levels revert to £13,000 per year
    - Supplementary payments may only be made to two non-executives in smaller trusts (annual turnover of up to £500m) and three non-executives in larger trusts (annual turnover above £500m).

- ***Chairs:***
    - Remuneration levels will be linked to the size of the trust, measured in terms of annual turnover, and the complexity of the role.
    - Lower, median and upper quartiles of remuneration will be established and would be applied on the basis of the complexity of the role and the experience of the chair. For example, upper quartile remuneration would be more likely in an organisation that was regarded as "*challenged*".
    - The categories of remuneration are set out below:

Trust size	Annual turnover (£ pa)	Designation	Chair remuneration (£ pa)		
			Lower quartile	Median	Upper quartile
Small	<200m	Group 1	40,000	43,000	45,100
Medium	201m–400m	Group 2	44,100	47,100	50,000
Large	401m–500m	Group 3	45,000	49,500	51,400
Extra large	501m–750m	Group 4	50,500	55,000	58,500
Supra large	>750m	Group 5	55,500	60,000	63,300

    - The structure also states that where a chair assumes responsibility for leading more than one provider trust, "*all relevant local factors will need to be considered in determining an appropriate level of remuneration. Notwithstanding, it is reasonable to expect that this is likely to be closer to the upper quartile value associated with the largest size organisation*".

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Appendix 2. The new framework for conducting appraisals of NHS provider Chairs

Key principles underlying the new framework

i. What does it require?

The new framework sets out a set of minimum expectations about how NHS provider chairs should be appraised:

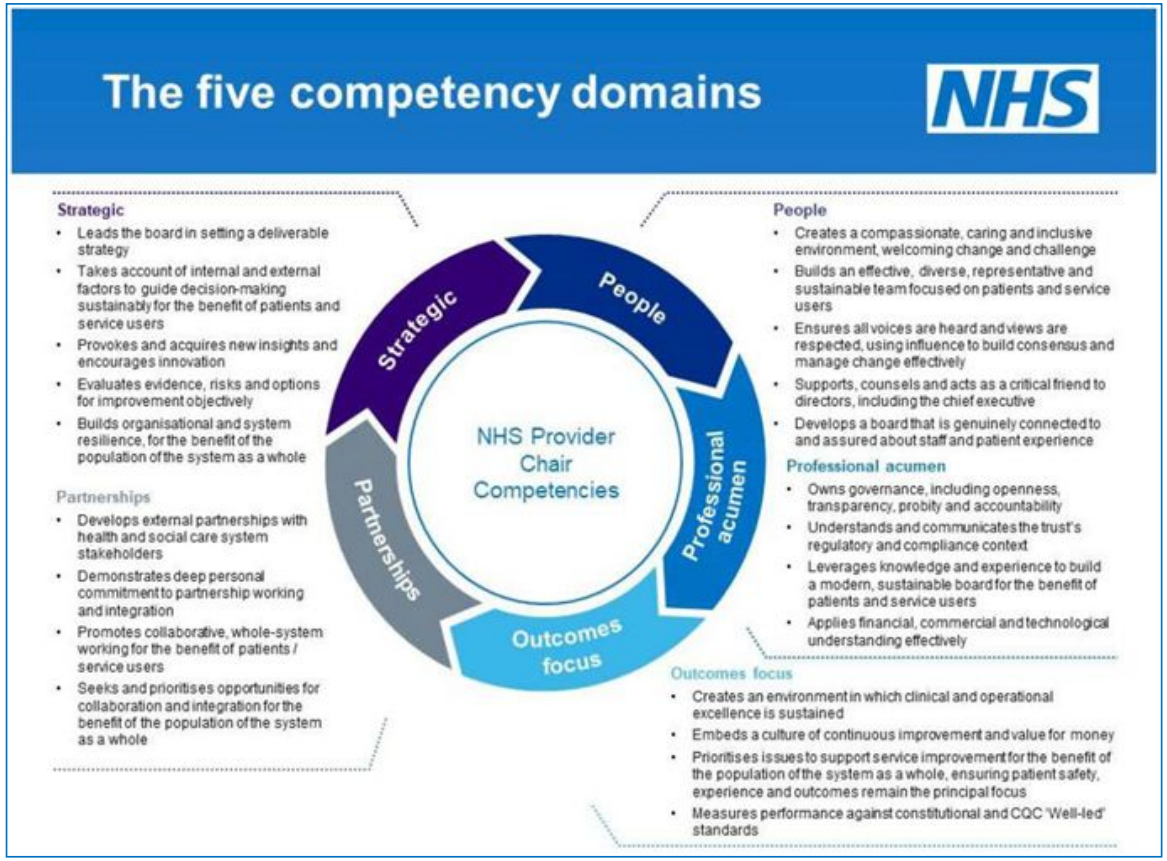
ii. How does our current approach match up?

We have assessed our current appraisal process for the Chairman against the new framework, which is already well aligned with these principles

1	Appraisals should be informed by self-evaluation	✓	The Trust's current approach involves the Chairman undertaking her own self assessment. Self assessment was incorporated into our policy in 2018/19
2	Appraisals should also be informed by assessments of impact and personal effectiveness from a range of internal and external stakeholders	✓	Our current approach involves seeking feedback from all NEDs, Executive Directors, Governors, and a range of system stakeholders. Introduced in 2018/19
3	The frame of reference for the self-evaluation and stakeholder feedback should be the five "competency" clusters of the new provider chair competency framework	−	Our current approach to self assessment and stakeholder feedback involves assessments against a range of defined competencies, which broadly reflect the new competency framework albeit not in exactly the same form
4	Preparation for and conduct of the appraisal should be facilitated by the Senior Independent Director (SID), who should receive all assessment feedback from stakeholders	✓	The Senior Independent Director leads on the Chairman's appraisal and receives all feedback and the self assessment prior to the appraisal discussion
5	The SID should place significant emphasis on developing a highly functional working relationship with the Chairman, built on openness, honesty and trust	✓	Although the Trust appointed a new SID (Ann Beasley) in October 2019 following Sir Norman Williams' departure, the relationship between the new SID and Chairman reflects this requirement
6	The Chairman should be genuinely willing to seek and act on constructive criticism about their impact and effectiveness	✓	The Chairman has demonstrated her commitment to the appraisal process and to reflecting and acting on feedback, as evidenced following previous years' appraisals
7	The outcomes of the appraisal should be recorded and shared with the relevant NHS England and NHS Improvement Regional Director.	✗	No NHS trust or NHS foundation trust has previously been required to do this, and our current approach does not reflect this. Our current approach is that the outputs of the appraisals are shared for information with Governors' RemCom

Appendix 3: The new competency framework for NHS provider Chairs

What does it involve and how is it integrated into appraisals?



As part of the new framework for the appraisal of NHS provider chairs, NHSE&I have launched a new competency framework for chairs. The new guidance, *The role of the NHS provider chair: a framework for development*, sets out:

- **A common description of the role of the role of the chair**, including five identified responsibilities: strategic, people, professional acumen, outcomes focus, and partnerships.
- **A common description of the values and principles** which all provider chairs should model (working together for patients; compassion; respect and dignity; improving lives; commitment to quality of care; everyone counts), and the seven (Nolan) principles of public life (selflessness; integrity; objectivity; accountability; openness; honesty; leadership)
- **A new common role description for provider chairs and person specification** to guide future appointments.

The new guidance sets out an expectation that the five competency domains (above and opposite) form the structure and basis of the questions to be asked of internal and external stakeholders as part of the multi-source feedback in the appraisal process. For each of the descriptors under the five domains opposite, respondents would be asked whether they "strongly agree", "agree", "disagree", or "strongly disagree".

Under the new framework, stakeholders providing feedback for the appraisal would also have the opportunity to:

- Describe what they see as the Chairman's strengths, and what they do particularly well;
- Identify opportunities as to how the Chairman could increase their impact and effectiveness
- Provide any additional comments relating to conduct, impact and effectiveness in their role.

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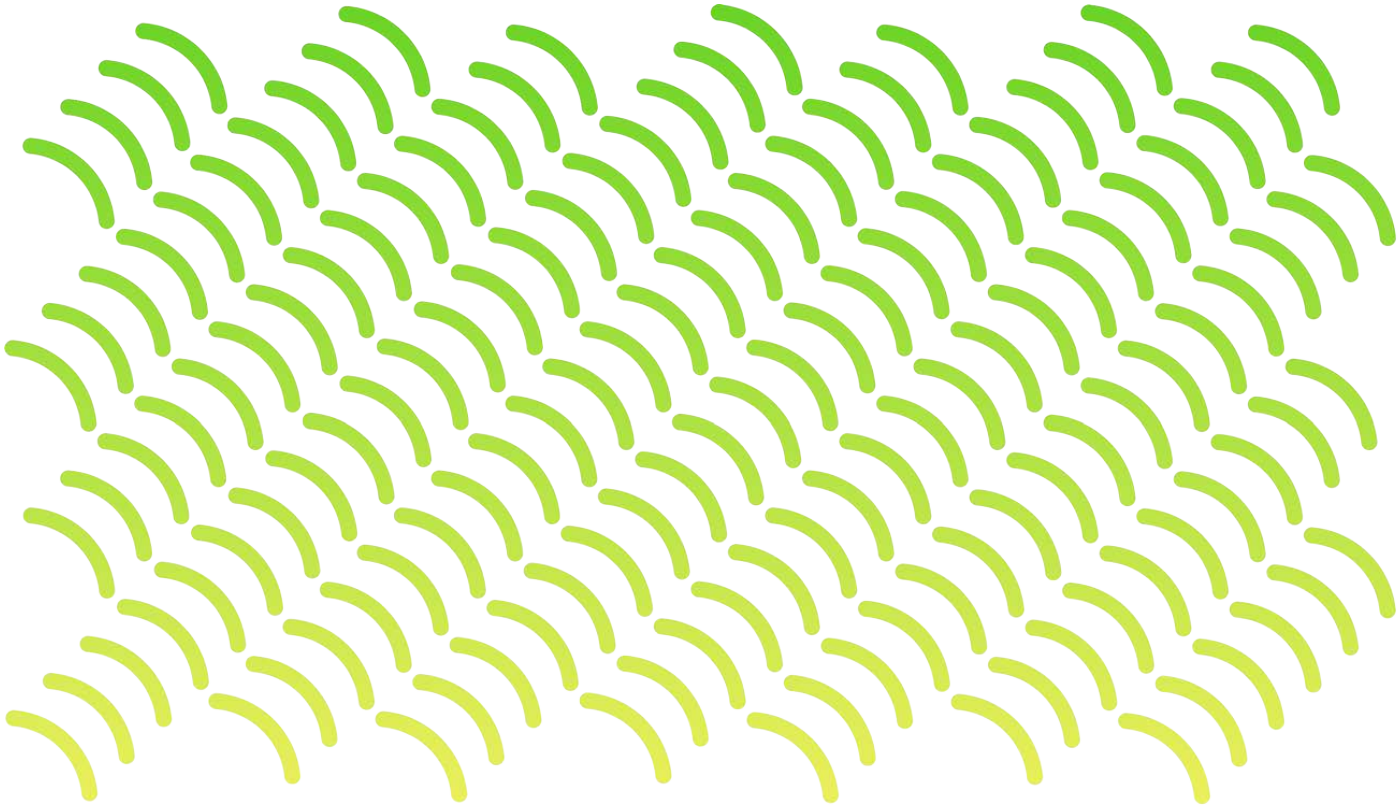

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Appraisal Process for the Chairman and Non-Executive Directors

4.1

Profile	
Version:	*Version 3*
Author:	*Stephen Jones, Chief Corporate Affairs Officer*
Executive/Divisional sponsor:	*Gillian Norton, Chairman*
Applies to:	*Chairman* *Non-Executive Directors* *Council of Governors* *Trust Secretariat*
Date issued:	*20 February 2020*
Review date:	*28 February 2022*
Approval	
Approval Executive or Committee:	*Council of Governors* *Council of Governors Remuneration & Nomination Committee*
Date:	*11 February 2020 (NRC)* *19 February (CoG)*

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Policy Gateway

Please complete the checklist and tables below to provide assurance around the policy review process.

☒ I have involved everyone who should be consulted about this policy/guidance
☒ I have identified the target audience for this policy/guidance
☒ I have completed the correct template fully and properly
☒ I have identified the correct approval route for this policy/guidance
☒ I have saved a word version of this policy/guidance for future reviews and reference

Please set out what makes you an appropriate person to conduct this review:
This policy was initially drawn together with expert input of Deloitte over the summer of 2017 based on a review of prevailing best practice. The views of the Chairman and Non-Executive Directors were also sought and their observations and requirements included. As Chief Corporate Affairs Officer, I am responsible for supporting the Council of Governors and the Board on all matters of corporate governance, including the process of appraisal of NED members of the Board.

Please set out the legislation, guidance and best practice you consulted for this review:
NHS Foundation Trust Code of Governance, Monitor (2014) Your statutory duties: A reference guide for NHS foundation trust governors Your duties: a brief guide for NHS foundation trust governors Framework for Conducting Annual Appraisals of NHS Provider Chairs, NHS England and NHS Improvement (2019) The Role of the NHS Provider Chair: A Framework for Development, NHS England and NHS Improvement (2019)

Please identify the key people you involved in reviewing this policy why, and when:
Deloitte – expert advisors on corporate governance (2017) Chairman – significant experience of appraising staff and responsible for setting objectives for the Non-Executive Directors Non-Executive Directors – experience of having participated in the appraisals process in 2018 and 2019

Summarise the key changes you have made and why:
The initial policy was developed as the Trust had never previously had a policy setting out how

the Appraisal Process for the Chairman and Non-Executive Directors. The policy was tweaked in 2018 to refine the process in light of the first year of its operation.

