Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting
Thursday 27 February 2020

Agenda and papers

St George's University Hospitals NHS
NHS Foundation Trust

Board Walkabout - Thursday 27th February 2020, 08:30 – 09:45

Meet in the Hyde Park Room at 08:30

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

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

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

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

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

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

Practicalities

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

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

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

Groupings- 27th February 2020

NED	Exec / Divisional Chair	Divisional Representation	Area Visiting, 08:30 – 09:45
Gillian Norton, Chair Elizabeth Bishop	Avey Bhatia	Debbie Graham (Director of Midwifery)	Gwillim Ward (Level 4 LNS) Carmen (Level 4 LNS)
Ann Beasley	Tom Shearer Stephen Jones	Kelly Davies (Head of Nursing)	Heart Failure Unit (Level 1 AMW) Charles Pumphrey Unit (Level 3 AMW)
Parveen Kumar	Andrew Grimshaw	David Main (Associate Director of Procurement) Elizabeth White	Procurement (Wandle Annex) IT (Wandle Annex)
Pui-Ling Li	Richard Jennings	Louise Ramadhan (Matron)	Florence Nightingale (Level 4 STJ) Vernon Ward (Level 4 STJ)
Prof Jenny Higham	Robert Bleasdale Suzanne Marsello	Alan Clarke (Ass Director Health & Safety) Marlene Johnson (Head of Nursing)	McEntee Ward (Level 2 STJ) Ruth Myles Ward (Level 2 STJ)
Stephen Collier	Harbhajan Brar	Linda Smith (Matron) Francis Cruz (Matron)	Allingham Ambulatory (Level 3 STJ) Cheselden (Level 5 STJ)
Tim Wright	James Friend	Ana Vaz (Matron)	Nye Bevan Unit (Ground floor STJ) Surgical Admissions Lounge (Level 1 STJ)

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NHS Foundation Trust

Trust Board Meeting (Part 1) Agenda

Date and Time: Thursday, 27 February 2020, 10:00-13:25
Venue: Hyde Park Room, 1st Floor Lanesborough Wing, St George's, Tooting

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	A	Visits to various parts of the site	Board Members	Note	Oral
STAFF VALUES AWARD					
10:25	B	Awarded to Oscar Bridgeman, Health Records Management	Chairman	-	Oral
1.0 OPENING ADMINISTRATION					
10:30	1.1	Welcome and apologies	Chairman	Note	Oral
	1.2	Declarations of interest	All	Assure	Oral
	1.3	Minutes of meeting – 30 January 2020	Chairman	Approve	Report
	1.4	Action log and matters arising	All	Review	Report
10:35	1.5	CEO's Report	Acting Chief Executive Officer	Inform	Report
2.0 QUALITY & PERFORMANCE					
10:40	2.1	Quality and Safety Committee Report	Committee Chairman	Assure	Report
10:50	2.2	Integrated Quality & Performance Report and Emergency Care Update	Chief Transformation Officer/Chief Operating Officer	Assure	Report
11:05	2.3	Cardiac Surgery Update	Chief Medical Officer	Assure	Report
11:15	2.4	Learning from Deaths (Q3) Report	Chief Medical Officer	Assure	Report
11:25	2.5	Transformation (Q3) Report	Chief Transformation Officer	Note	Report
3.0 WORKFORCE					
11:30	3.1	Workforce & Education Committee Report	Committee Chairman	Assure	Report
	3.1.1	Gender Pay Gap Report	Chief People Officer	Review	Report
	3.1.2	Ethnicity Pay Gap Report	Chief People Officer	Review	Report
	3.1.3	Medical Engagement Score	Chief Medical Officer	Review	Report
11:45	3.2	NHS 2019 Staff Survey Results	Chief People Officer	Assure	Report
4.0 FINANCE					
11:55	4.1	Finance and Investment Committee Report	Committee Chairman	Assure	Report

Time	Item	Subject	Lead	Action	Format
12:05	**4.2**	**FIC (Estates) Report**	**NED Estates Lead**	Assure	Report
12:15	**4.3**	**Finance Report (Month 10)**	**Acting Chief Financial Officer**	Update	Report
5.0 GOVERNANCE, STRATEGY & RISK					
12:25	**5.1**	**Education Strategy**	**Chief Medical Officer**	Approve	Report
12:35	**5.2**	**Digital Strategy**	**Chief Strategy Officer/Chief Information Officer**	Approve	Report
12:45	**5.3**	**Outpatients Strategy**	**Chief Strategy Officer/Chief Operating Officer**	Approve	Report
12:55	**5.4**	**Horizon Scanning Quarter 3 Reports:** ***5.4.1 Political, Legislative & Regulatory*** ***5.4.2 Local, Regional***	**Chief Corporate Affairs Officer/Chief Strategy Officer**	Note	Report
6.0 CLOSING ADMINISTRATION					
13:00	**6.1**	**Questions from the public**	**Chairman**	Note	Oral
	6.2	**Any new risks or issues identified**	**All**	Note	
	6.3	**Any Other Business**		Note	
	6.4	**Reflections on the meeting**		Note	
7.0 PATIENT/STAFF STORY					
13:10	**7.1**	**Being a patient and a patient partner**	**Liz Aram**	Note	Oral
13:25 CLOSE					

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

Thursday, 26 March 2020, 10:00-12:30
Hyde Park Meeting Room

Trust Board
Purpose, Meetings and Membership

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

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

Membership and In Attendance Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Andrew Grimshaw	Acting Chief Executive Officer	ACEO
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Elizabeth Bishop	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Prof. Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li	Associate Non-Executive Director	ANED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Operating Officer	ACOO
Rob Bleasdale	Acting Chief Nurse & Director of Infection, Prevention & Control	ACN/DIPC
Richard Jennings	Chief Medical Officer	CMO
Tom Shearer	Acting Chief Financial Officer	ACFO
In Attendance		
Harbhajan Brar	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Sally Herne	Quality Improvement Director – NHS Improvement	NHSI-QID
Secretariat		
Tamara Croud	Head of Corporate Governance/Board Secretary	HCG-BS
Apologies		
Jacqueline Totterdell	Chief Executive Officer	CEO
Ellis Pullinger	Chief Operating Officer	COO
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting
In Public (Part One)
Thursday, 30 January 2020, 10:00 –13:30
Hyde Park Room, St George's Hospital, Tooting

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Andrew Grimshaw	Acting Chief Executive	ACEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Prof Jenny Higham	Non-Executive Director (part)	NED
Prof Parveen Kumar	Non-Executive Director	NED
Dr Pui-Ling Li	Associate Non-Executive Director	ANED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection Prevention & Control	CN/DIPC
Dr Richard Jennings	Chief Medical Officer	CMO
Tom Shearer	Acting Chief Finance Officer	ACFO
IN ATTENDANCE		
Harbhajan Brar	Chief People Officer	CPO
James Friend	Chief Transformation Officer	CTO
Stephen Jones	Chief Corporate Affairs Officer	CCAO
Suzanne Marsello	Chief Strategy Officer	CSO
Ellis Pullinger	Chief Operating Officer	COO
SECRETARIAT		
Tamara Croud	Head of Corporate Governance/Board Secretary	HCG
APOLOGIES		
Jacqueline Totterdell	Chief Executive Officer	CEO
Sally Herne	NHSI Quality Improvement Director	NHSI-QID

Feedback from Board Visits
Board Members provided feedback from the visits conducted in the following areas: • Cardiac Investigations and Charles Pumphrey – Chairman and CTO • Brodie Ward and Mckissock– Ann Beasley, Pui-Ling and CN/DIPC • Thomas Young and Oncology Ambulatory Care–Prof. Parveen Kumar and CMO • Marnham and Cavell Ward – Sarah Wilton and CCAO • Recruitment Team and Staff Bank Team – Prof. Jenny Higham and CPO • Rheumatology Outpatients and Acute Gynaecology Unit – Stephen Collier and CSO

Feedback from Board Visits
• Security Team and Ingredients Restaurant – Tim Wright, COO and ACFO All visits were positive with very enthused staff brimming with ideas to drive quality improvement in their services and/or corporate departments. Staff reflected that although some of the earlier challenges in the transitional period of the new Mitie cleaning contract were abating there were still some issues, particularly in relation to cleaning at the weekends. Patients had also provided positive feedback during the visits. The responsiveness of the estates team to immediate estates and environmental issues were noted as improving, but there remained fundamental challenges with the estates infrastructure which could only be addressed through the longer term estates programme and additional capital investment. The visits to the corporate and support areas also demonstrated the breath and range of professionals it takes to run a hospital and deliver high quality patient care. The Trust had a wide range of corporate and support teams who were dedicated to providing services which keep the hospital functioning – from administrators, security teams and those who managing the restaurant. These teams not only demonstrated passion for the Trust and the services they provide but also commitment to improvement such as income generation in the restaurant, engaging with the system to introduce staff passports for new employee checks, and improving communications and awareness to keep the Trust secure. The Board welcomed and noted the updates. In relation to the feedback from Thomas Young, it also recognised that the Trust needed to continue to work with partners to reduce delays in social services which impact on the Trust's ability to discharge patients. The Board also noted the need to continue to deal with the remaining issues associated with the new cleaning contract. In addition, it recognised the importance of supporting echocardiogram teams to benefit from national training schemes.

Values Award
The Board welcomed and thanked Shamini Satish Nair, Registered Nurse in Outpatients' General Surgery, who had been nominated to receive a staff values award. Shamini was nominated by a patient for the calm, reassuring and patient care she provided.

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, Introductions and apologies** The Chairman welcomed everyone to the meeting and noted the apologies as set out above. The following governors were also in attendance as observers: • John Hallmark, Public Governor (Wandsworth) • Nick De Bellaigue, Public Governor (Wandsworth) • Anneke de Boer, Public Governor (Merton) • Alfredo Benedicto, Stakeholder Governor (Merton Healthwatch) • Mia Bayles, Public Governor (Rest of England) The Chairman reported that it was with sadness she had to inform the Board that Hazel Ingram, a patient partner at the Trust and a regular attendee at Board, had passed away over the Christmas period. Hazel's kind and gentle approach and support to the Trust had been invaluable both in her role as a volunteer and through her participation in patient experience activities across the Trust. The Chairman commented that Hazel would be much missed and the Board concurred.	

		Action
	The Chairman also welcomed new non-executive directors, Professor Dame Parveen Kumar and Elizabeth Bishop and associate non-executive director Dr Pui-Ling Li. Professor Kumar and Dr Li had already started their terms of office, and Elizabeth Bishop would officially start at the Trust on 1 February 2020. The Chairman noted that although not all elements of the fit and proper persons test (FPPT) checks had been completed she had conducted a thorough risk assessment and had concluded that, although it was far from ideal, on balance it was in the interests of the Board and its effective operation that the new non-executive directors commence their terms without delay. **The Chairman asked the CPO, as a matter of urgency, to ensure that that all elements of the FPPT were completed forthwith and were in place by the time of the February Board meeting at the latest.** In addition, the Chairman reported that the Jacqueline Totterdell, CEO, was unwell and in the interim Andrew Grimshaw had agreed to undertake the role of Acting Chief Executive until she returned, which was likely to be in March. Accordingly, Tom Shearer, Deputy Chief Financial Officer had stepped into the role of Acting Chief Financial Officer. The Chairman noted that, in accordance with the Trust's Standing Orders, the Acting CFO would exercise the full voting rights of the role of CFO as this was a formal acting-up arrangement. The Board thanked colleagues for their support and willingness to provider cover and wished Jacqueline Totterdell a full and speedy recovery.	**CPO**
1.2	**Declarations of Interest** There were no new declarations of interest reported.	
1.3	**Minutes of the meetings held on 19 December 2020** The minutes of the meeting held on 19 December 2020 were approved as an accurate record.	
1.4	**Action Log and Matters Arising** The Board reviewed and noted the action log and agreed to close those actions proposed for closure, and noted those actions not yet due.	
1.5	**Chief Executive Officer's Update** The ACEO presented the Chief Executive Officer's Update. The following key points were noted: • The six clinical commissioning groups (CCG) in South West London were progressing with their merger to form a single CCG from 1 April 2020. This was a significant step in terms of the move to system-wide working in South West London and the Trust was closely monitoring the developments and would need to work with the new body and other providers to clarify the governance structures across the area. • Finance remained a significant challenge. The Trust would not achieve the planned £3m deficit for the year and, following an extensive reforecasting process, the Trust now predicted a 2019/20 year-end deficit of £12m. The key contributing factors to this position included gaps in the savings programme particularly within the clinical divisions, activity and the broadly	

		Action
	unchanged underlying run rate. The Board noted its disappointment that the Trust would not achieve the original plan and reinforced the importance that the Trust delivered the new forecast and that there was no further deterioration. The revised year-end had been built on a robust forecasting exercise and for this reason the executive team were confident that the new plan was deliverable. The executive team also recognised that a significant amount of work was needed to change the culture of the organisation in relation to budget ownership and accountability for delivering local financial plans. • The Trust had appointed a number of Black Asian Minority Ethnic (BAME) staff to participate in recruitment panels for senior staff members (NHS pay band 8a/b and above). In addition, the Trust was making significant progress with the programme of work to improve the culture of the Trust, with great interest from staff members wanting to support the diagnostics phase and beyond. • The Trust Executive Committee had welcomed the newly appointed divisional chairs, Nick Hyde (Surgery, Theatres, Neurosciences and Cancer) and Rafik Bedair (Children, Women, Diagnostics and Therapies). Rafik and Nick replaced Justin Richards and Tunde Odutoye, and the Board thanked the outgoing divisional chairs for their contribution and support.	
2.0	**QUALITY AND PERFORMANCE**	
2.1	**Quality and Safety Committee Report** Professor Parveen Kumar, Chair of the Committee, presented the report of the meeting held on 23 January 2020 which set out the key matters raised and discussed at the meeting. The Committee heard about the trend of increasing 12-hour trolley breaches which were largely due to wider system challenges with mental health bed capacity. The key actions taken by the Trust included improving its rapid assessment processes in the emergency department and supporting medically fit patients to access more appropriate mental health provisions in the community. The Trust had good relationships with mental health providers but it was recognised that the frequency and quality of contact needed to be improved at senior management level and the Trust was seeking to do this through many forums including the Mental Health Reference Group. The Committee was assured by the actions taken to monitor and manage the challenges with infection control, in particular methicillin sensitive staphylococcus aureus (MSSA) and methicillin resistant staphylococcus aureus (MRSA). The Committee also heard about the challenges with referral to treatment and seven day services which would be discussed later on the agenda. The Committee and the Board were frustrated by the Trust's inability to close the outstanding Care Quality Commission action related to mandatory and statutory training in relation to basic life support. Despite the additional resources, increased senior and divisional scrutiny and enhanced communication programme the Trust missed the December 2019 deadline and hence the Trust had revised its trajectory to June 2020 to achieve the target for resuscitation training. The Board noted the report.	

		Action
2.2	**Care Quality Commission (CQC) 2019 Inspection Report** The Board received and noted the CQC Report from its inspection of the Trust during 2019, which had been published on 19 December. It was reported that, overall, the CQC had found significant progress and whilst the Trust retained its *'requires improvement'* rating the CQC had recommended to NHS England and NHS Improvement that the Trust be taken out of 'quality special measures'. The Trust had received two requirement notices, which was far lower than some other trusts with higher overall ratings and the response and actions to these had been submitted to the CQC by the deadline of 16 January 2020 and were included in the report. The Trust was in the process of developing the comprehensive action plan to respond to all the '*must'* and '*should' do* notices. Progress against implementing the action plans would be monitored through the Trust's governance forums including Patient Safety and Quality Group, Trust Executive Committee, the Quality and Safety Committee and locally at divisional management and governance meetings. The Trust was also developing a plan that looked beyond the 'must' and 'should' do actions that would help the Trust become outstanding. Notably there were significant improvements in services for example services to children and young people was now rated '*outstanding'* overall. The Board noted that the Trust had much to be pleased about with the progress documented in the CQC report, while there of course remained more to do. The Board also noted that the comprehensive action plan would be presented to and monitored by the Quality and Safety Committee.	
2.3	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR at Month 9 (December2019), which had been scrutinised at both the Finance and Investment Committee and the Quality and Safety Committee the previous week. Of note was the increase in non-elective length of stay for acute medicine patients. Elective day case activity was likely to pick up. Referral to treatment (RTT) performance had deteriorated with seven 52-week breaches against a zero target during the period. The Trust's DMO1s (diagnostics waiting times) had deteriorated further with the most significant pressure on six-week diagnostics waits. Cancer performance in quarter three was also challenged but the current trajectory suggested the Trust would be back on track to achieve the target in quarter four. The Trust continued to miss the 4-hour standard in its Emergency Department and only achieved 80% in December 2019 with a marginal improvement in month 10 at 81%. Closer scrutiny was being given to maternity performance. As a result of not fully achieving the targets against the treatment escalation plan and deprivation of liberty clinical priorities, the Trust was proposing rolling these priorities forward into 2020/21. 89.7% of staff had the flu vaccination and 60% of staff had completed the NHS staff survey which was demonstrative of the increasing engagement from the workforce and successful communications campaigns. The Trust had received a copy of the staff survey results but this was embargoed until February. The Trust's agency spend was below the cap and the lowest it had been in the past three years. The Board noted that there were significant challenges both across London and the wider NHS in achieving the 4-hour emergency department standard, but also noted that despite this the Trust needed to improve its own performance. The Board welcomed the performance against the agency cap and noted that this was a consequence of the significant amount of work by staff to get to this	

		Action
	positive position. The Trust had engaged with Public Health England about implementing plans to manage potential Coronavirus cases. The Board also flagged that further consideration must be given to how to improve engagement with staff on the appraisal process especially in relation to non-medical appraisals and it was reported that there was work underway with divisional leads. It was also noted that there was an open Board action in relation to the quality of appraisals which had been allocated to the Workforce and Education Committee. **The Board agreed that the Workforce and Education Committee would conduct a deep dive into non-medical staff appraisals and the executive team could learn from the work carried out in the estates team to improve the department's appraisal rates.** **The Board asked that the IQPR be enhanced where possible to include more benchmarking data on key performance indicators and more information regarding estates performance, drawn from the estates dashboard.** The Board received and noted the report.	**WEC/CPO** **CTO**
2.4	**Cardiac Surgery Update** The Board received and noted the cardiac surgery update. Since the Board considered its comprehensive update report in December 2019 there had been five inpatient post-operative deaths. In line with the Trust's governance processes these deaths had been considered at the Serious Incident Declaration Meeting (SDIM) and independently by an external expert from another South London trust. The independent mortality review into cardiac surgery deaths between April 2013 and December 2018 which had been commissioned by NHS England and NHS Improvement was expected to conclude shortly and a process of factual accuracy checking was underway. The Trust was awaiting the publication of the final report. The Board flagged that the risk register for the service remained unchanged and queried whether or not it should contain a risk in relation to team dynamics. It was reported that this had improved with the appointment of Steve Livesey as Associate Medical Director and Care Group Lead for Cardiac Surgery in December 2018. Once NHSI/E published the report the Trust would reassess the risk ratings. Significant changes had been made to the service, as set out in the December 2019 Board paper, and the service had improved as a result. The CQC inspection report had recognised these improvements, particularly in relation to leadership, and the Trust was no longer an outlier for mortality. The Board received and noted the report.	
2.5	**Emergency Preparedness, Resilience and Response (EPRR): Annual Assurance Submission to NHS England (London)** The Board considered the report on the outcome of the 2019-20 NHS England EPRR assurance process. The Trust's EPRR assessment was rated as 'substantially compliant'. The Trust also had in place an action plan with key priorities which addressed the gaps in compliance. The Board welcomed the substantial compliance rating for the Trust's	

		Action
	emergency preparedness, resilience and response processes for 2019/20.	
2.6	**Seven Day Services Implementation Update** The Board received and discussed the report charting progress on implementing the core standards to enable the Trust to provide seven day services by April 2020. A full assessment of progress against the four core standards had been completed and the Trust would not be fully compliant by the April 2020. The area of significant challenge for the Trust related to consultants seeing more than 90% of emergency patients within 14 hours of admission at weekends (Standard 2). The action plan in the report would support the Trust in achieving compliance with the core standards. **The Board noted the report and asked that the programme of work be integrated into the development of the annual plan for 2020-21, with the Trust Executive Committee providing oversight and scrutiny of progress.**	**TEC/CMO**
2.7	**Quality Improvement Academy (Q3) Report** The Board received and noted the report on the quality improvement academy in quarter three 2019/20.	
3.0	**FINANCE**	
3.1	**Finance and Investment Committee Report** Ann Beasley, Committee Chair, provided an update on the meeting held on 23 January 2020. The Trust had made great strides in managing and mitigating its ICT risks, but there remained concerns around data quality. With plans being progressed in the coming months it was anticipated that the Trust could move this risk to partial assurance. Finance remained the highest risk and biggest area of concern. The Trust's financial performance was in line with plan at month 9 however the underlying run rate was such that the Trust would not achieve the original planned £3m deficit at year-end as discussed under agenda item 1.5 above and below under agenda item 3.3. The 2019/20 year-end position would impact on the 2020/21 financial plan and addressing the underlying run rate was key. The Trust had begun the planning process but was waiting for NHS Improvement/England to publish the planning guidance. The Board noted the report.	
3.2	**Finance and Investment Committee (Estates) Report (FIC(E))** Tim Wright, NED Estates Lead, provided an update on the meeting held on 23 January 2020. The Trust's journey to improve transparency and assurance around key estates issues was bearing fruit. There was significantly greater visibility and engagement at Board level on estates issues. Fire and water remained key areas of focus. Clearing the historic backlog of outstanding estates works remained a key challenge for the team. There had also been some improvement on the Mitie cleaning contract but as mentioned in the feedback from the Board visits there was more to do. The current risk assurance rating was limited but the group was committed to moving this to partial assurance in quarter four 2019/20. The Trust would engage an external supplier to support development of the estates strategy and good progress was being made on the	

		Action
	capital programme. The Board noted the report.	
3.3	**Month 09 Finance Report** The Board noted the Month 9finance report. The ACFO reported that the Trust remained on plan at month 9. Capital and income were in line with the Trust's plan but as mentioned under agenda items 1.5 and 3.1 the Trust had needed to reforecast its year-end position. The Board noted the report.	
4.0	**GOVERNANCE, STRATEGY & RISK**	
4.1	**Audit Committee Report** Sarah Wilton, Committee Chair, provided an update on the meeting, held on 21 January 2020. The External Auditors had begun the planning process for the completing the audit of the 2019/20 financial and quality accounts. Good progress was being made on delivering the 2019/20 internal audit programme of work and the Committee considered several reports which attained substantial or reasonable assurance. The Committee also recognised the significant progress made on embedding the systems for managing policies and declarations of interests. The Committee had completed its effectiveness review and the results of this were positive which reflected the improvements made around governance and the control environment in recent years. The Board noted the report and approved the annual audit fee for the external auditors.	
4.2	**Quality and Safety Strategy (draft)** The Board received and discussed the draft Quality and Safety Strategy 2020-24 which had also been discussed at the December 2019 Board Seminar and January 2020 Quality & Safety Committee meeting. The strategy had been developed following a robust engagement process internally and with external stakeholders. The strategy outlined the seven priority areas: • Minimising avoidable harm • Improving outcomes for patients • Providing patients with an excellent experience • Improving staff experience • Providing patients with equitable access and quality • Embedding a culture which embraces quality, safety and learning • Providing and developing pioneering and leading edge treatments The Board noted that the strategy should be supported by practical granular actions which could be quantified and measured. It was helpful that there was priority on improving staff experience because when staff feel looked after they deliver better care to patients. The Board approved the Quality & Safety Strategy and noted the interdependency with other supporting strategies.	