Following the publication of the new national framework for the appraisal of NHS provider chairs and the new competency framework for NHS provider chairs, published in September 2019, the policy has been reviewed to incorporate:

- A preparatory meeting between the Chairman and Senior Independent Director at the outset of the process to confirm the identity of stakeholders form whom to seek feedback and to agree the timetable for the appraisal;
- The five domains of the new provider chair competency framework as the basis for the collection of multi-source feedback from internal and external stakeholders on the chair's effectiveness;
- The requirement for the Senior Independent Director to engage with NHS England and NHS Improvement at the start of the appraisal process to ascertain whether NHSE&I consider there are any areas of competency which should receive particular focus, and to introduce the process of submitting the outcomes of the appraisal to the Chair, Chief Operating Officer and Regional Director of NHS England and NHS Improvement;
- The new appraisal write-up template as set out in the new framework which will be submitted for information to NHSE&I at the completion of the process.

Executive Summary

- The purpose of this paper is to set out the process through which the performance appraisal of the Chairman and Non-Executive Directors will be conducted. This process takes account of:

  - A review of good practice in other Foundation Trusts;
  - The new general duties of NHS Governors in the Health and Social Care Act 2012 and relevant guidance from NHS England and NHS Improvement to NHS Foundation Trust Governors;
  - The competency framework for NHS provider chairs, published by NHS England and NHS Improvement in September 2019; and
  - The framework for the appraisal of NHS provider chairs, published by NHS England and NHS Improvement in September 2019.

The content of the policy has been approved by Council of Governors' Nominations and Remuneration Committee and by the Council of Governors.

1. Introduction

1.1 The Council of Governors is responsible for the appointment and re-appointment of the Chairman and Non-Executive Directors (NEDs) and should agree a process for the evaluation of the Chairman and the NEDs, with the Chairman and the NEDs. The outcomes of the evaluation of the Chairman and the NEDs should be reported to and agreed by the Council of Governors which should consider using the Senior Independent Director to lead the evaluation of the performance of the Chairman.

1.2 This is in line with the *Foundation Trust Code of Governance* section B.6.1, section 5.2 of the current draft of *Your statutory duties: a reference guide for NHS foundation trust governors* published on August 2013 (page 35) and the *Foundation Trust Governors Association Essential Brief 10*.

1.3 In addition, when developing a system for assessing and appraising the performance of the Chairman and the NEDs, the Trust should consider how it:

i. will form part of the overall assessment of the Board and its performance
ii. link to the achievement of the Trust's annual plan
iii. show whether each director continues to contribute effectively, to demonstrate commitment and has the relevant skills for the role
iv. assess performance against pre-defined priorities
v. identify training or development needs.

1.4 Furthermore since the primary aim of the Chairman's work is to lead the Directors in executing the Trust's annual plans, the appraisal should consider carefully the Chairman's performance as the leader of the Board of Directors, as well as their role as the Chairman of the Council of Governors

2. Status and Purpose

2.1 This document establishes the process through which the performance appraisal of the Chairman and Non-Executive Directors (NEDs) is to be undertaken at St George's University Hospitals NHS Foundation Trust.

3. Chair and Non-Executive Director Appraisal Process

3.1 In developing this appraisal process, key principles have been retained from the Trust's current appraisal system which includes objective, measurable performance criteria which apply to all NEDs (though with additional criteria for the Chairman to reflect their additional duties), 360º peer and stakeholder assessment, reflective self-assessment, and clear objective setting.

3.2 In line with the Chairman's duties as both the leader of the Board of Directors and the Chairman of the Council of Governors, the appraisal system has been designed to assess their performance in this dual capacity.

3.3 The appraisal process will be conducted during March and April of each financial year in

order to align the agreed objectives for the Chairman and Non-Executive Directors for the following year with the Trust's strategic objectives included within the Annual Plan.

3.4 Board members and Governors will be invited to participate in providing feedback to inform the review of the Chairman's and NEDs' performance and effectiveness though their contributions will remain non-attributable and anonymous. To enable objective review, a set of statements have been pre-prepared for Board Members / Governors to use to assess the performance of the Chairman and NEDs. For the Chairman, these reflect the five domains set out in the 2019 guidance issued by NHS England and NHS Improvement, *The role of the NHS provider chair: a framework for development.*[1] For the NEDs, these statements have been developed through a detailed review of role descriptions, regulatory requirements and good practice guidance. Only one response should be selected per statement, and comments boxes are provided to allow the respondent to articulate the rationale for responses (though this is optional).

3.5 In completing the survey for the Chairman, respondents are asked to review and consider the 2019 competency framework for effective NHS provider chairs and, as part of this, reflect on both the statements set out under each of the five competency domains as well as the values and principles set out in the guidance. In the case of the NEDs' appraisals, respondents are asked to consider the Board level behaviours identified by the NHS Leadership Academy's Healthcare Leadership Model.[2] A dedicated comments section is set out at the end of the form for respondents to offer reflections on how the Chairman's and NEDs' performance in demonstrating these behaviours. This includes the opportunity to provide free text comments on what the Chairman and each NED does effectively, opportunities for increasing their impact and effectiveness, and any additional commentary related to conduct, impact and effectiveness in their respective roles.

Process in Brief - Appraisal of Chairman

3.6 The following summarises the steps which will be followed to conduct the Chairman's appraisal:

a. At the beginning of the performance year, the Senior Independent Director and Chairman should meet to set some mutually agreed objectives for the coming year. This will be aligned to any perceived development needs and the findings from the previous year's appraisal.

b. Prior to the start of the appraisal process, the Chairman and the Senior Independent Director will meet to discuss which stakeholders should be approached to provide multisource feedback to help inform the appraisal and to agree on the precise timeline for the appraisal.

[1] *The role of the NHS provider chair: A framework for development,* September 2019, NHS England and NHS Improvement: https://improvement.nhs.uk/documents/6106/Chair_Competencies.pdf
[2] This is available at: https://www.leadershipacademy.nhs.uk/wp-content/uploads/2014/10/NHSLeadership-LeadershipModel-colour.pdf

c. The Senior Independent Director should, at this stage, be provided with the following documentation to help inform the appraisal:
    a. The Chairman's previous appraisal and personal development plan;
    b. The Chairman's agreed in-year objectives;
    c. The in-year Board development plan;
    d. A copy of the competency framework for NHS provider chairs;
    e. Any summary information regarding the performance of the Trust which the Senior Independent Director considers relevant to the appraisal.

d. The Senior Independent Director will contact the NHS England and NHS Improvement Regional Director for London to ascertain whether there are any particular areas of the 2019 NHS provider chair competency framework on which to focus the appraisal.

e. Executive Directors, Non-Executive Directors and Governors will be invited to complete the survey form at Appendix A, which is based on the five domains of competency for provider chairs identified by NHSE&I, and return this to the Chief Corporate Affairs Officer, who will treat the information provided in the strictest confidence. Typically, this will be completed through an online survey tool. It is expected that brief comments should be included in the space provided where a score of either 'Disagree' or 'Strongly disagree' has been awarded or where there is anything of consequence (positive or negative) that is relevant to the assessment of the Chairman of the Trust. As part of this, respondents will be asked to complete free text comments on the Chairman's strengths, opportunities for increasing their impact and effectiveness, and any additional comments relating to any aspects of the Chairman's conduct, impact and effectiveness in the role.

f. The Chairman of the Trust will also complete a self-assessment to inform the appraisal, using the same set of questions based on the five competency domains.

g. Completed survey forms will be collated into a "pack" of information and provided to the Senior Independent Director ready for the Chairman's appraisal meeting. This "pack" will also include information about the Chairman's attendance, any training undertaken within the year and the Chairman's annual objectives and the further information identified in paragraph 3.6(c) above.

h. The Senior Independent Director will evaluate all of the collated internal and external stakeholder feedback, and seek any further information from them if the SID considers this necessary. The SID will then evaluate this feedback alongside the Chairman's self-assessment.

i. The Senior Independent Director will meet to discuss the feedback received and to conduct the appraisal, taking into account the information in the pack. The appraisal discussion will be framed around the collective evaluation of multi-source feedback from internal and external stakeholders and the Chairman's self-assessment. Consideration will be given to in-year performance, any development and support needs will be identified, and performance against the in-year objectives will be reviewed.

j. A record of the appraisal discussion will be completed by the Senior Independent Director in the template specified by NHS England and NHS Improvement. The record of the appraisal will be shared with and agreed by the Chairman. This record will include an overall assessment of the Chairman's performance. It will highlight significant emergent themes from the stakeholder assessments, areas of strength and identified opportunities to increase impact and effectiveness. It will also include a summary of self-reflection by the Chairman on the multi-source stakeholder assessments. Proposed objectives for the coming performance year will also be discussed and documented as part of this meeting alongside any development and support needs.

k. The completed appraisal outcomes will be submitted to the Chair and Chief Operating Officer of NHS Improvement for review and to the Regional Director for London of NHS England and NHS Improvement for information. The Chair and COO of NHSI will acknowledge receipt of the appraisal documentation and will seek further information and request moderation of the outcomes where this is deemed necessary.

l. A report of the outcome of the appraisal will be made by the Senior Independent Director to the Governor committee responsible for NED appraisal, where the outcome will be considered.

m. A summary of the report provided to the Governor committee responsible for NED appraisal will be presented to the Council of Governors by the Senior Independent Director.

Process in Brief - Appraisal of the Non-Executive Directors

3.5 The following summarises the steps which will be followed to conduct the appraisals of the Non-Executive Directors:

a. At the beginning of the performance year, the Chairman and each NED should meet to set mutually agreed objectives for the coming year. This will be aligned to any perceived development needs and the findings from the previous year's appraisal.

b. Executive Directors, Non-Executive Directors and Governors will be invited to complete the survey form at Appendix B and return to the Chief Corporate Affairs Officer, who will treat the information provided in the strictest confidence. Typically, this will be completed through an online survey. In line within the new approach to the appraisal of the Chairman, the survey will include the opportunity for respondents to comment on the NED's strengths, opportunities for increasing their impact and effectiveness, and any additional comments relating to any aspects of the their conduct, impact and effectiveness in the role.

c. Non-Executive Directors will also complete a self-assessment to inform the appraisal, using the same set of questions.

d. Completed survey forms will be collated into a "pack" of information and provided to the Chairman ready for relevant NED's appraisal meeting. This "pack" will also

include information about attendance, any training undertaken within the year and the NED's annual objectives.

e. The Chairman will meet with each NED to discuss the feedback received, and to conduct their appraisal, taking into account the information in the pack.

f. A record of the appraisal discussion will be completed and agreed. This record will include an overall assessment of the NED's performance and highlight any development needs, including agreed training. Proposed objectives for the coming performance year will also be discussed and documented as part of this meeting.

g. A report on the outcome of the appraisal process will be provided to the Governor committee responsible for Non-Executive Director appraisal for consideration. A brief report summarising the outcome of the appraisal for each NED, including any recommendations will then be presented to the Council of Governors by the Chairman.

Timetable

3.6 As set out in 3.3, the appraisal process will be conducted in March and April of each financial year in order to align to the performance year for the Chairman and Non-Executive Directors.

3.7 It is intended that the timeline for the appraisal activities set out at 3.4 and 3.5 take place as follows:

March – Board Members and Governors multisource feedback surveys issued, completed and collated.

March / April – Pack of appraisal information collated and appraisal meetings undertaken with Chair and NEDs.

April early May – Outcomes of the appraisal discussions to be completed, recorded and agreed. In the case of the Chairman, the outcome report will be submitted to NHS England and NHS Improvement. Reports to summarise the outcome of appraisals for the Chair and NEDs provided to the Governor committee responsible for NED appraisal

May – Summary report of the outcome of the appraisals of the Chairman and NEDs to be presented to the Council of Governors.

3.8 Where NHS England and NHS Improvement request that the appraisal of the Chairman is moderated, or where significant further information is requested, this will be reported to the Governance committee responsible for NED appraisals and to the Council of Governors.

3.9 The outcome of the appraisal process for the Chair and NEDs will also be recorded in the Trust's Annual Report in line with the duty set out in the Foundation Trust Code of Governance, which requires that the Board of Directors undertakes a formal and rigorous annual evaluation of its own performance, and that of its committees and

individual directors, and state in the annual report how the evaluation has been conducted.

4. Dissemination

4.1 It is intended that this policy will be disseminated in line with the processes described in the Trust Policy for the Development and Implementation of Trust-wide Procedural

5. Monitoring compliance – Checklist and timelines

Process for Appraisal of Chairman	**Process for Appraisal of Non-Executive Directors**
Have the Chairman and Senior Independent Director agreed the stakeholders from whom to seek feedback and the precise timetable for the appraisal, and has the supporting information been shared with the SID? **MARCH**	
Has the Senior Independent Director engaged with NHSE&I to ascertain whether there are any particular aspects of the competency framework on which the appraisal should focus? **MARCH**	
Have Executive Directors, Non-Executive Directors and Governors been invited to complete a survey form (Appendix A) which will be confidential? **MARCH**	Have Executive Directors, Non-Executive Directors and Governors been invited to complete a survey form (Appendix B) which will be confidential. **MARCH**.
Have complete forms been collated by the Chief Corporate Affairs Officer and given to the Senior Independent Director in advance of the appraisal meeting with the Chairman? **MARCH/APRIL**	Have completed forms been collated by the Director of Corporate Affairs for each NED and provided to the Chairman in advance of the appraisal meeting? **MARCH/APRIL**
Has the Senior Independent Director met the Chairman to discuss feedback and to conduct the appraisal? Have new annual objectives been agreed? **MARCH/APRIL**	Has the Chairman met with each of the NEDs individually to discuss feedback and to conduct the appraisal? Have new annual objectives been agreed? **MARCH/APRIL**
Have the forms setting out the outcomes of the appraisal been completed and agreed by the SID and Chairman? **MARCH/APRIL**	Have the outcomes of the appraisal been agreed between the Chairman and the NED? **MARCH/APRIL**
Have the completed appraisal forms been sent to the Chief Corporate Affairs Officer for filing and sharing with NHSE&I? **MARCH/APRIL**	Has a record been completed and agreed and is a final copy stored with the Director of Corporate Affairs? **MARCH/APRIL**
Has a report of the outcome been produced by the Senior Independent Director for the Governor Committee responsible for NED Remuneration & Nomination? Has the Senior Independent Director been invited to	Has a report of the outcome been produced by the Chairman for the Governor Committee responsible for NED Remuneration & Nomination? **APRIL/MAY**

attend? **APRIL/MAY**	
Has a summary report been presented to the Council of Governors by the Committee and the Senior Independent Director? (which should be considered at the same time as the report on the NEDs' appraisal). The report should contain details of the Chairman's agreed annual objectives. **APRIL/MAY (Committee)** **MAY/JUNE (Council of Governors)**	Has a summary report been presented to the Council of Governors by the Committee and the Chairman? (which should be considered at the same time as the report on the NEDs' appraisal). The report should contain details of the NEDs' agreed annual objectives. **APRIL/MAY (Committee)** **JUNE/JULY (Council)**
Has any request for moderation of the outcome of the appraisal by NHSE&I been communicated to the Council of Governors? **JUNE/JULY**	

6. Associated documentation

- Agreed annual objectives for the Chairman and NEDs
- Monitor Code of Governance
- Your statutory duties - A reference guide for NHS foundation trust governors
- Your duties: a brief guide for NHS foundation trust governors

APPENDIX 1: CHAIRMAN'S PERFORMANCE MULTISOURCE FEEDBACK QUESTIONS

Part 1: Responses to statements relating to the NHS provider chair competency framework

Competency 1: Strategic	Strongly agree	Agree	Disagree	Strongly disagree
Leads the Board in setting an achievable strategy				
Takes account of internal and external factors to guide decision-making sustainably for the benefit of patients and service users				
Provokes and acquires new insights and encourages innovation				
Evaluates evidence, risks and options for improvement objectively				
Builds organisational and system resilience, for the benefit of the population of the system as a whole				

Competency 2: Partnerships	Strongly agree	Agree	Disagree	Strongly disagree
Develops external partnerships with health and social care system stakeholders				
Demonstrates deep personal commitment to partnership working and integration				
Promotes collaborative, whole-system working for the benefit of all patients and service users				
Seeks and prioritises opportunities for collaboration and integration for the benefit of the population of the system				

Competency 3: People	Strongly agree	Agree	Disagree	Strongly disagree
Creates a compassionate, caring and inclusive environment, welcoming change and challenge				
Builds an effective, diverse, representative and sustainable team focused on all staff, patients and service users				
Ensures all voices are heard and views are respected, using influence to build consensus and manage change effectively				
Supports, counsels and acts as a critical friend to directors, including the chief executive				

Competency 4: Professional acumen	Strongly agree	Agree	Disagree	Strongly disagree
Owns governance, including openness, transparency, probity and accountability				
Understands and communicates the trust's regulatory and compliance context				
Leverages knowledge and experience to build a modern, sustainable Board for the benefit of patients and service users				
Applies financial, commercial and technological understanding effectively				

Competency 5: Outcomes focus	Strongly agree	Agree	Disagree	Strongly disagree
Creates an environment in which clinical and operational excellence is sustained				
Embeds a culture of continuous improvement and value for money				
Prioritises issues to support service improvement for the benefit of the population of the system as a whole, ensuring patient safety, experience and outcomes remain the principal focus				
Measures performance against constitutional standards, including those relating to equality, diversity and inclusion				

Part 2: Strengths and opportunities

Please highlight the chair's particular strengths and suggest any areas in which there are opportunities for increasing their impact and effectiveness.

Strengths: What does the Chairman do particularly well?

Opportunities: How might the Chairman increase their impact and effectiveness?

Part 3: Additional Commentary

Please provide any additional commentary relating to any aspect of the Chairman's conduct, impact and effectiveness in their role.

Additional commentary

Guidance Notes for Completion

- Your response will remain non-attributable and anonymous
- These statements are for Board Members / Governors to review in order to assess the performance of the Chairman and Non-Executive Directors.
- They have been developed through a detailed review of role descriptions, regulatory requirements and good practice guidance.
- Only one response should be selected per statement, and comments boxes are provided to enable you to articulate the rationale for responses (this is optional).

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Appendix B: **Non- Executive Directors' performance statements – for completion by Board Members and Governors**

I am a…..		Board Member		Governor			
	Statement	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**	**Cannot say**	**Comments**
Corporate understanding and strategic awareness							
1	Demonstrates a well-rounded knowledge of the Trust						
2	Demonstrates a breadth of contribution across a range of topics						
Leadership							
3	Behaves consistently with the values of the Trust						
Commitment							
4	Is visible in committing their time to the Trust to understand the environment in which it operates						
Contributions and holding to account							
5	Challenges constructively and in a way that adds value						
6	Challenges predominantly in relation to strategic matters and the management of corporate risks						
7	Contributes to debate across the entirety of the Board agenda						
Personal development, style and impact							
8	Consistently acts in the best interests of patients and the public						
9	Contributes meaningfully to the effectiveness of the Board as a team						
Additional comments							
10	[Respondents to offer any additional comments in relation to: (i) strengths and what they do well; (ii) opportunities for increasing their impact and effectiveness; (iii) any additional comments relating to their conduct, impact and effectiveness						

Guidance Notes for Completion

- Your response will remain non-attributable and anonymous
- These statements are for Board Members / Governors to review in order to assess the performance of the Chairman and Non-Executive Directors.
- They have been developed through a detailed review of role descriptions, regulatory requirements and good practice guidance.
- Only one response should be selected per statement, and comments boxes are provided to enable you to articulate the rationale for responses (this is optional).

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4.2

Meeting Title:	**Council of Governors**		
Date:	19 February 2020	**Agenda No**	4.2
Report Title:	**Proposed temporary changes to the Trust's Constitution**		
Lead Director	Gillian Norton, Chairman		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Approval		
Executive Summary:	This paper proposes temporary changes to the Trust's Constitution, and to the Standing Orders, in order to clarify the membership of the Trust Board, and associated voting rights, following the departure of the Chief Operating Officer and the adoption of interim arrangements to cover that role until a substantive replacement is appointed. The Board has considered and approved the proposed changes to the Constitution. These changes must now be considered by the Council of Governors. A comprehensive review of the Trust's Constitution is being undertaken in parallel with these temporary changes, the first such review to be undertaken since the Trust was authorised as an NHS Foundation Trust and its Constitution approved by Monitor on 1 February 2015. The outputs of this, and any consequential proposals for amendment, will be reported to the Board and the Council of Governors in the coming months.		
Recommendation:	The Council of Governors is asked to: 1. Agree to a temporary amendment to the Trust's Constitution to expand the composition of the Board to include the role of Chief Operating Officer as set out at Appendix 1 (with full voting rights); 2. Agree that this change be for a temporary period until a substantive appointment commences in post, and in any case no longer than nine months from the date on which the Council of Governors approves the amendment; 3. Note the wider review of the Constitution currently underway, which will report in the coming months.		
Supports			
Trust Strategic Objective:	Build a better St. George's		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well Led)		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	As set out in the paper		

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Resources:	N/A		
Previously Considered by:	Trust Board of Directors	**Date:**	13 February 2020
Appendices:	Appendix 1: Proposed changes to the Trust's Constitution		

4.2

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Proposed temporary changes to the Trust's Constitution

Council of Governors, 19 February 2020

4.2

1.0 Issue

1.1 This paper proposes temporary changes to the Trust's Constitution in order to clarify the membership of the Trust Board, and associated voting rights, following the departure of the Chief Operating Officer and the adoption of interim arrangements to cover that role until a substantive replacement is appointed.

2.0 Background

2.1 Following the departure of the Chief Operating Officer, the Chairman and Chief Executive have agreed that the current Chief Nurse and Director of Infection Prevention and Control, will take on the role of Chief Operating Officer until a substantive replacement is appointed.

2.2 It has also been agreed that the Deputy Chief Nurse will formally act-up into the role of Chief Nurse and Director of Infection Prevention and Control for the duration of substantive post holder's temporary appointment as Chief Operating Officer.

2.3 These interim arrangements have implications for the both the membership of the Board and the persons holding voting rights at Board.

3.0 Requirements regarding the composition of the Board

3.1 The composition of the Board of Directors is governed by:

- The NHS Act 2006, as amended by the Health and Social Care Act 2012
- The Trust's Terms of Authorisation as an NHS Foundation Trust
- The Trust's Constitution
- The Trust's Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

3.2 Under paragraph 23 of the Trust's Constitution, which reflects the Trust's Terms of Authorisation as an NHS Foundation Trust and the requirements of Schedule 7 of the NHS Act 2006, the Board currently comprises:

- A non-executive Chairman
- Six other non-executive directors
- Four executive directors

3.3 Of the four executive directors:

- One must be the Chief Executive, who also acts as the Accounting Officer;
- One must be the finance director;
- One must be a registered medical practitioner or a registered dentist

- One must be a registered nurse or a registered midwife

3.4 The Standing Orders of the Trust further provide that the executive directors include "the Chief Executive (who is also Accounting Officer), the Chief Financial Officer, the Medical Director, and the Chief Nurse" (SO 3.2(4)).

4.0 Implications of the interim arrangements on Board membership and voting rights

4.1 The interim arrangements put in place to cover the role of Chief Operating Officer would involve the Deputy Chief Nurse acting up into the role of Chief Nurse and thereby taking on the voting rights associated with that role under the Trust's Standing Orders.

4.2 The role of Chief Operating Officer is not, formally, a member of the Board of Directors. Instead, the role is that of a director who attends Board. In transitioning to the role of Chief Operating Officer, albeit on a temporary basis, the current Chief Nurse would cease to be a voting member of the Board.

4.3 The Trust Board of Directors considers that it would be inappropriate to ask the current Chief Nurse to relinquish her voting rights – albeit on a temporary basis.

5.0 Proposed actions

5.1 It is proposed that the appropriate and most robust way forward would be to amend the Trust's Constitution to expand the number of executive directors to five, one of which would be the Chief Operating Officer. This would not impact on the requirement for the non-executive directors to hold a majority of the voting positions on the Board; the Board continues to have in place seven substantive non-executive directors, including the Chairman, all of whom hold voting rights in addition to the non-voting associate non-executive director.

5.2 This change would be for a strictly time-limited period only and would cease upon a substantive appointment being made and commencing in the role.

5.3 To underscore the temporary nature of this change, it is also proposed that this amendment to the Constitution is explicitly time-limited to nine months from the date on which the Council of Governors approves the amendment. This maximum period would provide for sufficient time for a recruitment process to be conducted and any notice period to be served prior to the successful appointee starting in post. After this time, if a substantive appointment has not yet commenced, the Board and the Council of Governors will need to agree an extension of these arrangements in order for them to continue in place.

6.0 Amending the Constitution

6.1 The Trust is able to make amendments to its Constitution only if:

- More than half of the members of the Board of Directors of the trust voting approve the amendments; and

- More than half the members of the Council of Governors voting approve the amendment.

6.2 Any amendments take effect immediately once these criteria are satisfied and must be notified to NHS Improvement.

6.3 Since the Trust was authorised as an NHS Foundation Trust on 1 February 2015, the Trust has monitored its compliance with its Constitution but has not yet undertaken a comprehensive review of the Constitution to ensure it remains fit for purpose in light of the Trust's current position and future direction. This review is being undertaken during 2020 and includes a review of the composition of the Board of Directors. The output of this, and any consequential proposed amendments, will be presented to the Board and Council of Governors in the coming months.

7.0 Recommendation

7.1 The Council of Governors is asked to:

i. Agree to a temporary amendment to the Trust's Constitution to expand the composition of the Board to include the role of Chief Operating Officer as set out at Appendix 1 (with full voting rights);

ii. Agree that this change be for a temporary period until a substantive appointment commences in post, and in any case no longer than nine months from the date on which the Council of Governors approves the amendment;

iii. Note the wider review of the Constitution currently underway, which will report in the coming months.

Stephen Jones
Chief Corporate Affairs Officer
14 February 2020

Appendix 1: Proposed amendment to the Trust's Constitution

Proposed amendments to the current provisions of paragraph 23 of the Trust's Constitution are set out in red below:

*"**23. Board of Directors – composition***

23.1 The trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive chairman;

23.2.2 6 (six) other non-executive directors; and

23.2.3 ~~4 (four)~~ 5 five executive directors.