		Action
4.3	**Corporate Objectives (Q3) Report** The Board received the update to the quarter three 2019/20 corporate objectives. There had been some improvement since the quarter two report but there remained a number of areas where the Trust was not delivering the agreed commitments. The training compliance objective should be rated as 'red' given continued challenges with achieving the outstanding Care Quality Commission requirement related to mandatory and statutory training. The Board noted the report and reflected that many actions were rated '*amber*' and asked that the executive give more focus on delivering the corporate objectives as well as, for the objectives for the next year, being clearer about the task and the expected outcome.	
4.4	**Board Assurance Framework (Q3) Report** The Board received and discussed the quarter three 2019/20 board assurance framework (BAF). The responsibility for the BAF would move from the CN to the CCAO from April 2020. Strategic risk three (*patients waiting too long for treatment*) had increased (previously scored 12 now 16) to reflect the deterioration in referral to treatment, DMO1s and seven day services. The highest risk remained strategic risk seven (*achieving financial balance*) with a risk score of 25. The Trust would ensure that it reflected on the comments made by the Care Quality Commission about the Board Assurance Framework especially in relation to the engagement at divisional level. With the programme of work around diversity and inclusion the Trust was assured that many of the risks in strategic risk 12 had been mitigated but the risk score would remain the same until the actions taken have been suitable embedded. The Board received and endorsed the Board Assurance Framework.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from the public** There were no questions from the public.	
5.2	**Any other risks or issues identified** There were no other risks or issues identified.	
5.3	**Any Other Business** The Chairman advised that the process to elect new governors to join the Trust's Council of Governors would close later in the day and the results would be announced on 31 January 2020.	
5.4	**Reflections on the meeting** The Chairman invited Sarah Wilton to offer reflections on the meeting noting that this would be Sarah's last Board meeting having completed her final term of office. Sarah reflected that since joining the Trust in 2011 there had been a significant number of changes in the Board membership but was pleased to see an established team in place. There had been marked improvements in a number of areas for example more focus on quality, demonstrable change and	

		Action
	better quality of reporting and engagement of executive Board members, improved governance, better project management (i.e. iClip across both sites), returning to reporting for the referral to treatment pathway and the patient voice was more visible at the Board meetings. New members of the Board also commented that there was a feeling of openness at the Board which was also reflected on the Board visits. The Chairman, on behalf of directors and governors, thanked Sarah Wilton for her support and contribution to the Board. She had been highly effective in contributing to the Board and had been a stalwart supporter of the Trust. She had also been at the forefront of driving change and providing robust but constructive challenge. She would be very much missed by the Board.	
6.0	**PATIENT & STAFF STORIES**	
6.1	**Patient Story: Patient Experience: Cancer Pathway** The Board welcomed Ms Sarina Vitalis who relayed her experience as a sickle cell patient attending the Trust's emergency department. During a sickle cell crisis Ms Vitalis had on a number of occasions come into the Trust's emergency department. She described the intense level of pain she feels when she presents at the emergency department and the way she had been treated. On a daily basis she manages her pain at home with high concentration of pain medication. She has a protocol on her medical records which staff should use when she attends the hospital and because of past experience she also carries a copy with her. Despite the protocol being in place she had often been treated with distain by staff, or treated suspiciously as someone looking to obtain drugs, and she described occasions which highlighted this. In addition to being ignored and left alone scared she described the discriminatory attitude of staff. She and her family were her only advocates and only when clinical specialists were contacted was she treated in the right way. It was reported that the Trust recognised these issues and accepted that there needed to be significant change and the ED team was working with the clinical specialist in the haemoglobinopathies to develop standards and educate ED staff on how to support and care for sickle patients. This work was ongoing and being supported by patients with sickle cell. The Trust also had two sickle cell nurse champion in the ED and there was a standard set of protocols in place. The Board reflected that the treatment Ms Vitalis received was unacceptable and distressing and apologised to her for this shortfall in service. **The Board thanked Ms Vitalis for sharing her story and agreed that a follow-up report would be presented to the Board setting out the actions that had been taken to ensure that her poor experiences would not be repeated either for herself or for others.**	**CN**

Date of next meeting: Thursday, 27 February 2020 in the Hyde Park Room, St George's Hospital, Tooting

Trust Board Action Log Part 1 - February 2020

Action Ref	Section	Action	Due	Lead	Commentary	Status
TB27.06.19/01	**Integrated Quality and Performance Report (IQPR) (Month 02)**	It was agreed that the CMO and CPO would look into reviewing quality of appraisals and report to the Workforce and Education Committee.	~~19/12/2019~~ 27/02/2020	CMO/CPO	Workforce & Education Committee considered a report on non-medical appraisals at its next meeting on 18 February 2020 and an update is provided its report to the Board under agenda item 3.1.	**PROPOSED FOR CLOSURE**
TB19.12.19/03	**Cardiac Surgery Report**	It was also agreed that the CMO would seek other sources of comparative data to include in future reports.	27/02/2020	CMO	**See Agenda Item 2.3** Previous Update (30/01/2020):The CMO is exploring what, if any other appropriate performance management benchmarking can be included in the Cardiac Report and an update would be provided in February.	**DUE**
TB19.12.19/09	**Finance and Investment Committee (Estates) Report (FIC(E))**	The Board noted the report and asked that the Health and Safety inspection report be presented to the Committee as a matter of urgency.	27/02/2020	ACEO	ACEO to provide a Verbal Update at the meeting.	**DUE**
TB30.01.20/01	**Welcome, Introductions and apologies**	**New NEDs FFPT:** The Chairman asked the CPO, as a matter of urgency, to ensure that that all elements of the FPPT were completed forthwith and were in place by the time of the February Board meeting at the latest.	27/02/2020	CPO	CPO to provide a Verbal Update at the meeting.	**DUE**
TB26.09.19/04	**Mental Capacity Act and Deprivation of Liberty Standards (Annual Report 18-19)**	**Developing Annual Reports for other performance areas:** The Board agreed that it would be useful to complete annual reports for certain other performance areas such as treatment escalation plans and that proposals on which areas would benefit from this approach would be presented to the Quality and Safety Committee for consideration.	26/03/2020	CN/CTO	Not yet due.	**NOT DUE**
TB28.11.19/01	**Medication Incidents and Controlled Drugs Q1-2 Report**	The CMO agreed that the next iteration of the medicine incident and controlled drugs report would include relevant benchmarking data.	28/05/2020	CMO	Not yet due.	**NOT DUE**
TB28.11.19/05	**Annual Research Report**	The Board noted the annual research report and agreed that the next iteration would include comparative data to demonstrate where the Trust sits in relation to other organisations.	Q1 2020/21	CMO	Not yet due.	**NOT DUE**
TB19.12.19/01	**Action Log & Matters Arising**	**Plans for Providing Effective Assurance at Committees (Corporate Objectives):** The Board agreed that plans for reporting on and providing effective assurance through Committees to the Board on corporate objectives would be picked up as part of the process for agreeing the objectives for 2020/21.	26/03/2020	CSO/CCAO	Not yet due.	**NOT DUE**
TB19.12.19/07	**Freedom to Speak Up Guardian Report**	The Board agreed that the executive team would ensure that the organisation understands the need to engage with the FTSU process in a timely way and provide a method for the FTSUG to escalate non-engagement.	26/03/2020	TEC	Update to be provided following Workforce & Education Committee 18 February 2020	**NOT DUE**
TB19.12.19/08	**Freedom to Speak Up Guardian Report**	The Board also agreed that arrangements for executive sponsorship of the Freedom to Speak Up function should be reviewed.	26/03/2020	CEO	Update to be provided following Workforce & Education Committee 18 February 2020	**NOT DUE**
TB30.01.20/02	**Integrated Quality and Performance Report (IQPR)**	**Non-Medical Appraisals Deep Dive at WEC:** The Board agreed that the Workforce and Education Committee (WEC) would conduct a deep dive into non-medical staff appraisals and the executive team could learn from the work carried out in the estates team to improve the department's appraisal rates.	28/05/2020	CPO		**NOT DUE**
TB30.01.20/03	**Integrated Quality and Performance Report (IQPR)**	The Board asked that the IQPR be enhanced where possible to include more benchmarking data on key performance indicators and more information regarding estates performance, drawn from the estates dashboard.	26/03/2020	CTO		**NOT DUE**
TB30.01.20/04	**Seven Day Services Implementation Update**	The Board noted the report and asked that the programme of work be integrated into the development of the annual plan for 2020-21, with the Trust Executive Committee providing oversight and scrutiny of progress.	23/03/2020	CMO		**NOT DUE**
TB30.01.20/05	**Patient Story: Sickle Cell Patients in the Emergency Department**	The Board thanked Ms Vitalis for sharing her story and agreed that a follow-up report would be presented to the Board setting out the actions that had been taken to ensure that her poor experiences would not be repeated either for herself or for others.	30/06/2020	CN		**NOT DUE**

Meeting Title:	**Trust Board**		
Date:	25 February 2020	**Agenda No**	**2.1**
Report Title:	**Integrated Quality and Performance Report**		
Lead Director/ Manager:	James Friend, Chief Transformation Officer		
Report Author:	Emma Hedges, Mable Wu, Kaye Glover		
Presented for:	Information and assurance about Quality and Performance for Month 10		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, quality, patient access and performance. **Our Finance & Productivity Perspective** Outpatient activity remains below plan; all other activity is on plan. Non-elective Length of stay is above the upper process limits impacted by a new emergency department initiative, Rapid Assessment Zone (RAZ) and an increase in Senior Health length of stay. **Our Patient Perspective** The Trust had one Never Event reported in January and the serious incident investigation has commenced. Support will be provided to staff involved in this incident with emphasis on the importance of learning from this event There were no MRSA incidents reported in January. There were five Cdiff incidents reported in January bringing the year to date total to 42 against a threshold limit of 48. The Trust's Friends & Family positive response rate for inpatient, community and maternity services exceed the target of 90%. There has been an improvement in the Friends & Family positive response rate for emergency department services. **Our Process Perspective** **Emergency Flow** - The Trust reported a monthly improvement against the Four Hour Standard in the month of January with a performance of 81.7%. The Trust's trajectory for January was 85%. Occupancy for the General and Acute wards has seen an increase with the number of patients in a hospital bed for over 21 days increasing to an average of 135 in the month of January compared to 127 in December. In the reporting month eighteen patients were reported as waiting in the Emergency Department over twelve hours following a decision to admit. **Cancer** – In the month of December three cancer standards were not met, this included two week rule standard, two week rule standard breast symptomatic and 62 day referral to treatment screening standard. The main reason for this under delivery is patients choosing not to have their outpatient appointment over the Christmas period. However, the Trust has achieved two week rule standard for Q3 2019/20. **Diagnostics** – The Diagnostic position in January showed some improvement however the standard of 1% was not achieved, reporting a position of 5.4%. Recovery plan and trajectory in place to bring waits for echo to within the 6 week's by May 2020.		

	On the Day Cancellations – Compared to the same period last year the Trust has seen a reduction of 42% in the number of patients cancelled on the day of their operation for non-clinical reasons. Re-booking performance within 28 days of cancellation date continues to show improved sustainability. **Referral to Treatment** - The Trust reported nine 52 week breaches in December 2019 against a planned trajectory of zero. Monthly performance was reported at 82.6% against a trajectory of 86.8%. Targeted work continues to reduce the volume of patients on the patient tracking list (PTL), through both additional clinical activity and/or improved RTT coding and in the month of December the PTL size decreased by 3.5% overall. **Our People Perspective** The Trust's the monthly agency cost in January was £1.26m against a target of £1.25m. Appraisal rates for clinical and non-clinical areas remain consistently below target of 90% with rates of 84.9% and 72.0% respectively. **Benchmarking** An informal peer review of how benchmarking data is reported to equivalent Trust Boards has been undertaken. Where such information is included for headline performance figures the format varies. This can be to quote a regional league table of raw data through to national or regional rankings. In some instances, in particular for workforce data, the time periods being benchmarked are either not stated or are slightly historic. From reading listed Actions and Risks in such reports, it is not clear that other Trusts derive value from reviewing such benchmarking data, but rather the tendency is to remain focussed on absolute delivery locally. Although the review has not been exhaustive, no examples have been found of "Plot the Dots" style presentation of benchmarking data such as is included within the Integrated Quality & Performance Report ("IQPR"). Additional benchmarking data could be produced from the NHS England / Improvement Website "Statistical Work Areas" section and included in the IQPR. The quantity of data available is significant, from Friends and Family Test feedback to Referral to Treatment Times, and additional resource would be required to include this on a monthly basis, at least until such time as the metrics within the report are fully automated for production through the Business Intelligence function. An alternative approach would be to encourage colleagues when writing thematic Annual or Quarterly Reports to the Trust Board to include clear benchmarking data alongside their specific and detailed "Plot the Dots" data presentations.
Recommendation:	The Board is requested to note the report.
Supports	
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led
Single Oversight Framework Theme:	Quality of Care Operational Performance

Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:	The trust remains in Quality Special Measures based on the assessment of the Regulator NHS Improvement		
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Previously Considered by:	Trust Executive Finance and Investment Committee Quality and Safety Committee	**Date**	19/2/2020 20/2/2020 25/2/2020
Equality Impact Assessment:			
Appendices:			

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 27 February 2020

Reporting Period – January 2020

James Friend
Chief Transformation Officer

13th February 2020

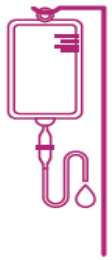
How Are We Doing?

January 2020

Daycase and Elective Surgery operations

Actual: 5,384

Target: 5,514



AMU bed occupancy at 12 Noon

Actual: 93% Target: 85%

Four Hour Emergency Standard

Actual: 81.7%

Plan: 95%

Whole Trust Inpatient Friends and Family Test

Actual 96.8%

Target 95%

Outpatient First Attendence

Actual 16,365

Plan 18,509

December 2019

Referral to Treatment Standard - Incomplete pathways

Actual:

82.6%

Target:

92%

Balanced Scorecard Approach

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

Key

Current Month

A Previous Month

Executive Summary – January 2020

Our Finance and Productivity Perspective

- Outpatient Activity at Trust level is 3% below SLA plan year to date. Activity levels remained within normal process limits thought the activity level has been below the mean for the past six months showing special cause variation.
- Outpatient Did Not Attend (DNA) rates fell below the lower process limit likely due to an increase in voice reminders two and seven days prior to patient appointments.
- Daycase and Elective activity is just below SLA plan year to date with the number of procedures per working day returning to above the long term mean. The Trust's Elective activity is currently 6.3% ahead of the same year to date period last year. Theatre utilisation remains within the upper and lower control limits however average cases per session remains below the mean.
- Non-elective length has increased above the upper control limit showing signs of special cause variation. The increases are primarily within Acute medicine where front door pathway changes have reduced the number of zero stay admissions and an increase in Surgery and Trauma length of stay.

Our Patient Perspective

- The Trust continues to meet its commitment to respond in a timely manner with the percentage of complaints responses within 25, 40 or 60 days exceeding their respective targets.
- There was one Never Event reported in January.
- In January, there were no MRSA incidents reported; there were five Cdiff incidents reported in month bringing the year to date total to 42 against a threshold limit of 48.The Trust has exceeded its own internal thresholds of MSSA and E-Coli incidents.
- The Trust's Friends & Family positive response rate for inpatient, community and maternity services exceed the target of 90%. There has been an improvement in the Friends & Family positive response rate for emergency department services.

Our Process Perspective

- The Trust's January four hour performance was 81.7% against a target of 95% which is an improvement from the December position of 79.4%.
- The Trust met four of the seven cancer standards in December. Standards that were not met were the 14 day standards at 90.3%, the 14 day Breast Symptomatic standard at 90.0% and the 62 day referral from Screening to Treatment at 86.4%.
- In January, the Trust did not achieve the six week diagnostic standard with an adverse performance of 5.4% against a National Threshold of 1% and London performance of 3.4%.
- In December, the Trust remained behind trajectory for incomplete Referral To Treatment (RTT) performance. The submitted performance was 82.6% against a trajectory of 86.8%.

Our People Perspective

- The total agency cost for January was adverse to target by £0.01m with agency costs of £1.26m against a target of £1.25m
- The Trust's total pay for January was £45.30m. This is £1.55m adverse to a plan of £43.75m.

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **FINANCE** & **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity	Performance against Budget	CIP Delivery
OUR **PATIENT** PERSPECTIVE	Patient Safety R	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
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OUR **PEOPLE** PERSPECTIVE	Workforce		Agency Use		Estates Health and Safety	

Key

Current Month

A Previous Month

Our Finance & Productivity Perspective

Activity against our Plan

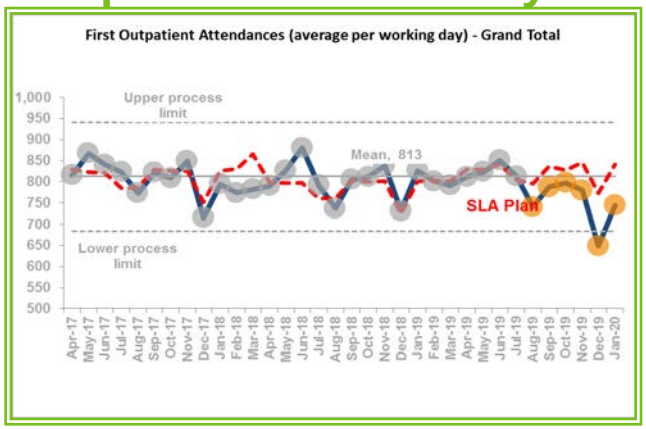
		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Jan-19	Jan-20	Variance	Plan Jan-20	Variance	YTD 18/19	YTD 19/20	Variance	Plan YTD	Variance
ED	ED Attendances	14,637	13,997	-4.37%	14,374	-2.62%	140,553	141,676	0.80%	141,893	-0.15%
Inpatient	Non Elective	4,072	4,140	1.67%	4,173	-0.79%	40,015	40,300	0.71%	40,015	0.71%
	Elective & Daycase	5,128	5,384	4.99%	5,514	-2.36%	48,414	51,481	6.33%	51,834	-0.68%
Outpatient	OP Attendances	60,259	57,776	-4.12%	61,167	-5.54%	561,045	557,115	-0.70%	576,667	-3.39%

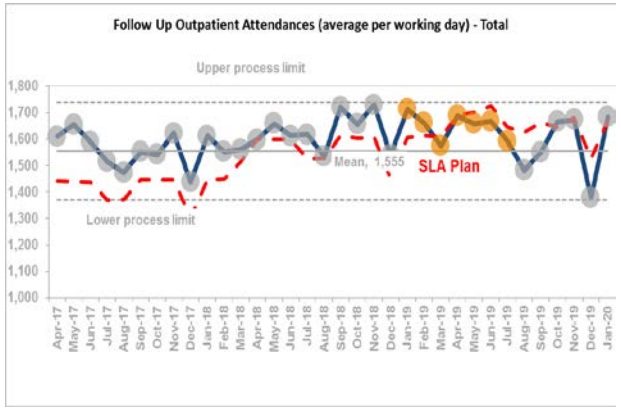
>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

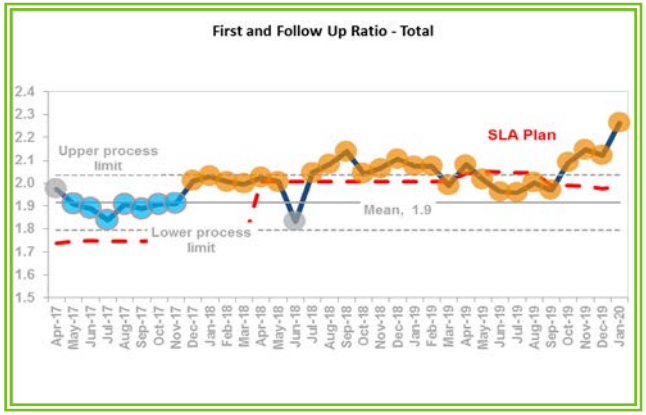
Note: Figures quoted are as at 10/02/2020, and do not include an estimate for activity not yet recorded (eg. un-cashed clinics). The expected performance vs. plan by Point of Delivery (POD) post catch up is:

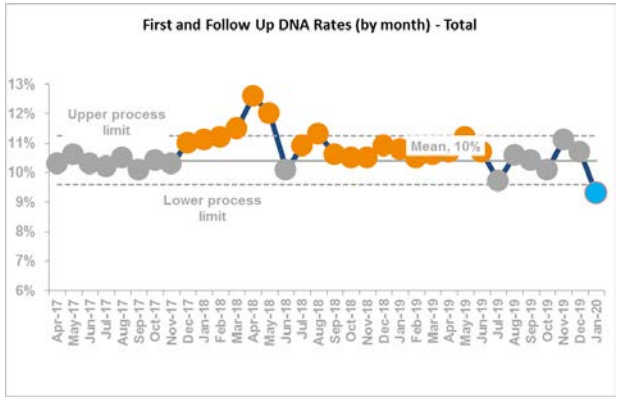
ED – No change
Elective and Daycase – On Plan
Outpatients – Underperformance against plan (c3%)

Outpatient Productivity









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

What the information tells us

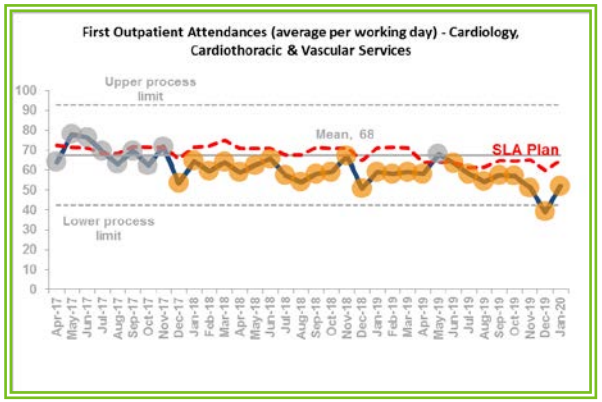
- Outpatient first activity has now performed below the mean for the sixth consecutive month showing special cause variation and currently below SLA plan. Cardiology, Cardiothoracic and Vascular Services as well as Surgery first outpatients activity remains below the mean. Women's services has seen a steady drop in first outpatient activity and has fallen below the lower control limit in January, however we expect this to increase once coding has fully completed. All other services are within their control limits.
- At Trust level, follow-up activity remains within its process limits; both Cardiothoracic and Vascular services and Surgery are performing below the mean for a sustained period of time.
- The Trust's first to follow-up ratio is currently above the upper control limit, continuing to show special cause variation. A number of specialties are seeing increases with Specialist Medicine, Surgery and Women's services above the upper control limit in the month of January.
- The Trust DNA rate has fallen below the lower process limit in the month of January reporting 9.3% showing significant improvements in a number of specialties. Cardiology services, Surgery, Renal & Oncology and Trauma & Orthopaedics are all showing a DNA rate below the lower control limit. The lower DNA rate is likely due to an increase in voice reminders sent to patients two and seven days ahead of their appointments.

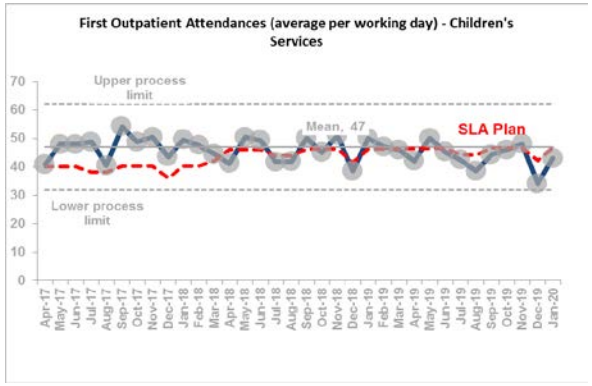
Actions and Quality Improvement Projects

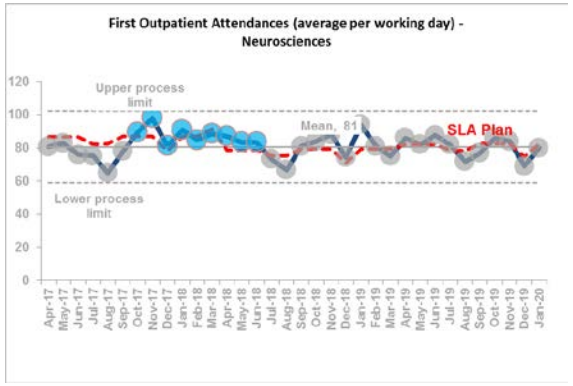
- Activity is tracked weekly to ensure all available slots are utilised. Previous gaps in Consultant workforce are now once again fully established within General Surgery and with a full management team for the first time since April 2019, the service can expect to see improved activity and performance going forward.
- Cardiology working with Care Group Lead and Consultants to paper triage referrals whilst current admin issues are resolved working towards a long term solution. Demand and Capacity analysis to be undertaken for the service.
- Vascular scans that have previously been coded as outpatient activity is now captured under the Patient Outcome Data (POD) of diagnostics. The service has also seen high cancellation rates , the service together with the Care Group Lead and Head of Nursing are reviewing to understand and address the current issues.
- Thoracic – although this is a small service there has been a reduction in the number of referrals received and clinics have not been fully utilised, service are currently investigating reasons as to why this would be.

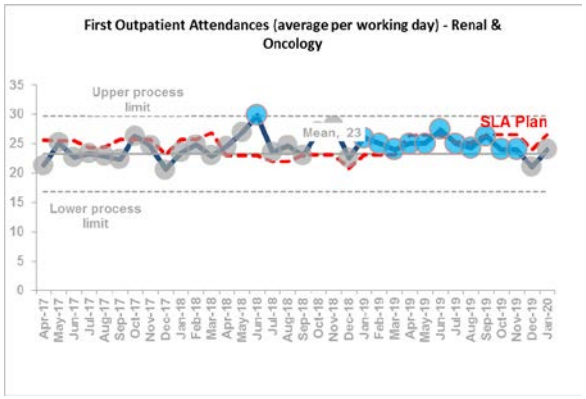
Number of First Outpatient attendances per Working Day

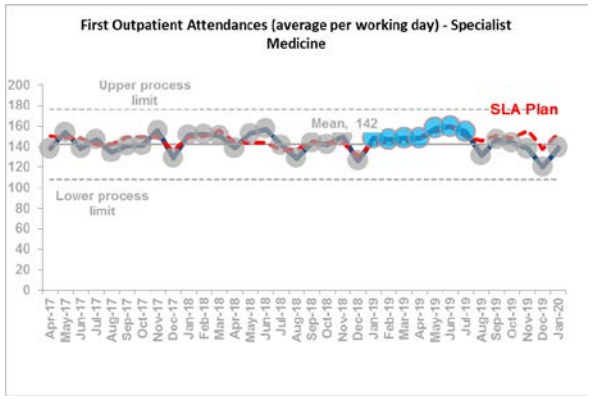
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

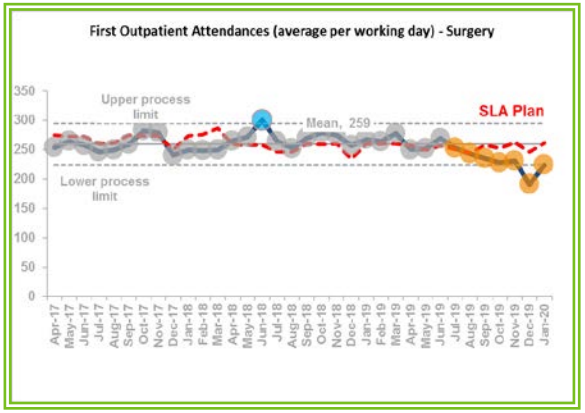


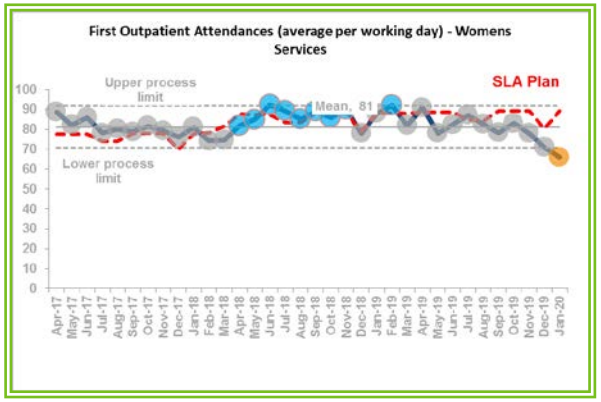


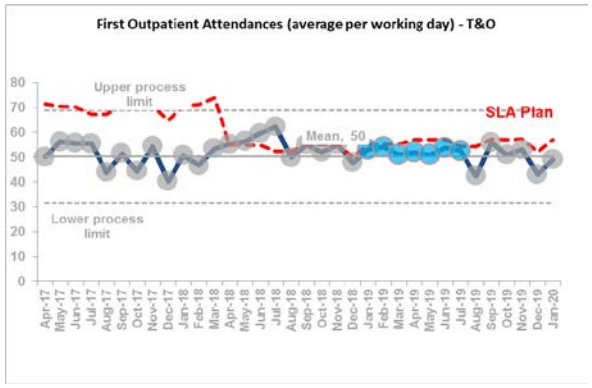






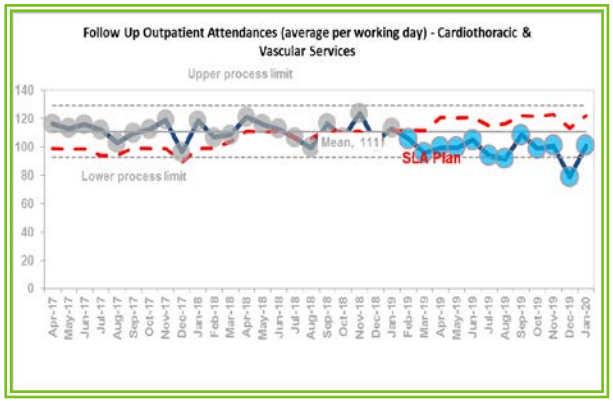


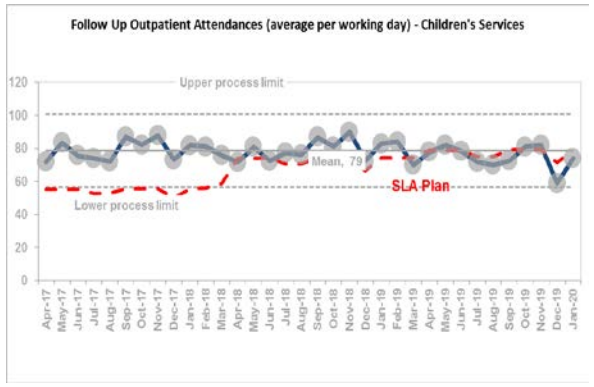


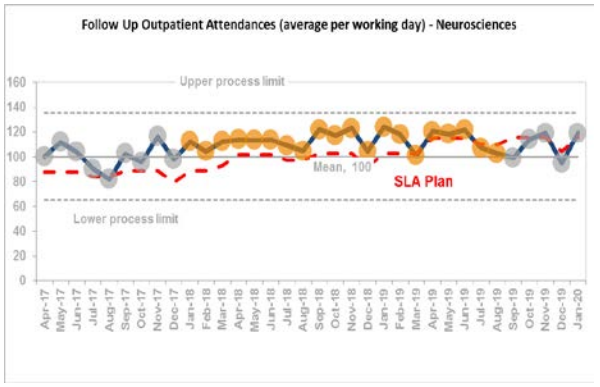


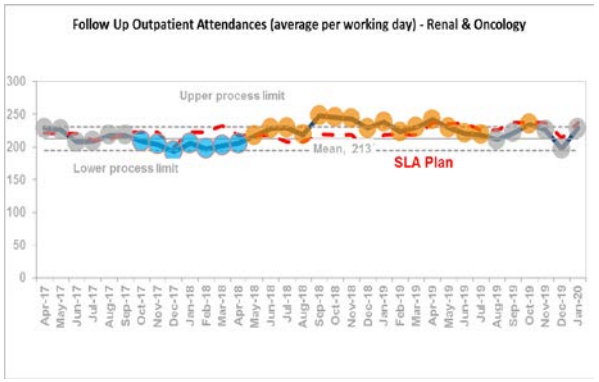
Number of Follow Up Outpatient attendances per Working Day

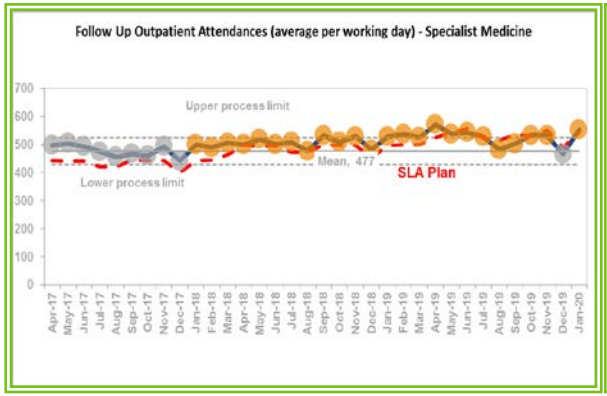
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

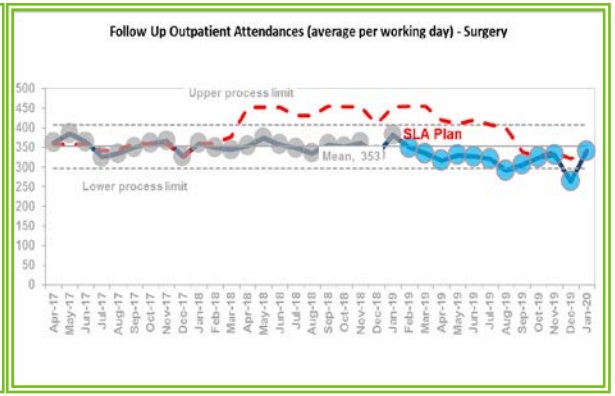


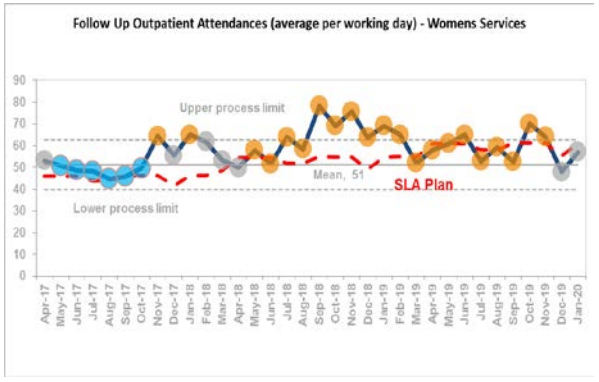


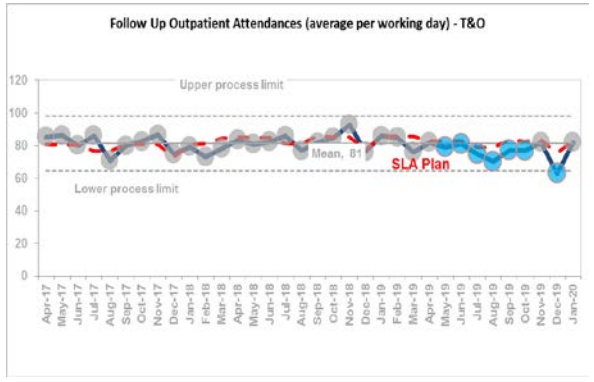






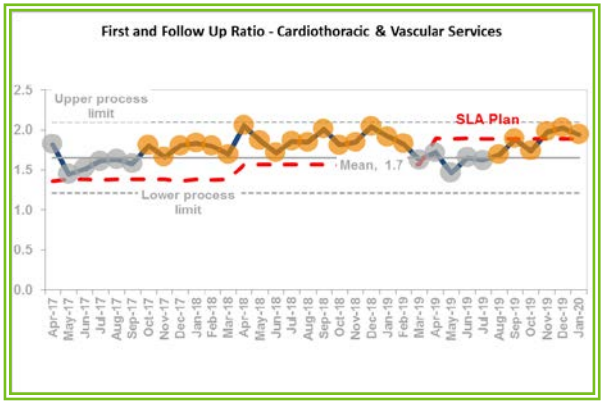


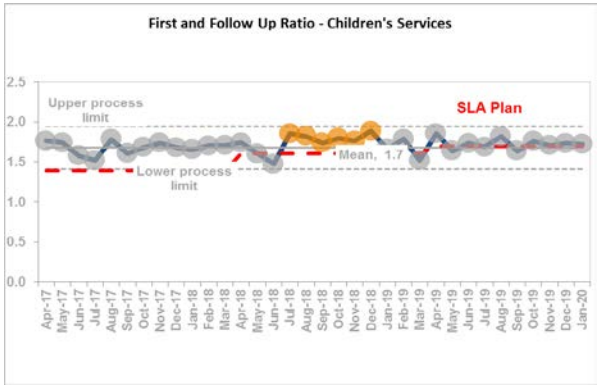


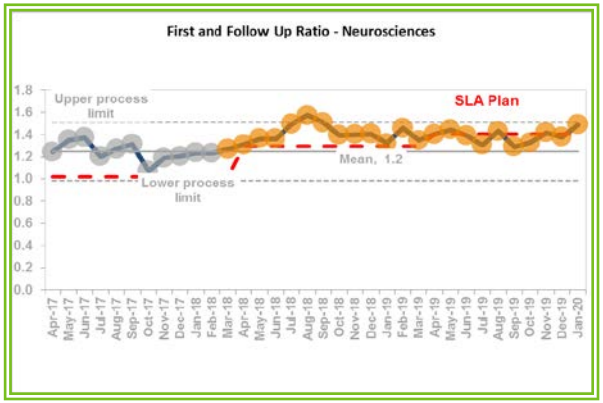


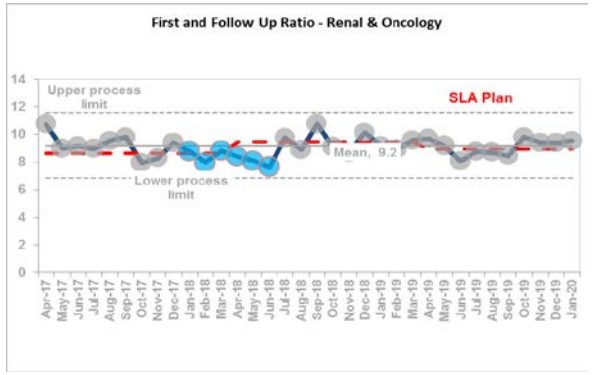
New to Follow Up Ratios

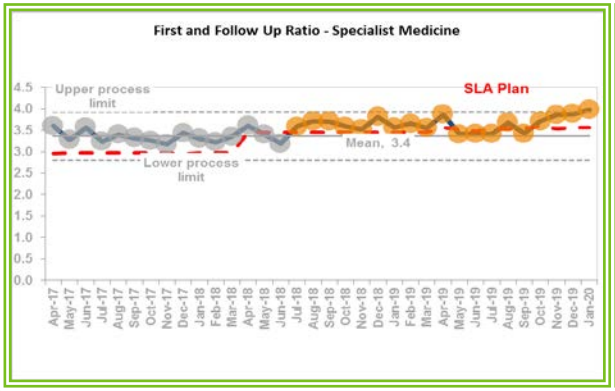
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

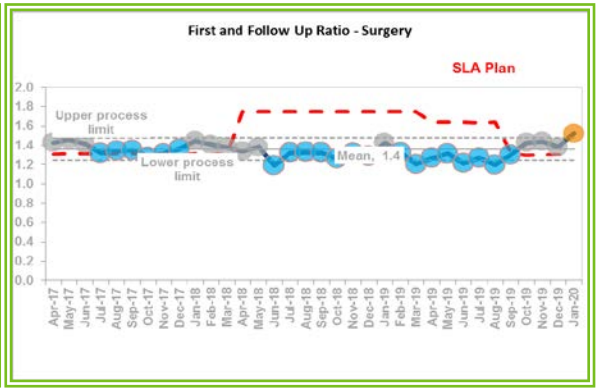


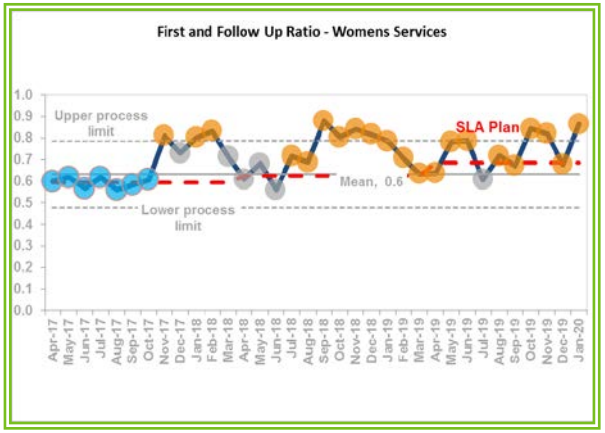


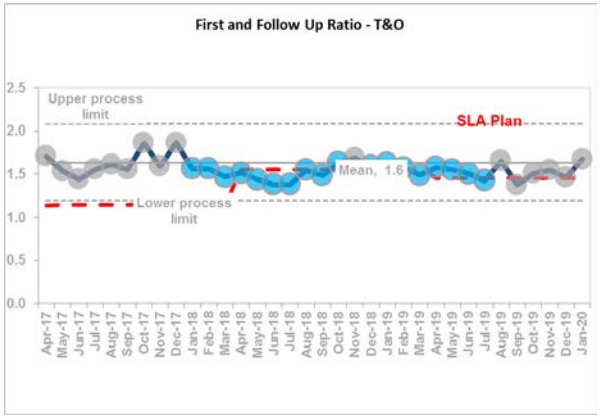








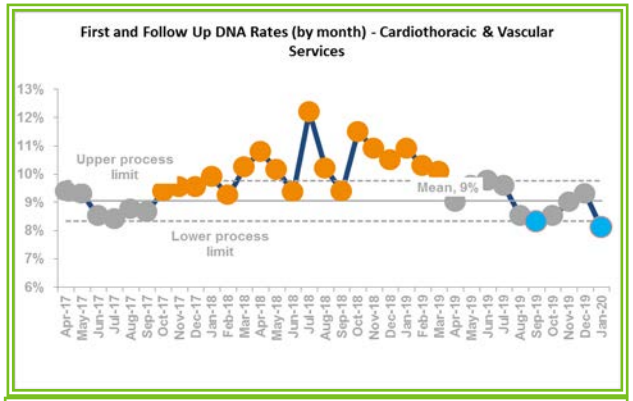


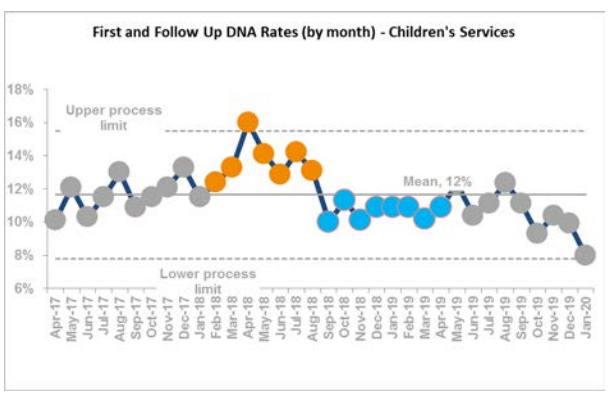


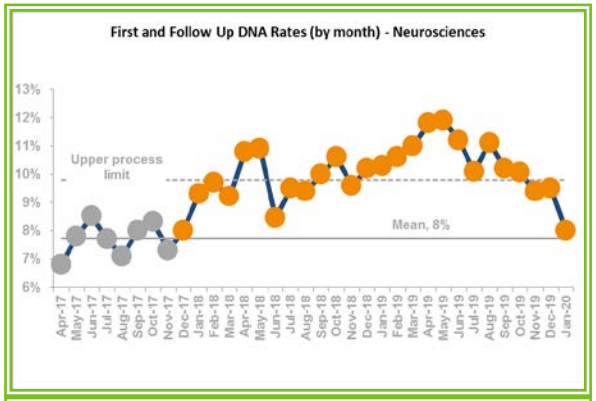
Our Finance & Productivity Perspective

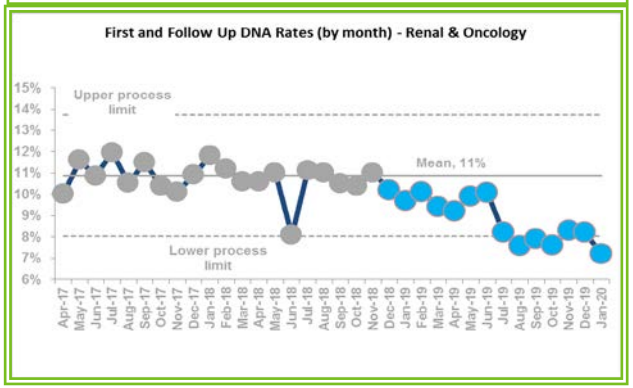
Number of Patients that did not attend

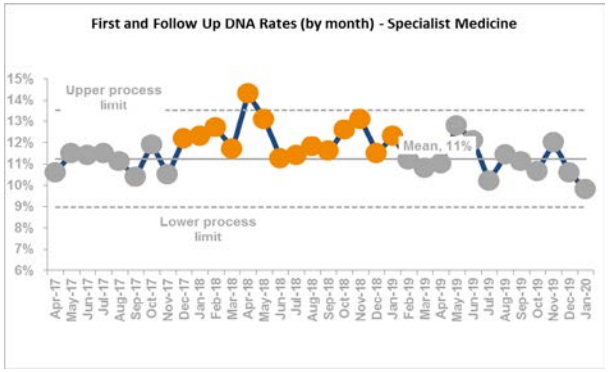
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