23.3 One of the executive directors shall be the chief executive

23.4 The chief executive shall be the Accounting Officer.

23.5 One of the executive directors shall be the finance director.

23.6 One of the executive directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the executive directors is to be a registered nurse or a registered midwife.

23.8 One of the executive directors is to be the chief operating officer."

The Trust's Constitution is available in full on the Trust's website at:
https://www.stgeorges.nhs.uk/wp-content/uploads/2015/07/St-Georges-University-Hospitals-NHS-FoundationTrust-Constitution-10-03-15.pdf

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4.3

Council of Governor Effectiveness Review Forward Plan

Stephen Jones
Chief Corporate Affairs Officer

19 February 2020

Introduction
Purpose and Context

Purpose

This paper sets out proposed plans for the Council of Governors in 2020/21. The plan is based on the feedback received through the Council of Governors Effectiveness Review 2019-20.

Background and Context

At its meeting on 17 December 2019 the Council received a report on the results of the Council of Governors Effectiveness Review 2019-20 and proposed actions to address the issues, identified for development. This forward plan outlines the actions and activities proposed for 2020-21.

Recommendation

The Council is asked to consider the proposed forward plan and programme of activities to enable to Council to become more effective in line with the action plan outlined in the effectiveness review.

“

- ***The Council is “reasonably effective’ and had become more effective in the past year.***

- ***There is significant scope for the Council to become more effective.***

Feedback from Council Effectiveness Review 2019/20

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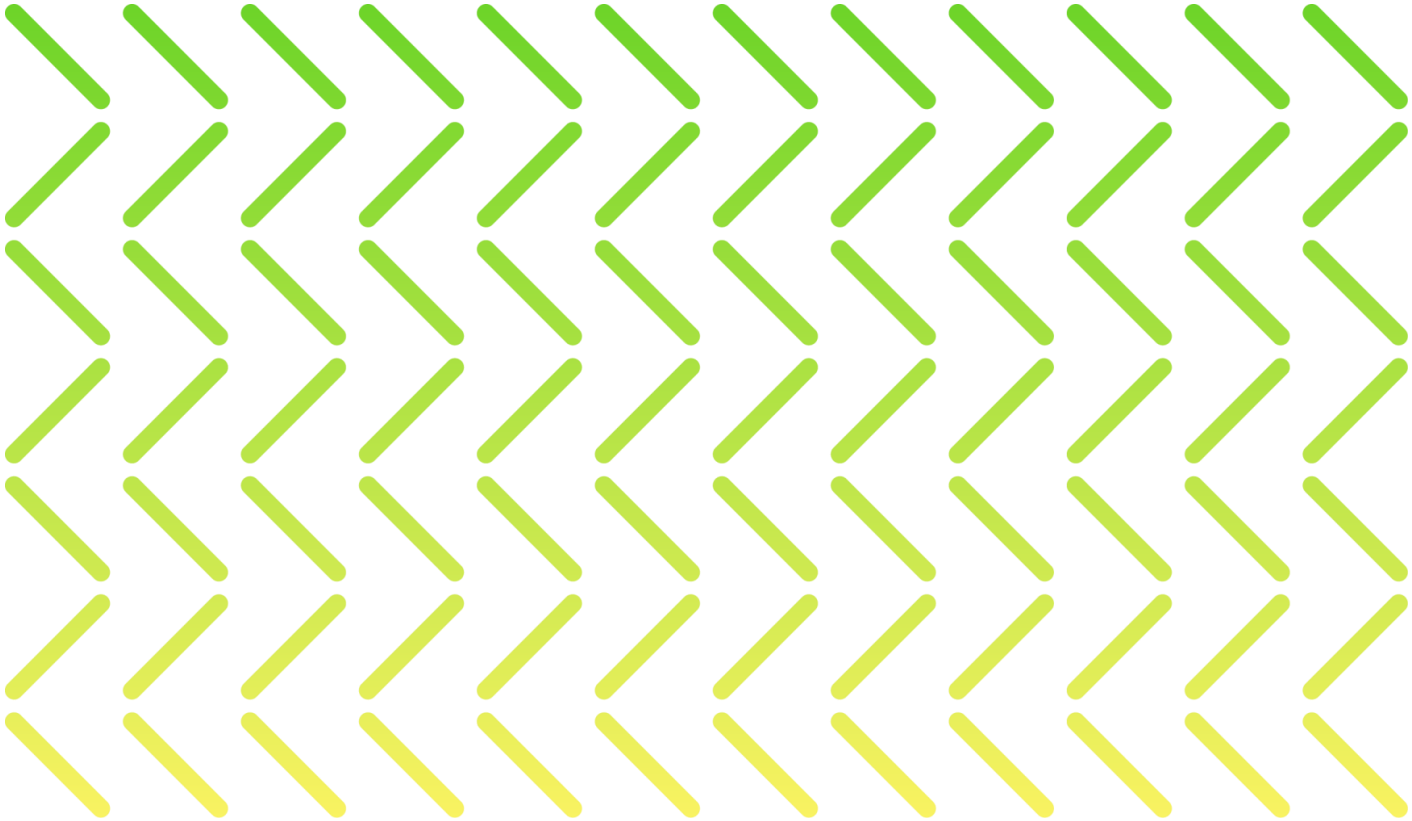
Council of Governors Effectiveness Review 2019/20

As part of the Council of Governors Effectiveness review for 2019/20, respondents identified the following areas for development and improvement.

Areas for development

Areas for improvement

How does the Council move to Significantly Effective?



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Effectiveness Review 2019/20

Actions to address areas for development

Well equipped to hold NEDs to account
Effective NED challenge

- Governors can attend Board Committees and there is a section at the end of each meeting were Governors are invited to ask questions/comments.
- All Governors invited to the Board meetings (private and public).
- NEDs attend each Council meeting and present updates on their respective areas and give Governors the chance to ask questions of NEDs.
- **New! Forward Schedule of Meetings (See Appendix 1) for Governors includes a development day which will include a session from on how to effectively hold NEDs to account and ask challenging questions.**
- **New! Introducing new template to standardise feedback from Governors observing Board Committee meetings in order to help dissemination of information to other Governors.**

Effectiveness Review 2019/20

Information needed to hold NEDs to account
Quality of papers

- All Governors provided with papers for both private and public.
- Governors provided with papers from Council of Governor meetings.
- Special briefings arranged for Governors on topical issues between meetings.
- **New! Forward programme includes informal Governor sessions/workshops which would be used to provide information on key issues such as Finance, Estates, Quality, Strategy and Workforce.**
- **New! Governor Portal being developed and enhanced to provide a library of information such as relevant guidance, meeting papers, information about the Trust and key communications – will be launched April 2020.**
- **New! Governor Bulletin will be developed and issued each month starting from April 2020. The bulletin would be for Governors include a range of updates and information on Trust issues. The bulletin will include up to date information which would support Governors when they engage with Members and the public.**
- **New! Refreshed templates for papers to the Council of Governors and its sub-committees.**
- **New! Develop a comprehensive programme of work (See Appendix 2) for the Council which will help with planning and timely circulation of meeting papers for Council meetings.**

Effectiveness Review 2019/20

Training and development

- All Governors have the opportunity to attend NHS Provider training courses. Full list of courses to be circulated to Governors in due course.
- All Governors encouraged to join NHS network events. Details to be circulated to Governors in due course.
- All Governors can request specific topics for addition briefings.
- **New! Informal Governor Sessions/Workshops launched from April 2020 which would provide training and development on risk management, assurance and accountability, interpreting data and other issues requested by Governors.**
- **New! Governor Development Day scheduled each year facilitated by NHS Providers and/or other external provider and will include core training for governors and other specific areas such as effective challenging and questioning, holding NEDs to accounting, chairing of meetings, membership engagement etc.**

Effectiveness Review 2019/20

Representing Members and the Public

Council holding itself accountable for the effectiveness of its engagement with members (1 of 2)

•Elective Governors are representative of the Membership body by virtue of being elected by their respective constituencies and therefore provides a representative voice to discussions at the Council meetings.

•Governors attend the Patient Partnership and Experience Group made up of Trust Members and members of the public. Governors feedback any intelligence from these meetings and support the progression of any common areas of interest or issues impacting on Members and the public.

•Meet your Governor Events are an opportunity for Governors to speak to Members and the public to capture their views and issues. These issues are feedback to the Trust and actioned as part of the Trust governance processes. Regular reports are presented to the Membership and Engagement Committee.

•Governors help with the selection of Trust Quality Priorities each year, provide feedback on the Trust's strategy and are part of any decision making about any major proposed service changes.

•**New! The Council approved a Membership Strategy and the Trust is putting in place a number of initiatives to enable Governors to engage and involve Members and the public. Governors can use these activities to hear from Members and the public and ensure these form part of their contemplation when asked to make decisions or inform Trust activities. Activities include, Constituency Question Time Events, Members Talks, Meet Your Governor, Annual Members Meeting, Corporate Induction and other engagement activities in the Trust and with stakeholder organisations.**

Effectiveness Review 2019/20

Representing Members and the Public

Council holding itself accountable for the effectiveness of its engagement with members (2 of 2)

- **New!** Governors will have a regular feature in the Trust's stakeholder newsletter, 'The Brief' which is sent to Members and other stakeholders.

- **New!** Council Governors forward plan include programme of site visits where Governors can hear first hand from staff, patients and the public.

- **New!** Membership and Engagement Committee endorsed the programme of engagement and involvement activities which will be monitored at each Committee and reported to the Council. This will help the Council track how effective it is engaging with Members and the public.

- **New!** Lead Governor would present as a standing item at each Council meeting a report on all activities outside Council meetings that Governors have been involved in. This will commence at the start of the new financial year 2020/21.

- **New!** An annual report on Council activities would be presented each year which would map out activities undertaken by governors and the degree to which this has increased the engagement of Members and the public – i.e. attendance levels at AMM, Members Talks and elections turnout.

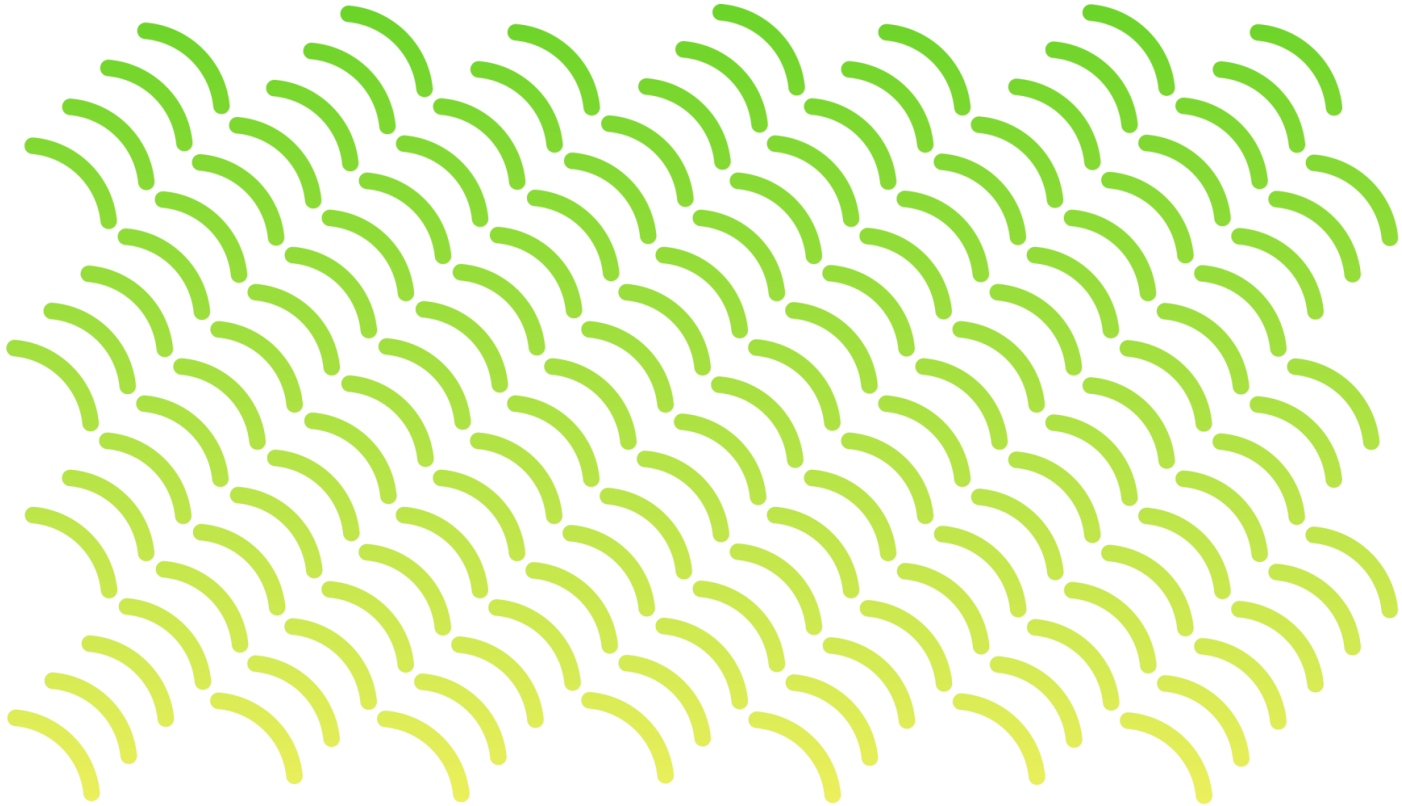
Draft Council of Governors Forward Plan – April 2020- March 2021

Scheduled, Standing Agenda Item	Frequency	Lead	Author(s)	18/02/2020	05/05/2020	09/07/2020	10/09/2020	10/12/2020	16/02/2021
OPENING ADMINISTRATION									
Welcome, Introductions and Apologies for Absence	Standing	All	Secretariat	√	√	√	√	√	√
Declarations of Interest	Standing	All	Secretariat	√	√	√	√	√	√
Minutes of Previous Meeting	Standing	Chairman	Secretariat	√	√	√	√	√	√
Matters Arising (Tracker) and Action Log	Standing	Chairman	Secretariat	√	√	√	√	√	√
Chief Executive's Report & Key Issues	Standing	Chairman	Secretariat		√		√		√
Non-Executive Director Board Committee Reports	Standing	NED	Secretariat	√	√	√	√	√	√
Council Attendance Register	Standing	Chairman	Secretariat		√	√	√	√	√
STRATEGY & ANNUAL PLAN									
Digital Strategy	Annual	CSO	CSO	√					
Outpatient Strategy	Annual	CSO	CSO	√					
Volunteer Strategy	Annual	CSO	CSO		√				
Trust Clinical Strategy Update	Annual	CMO	CMO			√			√
Draft Trust Annual Plan	Annual	CSO	CSO						√
MEMBERSHIP & ENGAGEMENT									
Governor Engagement & Involvement Report	Standing	Lead Governor	Secretariat		√	√	√	√	√
Membership Engagement Strategy (Implementation/Forward Plan Update)	Annual	CCAO	CCAO			√			
Membership Engagement Committee Report	Standing	Committee Chairman	Secretariat	√	√	√	√	√	√
Governor Election (Results 2020 and Forward Plan 2021) (as required)	Standing	CCAO	CCAO	√	√			√	
Annual Members Meeting (Plan and Debreif)	Annual	CCAO	CCAO			√		√	
Patient Experience include updates from PPEG/Complaints etc	Annual	CN	CN		√			√	
TRUST QUALITY, PERFORMANCE, WORKFORCE									
Care Quality Commission Update	Annual	CN	CN	√					√
Quality Priorities, Quality Indicator Testing & Draft Quality Account Update	Annual	CN	CN	√ (Update & Indicator)	√ (Draft Quality Accounts)				√ (Update & Indicator)
Final Quality Account and External Auditor's Report Quality Indicator Testing	Annual	External Auditors	External Auditors			√			
Quality Improvement & Transformation Update	Annual	CTO	CTO		√				
Financial Update	Annual	CFO	CFO				√		
Trust Workforce, Staff Engagment and Culture/Leadership Update	Annual	CPO	CPO			√			√
BOARD/LEADERSHIP									
Outcome of Chairman and Non-Executive Director Appraisals	Annual	SID/Chairman	CCAO		√				
Nominations and Remuneration Committee Report (as required)	Standing	Chairman	Secretariat	√	√	√	√	√	√
COUNCIL GOVERNANCE									
Annual Report on Council Activities	Annual	CCAO	Secretariat					√	
Council Training & Development - Self-Assessment against Foundation Trust Licence	Annual	CCAO	Secretariat		√				
Effectiveness Review (Update/Plan/Review Results)	Annual	Chairman	Secretariat			√		√	
Constitution Review and Update	Annual	CCAO	Secretariat			√			
Council Terms of Reference	Annual	Chairman	Secretariat			√			
Council Sub-Committees Terms of Reference and Annual Review	Annual	Chairman	Secretariat				√		
CLOSING ADMINISTRATION									
Items for the next meeting	Standing	All	Secretariat	√	√	√	√	√	√
Any other business	Standing	All	Secretariat	√	√	√	√	√	√
Reflection on the meeting	Standing	All	Secretariat	√	√	√	√	√	√

Proposed Council of Governors Schedule of Meetings & Involvement Activities– April 2020- March 2021

Meeting	Time	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Facilitator
Council of Governors Meetings														
Governors Pre-Meeting	14:00-15:00		5		9		10			10		16		Membership & Engagement Manager
Council of Governors	15:00-18:00*		5		9		10			10		16		Membership & Engagement Manager
Sub-Committee Meetings														
Nomination & Remuneration Committee	15:30-17:00	28												Membership & Engagement Manager
Membership & Engagement Meeting	14:00-16:00	7		11	27				12 (13:00-15:00)		18			Membership & Engagement Manager
Engagement Involvement Activities														
Annual General Meeting	17:30-20:30						10							Membership & Engagement Manager
Question Time Events	Various*								7/12 & 14				Dates TBC	Membership & Engagement Manager
Meet Your Governor Events	10:00-14:00	20	11 (STG) & 19 (QMH)	9	6	3	1	29	5 (QMH	2	1	18		Membership & Engagement Manager
Governor Site Visits	13:30-15:00	21		9				20			12		16	Membership & Engagement Manager
GOVERNOR DEVELOPMENT & INFORMATION SESSIONS														
Workshops/Seminar Session (Informal)	15:00-17:00*	21		9				20			12		16	Membership & Engagement Manager
Council of Governors Development Day	10:00-16:30					18								Membership & Engagement Manager/External Provider

*Taking into consideration comments from Governors the team will work to delivery at least two of these meetings at different times in the day/evening.



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5.1

Meeting Title:	**Trust Board**		
Date:	30 January 2020	**Agenda No**	**4.1**
Report Title:	**Audit Committee Report**		
Lead Director/ Manager:	Sarah Wilton, Chair of the Audit Committee		
Report Author:	Sarah Wilton, Chair of the Audit Committee		
Presented for:	Assurance/Approval		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on 21 January 2020.		
Recommendation:	**The Board is asked to:** • **Note the update in the report; and** • **Approve the audit plan and audit fees for the financial and quality accounts audit for the period 01 April 2019 – 31 March 2020.**		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability		
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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Audit Committee Report – January 2020
Trust Board, 30 January 2020

Matters for the Board's attention:

1. Annual Reporting and External Audit Reports

1.1. External Audit Reports

The Committee received the External Auditors' progress report, the annual audit plan for 2019-20 and the audit fees letter. The scope of the audit 2019-20 is largely in line with previous years. Similarly, the External Auditors will focus on key risks areas pertaining to management override of controls, revenue recognition, valuation of land and buildings and going concern. All organisations will be required to make a declaration against the new financial regulations standard, International Financial Reporting Standard (IFRS) 16 (Leases) in 2020-21 financial reports. This represents a significant change for the Trust, and other public sector organisations. The standard comes into force on 01 April 2020 and the Trust would be required to assess the degree to which all its contracts and arrangements amount to an operating lease this represents a complete change to the balance sheet and the Trust will need to conduct a significant amount during the year in readiness to make the declaration. NHS Improvement/England (NHSI/E) also plans to conduct an audit in autumn 2020 of organisations' readiness to make the declaration for year ending 31 March 2021. The Committee will continue to monitor progress and agreed that the management team will provide an assurance report to the next Committee meeting setting out plans to complete the work to analyse its contracts and arrangements. The Committee was assured by the plans for completing the audit work for the financial and quality accounts in the period 2019/20 and endorsed the proposed audit fees which the Board is now asked to approve (see Appendix 1).

1.2. Annual Report, Financial Accounts and Quality Accounts Plan and Annual Policies 219/20

The Committee also considered and endorsed the internal reports which outlined the plan and timetable for completing the annual report, financial accounts and the quality accounts/report. The Committee approved the draft accounting policies and notes which need to be incorporated in the financial accounts for 2019/20. There was no substantive change in approach from previous years, and only minor amendments had been made to the Foundation Trust Annual Reporting Manual published by NHSE&I.

2. Internal Audit Report

The Committee considered the following reports from the Internal Auditor:

- Progress Report against the Refreshed Internal Audit Plan 2019/20
- Internal Audit Review Recommendation Tracker
- Draft Internal Audit Plan 2020-21 and 2020-30 Audit Strategy
- Final Internal Audit Report:
  - Learning from Incidents (Substantial Assurance) and Complaints (Reasonable Assurance)
  - Diversity & Inclusion (Reasonable Assurance)
  - ICT Review of Data Quality – Roll-out of iClip to Queen Mary's Hospital (Substantive Assurance)
  - General Data Protection Regulation (GDPR) Compliance (Reasonable Assurance)

The Committee welcomed the good progress made on the internal audit plan for 2019-20. Likewise, good progress continued to be made on completing internal audit recommendations with only six recommendations outstanding.

The Committee approved the draft internal audit plan (2020-21) and strategy (2020-23). In light of recent work to improve governance across the Trust the Committee asked the management team to look at either bringing forward the divisional governance review to 2021/22 (scheduled for 2022/23) or finding a mechanism, via another internal review (such as the scheduled 2022/22 governance framework review), to take a temperature check of progress to improve divisional governance.

The Committee was very pleased to note the reasonable and substantial assurance ratings for the aforementioned internal reviews. The learning from incidents and complaints review rating was split to reflect that there was more evidence that learning from serious incidents was routinely documented which was not the case in relation to complaints. The Committee heard that management are strengthening the mechanisms to track actions and learning from complaints and processes for management of complaints at divisional levels. The Committee recognised the significant progress on diversity and inclusion work which culminated in the reasonable assurance rating. Management reassured the Committee that by delivering its diversity and inclusion strategy and the action plan the Trust would meet its regulatory requirements. The internal audit review findings and substantive assurance rating in relation to the ICT Review of Data Quality: Roll-out of iClip at Queen Mary's Hospital was aligned to the findings from the independent external audit which was conducted as part of the project. Whilst it was good that the project had gone well, management is cognisant of the need to continue to embed the system and provide continuous training for staff. In 2018, internal auditors gave a no assurance rating on the Trust's GDPR Compliance. The recent review was rated reasonable assurance and reflects the significant level of work and focus given to this area and the Committee was assured that once the Trust had completed the four recommendations from the review the Trust would be complaint and on par with other similar organisations. The Committee also noted that information governance training had been organised for board members in January 2020.

3. Internal Compliance and Assurance

The Committee received and discussed the following reports pertaining to the Trust's internal governance mechanisms.

3.1. Data Security and Protection Toolkit

The Committee was assured by the plans in place to ensure the Trust is compliant with the National Data Guardian's 10 data security standards. Significant focus would be given to completing the actions to meet the mandatory standards with key emphasis being on attaining training targets, cyber security and updating the policy framework.

3.2. Counter Fraud Report

The Committee considered the quarter three Counter Fraud report and welcomed the enhanced report. There had been 18 new issues raised to the counter fraud team in the quarter and there are four cases under review. The Committee would consider the lessons learnt in the next report.

3.3. Risk Management and Board Assurance Framework Update

The Committee received the update on Risk Management and Board Assurance Framework (BAF) in response to previous actions raised at the Committee and by the Board. The Committee noted that the Trust had commissioned a review of its risk management

processes to address know challenges with scrutiny and management of risks across the organisation. The review would be undertaken by the internal auditors, TIAA, and NHSI&E would support the development of the scope and terms of reference. The Committee would receive the terms of reference ahead of the review being undertaken. The Committee also noted that the executive responsibility for the BAF would move, with adequate supporting resources, from the Chief Nurse to the Chief Corporate Affairs Officer who would lead on the planning for the 2020/21 BAF.

3.4. Freedom Speak Up Guardian

The Committee considered the Freedom to Speak Up (FTSU) Guardian report which outlined the number FTSU concerns raised during the period October - December 2019. The Committee noted the report and reflected that given the Workforce and Education Committee was also reviewing the detail of the issues raised future reports to the Audit Committee would focus on assurance around the internal controls, processes and mechanisms to manage and deliver an effective FTSU function at the Trust. The Committee took reasonable assurance from the report and noted that the Board in December 2019 had requested that arrangements for executive sponsorship of FTSU be reviewed.

3.5. Updates on Trust-wide Policies and Declarations of Interests (Managing Conflict of Interest)

The Committee welcomed the good progress made on improving the internal controls, systems and mechanisms for the management of trust-wide policies and managing conflicts of interest. There are now robust mechanisms in place to manage policies and notifying policy owners when policies are due for review and ensuring that the correct policies are available centrally. The Committee flagged the number of patient care and ICT policies due to be reviewed. It was noted that the Quality and Safety Committee would consider the progress made against patient care policies at its next meeting. The Committee also heard that 40% of 1300 decision making staff had made the required declarations in line with the Trust's Managing Conflict of Interest policy and national guidance. These declarations are captured in the self-declaration system Declare and available on the Trust's website. Focussed communication is sent out to staff and more work is being done to ensure other hard to reach staff groups are making the required declarations. The Committee welcomed the progress made and agreed to receive update reports on both areas at its next meeting.

3.6. Aged Debts, Losses & Compensation Payments and Breaches & Waivers Reports

The Committee were pleased to note the continued grip on the management of the Trust's losses and compensations and breaches and waivers processes with marked improvement in both areas. The Committee was reasonably assured by processes to manage aged and bad debts. The Committee also noted the debt write-off of overseas patient income and requested further assurance on management of overseas patients' debt going forward.

3.7. Committee Effectiveness Review

The Committee also reviewed the results from its effectiveness review and was pleased to note that 86% of respondents (12/14) reported that the Committee was very effective. The Committee would progress the actions to further improve the Committee and more information would be provided in the Committee's Annual Report to the Board.