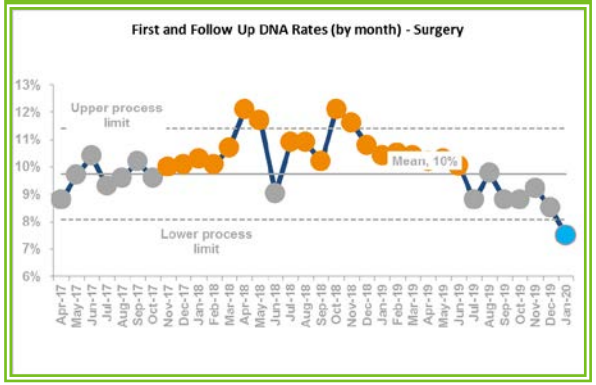


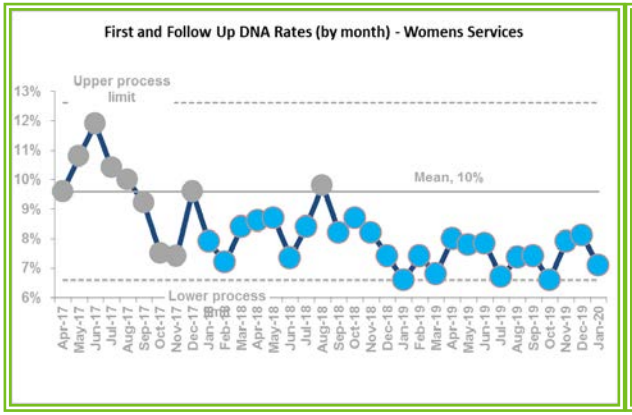


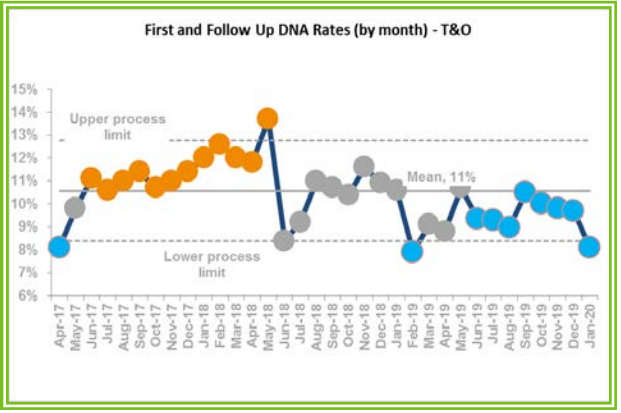


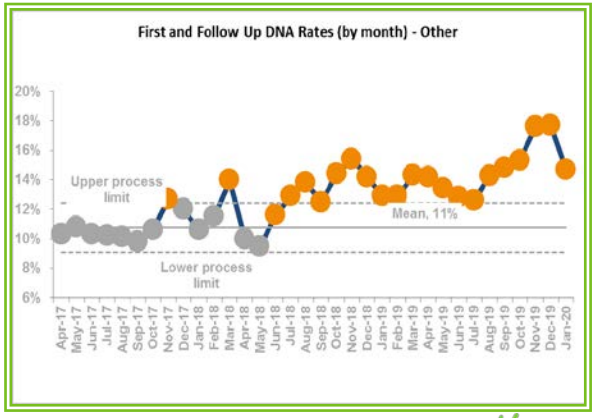








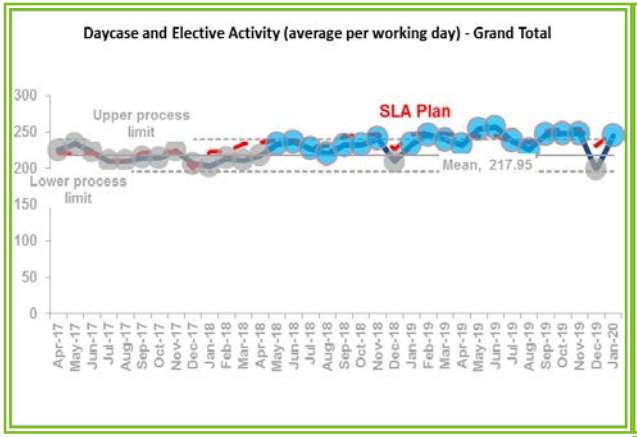


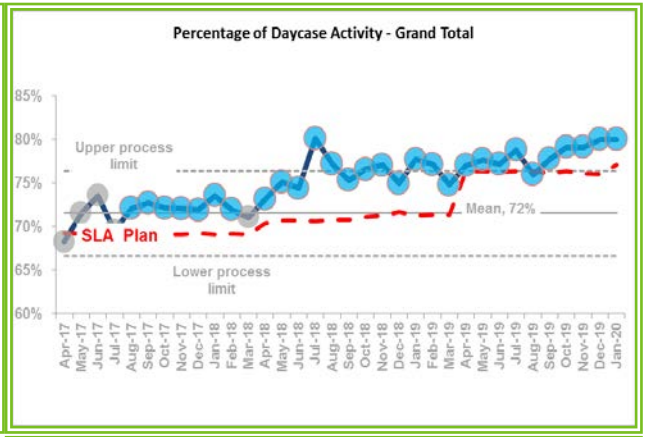


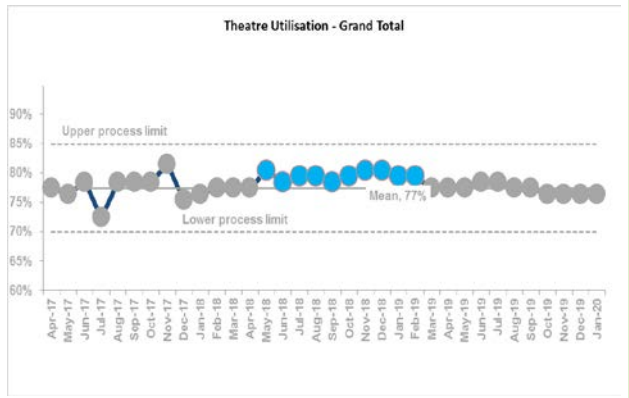
Our Finance & Productivity Perspective

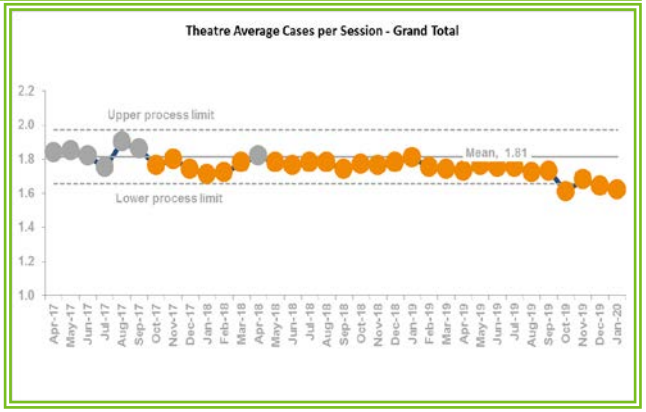
Theatre Productivity

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









Actions and Quality Improvement Projects

- Theatres are ensuring that there is focused work supporting a prompt start to all theatre sessions. This is linked to a weekly task and finish group.
- Agreement and plan to change Theatreman Diagnosis codes (currently SNOMED) to OPCS 4.8 codes which will support more accurate timings of theatre cases and utilisation.
- The Theatre Improvement Programme has been re-launched reviewing the entire admissions pathway, with a focus on patient and staff experience. The change management process is being led by staff in theatres and booking teams.
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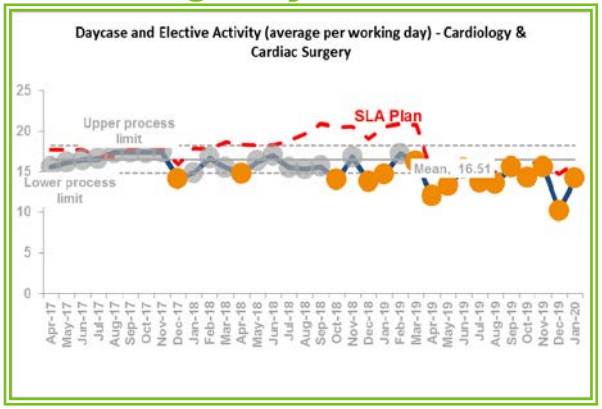
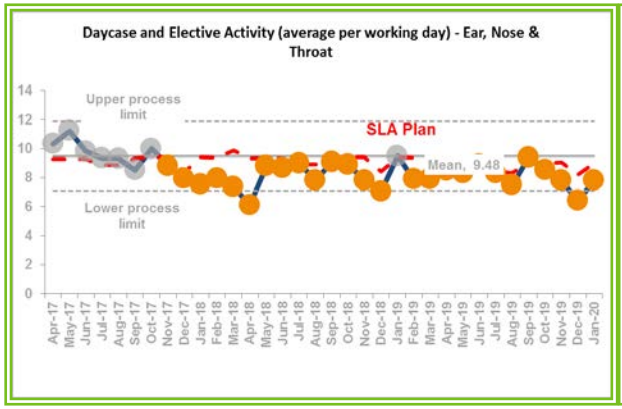
What the information tells us

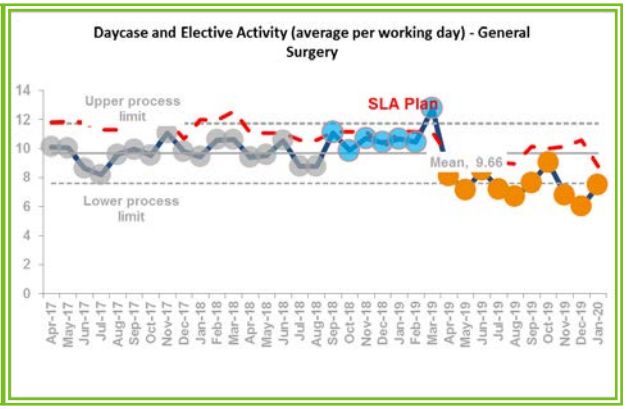
- Activity data for elective treatments has returned to being above the mean for the month of January and is currently below plan year to date of less than 1%. There will be an element of data correction and catch up.
- Cardiology & Cardiac Surgery, General Surgery and Ear Nose and Throat specialties are showing special cause variation as these specialties are below their means for over six months. Neurosurgery activity is slightly below the lower control limit in January.
- All of the other specialties are within their expected process limits with the exception of Neurology and Plastics where the service is performing above the mean and ahead of SLA plan.
- The percentage of daycase activity is currently above the upper control limit at Trust level and performing above target. A number of specialties have seen activity levels consistently above the mean with Oncology, Trauma & Orthopaedics, Plastic Surgery are above the upper control limit.
- The Trust's Cases per Session has fallen below its lower process control limit indicating special cause variation. General Surgery, Plastic Surgery and Neurosurgery continue to see a trend below the mean for a period more than six months.
- The Trust's Theatre utilisation remains within its control limits.

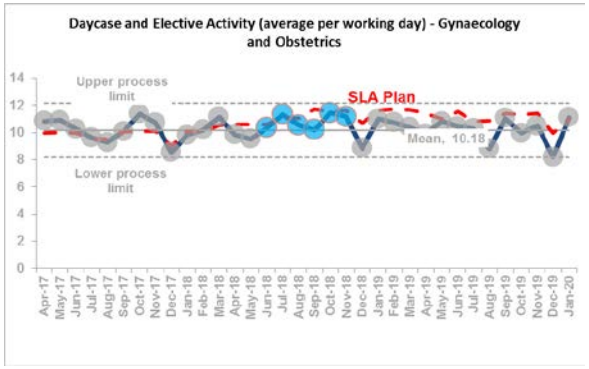
Number of Elective and Daycase Patients treated per Working Day

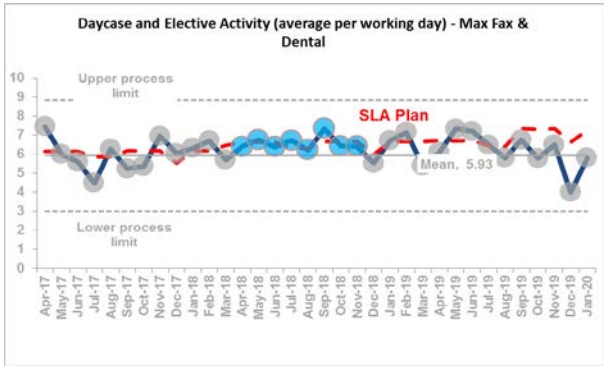
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

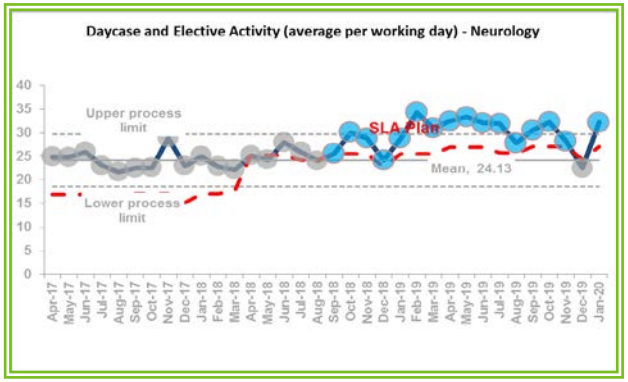


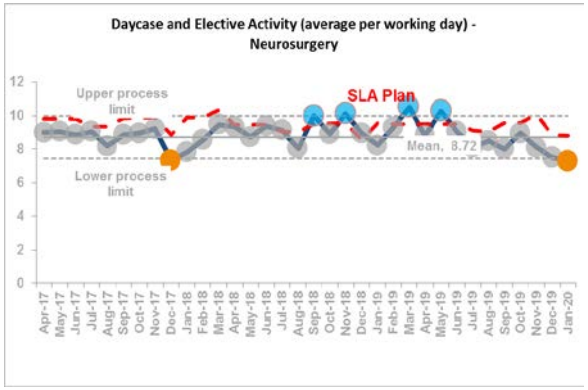


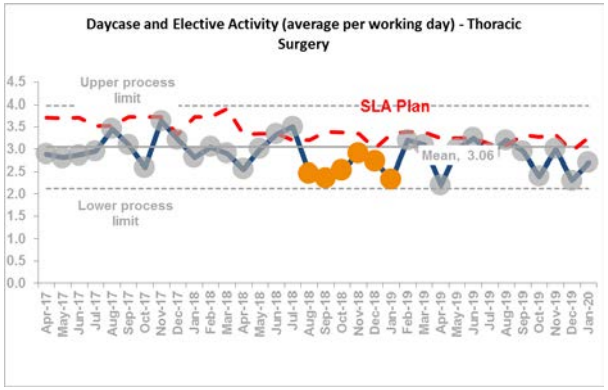


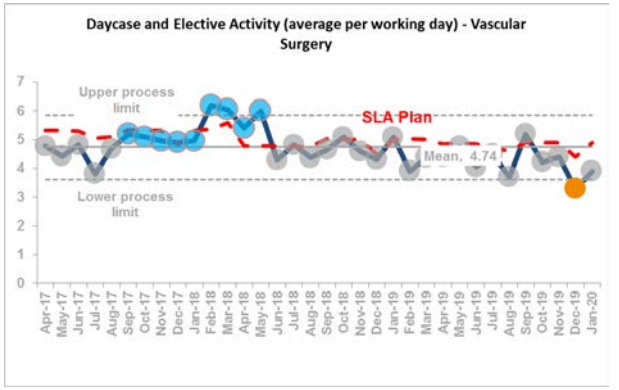






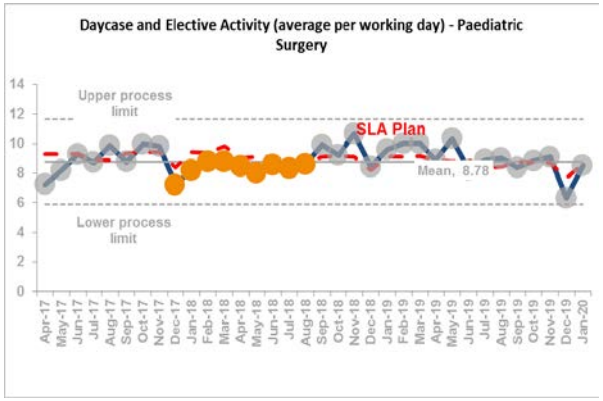


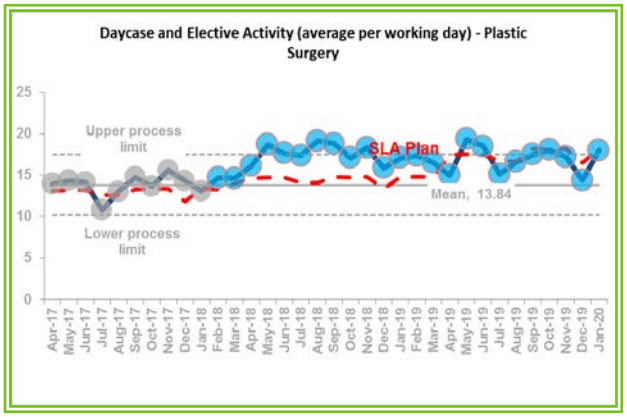


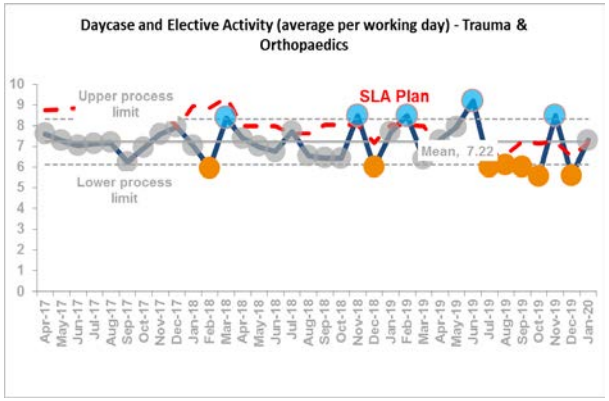


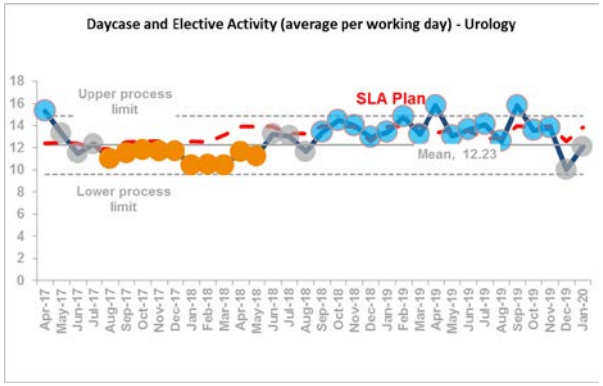
Number of Elective and Daycase Patients treated per Working Day

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





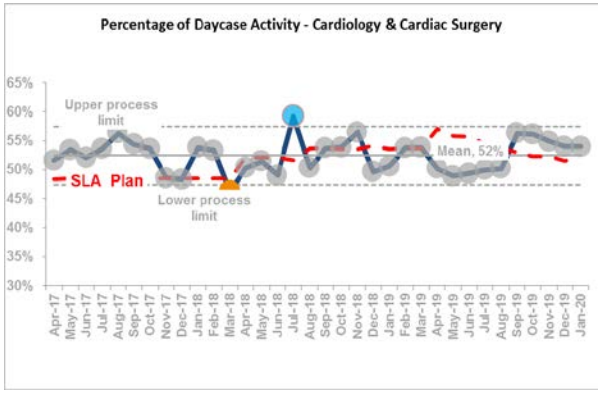


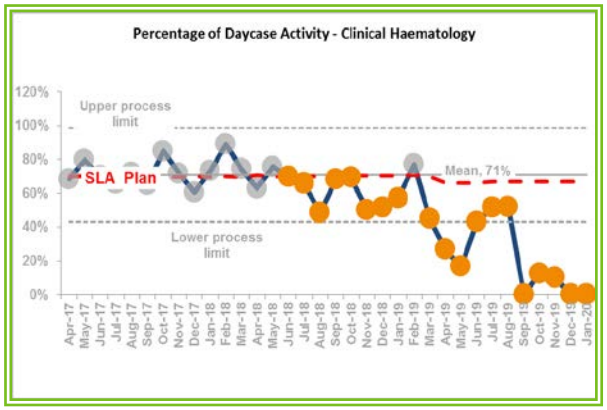


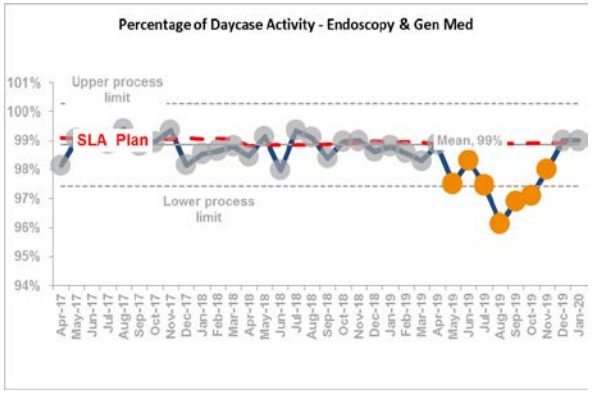
Our Finance & Productivity Perspective

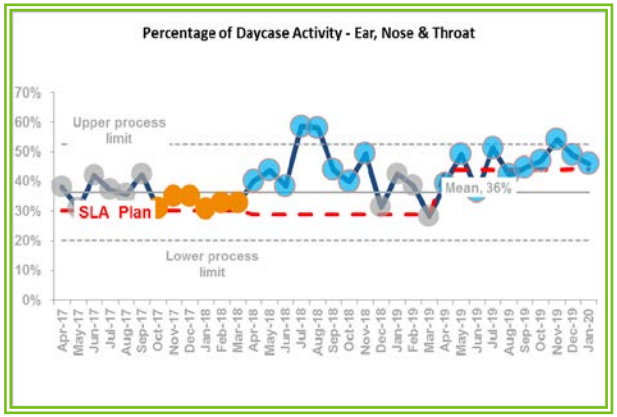
Percentage of daycase activity

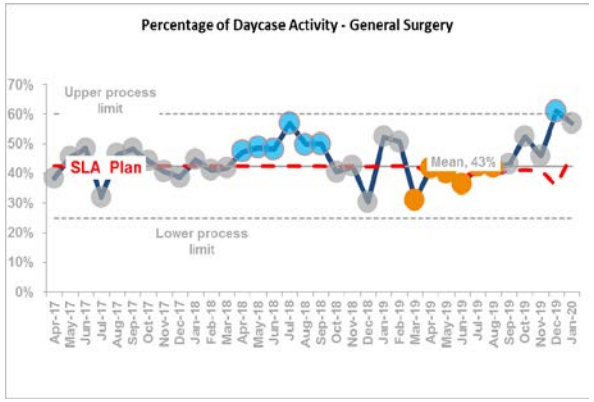
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

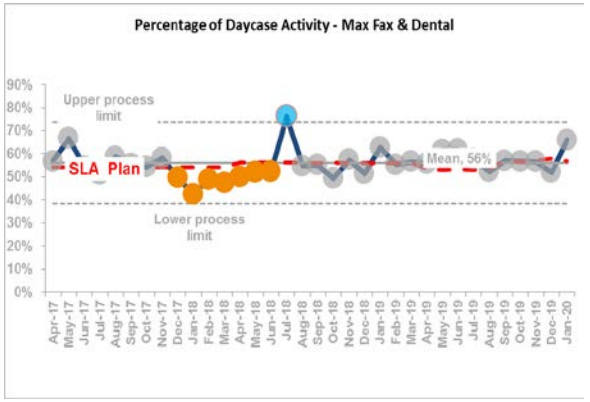


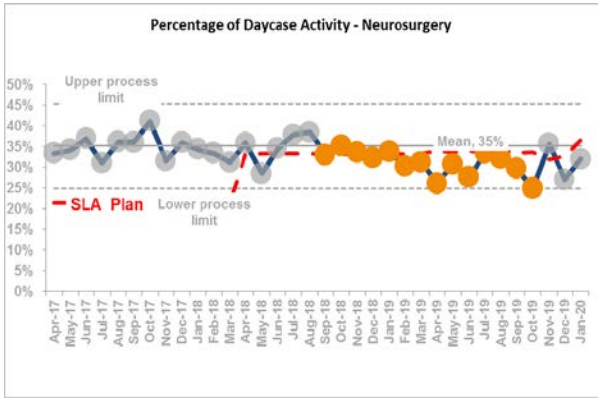


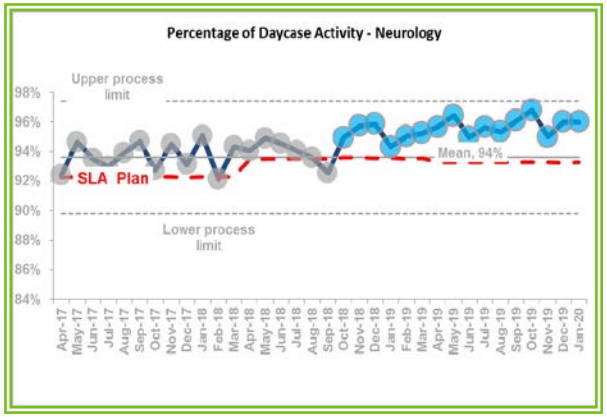


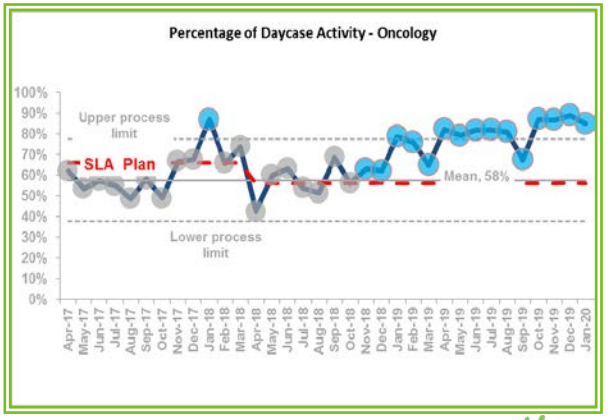






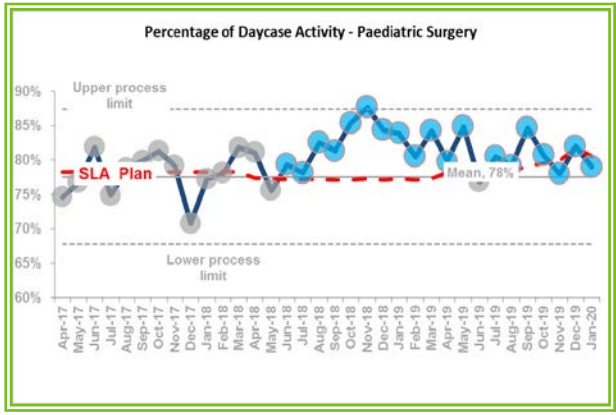


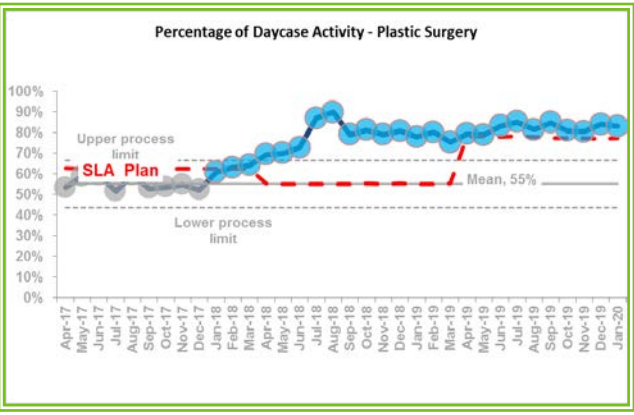


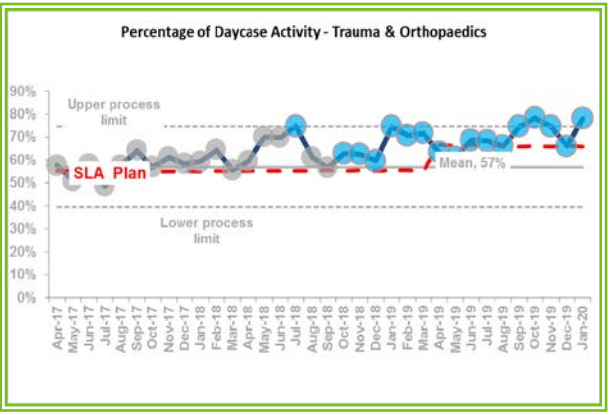


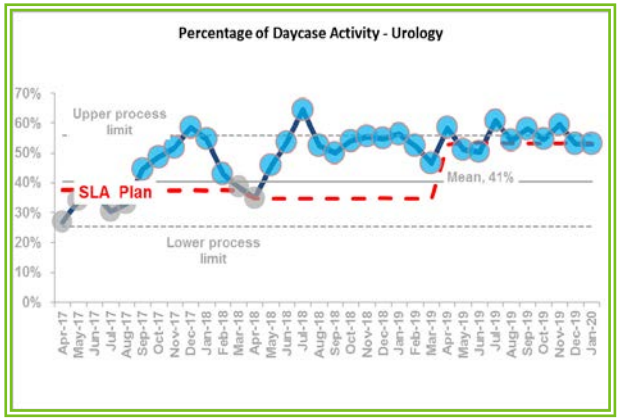
Percentage of daycase activity

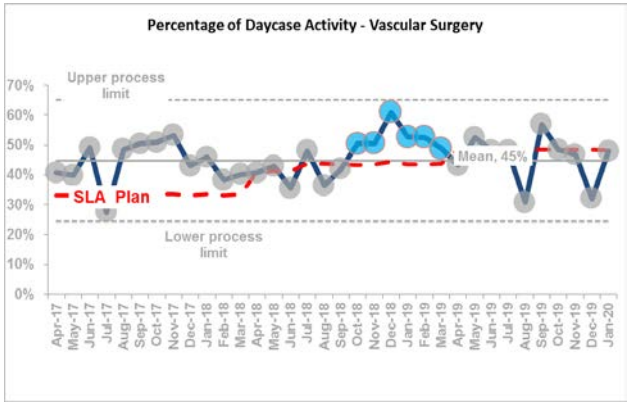
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance





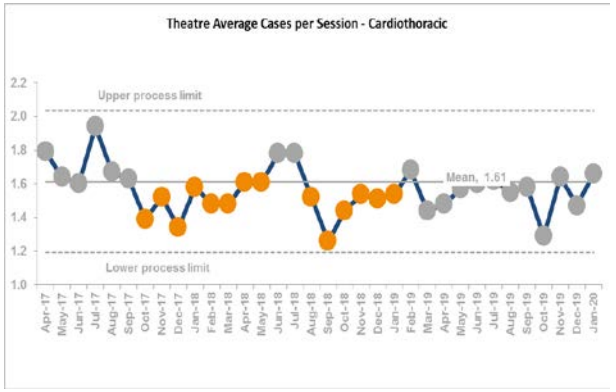


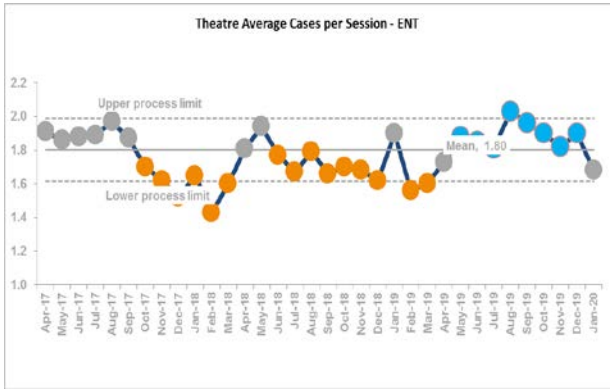


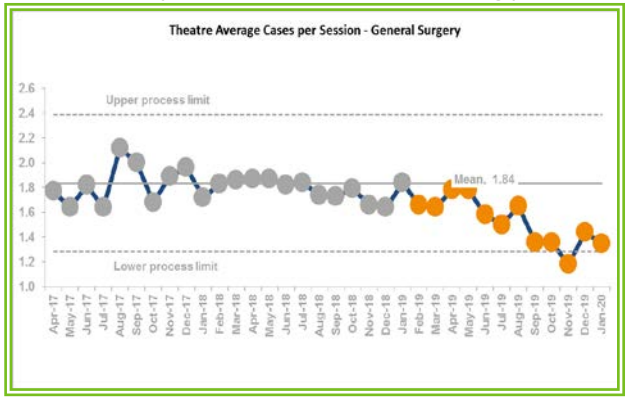


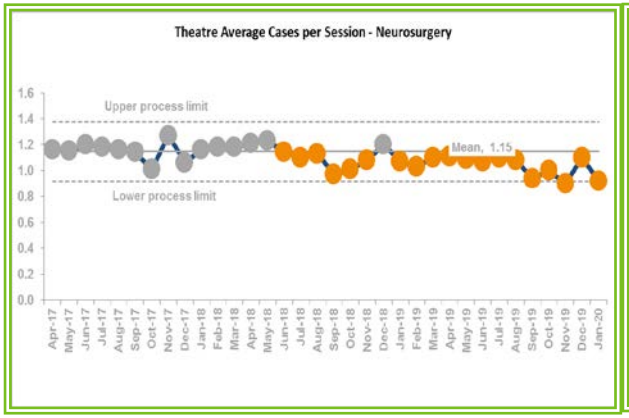
Theatre productivity – Cases per Session

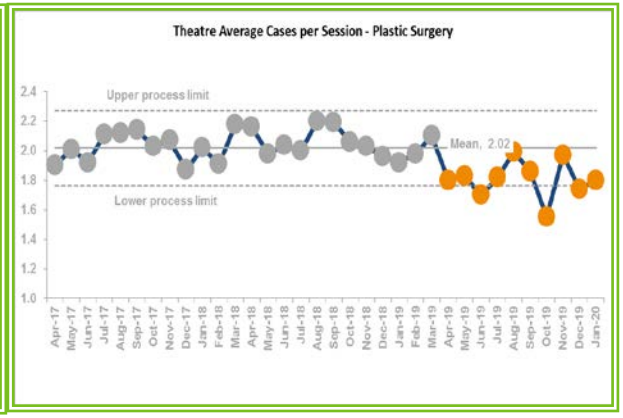
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

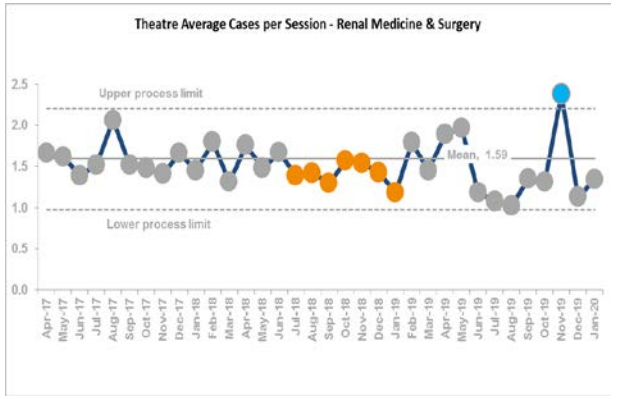


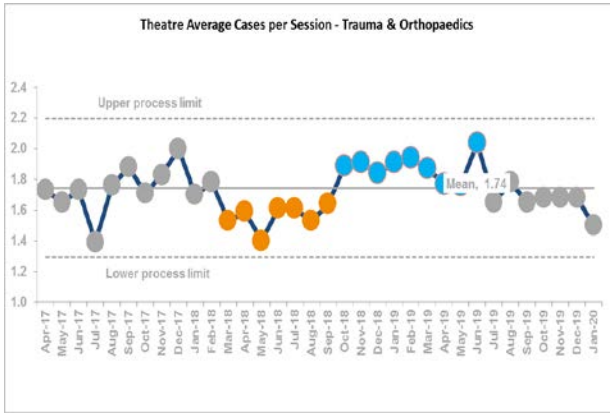


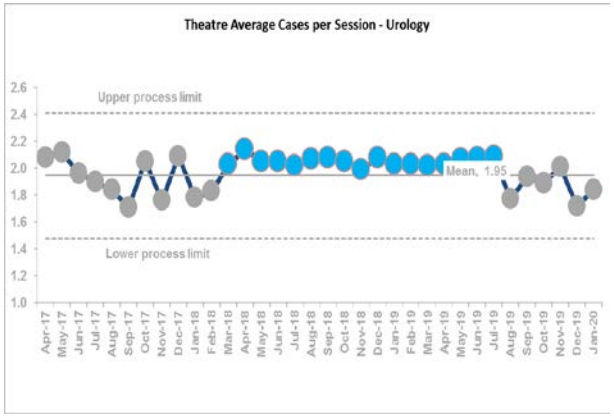


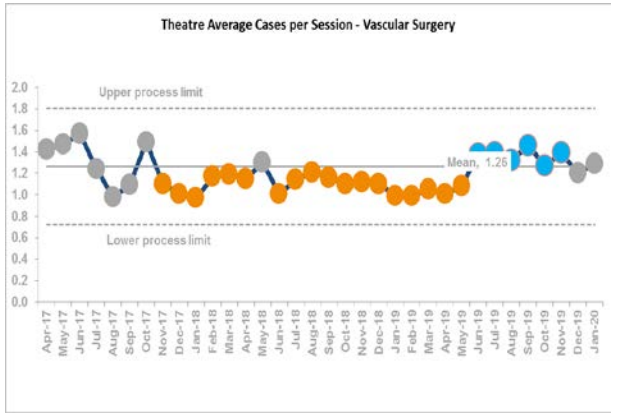






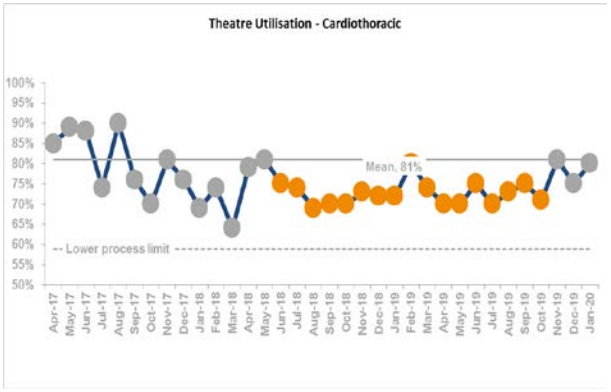


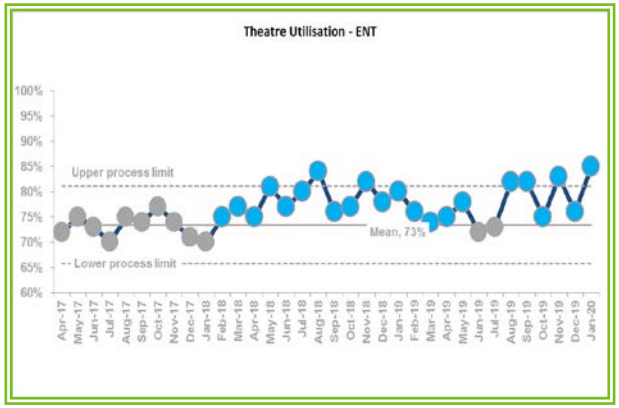


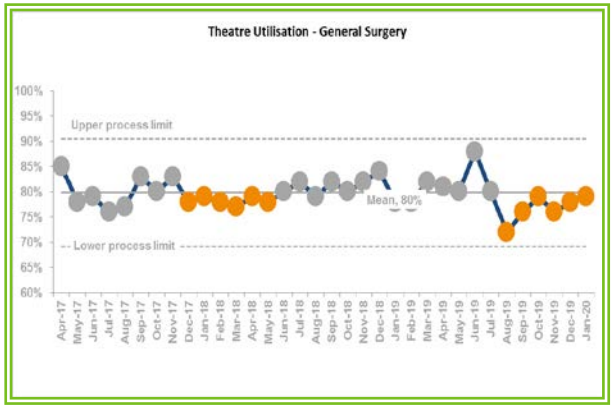


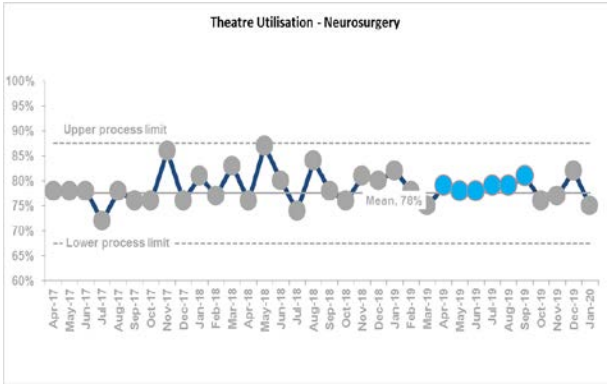
Theatre productivity – Utilisation

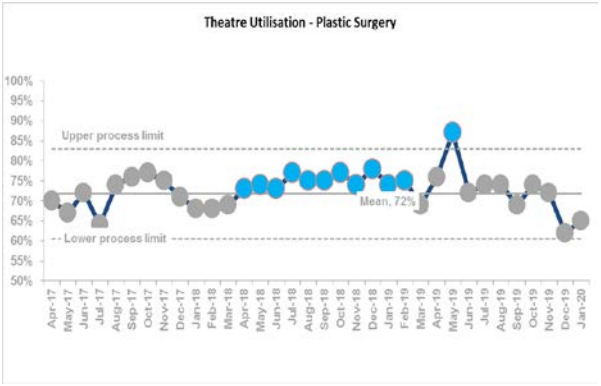
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