3.8. Committee Chair

The January 2020 meeting was my last as Committee Chair before I step down as a non-executive director after nine years at the Trust. As Audit Chair, I have seen a very significant improvement both in the operation of the Committee and in the financial and governance business it has considered it in recent years, and I am pleased to hand over my role as Committee Chair to Elizabeth Bishop, who takes up her role as non-executive director at the Trust next month.

Recommendation

The Board is asked to:

- **Note the update in the report; and**
- **Approve the audit plan and audit fees for the financial and quality accounts audit for the period 01 April 2019 – 31 March 2020.**

Sarah Wilton
Audit Committee Chair, NED
January 2020

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NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	19 December 2019	**Agenda No**	**4.1**
Report Title:	**Finance and Investment Committee (Core) report**		
Lead Director/ Manager:	Sarah Wilton, Acting Chairman of the Finance and Investment Committee		
Report Author:	Sarah Wilton, Acting 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 12th December 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		

5.1

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St George's University Hospitals NHS Foundation Trust

Finance and Investment Committee (Core) – December 2019

The Committee met on 12 December and in addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on the 2020/21 Financial Plan and an Emergency Capital Bids paper.

Committee members discussed the BAF risks on finance and ICT. A paper on financial risk confirmed the change in the functional risk 'Managing Income & Expenditure in line with budget' to a '25', as well as noting other changes to risk against the forecast risk position. The Committee noted targets not met in Diagnostics, RTT and Emergency Flow as well as outlining the process being undertaken to improve each one. The Committee discussed actions being undertaken to improve the current financial performance in view of the forecasted year end position, and the current work being done in South West London as we move towards a new financial year. **The Committee wishes to bring the following items to the Board's attention:**

1.1 Finance Risks – the Deputy Chief Financial Officer (DCFO) introduced a paper on financial risks. He noted the increasing of the functional risk 'Managing Income & Expenditure in line with budget' to the maximum score of '25', due to the forecasted year end position, as well as some reduction to risk scores forecasted in cash management and procurement. In addition the 'Manage commercial relationship with non-NHS organisations procuring services from the Trust' risk has not reduced as expected owing to the enhanced focus required on delivering the 19/20 financial position. The Committee accepted the proposed changes.

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 RTT Update – the CTO updated the committee on RTT performance in October, where 52 week waits have reduced to 1 against an October target of 0, and the RTT incomplete trajectory in October has a performance of 85.1% against a target of 86.1%. The COO noted the challenge of QMH activity and focus on 52 week waits as contributing to the adverse position. He noted that an outpatient manager was being transferred to QMH to support this.

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 79.4% in November, which is under the Trust's trajectory of 87.5% delivery in the month. The Committee were again concerned at the continued deterioration in performance. The COO outlined some of the focus on long stay patients in the trust, and rapid assessment teams, to improve performance.

1.5 Financial Performance – the DCFO noted performance to date at Month 8 was in line with plan showing a £34.0m Pre-PSF/FRF/MRET deficit.

1.6 Financial Forecast – the DCFO provided an update for the Committee on the Trust's financial forecast. The CFO updated the Committee on the weekly financial recovery meetings, and the Executive Leads updated on each of their areas of responsibility, including individual schemes to improve financial performance. The areas of responsibility are: 'Income, Non Pay and Provisions', 'Medical pay', 'Nursing and AHP pay', 'Other pay' and

'Divisions'. The Committee expressed concern at the continued challenge in financial performance, and the CFO advised that a further update would be provided at the next committee meeting on progress.

1.7 2020/21 Planning Update – the Director of Financial Planning (DFP) introduced the Committee to the paper providing an update on the financial plan for 2020/21. The Committee welcomed the update and further information expected in January.

1.8 FAC Update – the CFO introduced an update to the committee on the Finance and Activity Committee (FAC) which involves the NHS organisations in South West London. He observed the financial gap of the group of organisations in 2020/21, and discussions ongoing to try to close it.

2.0 Recommendation

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

Sarah Wilton
Acting Finance & Investment Committee Chair
December 2019

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NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 January 2020	**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 23rd January 2020.		
Recommendation:	The Board is asked 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		

5.1

Finance and Investment Committee (Core) – January 2020

The Committee met on 23 January and in addition to the regular items on strategic risks, operational performance and financial performance, it also considered papers on Costing, the MRI business case, SWL PACS Procurement, the 2020/21 Financial Plan, a policy update and a Procurement Report.

Committee members discussed the BAF risks on finance and ICT. A paper on ICT risk led to discussion on the expectation the overall rating would move from 'limited' to 'partial' assurance at Q4. The Committee noted targets not met in Diagnostics, RTT and Emergency Flow as well as outlining the process being undertaken to improve each one. The Committee discussed actions being undertaken to improve the current financial performance in view of the forecasted year end position, as well as the different implications of the current Trust forecast. **The Committee wishes to bring the following items to the Board's attention:**

1.1 ICT Risks – the Chief Information Officer (CIO) noted that there were no material changes to the ICT risks and the committee discussed whether the current position required a further forward look on potential changes to each risk. In view of the improving position on ICT risks, the committee agreed to maintain the limited assurance rating at Q3 for the Board Assurance Framework, while noting that it was expected to move to 'partial' assurance for Q4.

1.2 Diagnostics Performance – the Chief Operations Officer (COO) observed the challenge in Diagnostics performance in December, where 6.7% of patients had a Diagnostic wait over 6 weeks compared with a target of 1%. He noted particular work required in Echocardiography waits, and the intended recovery plan to move to compliance by May 2020. The Committee noted this update.

1.3 Cancer Performance – the COO noted that a provisional closing position for the two week rule and breast symptomatic standard for December will show non-compliance, owing to challenges in booking patients over the Christmas period that were not managed as actively as they could have been. The Committee noted this update.

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 79.4% in December, which is adverse to the Trust's 87% trajectory in the month. The Trust continues to develop its Rapid Assessment Zone (RAZ) and the COO noted the improvements seen through this development. The Committee were encouraged by this while noting that more focus was needed, especially on patients admitted to the hospital from the ED.

1.5 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance of 84.2% was below the incomplete target trajectory of 86.5%, and the number of 52 week waits of 7 was more than the trajectory of 0. The size of the waiting list (including QMH patients) was 48,640 patients. The committee noted the balance in performance between the three metrics above and the COO agreed to set out the implications for the three metrics under certain scenarios through to the financial year end.

1.6 Financial Performance – Tom Shearer, the Acting Chief Financial Officer (ACFO) noted performance to date at Month 9 was in line with plan showing a £38.4m Pre-PSF/FRF/MRET deficit. The Committee noted the current cash requirements in view of the expected year end

position and the potential availability of capital funding in 2019/20 (and the Trust's plan to spend it should this be confirmed).

1.7 Financial Forecast – the ACFO provided an update for the Committee on the Trust's financial forecast, which shows a £9m adverse variance against the £37.7m pre-PSF/FRF/MRET plan at year end. The ACFO explained actions being taken and also implications from the change in year-end deficit. The Committee expressed disappointment on this position and noted the importance of achieving this new forecast at year end.

1.8 PLICS/Costing update – the Director of Financial Planning (DFP) provided an update for the Committee on the latest Costing information for the Trust. He noted that the reference costing index score of 101 for 2018/19 was a further improvement on previous years which was welcomed by the committee, although more work was still required to improve this further.

1.9 2020/21 Planning Update – the DFP introduced the Committee to the paper providing an update on the financial plan for 2020/21. The DFP noted that the national planning guidance was still to be disseminated, and the Committee observed the increase in reliance on external factors in developing plans for future years.

1.10 MRI Business Case – the DFP introduced an Outline Business Case (OBC) exploring options for the replacement of aged MRI equipment at the trust. The Committee recommended the preferred option being approved at Trust Board subject to a clearer understanding being given on the need to have a larger Estates footprint in the preferred option in the Full Business Case (FBC).

1.11 SWL PACS Business Case – the DFP introduced an Outline Business Case (OBC) which sets out the case and options to deliver a collaborative radiology image sharing platform across the four acute Trusts within South West London (SWL). The Committee recommended the preferred option for approval at Trust Board.

1.12 Policies Update – the Committee reviewed policy updates on Financial Planning and Procurement. The Committee agreed to the updates on both policies while governance arrangements were checked with respect to executive oversight.

1.13 Procurement Update – David Main, Associate Director of Procurement (ADP), noted further progress in the procurement function, in terms of breaches and waiver and departmental recruitment. The Committee welcomed this further progress.

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,
January 2020

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Meeting Title:	**Trust Board**		
Date:	19 December 2019	**Agenda No**	**4.2**
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 12 December 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		

5.1

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NHS
St George's University Hospitals
NHS Foundation Trust

Finance and Investment Committee (Estates) – December 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 December 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 December 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 verbal updates on overall Estates risk, the Procure 22 (P22) Project and the Premises Assurance Model (PAM). Committee members thanked the Estates team for their continued efforts in challenging circumstances, noting that good progress continues to be made. The Committee also reflected on the potential to produce a KPI report to summarise all the key information streams and that from April 2020 it may be appropriate for future FIC E meetings to convene less often.

The Committee welcomed updates from the ADs that included information on the Mitie contract, progress on Water, Violence and Aggression, and Fire Safety.

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

1.1 Risk Review - the Chief Financial Officer (CFO) gave a verbal update on Estates risks. He noted no major changes to individual or strategic risks and advised that a full risk review would be provided in January. Water and Fire remain the highest risks and where continued attention is focussed.

1.2 AD Report – Divisional Overview - the Deputy Director of Estates & Facilities (DDE&F) advised that a skilled external resource is now in place to assist with developing the Estates Strategy. A consolidated report has also now been produced on fire safety which draws together previous findings across the site going back to 2018. An external review has identified some particular concerns around fire management in Atkinson Morley Wing which are being discussed with the PFI service provider.

The Committee discussed the latest position on the Cardiac Catheter Labs project where the responsiveness of the PFI provider has improved but progress remains slow. Performance of Mitie has now recovered to contract standard and some helpful lessons learned for future implementations of this kind namely; taking a phased approach to the implementation of change and ensuring adequate provision in plans is made for staff communications and union consultation. The DDE&F also noted the challenge in producing the Community Premises Assurance Model (PAM), where the model is not ideal for community services and will require more work than initially expected.

1.3 AD Report - Estates - the Assistant Director of Estates (ADE) introduced a paper on current performance, highlighting a number of key incidents that occurred during November, a condensate steam failure and an automatic electrical transfer switching issue were amongst them. The Committee discussed the reasons for these issues, the risk based prioritisation approach being applied to maintenance and praised the continued work of the Estates team outside of standard work hours to resolve them.

1.4 AD Report - Facilities - the Assistant Director of Facilities (ADE) confirmed an overall positive assessment for PLACE audits and the Committee noted that appropriate action plans are being developed in response. The team are working closely with Mitie to

understand what is working well across their contracted scope and where further improvement can be made. It was noted that there will be increased pressures during the winter months which will require careful attention. The Committee discussed issues of Harassment and Bullying and shared concern that Divisional Governance Boards need to play their full role in gripping the required actions as it is important that we provide full support to our staff The Committee enquired about the governance process to revise arrangements covered by the Mitie contract and it was advised that EMG and TEC would provide this.

1.5 AD Report – Capital Projects - the Assistant Director of Capital Projects (ADCP) introduced an update on Capital Projects. He noted the completion of the Heberden Ward recant earlier in the month, the imminent intention to decant McEntee to Caeser Hawkins and noted that the MRI planning application is now in process. The Committee noted that an advert for a substantive Capital Projects Project Manager is now out with a view to interviewing early in the New Year. Support from the St George's Hospital Charity for capital projects including the newly proposed Renal development was welcomed and it was noted that the working arrangements and cooperation between the Trust and the charity are much improved.

1.6 AD Report- Medical Physics & Clinical Engineering – The paper reporting on this domain was noted as having no significant update for the committee from the last meeting.

1.7 AD Report- Health & Safety –The AD Health & Safety (ADHS) introduced the paper updating the committee on Health & Safety. He noted the good progress being made on Fire Safety where the team are pushing hard on capital works to address everything from compartmentalisation to fire detection systems and fire evacuation routes. The Committee also reviewed Health & Safety incidents that have been documented, and how these can be more clearly outlined to the Board in future through the Integrated Quality & Performance Report.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Estates) on 12 December 2019 for information and assurance.

Tim Wright
Lead Non-Executive Director, Estates
December 2019

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	30 January 2020	**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 23 January 2020.		
Recommendation:	The Board is asked 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		

5.1

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St George's University Hospitals NHS Foundation Trust

Finance and Investment Committee (Estates) – January 2020

This Part 2 Finance and Investment Committee (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 January meeting was shortened as the Part 1 FIC (Core) meeting had been extended to allow more time to discuss the Trust's financial position.

The January 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 a verbal update on overall Estates risk. Committee members thanked the Estates team for their continued efforts in challenging circumstances, noting that good progress continues to be made. The Committee also reflected that the committee was continuing to develop and may benefit from a more abridged set of Estates reports, which may come from the committee returning to being part of the main FIC (Core) in the coming months.

The Committee welcomed updates from the ADs that included information on the Procure-22 (P22) contract, Mitie contract, progress on Water, Violence and Aggression, and Fire Safety.