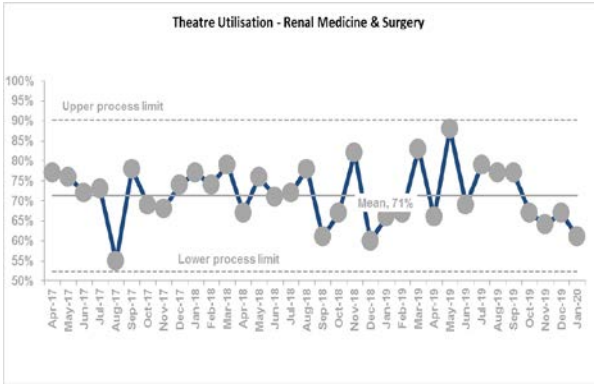


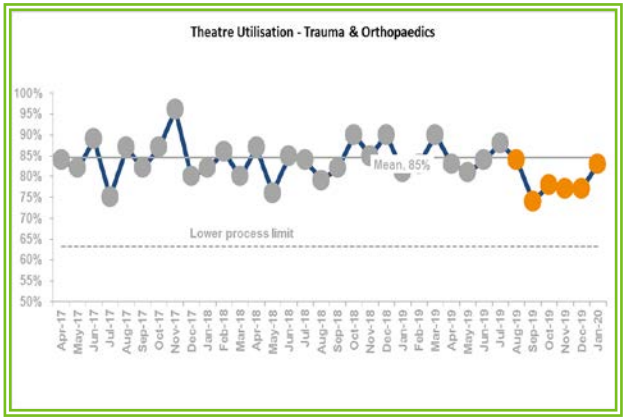


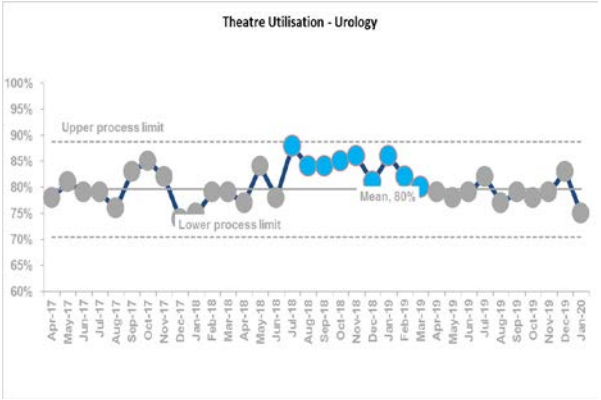


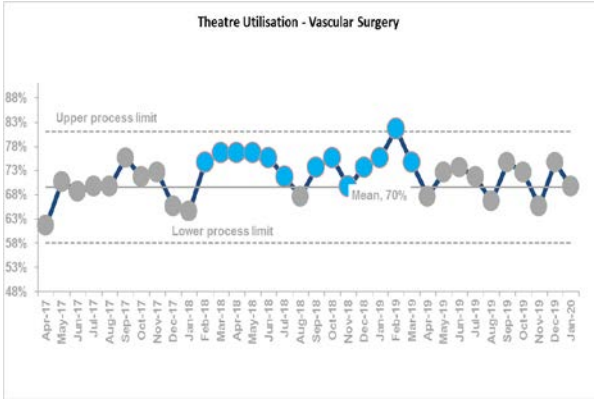




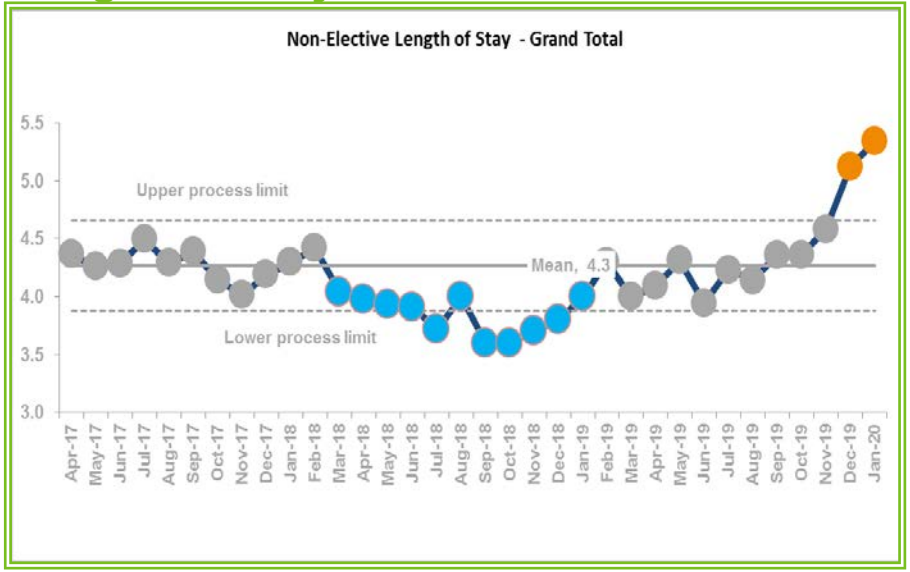


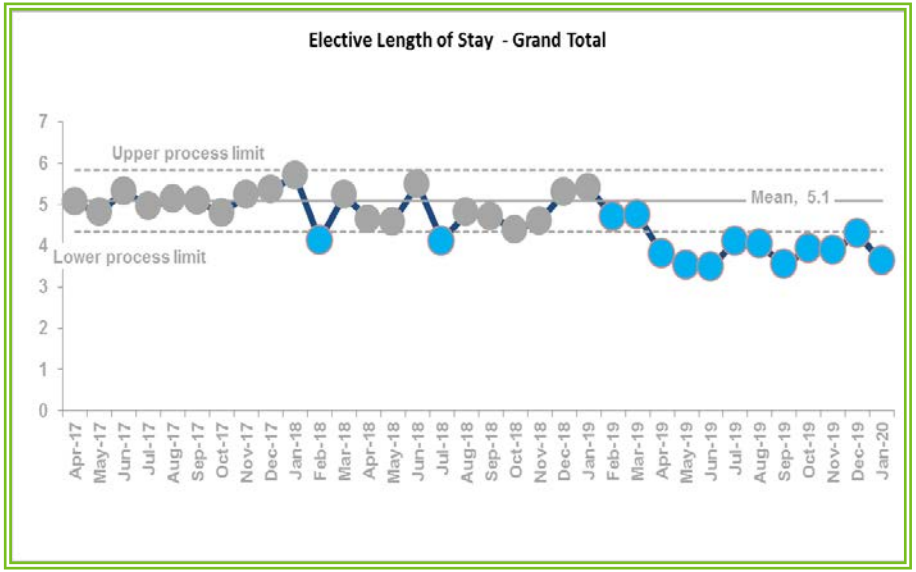






Length of Stay





What the information tells us

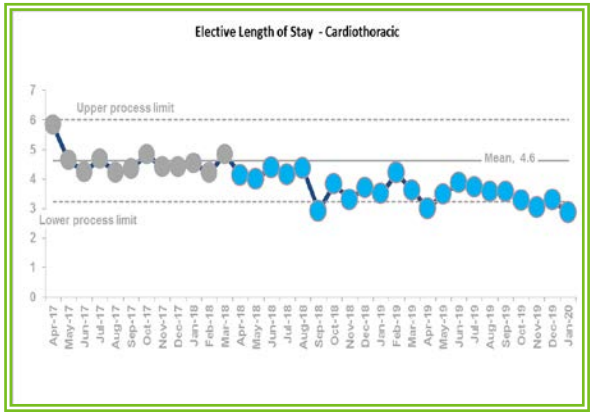
- The Trust's Non-Elective length of stay continues to show special cause variation with an increase above the upper control limit in the month of December and January.
- The increase is primarily seen within Acute Medicine where there has been a reduction in the number of patients with a zero length of stay due to a change in pathway within the emergency department therefore affecting the number of patients admitted for short stay. Special cause variation has also been seen within Senior Health in the month of January increasing to an average of 24 days.
- The average number of patients in a hospital bed with a long length of stay has increased in the reporting period and continues to perform above the mean.
- The Trust's overall elective length of stay continues to perform below its lower control limit showing a sustainable improvement.

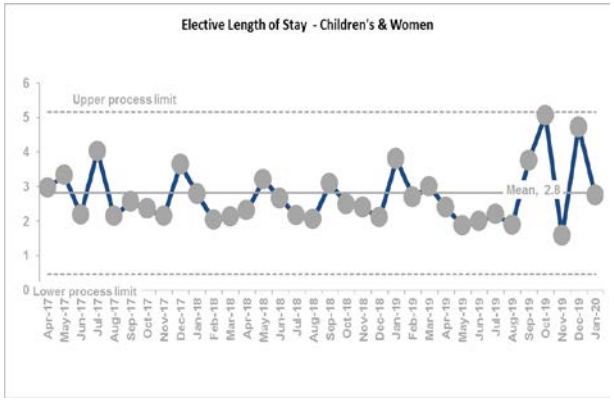
Actions and Quality Improvement Projects

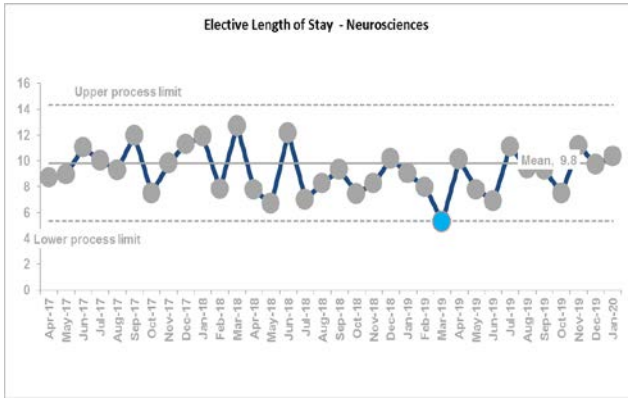
- Established long length of stay meetings to prioritise and manage appropriate system wide actions for each patient with on-going attendance by both Wandsworth and Merton Commissioning Groups
- Trust held a multi-disciplinary event with system partners (social services and community providers) on 15 January 2020 focusing on long length of stay patients in the Trust which resulted in 61% of patients either discharged or moved to the right place of care.
- Additional support, coaching, refining of processes, early identification of delays and escalation actions are actively being managed on a daily basis on seven key wards.
- Senior Managers from Acute Medicine and Senior Health wards continue to attend board rounds to support and take away internal delay actions.

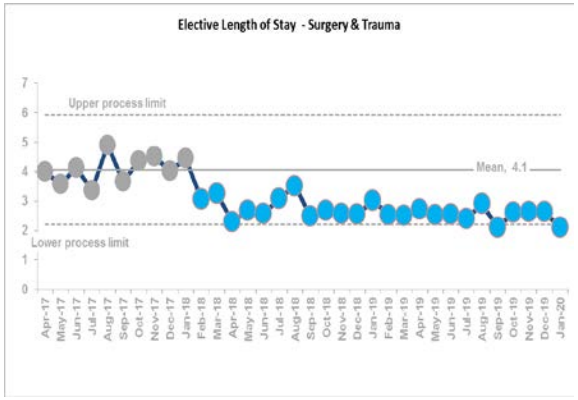
Elective Length of Stay (excluding daycase)

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



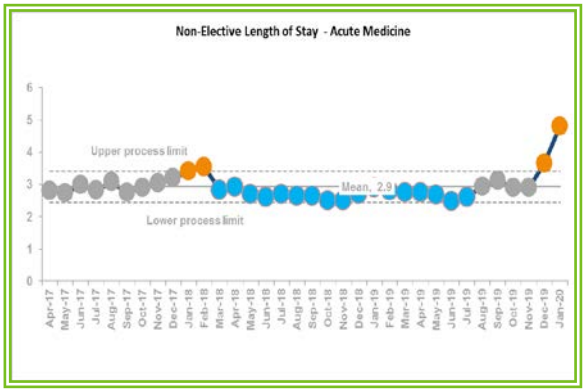


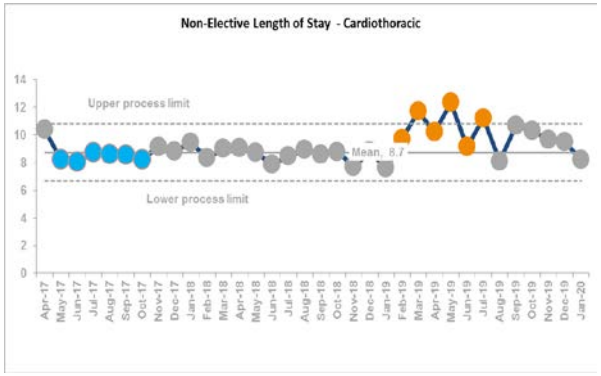


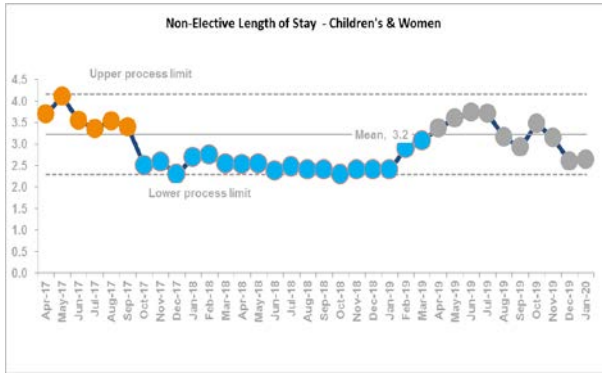


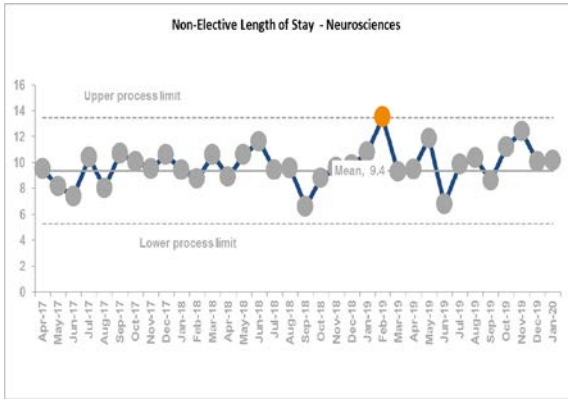
Non Elective Length of Stay

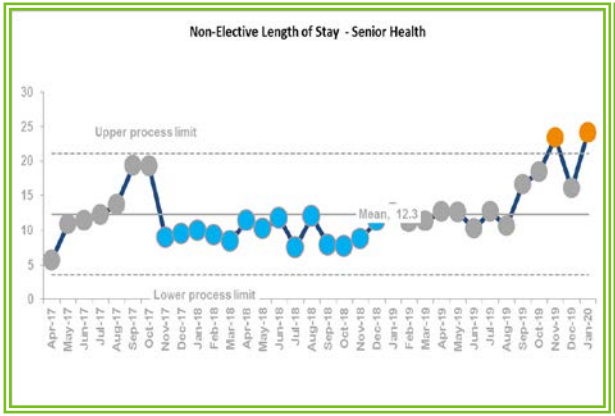
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

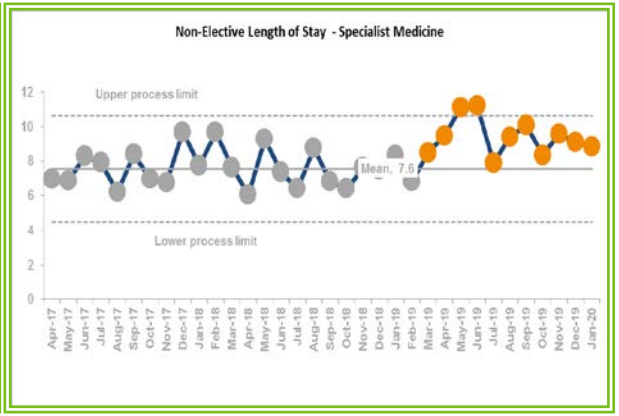


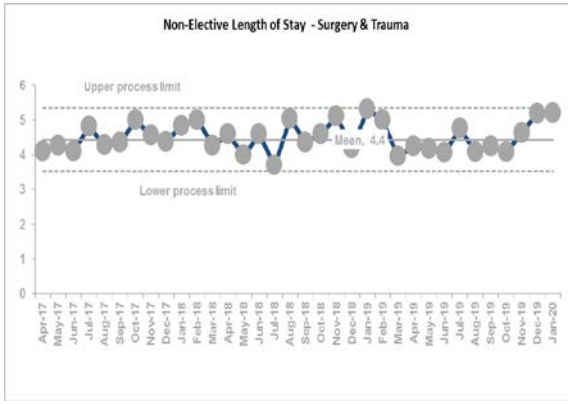


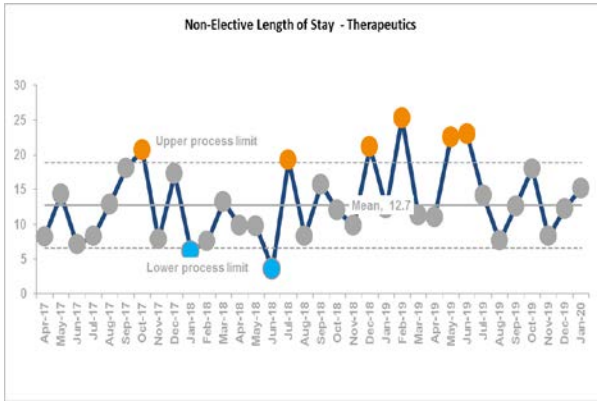












Our Finance & Productivity Perspective

Balanced Scorecard Approach

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

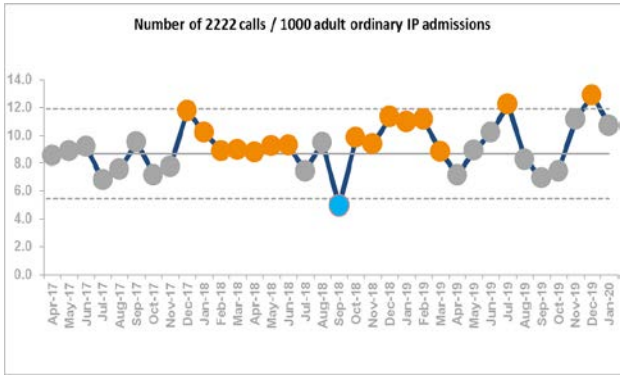
Key

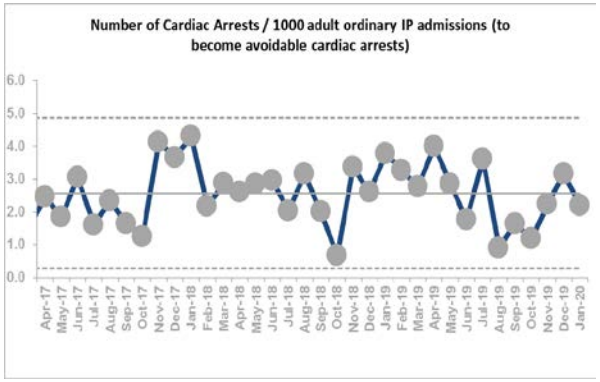
Current Month

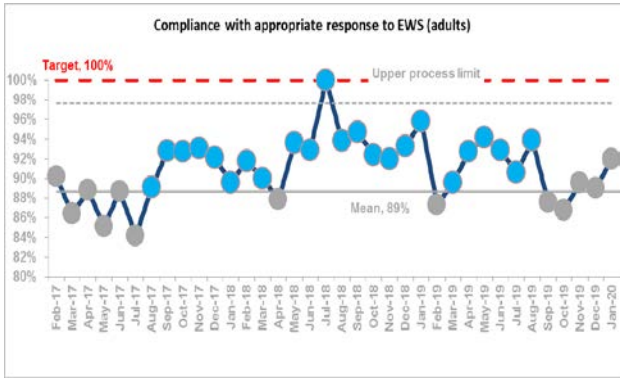
A Previous Month

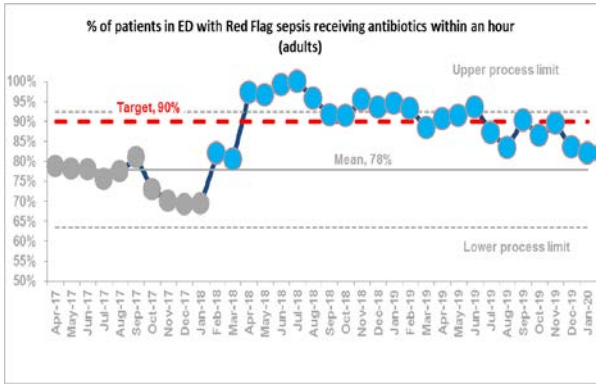
Our Patient Perspective

Quality Priorities – Treatment Escalation Plan









What the information tells us

- The number of 2222 calls is within common cause variation.
- The Trust position of treating at least 90% of adult patients in Emergency Department with Red Flag Sepsis receiving antibiotics within an hour was 82% in January and is within control limits.
- Compliance with appropriate response to Early Warning Score (EWS) saw an increase in performance

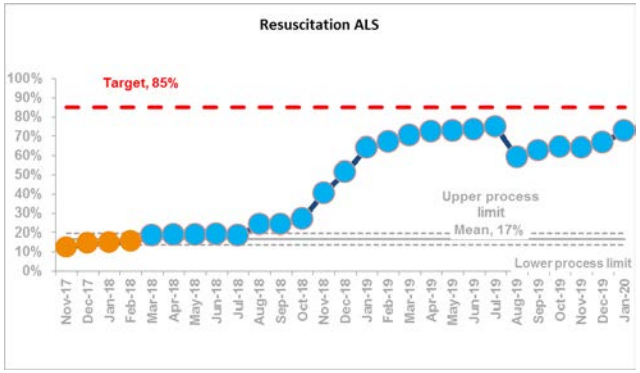
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

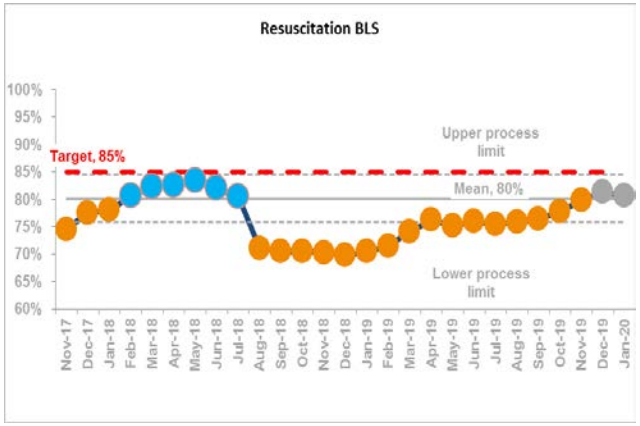
Actions and Quality Improvement Projects

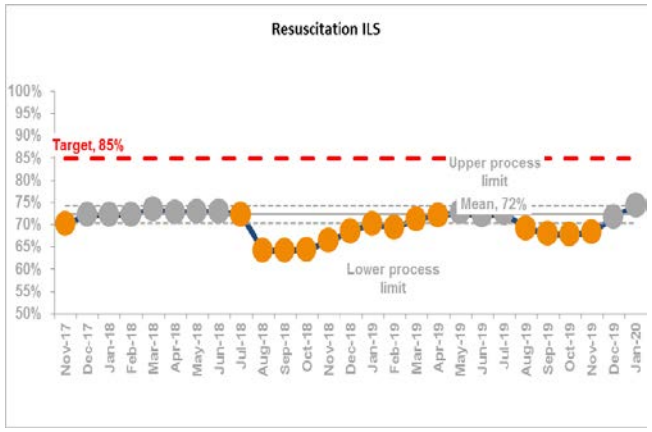
- The team continue to work with IT to implement Treatment Escalation Plans in iClip.