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

1.1 Risk Review – the Deputy Director of Estates & Facilities (DDE&F) noted the update on Estates risks as part of the Divisional Overview paper. The Committee agreed that associated BAF risks 9 and 10 related to Estates were assessed as 'Limited' for Q3, with potential to move to 'Partial' assurance for Q4.

1.2 AD Report – Divisional Overview - the DDE&F highlighted the key updates from the division, including the PFI review, the Cath Labs upgrade, Premises reviews, and MAST/appraisal compliance. Andrew Grimshaw, Acting Chief Executive Officer (ACEO) noted that the executive team agreed the indemnities for the Cath Lab upgrade at low risk as per the current trust scheme of delegation. The Committee welcomed the divisional update.

1.3 AD Report - Estates - the Assistant Director of Estates (ADE) introduced a paper on current performance in Estates which included key incidents that have taken place in the last month. Discussion was held on the skills matrix used for Estates work required.

1.4 AD Report - Facilities - the Assistant Director of Facilities (ADF) introduced an update on the Mitie contract, the HATs CQC inspection, Waste services and Security services. The CFO noted the recent industrial action by university staff and the assurance that the associated disruption would not happen again.

1.5 AD Report – Capital Projects - the Assistant Director of Capital Projects (ADCP) introduced an update on Capital Projects, including the work on the P22 project. The Committee discussed the resourcing associated with these projects.

1.6 AD Report- Medical Physics & Clinical Engineering – the Assistant Director of Medical Physics & Clinical Engineering (ADMPCE) introduced the paper reporting on this domain. He highlighted some of the key metrics, and the committee discussed the statutory compliance on radiation detection that required support from other organisations.

1.7 AD Report- Health & Safety/Fire –The AD Health & Safety (ADHS) introduced the paper updating the committee on Health & Safety. He noted the progress in setting up the Fire Safety Management Strategy Group among other developments in this area.

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St George's University Hospitals NHS Foundation Trust

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Estates) on 23 January 2020 for information and assurance.

Tim Wright
Lead Non-Executive Director, Estates
January 2020

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NHS
St George's University Hospitals
NHS Foundation Trust

5.1

Meeting Title:	**Trust Board**		
Date:	**Thursday, 12 December 2019**	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	**Tim Wright, Interim Chairman of the Quality and Safety Committee**		
Report Author:	**Tim Wright, interim 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 December 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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NHS
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NHS Foundation Trust

Quality and Safety Committee Report

Matters for the Board's attention

The Quality and Safety Committee met on 12 December 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 8. The Committee discussions focused on the maternity services and quality and safety issues arising from the continued challenged emergency care services. The Trust's performance against the indicator for the percentage of women booked by 12 weeks and six days is within the standard deviation however there has not been much progress in increasing performance which needs close monitoring to observe impact of improvements underway. The Committee discussed the challenges which includes room availability and changes to processes. The Committee agreed that this would be an area of focus as part of its deep dive programme and will keep the Board abreast of developments. The Committee also heard that during October the total number of women giving birth increased. To manage this busy period the Trust deployed maternity staff from elsewhere to ensure that services remained safe.

The performance on the emergency care department will be discussed later in the Board agenda and was considered in depth at the Finance & Investment Committee, however, the Committee noted that given the pressures within the department a review of incidents would be undertaken including consideration of patient experience information to ensure there were no underlying quality and safety issues.

2. Exception Report: Care Quality Commission Outstanding Actions

The Committee noted that progress related to achieving mandatory training targets remained below target as a result of not being able to achieve 85% on resuscitation training. Enhanced scrutiny across the Trust at departmental/divisional level continues and the required resources and new systems to support delivery training were confirmed to be in place. The Chief Medical Officer and/or Chief Nurse have also sent personalised letters to staff that 'did not attend' (DNA) resuscitation training without good reason and it was noted that staff are already engaging and responding positively as a result. The Committee was disappointed to learn that despite these efforts the Trust faces a material risk of missing the 31 December 2019 deadline. Work is now underway to develop a revised trajectory for meeting the target in the event that the Trust misses the deadline. The Trust will update the Care Quality Commission on its progress. The Committee will continue to review this area each month.

3. Cardiac Surgery Update

The Committee noted the monthly Cardiac Surgery Update which is discussed later on the Board agenda.

4. Serious Incident Reporting

Following on from discussions in November 2019 the Committee considered a report on serious incidents declared and previous closed investigations. The Committee noted that the numbers of serious incidents were less than during the same period in the previous year and that in the last three months the number of serious incidents reported had reduced. The Committee agreed to receive a monthly report on serious incidents, the outputs of a 6 month thematic analysis and an annual report which focuses on learning and how it has been embedded across the organisation.

5. Clinical Governance Review

The Committee noted the Clinical Governance Review which is discussed later on the Board agenda and requested to see the consolidated action plan at a future meeting.

6. Referral to Treatment Clinical Harm Review – Closure Report

The Committee received and considered the closure report following the review into the potential impact of clinical harm as a result of delays in referral to treatment. This report will be discussed later on the Board agenda.

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

The Committee received a summary report from the PSQG meeting held in November 2019. The Committee heard that following the incident of wrong blood in tube (WBIT) all staff are now mandated to follow the standard operating procedure (SOP) which dictates that labelling of blood samples are only to be completed at the bedside of the patient. The Committee were also provided with an overview of the adverse incident and potential harm related to a backlog of of Initial Health Assessments (IHAs) for looked after children. These should normally be completed within 20 days of a child being accommodated in care. The Trust has completed all actions arising from the investigation and the Committee noted that all IHAs are now being completed within the required timeframe. As reported last month the Committee were disappointed to learn that a proportion of NICE guidance had not yet been assessed but noted that divisions have been instructed to complete and submit assessment documentation. A weekly task and finish group has been established to monitor completion of the outstanding assessments by 31 January 2020 and this will be a standard item on PSQG agenda with quarterly reports to the Committee.

8. Complaints Annual Report (2018-2019)

The Committee considered the annual complaints report which is covered later on the Board agenda (item 2.1.1). The Committee discussed the performance for 2018/19 and noted that significant improvements had been made during 2019/20. Sustaining the performance and focussing on learning is the priority. The Committee also welcomed contributions from the Healthwatch representative concerning the completion of satisfaction surveys and tracking improvement actions from complaints.

9. 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 and risk scores but noted that some updates were required on the risk reduction schedule. The Committee requested, as discussed by the Board, that the risk be incorporated in the Board Assurance Framework related to seven day services. This will be considered at the next meeting.

10. Committee Effectiveness

The Committee received and discussed the update on its Committee Effectiveness action plan, agreed the approach for completing the next review and the timetable for reporting to the Board. The Committee recognised that more work was required on its workplan, the deep dive programme and developing formats and guidance for report authors and presenters some of which will be part of the wider work being conducted by the corporate governance team.

Tim Wright
Committee Chair
12 December 2019

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NHS
St George's University Hospitals
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	**Thursday, 30 January 2020**	**Agenda No**	**2.1**
Report Title:	**Quality and Safety Committee Report**		
Lead Director/ Manager:	**Dame Parveen Kumar, Chairman of the Quality and Safety Committee**		
Report Author:	**Dame Parveen Kumar, Chairman of the Quality and Safety Committee**		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting in January 2020.		
Recommendation:	The Board is asked to note this report.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

5.1

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St George's University Hospitals NHS Foundation Trust

Quality and Safety Committee Report

Matters for the Board's attention
The Quality and Safety Committee met on 23 January 2020 and agreed to bring the following matters to the Board's attention:

1. Deep Dive: 12 Hour Trolley Breaches

This month's deep dive focused on the number of patients waiting in the Trust's Emergency Department (ED) for inpatient admission in excess of 12 hours during the period April – November 2019. The Trust recorded 21 trolley breaches in this period related to patients on an acute care pathway but most of these adverse incidents related to patients waiting for admission on a mental health pathway.

The Trust commissioned the Emergency Care Intensive Support Team (ECIST) to review the Trust's mental health provision and analysis concluded that the trolley breaches related to limited suitable space or sufficient flexibility at high demand times in the ED, not having sufficient psychiatric liaison capacity to meet demand and similarly the limited number of approved mental health professionals and approved doctors to conduct mental health act assessments. Significantly, the core of the issue is the number of beds available in mental health providers in the catchment area. This means that patients with mental health needs who are medically fit may be admitted to an acute bed. A times of pressure this then impacts on the ability to admit patients on an acute care pathway.

The Trust is cognisant of the current upward trend in the number of 12 hour trolley breaches and wants to introduce a zero-tolerance to 12 hour trolley breaches for patients on an acute care pathway. The following actions have been identified as part of its Emergency Care Delivery Board (ESDB) programme:

- Conduct a pilot of rapid deployment of mental health assessment in the ED Department and redirect patients to more appropriate community or mental health care settings if they are medically fit;
- As an identified Health-Based Place of Safety the Trust is required to admit any mental health patient if there are no mental health beds in the system. However it is recognised that the Trust needs to consider how it works with its mental health partner organisations to ensure that the system is operating within the framework of the Mental Health Compact; and
- Review all adverse incidents for 12 hour trolley breaches at the ECDB.

The Committee noted the systemic issues and the challenges that are inherent when supporting patients with mental health needs. Having mental health patients who are medically fit in an acute bed is not the right place for these patients and the Trust needs to work with mental health organisations to ensure that these patients are repatriated to the right care setting. The Trust needs to work on its processes to ensure that where mental health patients present to the ED with no physical medical issues they are redirected to local and community settings such as their GPs, crisis cafes etc. The Committee remains concerned about the current trend in 12 hour trolley breaches and as such agreed to receive a further report once the actions have been embedded before it is assured that the Trust is moving toward zero-tolerance.

2. Integrated Quality and Performance Report (IQPR)

The Committee considered the key areas of quality performance at month 9. The Committee noted there was a never event which was related to a retained product following eye surgery. The retained product was discovered and removed before the patient was discharged home well. This incident should never have occurred as the retained product should have been part of the surgical count at the beginning and end of the procedure. This message has been strongly reinforced with teams. During the reporting period the Trust also

had one patient test positive for legionella. Given the patient was in the Trust for a very short period of time and due to the mitigations the Trust put in place Public Health England has decided not to assign the incident to the Trust. The patient was well and discharged home with antibiotics. Whilst the Trust has a long standing issue with legionella in the past year it has embedded a robust estates and infection control programme to ensure that all taps are fitted with filters and regular audits are undertaken. The Trust's infection control scorecard was red in month 9 and this relates to one methicillin-resistant staphylococcus aureus (MRSA) incidents in October 2019 (with a further MRSA in January 2020), against a threshold of zero. The position was also being impacted by 26 Methicillin-sensitive Staphylococcus aureus (MSSA) cases against a threshold of 25 cases for the year. The Committee noted that root cause analyses were being undertaken for MSSA and MRSA incidents however wanted further assurance that learning from these incidents was truly embedded.

3. Care Quality Commission (CQC): Response to 2019 Inspection

The Committee received and discussed the CQC inspection report and Trust response to the two requirement notices which is discussed later on the Board agenda.

4. Exception Report: Care Quality Commission Outstanding Actions

The Committee continues to receive monthly reports on the outstanding CQC action related to achieving the mandatory training target of 85% which is being largely impacted by the Trust's inability to attain the target for resuscitation training. The Committee noted that June 2020 is the revised trajectory for delivery against the 85% performance standard (subject to approval at the Trust Executive Committee) and that this action would be incorporated in the full action plan for 2019 inspection. The Committee also heard that attendance at mandatory training was being monitored through staff appraisal.

5. Nurse Staffing Report (Planned vs. Actual)

The Committee considered the nurse staffing reports for November and December 2019. The overall fill rate for was 96% and 95% respectively. 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 were raised these were effectively managed and mitigated.

6. Cardiac Surgery Update

The Committee noted the monthly Cardiac Surgery Update which is discussed later on the Board agenda.

7. Serious Incident Reporting

The Committee considered the serious incidents declared and previous closed investigations. The Committee noted that there were no key trends arising from the serious incidents in the month and that although it must always be of concern if any never events occur, the patient did not suffer serious harm from the never event that occurred in this reporting period.

8. Update on 2019 Quality Priorities

The Committee heard that a comprehensive review of the nine quality priorities within the Quality Account 2019/20 had been completed and although progress had been made in all areas and completed in one area, the Trust had not been able to achieve all the targets set for these priorities. As such the management team are exploring rolling these over into the Quality Account 2020/21 or where appropriate have incorporated these improvement priorities into the Quality and Safety Strategy 2019-24 which is discussed later on the Board agenda.

9. Quality Improvement Academy (Quarter 3) Update

The Committee received the quarter three update from the Quality Improvement Academy which is discussed later on the Board agenda. The Committee noted that audits are conducted to assess progress and the degree to which quality improvement initiatives are embedded in the Trust. The Committee also asked that future reports include measurement of impact for each initiative.

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

The Committee received a summary report from the PSQG meeting held in December 2019. The Committee heard that work continues to complete NICE compliance assessments with 21 assessments undertaken since the last meeting and it is expected that all assessments would be completed by end-January 2020.

11. Elective Care Update: Referral to Treatment (RTT) Quarter three

The Committee considered the quarter three report on RTT. The Trust's performance for incomplete RTT was 84.2% against a trajectory of 86.5% in November 2019 and it was also noted that the 52 week breach position had deteriorated. The Improvement Support Team (IST) conducted a data quality assessment in November 2019 and the Trust was progressing the nine recommendations.

12. Seven Day Service Standards Implementation

The Board at its November 2019 meeting asked the Committee to consider the progress made in preparing the Trust to meet the seven day service standards by April 2020. The Committee considered the report and noted the action plan for the Trust to improve its performance against the seven day service clinical standards. The Committee heard that it was very unlikely that the Trust would achieve full compliance by April 2020 as there was a particular challenge to attain Standard 2 in all clinical areas (*all emergency admissions seen and having a thorough assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital)*. It was recognised that only a minority of Trusts have achieved full compliance with the core clinical standards nationally, but that they remain very important quality and safety goals, and that this Trust's performance against them can and should improve. The report will be discussed later on the Board agenda.

13. Update on Policy trust-wide

The Committee noted the update on patient care related trust-wide policies. There is now a robust process of tracking and monitoring Trust policies however the responsibility for updating policies lay with the relevant clinic teams and divisions. Good progress had been made with updating patient care policies with 61% being in-date. This will improve to 80% of patient care policies in-date by the end of March 2020. The remaining 20% out-of-date require a confirmed plan as to the timeline for reviewing these policies and will be addressed at PSQG.

14. Quality & Safety Strategy

The Committee noted and endorsed the Quality & Safety Strategy which will be discussed at later on the Board agenda. The Committee recommends that the Board approve the strategy.

15. Board Assurance Framework & Corporate Risk Registers

The Committee received the Board Assurance Framework (BAF) and Corporate Risk Register focusing on the four strategic risks (SR) which fall within its remit. Three new risks were added to the corporate risk register related to delivery of paediatric and adult echocardiogram services and meeting the seven day service standards. The Committee agreed that in relation to strategic risks SR1, SR2, SR3 and SR16 to accept the partial assurance rating and risk scores. The BAF would be discussed later on the Board agenda.

16. Committee Member

The January 2020 meeting was Sarah Wilton's last before she steps down as a non-executive director after nine years at the Trust. The Committee thanked Sarah Wilton for her invaluable support and contribution to the Trust and the Committee.

Dame Parveen Kumar
Committee Chair
January 2020

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	Trust Board Meeting		
Date:	19 December 2019	**Agenda No.**	**3.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Stephen Collier, Chair of Workforce and Education Committee		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Assurance		
Executive Summary:	This paper sets out the key risks and issues reviewed by the Committee at its meeting on 05 December 2019, including commenting on assurance to the Board on key risks allocated to the Committee.		
Recommendation:	The Board is asked to receive this report.		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Are services at this Trust well-led		
Single Oversight Framework Theme:	Board Assurance, Risk management		

1. Committee Chair's Overview

We had good attendance at the meeting although it was disappointing that representatives of MedCard and CWDT did not attend, or apologise for absence. The areas of focus at this month's meeting were: updates on staff engagement; update reports from both of our Guardians; and a detailed review of staffing levels and cost, against a background of increasing financial pressure within the Trust.

We received good assurance on the processes to identify the need to use additional resource via our flexible workforce of bank and agency staff, and looked at current trends. However, we remained concerned about the level of Trust-wide planning behind this. Those present at the meeting could not identify a single, agreed, forward-looking target or budget metric for WTE staff numbers or pay spend across the Trust, against which performance could be managed. In the absence of a definitive answer here, we agreed that this question would be progressed by the Finance and Investment Committee. The issue was raised at FIC and confirmation provided there that there is a clear plan. A follow-on briefing meeting is to be held to address this.

2. Key points:-

Board Assurance

The Committee has five Trust level risks[1] allocated to it by the Board as part of the Board Assurance Framework, and the Committee's assessment of these risks was discussed. The Committee concluded that it would recommend to the Board that risk ratings for these should remain as currently set, albeit that solid progress was being made in many areas to mitigate the risks.

Strategic Themes

Theme 1 - Engagement

Staff Survey – the NHS national staff survey had closed with a combined response rate from St George's and Queen Mary's staff of c57.6%, an improvement on last year's 54.6%. The results will expected be published in March next year.

Staff Engagement Plan 2019 - 21 – Liz Wood reported to us on a new initiative, to be personally led by the Trust CEO, to move forward the culture of the Trust, and wider organisational development. The delivery mechanism for this will include the Staff Engagement Plan, and whilst the actions and timescale in this remain unchanged, they will be absorbed into a wider programme of action. Whilst welcoming of this wider initiative, we want to retain focus on the engagement plan, and will therefore receive a detailed progress update on this, as originally planned, at our February meeting.

WRES - The Trust lead is now back at work and we look forward to the re-initiation of progress here. The interim support from Epsom and St Helier has made solid progress in the meantime, and we hope that this support can be continued for a while. We received a report on the progress being made on actions within the Diversity and Inclusion Strategy.

Pension Scheme – ***Lifetime and Annual Allowances*** - the Committee was briefed on an initiative from DHSC which would, if implemented, address a number of concerns raised by our Consultants and potentially remove an impediment to additional working hours. However, this would not address the position of other senior staff.

Partnership Forum – it was reported to us that this forum, involving staff-side liaison is being re-invigorated.

Theme 2 – Leadership and Progression

We received a report that the Trust has commenced a programme of work on changing the culture of the organisation and is inviting a cross section of staff to become culture champions, who will work as part of

[1] SR 11 – cultural shift (staff feel engaged, able to raise concerns); SR12 diversity and inclusion; SR13 failure to address culture of bullying and harassment; SR14 recruit and retain the right workforce; and SR15 unable to deliver new and innovative roles and ways of working.

a team being led by the CEO and who will be taught to use the NHSI/E culture tools to start to deliver sustainable culture change across the Trust.

Theme 3 - Workforce Planning and Strategy

The draft Workforce Strategy we had reviewed at an earlier meeting had been updated, and then approved by the Trust Board at its November meeting. The focus on three core areas (recruitment; retention; and new roles) was also approved by the Board, and we had a short update on how the strategy would be translated into a series of targeted initiatives. We endorsed the proposed approach and will, at our February meeting, review the 2020/21 Delivery Plan that is now being created.

We reviewed a number of **workforce statistics**. Sion Pennant-Williams summarised the differences between the two 'establishment' numbers the Trust maintains, and whilst these could be reconciled more closely, there remained a material variance. One result of this reconciliation has been to allow the Trust's vacancy rate to be recalculated, with a consequent reduction to 9.68%. The same report to the Committee noted that "…*it is clear that actual FTE plus bank and agency FTE are higher than the established FTE..*" .

This raised a question of whether the Trust was deploying more resource than planned. There was a helpful discussion on this, but the Committee noted with concern that there appeared to be no single, agreed forward-looking target or budget metric for WTE staff numbers across the Trust, against which performance could be managed. The long discussion on this ultimately did not yield a conclusion, and it was agreed that this would therefore be raised at the Finance and Investment Committee the following week.

Sickness levels across the Trust as a whole had risen slightly to 3.73% (but down from the 4% reported 12 months ago), but some areas had sickness levels well in excess of 7%. Given the cost to the Trust of staff sickness, the Committee will review current practice at its next meeting. MAST compliance continues to trend at c 90%. Staff turnover is up almost 1% on a year ago, at 17.78%. The flu vaccine uptake by staff was 81.7% at the time of the Committee meeting.

We received a detailed report from Justin Sharp (our Temporary Staffing Manager) on the Trust's use of flexible staff (via bank or agency). An extract is attached in Appendix 1. Justin summarised the current position, and some of the market challenges. Flexible staff currently represents circa 10% of our deployed WTEs and are therefore a critical part of our workforce on a continuing basis. The reality is that our use of such staff is not temporary, but rather a critical and continuing part of our total deployed workforce. Justin reminded us that a good proportion of our bank (3,800 or 62%) comprises staff with a substantive contract at the Trust choosing to work additional hours.

An increasing number (currently 2,300, representing 37% of bank staff) are choosing to work on a Full Bank (or bank-only) basis with the Trust. Justin set out how our rostering systems across the Trust engage with bank staff and ensure timely allocation of shifts, although a number of these are allocated within 24 hours of start time. For nursing bookings with a long lead-time, bank fill achieved was 92% - although for short-term bookings it was more difficult to secure a bank fill, and therefore bank fill fell to 41% and agency use increased to 25%. The clear message was that early notice of demand supports a cost-effective solution. There is a move for the bank to work collaboratively across the whole of south-west London.

Theme 4 – Compliance

Freedom to Speak Up – we received a progress report from Liz Woods on the Trust's Guardian programme, and noted that the processes appeared to be working, with concerns being raised and escalated. This Report covered the period July to September with 19 concerns raised, 15 related to bullying and four to patient safety. (The previous quarter had seen 9 concerns in total, although it is not clear whether the increase reflects increased awareness of the Guardian's role, or a step change in the level of concern within the Trust) However, the speed with which concerns are being addressed and resolved by the Trust is an increasing issue, and so Harbhajan Brar will review with the Guardian what steps can be taken to address this, and report back to the Committee at its next meeting.

Safe Working – Junior Doctors - We reviewed a detailed report from the Trust's Guardian Of Safe Working Hours, Dr Serena Haywood. The general picture is of a modest reduction (against prior quarter) in exception reports, but still an increase on prior year as reporting becomes more established. The position across different care groups is stark and it is clear that there are some areas where there is a persistently high level of exceptions being reported. One cause of this is rota gaps in those areas, generally driven by the challenges of recruiting to junior doctor posts. Across the Trust, as at the end of November, there were 18 rota gaps (out of 172 posts) and it was noteworthy that 11 of these gaps were in adult critical care. Serena acknowledged that the Trust was getting better at covering these, but one consequence was that this was shifting the pressure from our junior doctors to our Consultants and our Hospital Trust Doctors and Fellows although a reporting system like that for the trainees would help provide the scale of this. Serena's full report will be in the Board papers.

Serena's assessment continues to be that our junior doctors are generally more willing to flag and report concerns, and that consultants are becoming more receptive to this and taking actions to address it. Engagement from Divisional representatives appeared to be better, with an improved focus on addressing issues as they arose, rather than after the event. Improved anticipation of rota gaps would help address them in advance, and the roll-out of the e-rostering would flag gaps earlier. The Trust has still not reached a decision on how the £60K junior doctor wellbeing grant from DHSC is to be used, although a working group has now been set up to progress this.

The overall conclusion though was that despite good intentions all round, the core driver remained rota gaps (currently running at circa 10%, and largely a function of a tightening junior doctor employment market) and the intensity of out-of-hours service demand at busy times.

The Committee noted the changes that were being made to rotas following the 1 December implementation of the new contract for junior doctors. This will create additional pressures, notably as a result of its prohibition of 1 in 2 working. Much work has been done internally to prepare for this, but there will be some areas that cannot deliver compliance and which will therefore, for a permitted transitional period, continue to use a 1-in-2 rota.

Fit and Proper Persons Test - Policy – we reviewed and endorsed an updated FPPT Policy, and this has already been to Board for approval.

MHPS – we received an update on the work being done to update the Trust's policy on Managing High Performance Standards for Consultants and Hospital Doctors.

Other – we sought and received assurance from Harbhajan Brar that he was not aware of any areas where there had been or was any **non-compliances by the Trust**.

Stephen J Collier

10 December 2019

Appendix 1 – Temporary Staffing Fill charts

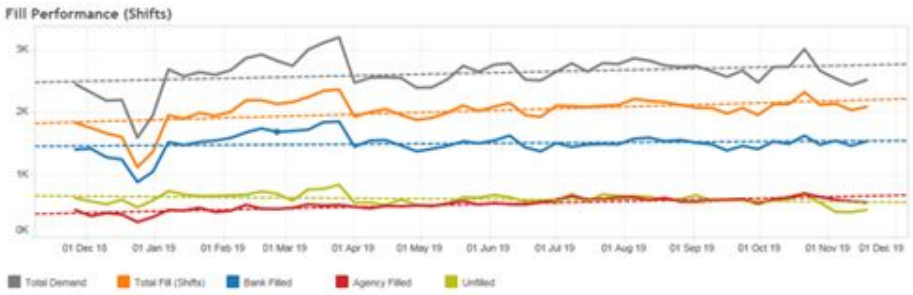
Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

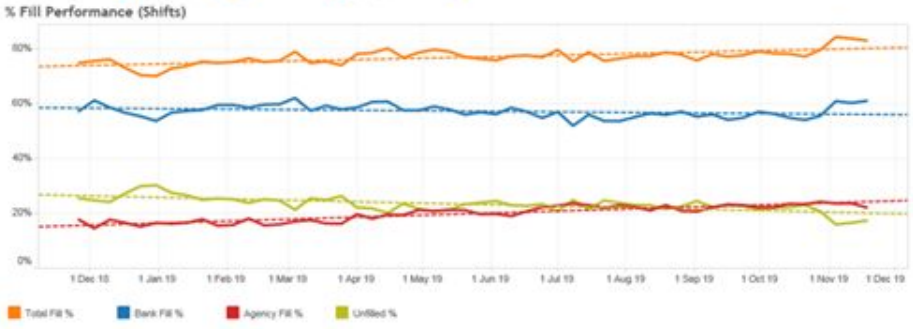
5.1

Temporary Staffing Demand and Fill performance

Trust total



Over the last year the trend for Temporary Staffing Demand has increased, Bank fill has a small increase, Agency fill has significantly increased, and unfilled shifts have slightly decreased.



The graph above shows that Bank is filling more actual hours, as a percentage of the total Demand, Bank fill is slowly decreasing. Agency fill % is increasing dramatically, and unfilled shift % is decreasing.