Our Patient Perspective

Quality Priorities – Deteriorating Patients







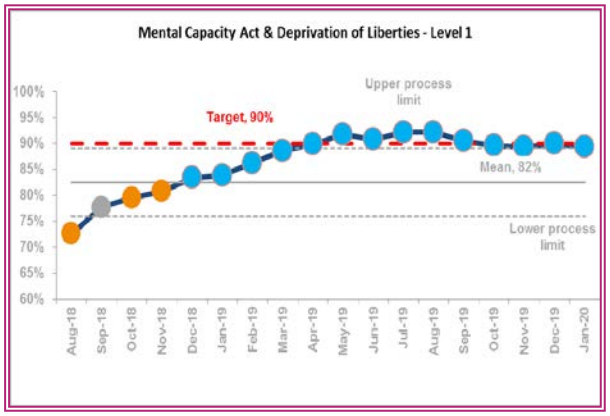
- ALS (Advanced Life Support) training performance shows improved performance but has not met the 85% performance target.
- BLS (Basic Life Support) and ILS (Intermediate Life Support) training performance is within the process control limits but continue to underperform against the 85% performance target

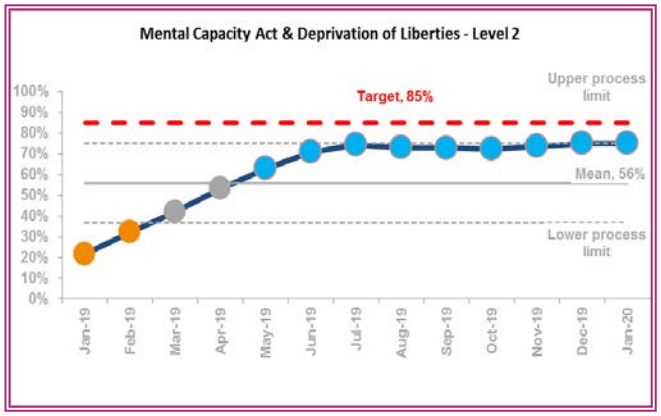
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

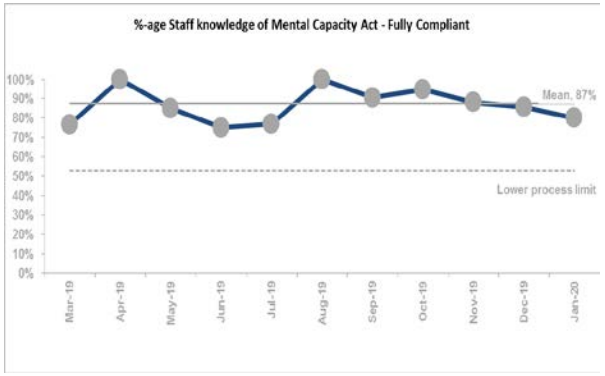
Actions and Quality Improvement Projects

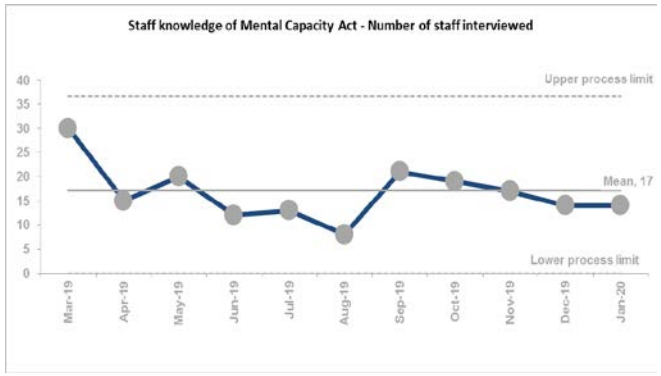
- The matron for the Outreach Team has been recruited to post.
- The Outreach team is working with Information Technology Department (IT) to get a whole Trust view of patients with National Early Warning Scores (NEWS) scores greater than 5 which will enable the team to be more pro-active

Quality Priorities – Mental Capacity Act & Deprivation of Liberties









What the information tells us

- Mental Capacity Act and Deprivation of Liberties Training – Level 1 remains within target
- Level 2 training performance has plateaued.
- Metrics taken from the ward accreditation system shows the number of staff interviewed and their level of knowledge. Of the 14 staff interviewed in January, 80% could fully answer the question on MCA/DoLs.

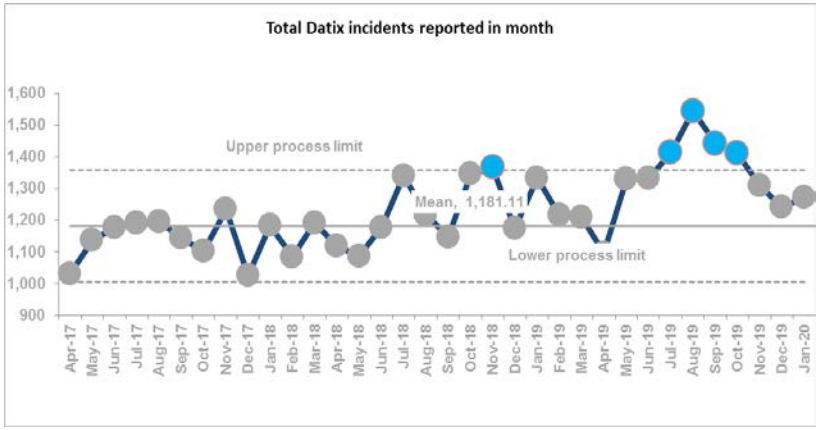
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

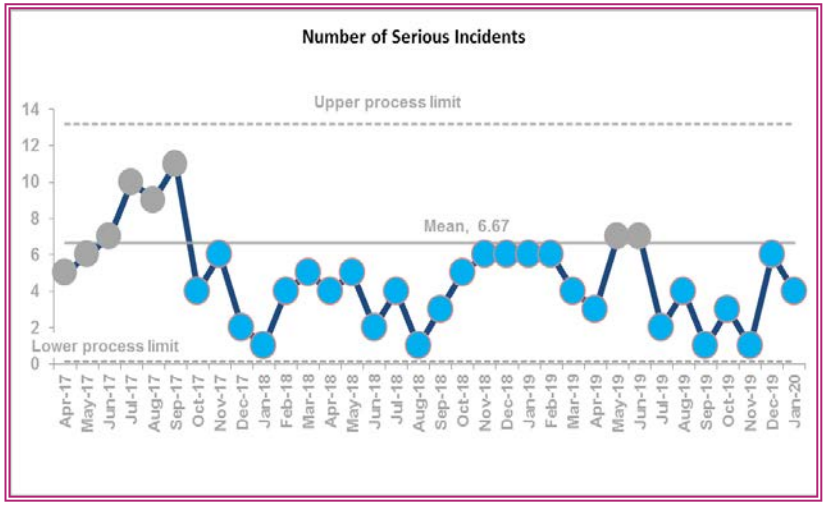
Actions and Quality Improvement Projects

- The team are awaiting IT implementation of required forms to standardise recording and enable efficient audit processes.
- The Trust is launching a quarterly staff knowledge audit in February. This audit was developed in partnership with South West London partners and will enable the Trust to benchmark itself with local organisations.
- An MCA & DoLs lead was appointed and will start on 17 February 2020.

Quality Priorities – Learning from Incidents

Indicator Description	Threshold/Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Total Datix incidents reported in month		1,333	1,215	1,208	1,096	1,329	1,332	1,413	1,544	1,442	1,410	1,309	1,241	1,271
Monthly percentage of incidents of low and no harm					97.0%	97.0%	99.0%	97.0%	98.0%	97.0%	97.0%	96.0%	96.0%	data one months in arrears
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%				100.0%	92.0%	100.0%	97.0%	93.0%	97.0%	97.0%	98.0%	data two months in arrears	





What the information tells us

- Serious Incident (SI) investigations are being completed in line with external deadlines, 60 working days.
- The number of reported adverse incidents remains constant, with 96% of those reported in December 2019 resulting in no / low harm.
- There was one Never Event in January 2020.

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

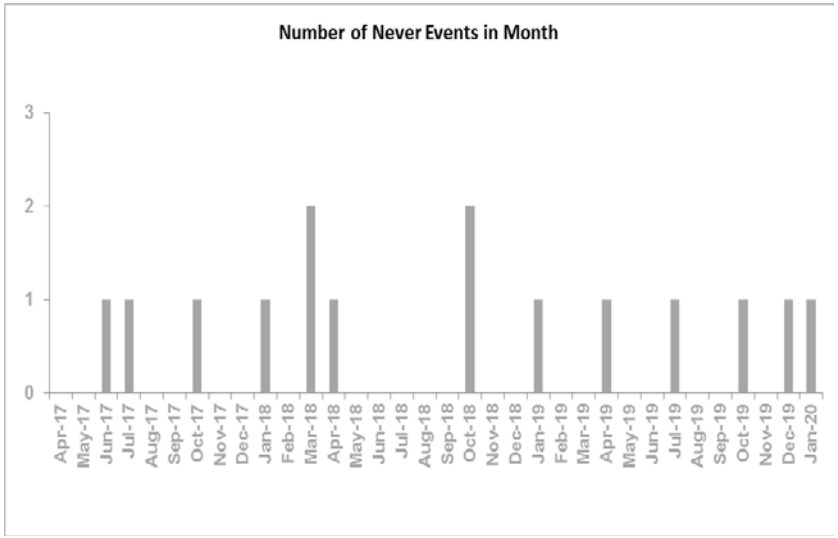
Actions and Quality Improvement Projects

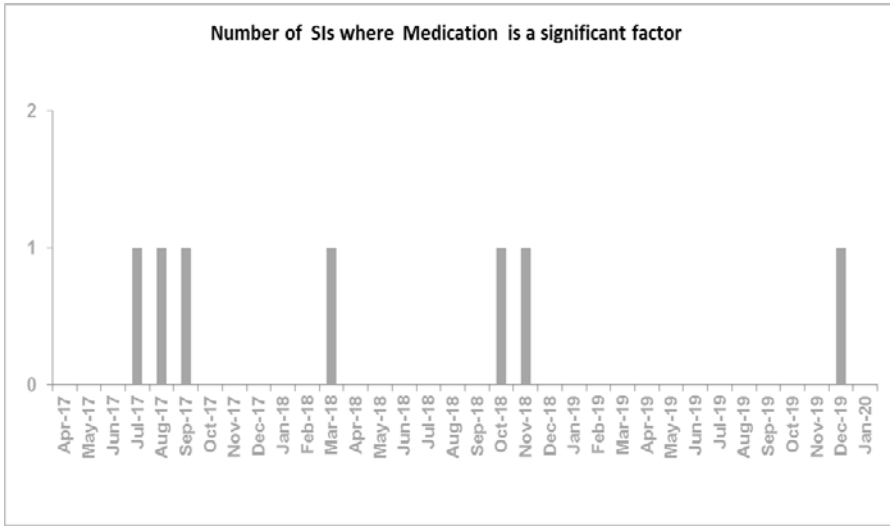
- Incidents – The monthly percentage of incidents of low and no harm is now being reported. This will allow for benchmarking against other Trusts and tracking of the harm profile.

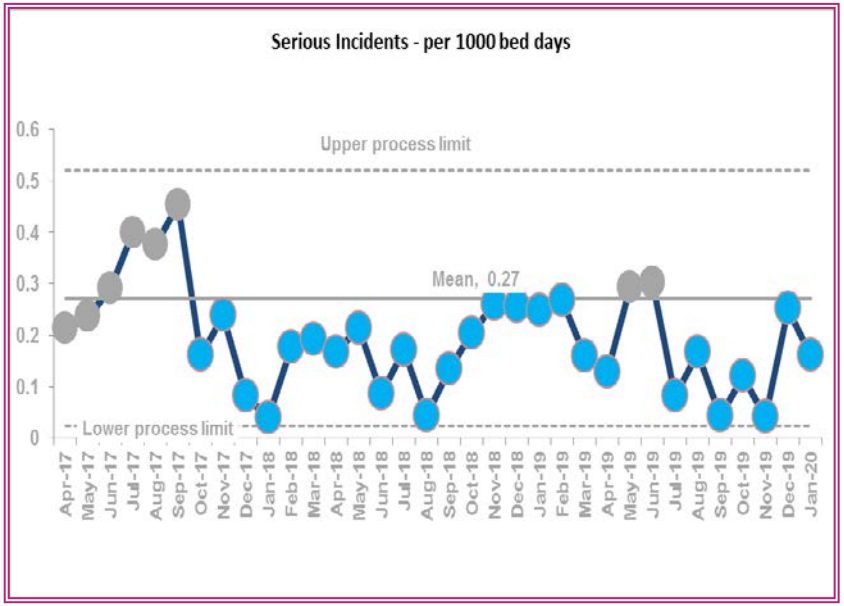
- Never Event – The serious incident investigation has commenced. Support will be provided to staff involved in this incident as best as possible and emphasise the importance of learning from this event

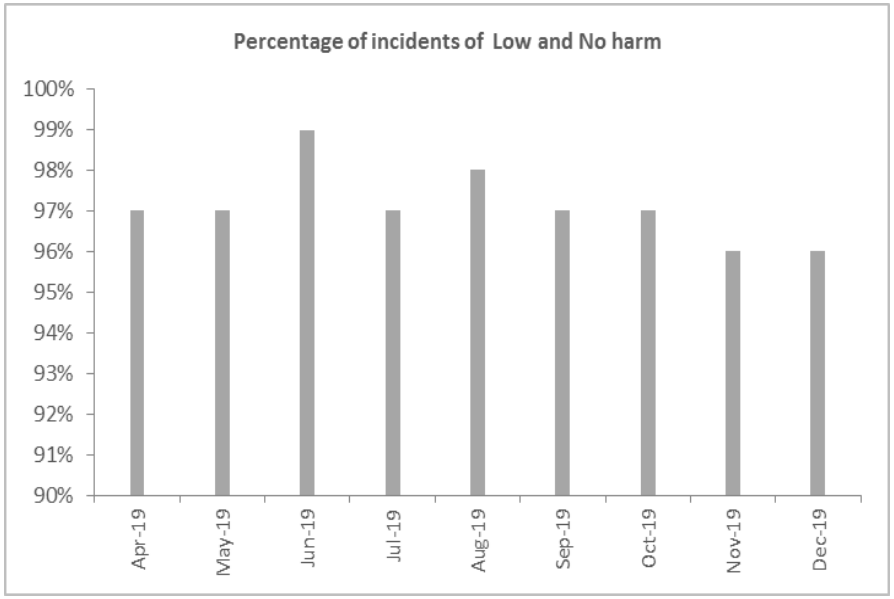
Quality Priorities – Learning from Incidents

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



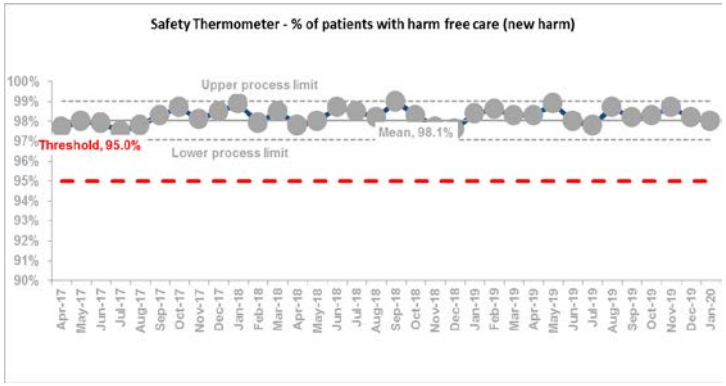


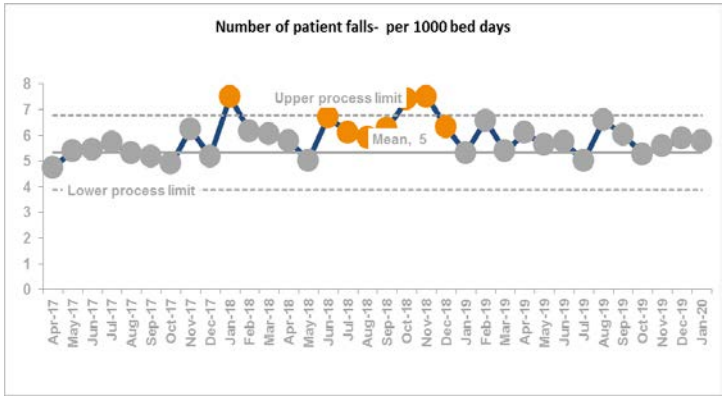


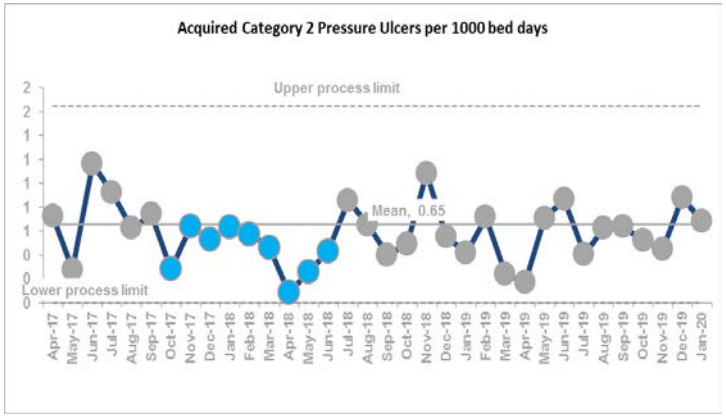


Data is 1 month in retrospect

Patient Safety







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

What the information tells us

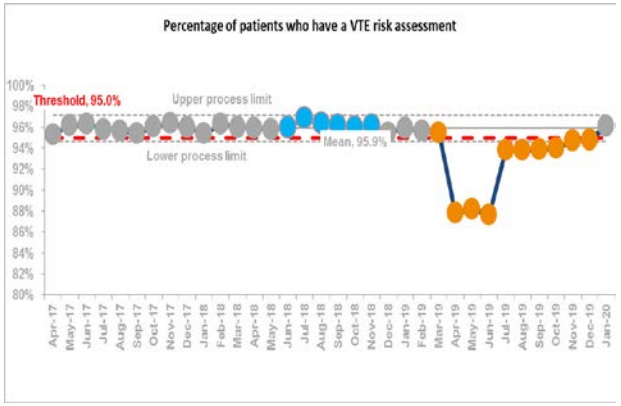
- VTE *data* –Changes to the reporting has resulted in performance exceeding the target and within common cause variation for the first time since February 2019.
- All other metrics also show variation due to common cause

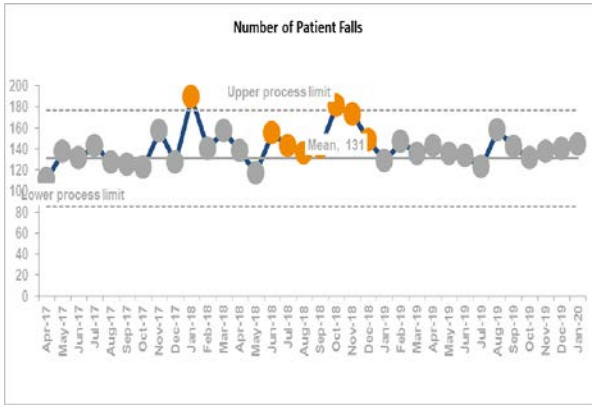
Actions and Quality Improvement Projects

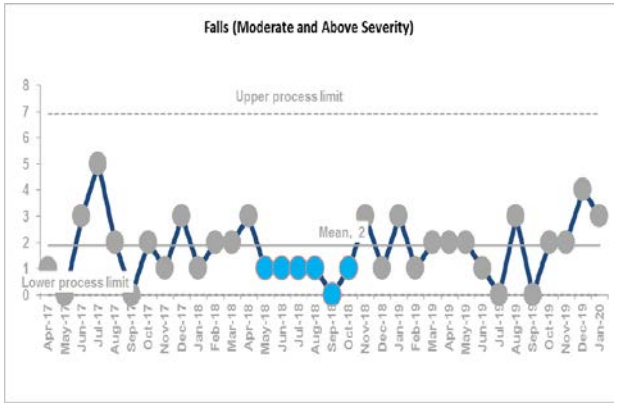
- Going forward patients who have a length of stay less than 14 hours will be excluded from the VTE risk assessment compliance figures as per NICE guidelines. All non-inpatient areas will also be excluded.
- The Trust is working to deliver the Falls CQUIN, specifically focussing on lying and standing for patients over 65 in line with NICE guidance. Target work has been completed in Senior Health with respect of this.
- The category 3 and above pressure ulcers have undergone RCA to identify any key learning and are discussed at a cross divisional meeting.
- Target work underway for staff in critical care areas to raise awareness of medical device associated pressure area damage

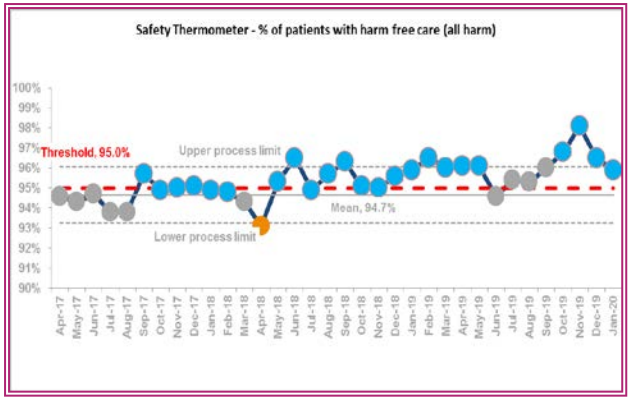
Patient Safety

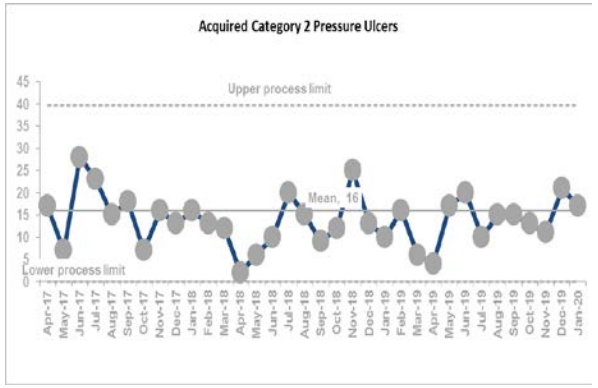
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

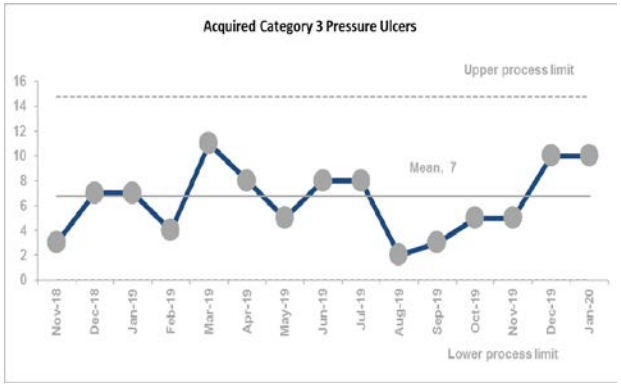


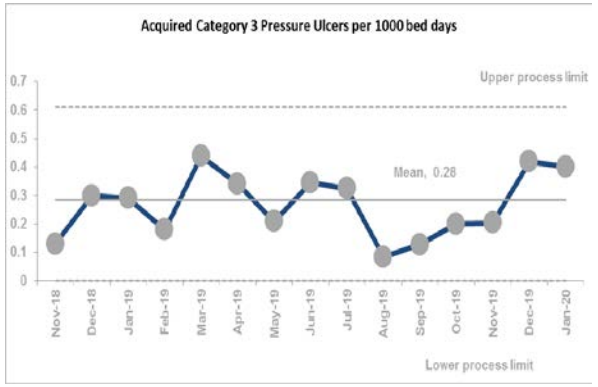












Our Patient Perspective

Infection Control

Indicator Description	Threshold	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD Actual
MRSA Incidences (in month)	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Cdiff Hospital acquired infections	48	2	1	3	4	4	3	4	4	6	3	2	2	5	42
Cdiff Community Associated infections					0	0	2	0	1	0	0	2	0	0	
MSSA	25	3	2	2	4	6	1	0	3	2	2	3	5	6	32
E-Coli	60	1	4	6	4	7	5	7	7	8	6	4	8	5	61

What the information tells us

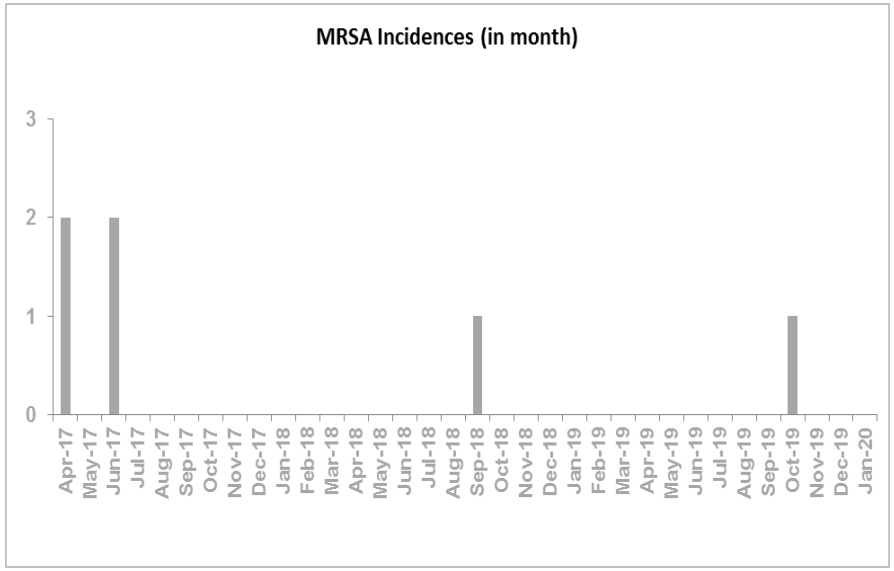
- The Trust has had no MRSA incidents this month.
- This month there were five Cdiff incidents all were Hospital Acquired. The Cdiff YTD position is 42 with 37 Hospital Acquired infections and five Community Associated infections. This is close to our yearly target of 48 and will be monitored closely.
- The number of Ecoli cases reported remains within the control limits. MSSA infection rates show special cause variation with the highest number of incidents seen in nine months. The Trust has now exceeded the yearly target for both Ecoli and MSSA incidents.

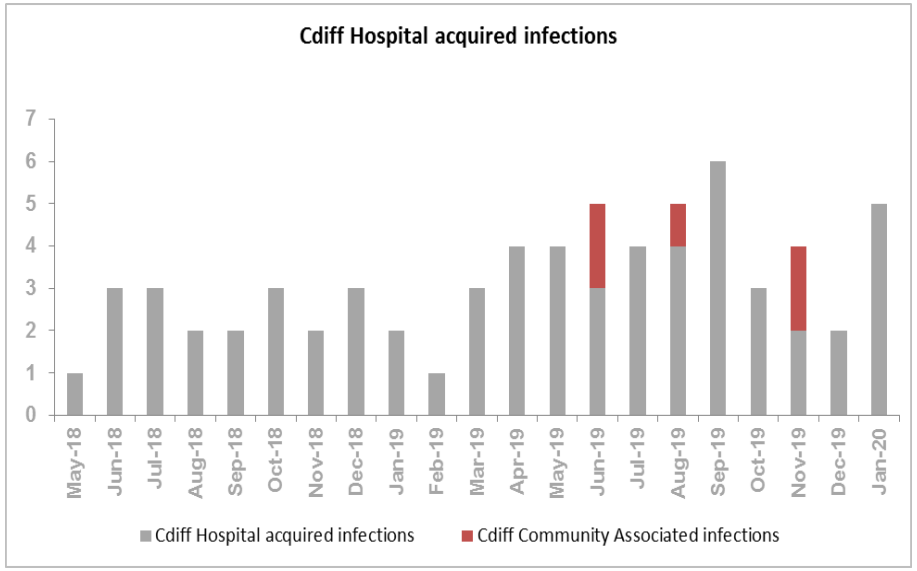
Actions and Quality Improvement Projects

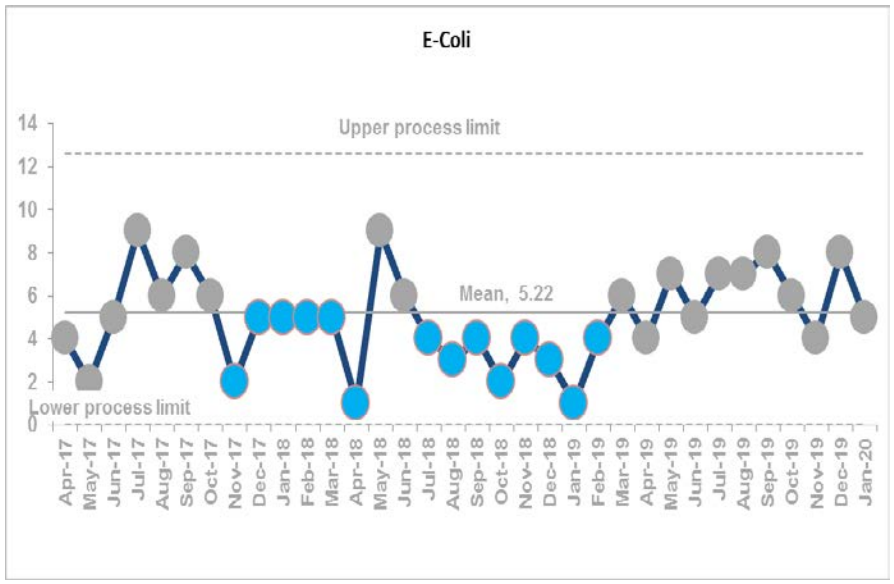
- The Trust continues with infection control measures including additional winter planning interventions
- Infection control and cleaning standards are measured through the ward accreditation process
- Areas where Hospital acquired infections have occurred are placed under a higher frequency surveillance and audit programme.

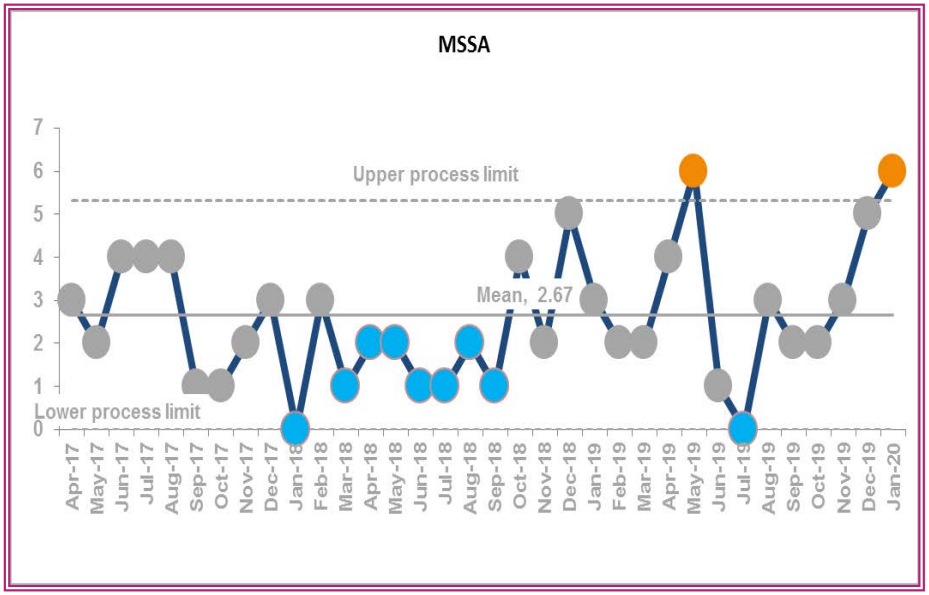
Infection Control

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









Our Patient Perspective

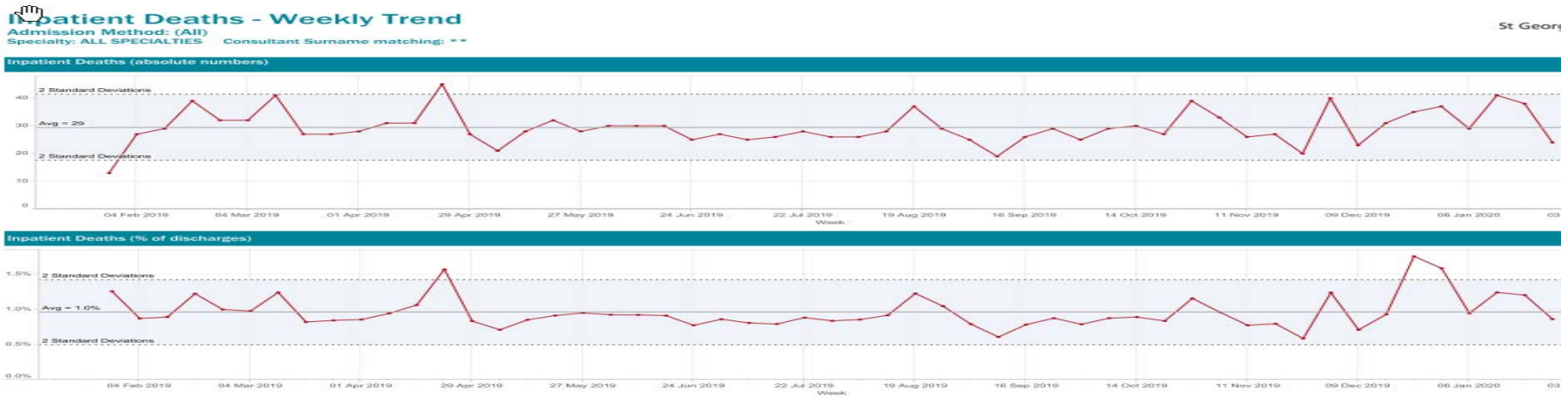
Mortality and Readmissions

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

Indicator Description	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	Jun-19 Dr Foster did not update date for May	Jul-19	Aug-19	Sep-19	Oct-19	Nov 2018 to Oct 2019
Hospital Standardised Mortality Ratio (HSMR)	76.9	74.5	77.6	78.1	79.4	79.4	91.9	105.5	87.9	92.1	88.5	95.0	90.6
Hospital Standardised Mortality Ratio Weekend Emergency	113.3	79.1	74.6	85.2	82.9	82.9	91.3	113	77.2	93.8	107.3	80.6	91.2
Hospital Standardised Mortality Ratio Weekday Emergency	64.9	78.2	79.4	74.1	76.3	76.3	91.5	100.4	90.8	96.2	80.4	102.9	90.6

Indicator Description	Jul17-June18	Oct17-Sep18	Jan18-Dec18	Feb18-Jan19	Mar18-Feb19	Apr18-Mar19	May18-Apr19	Jun18-May19	Jul18-June19	Aug18 to Jul19	Sep18-Aug19
Summary Hospital Mortality Indicator (SHMI)	0.84	0.84	0.84	0.83	0.81	0.82	0.82	0.81	0.83	0.83	0.83

Indicator Description	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	8.2%	7.2%	8.2%	7.9%	8.0%	7.0%	8.3%	9.3%	9.7%	8.4%	9.6%



Note: HSMR data reflective of period Nov 2018 – Oct 2019 based on a monthly published position.
SHMI data is based on a rolling 12 month period and reflective of period September 2018 to August 2019 published (January 2020).
Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways.

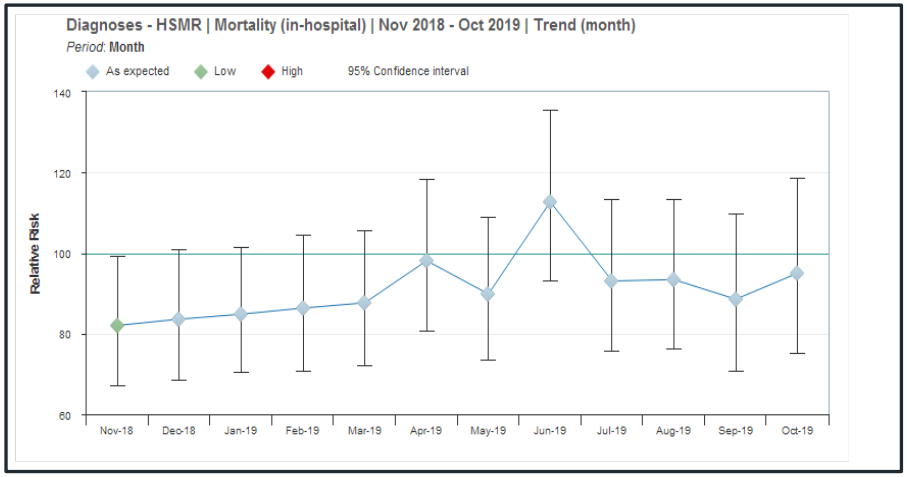
What the information tells us

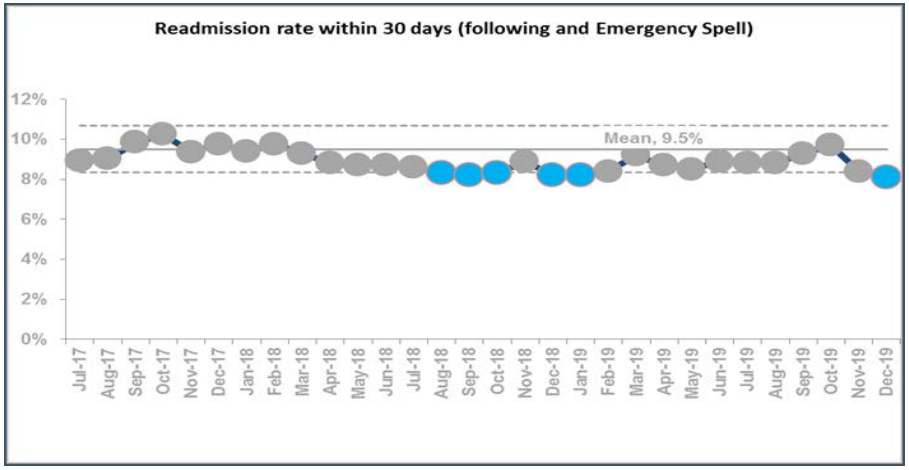
Both of the Trust-level mortality indicators (SHMI and HSMR) remain lower than expected for the last 12 month period available. Caution should be taken in over-interpreting these signals, however as they mask a number of areas of over performance and also under performance. We also monitor and investigate mortality signals in discrete diagnostic and procedure codes from Dr Foster through the Mortality Monitoring Committee (MMC). Investigations are currently underway in relation to two signals, Acute Myocardial Infarction and Coronary Angioplasty. The outcome of these investigations by the clinical service will be reported to the MMC in due course

Mortality and Readmissions (Hospital Standardized Mortality Rate)

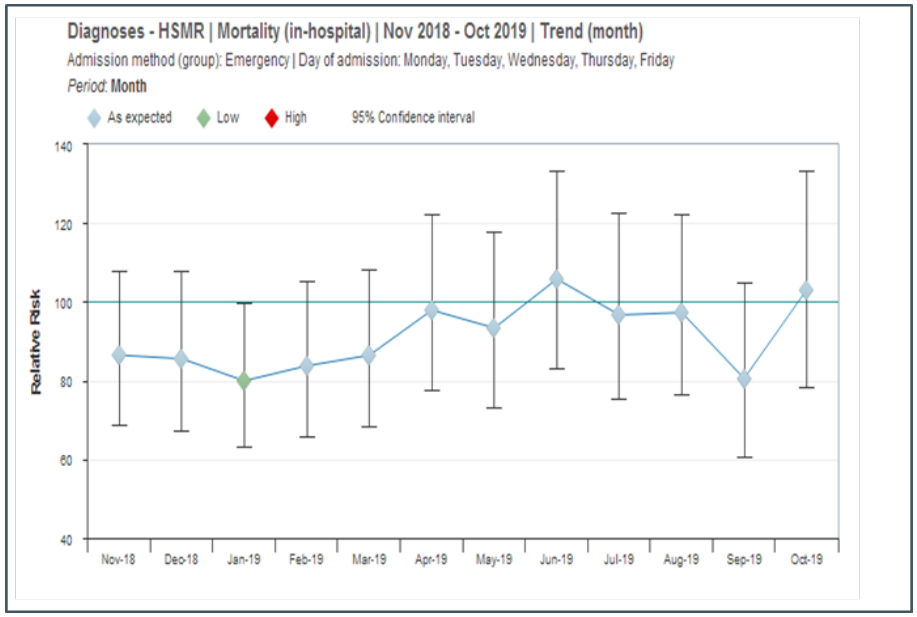
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

HSMR

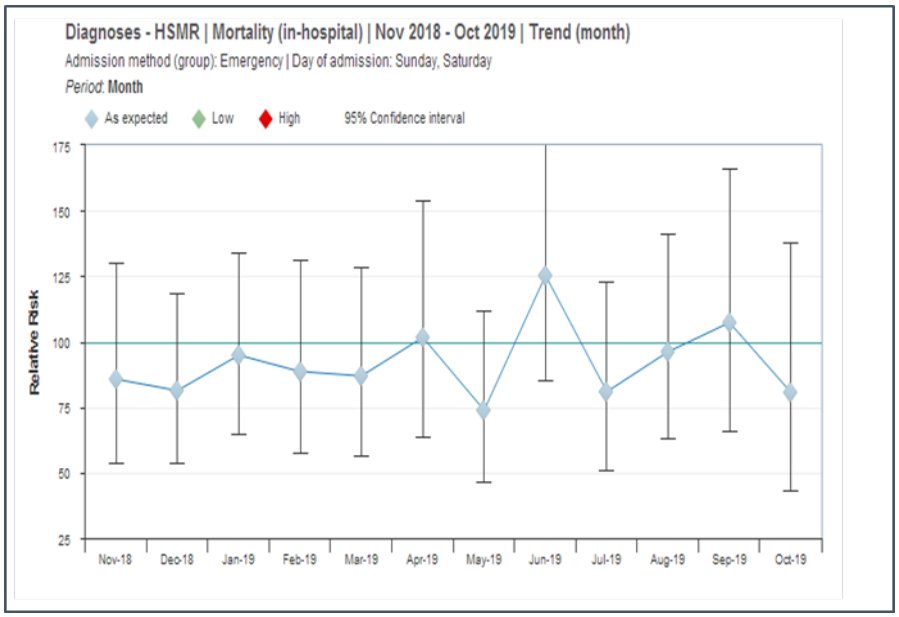




HSMR Weekday

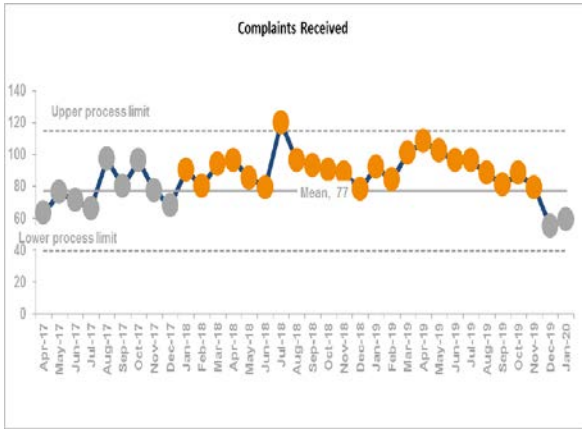


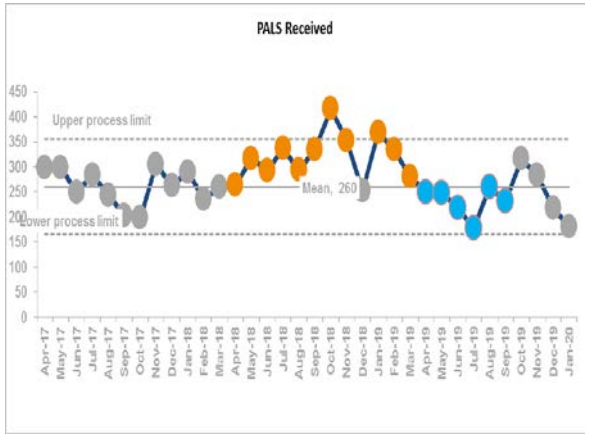
HSMR Weekend

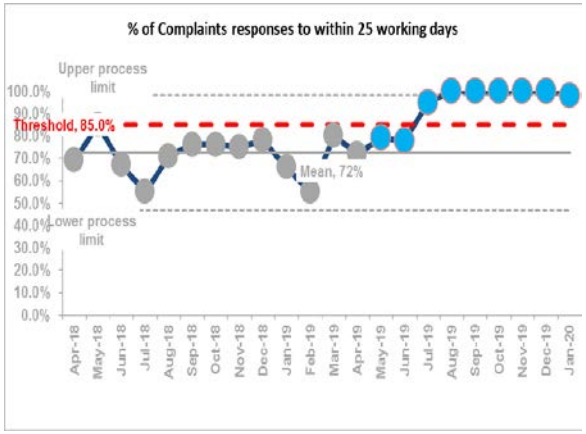


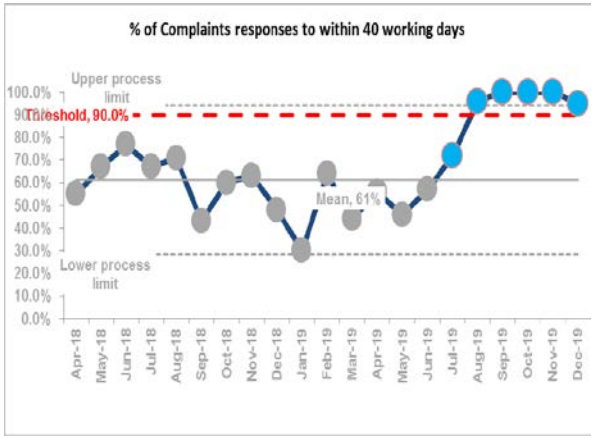
Complaints

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Complaints Received		92	84	101	108	102	96	96	88	81	88	79	55	59
% of Complaints responses to within 25 working days	85%	66%	55%	80%	72%	79%	78%	95%	100%	100%	100%	100%	100%	98%
% of Complaints responses to within 40 working days	90%	30%	64%	44%	56%	46%	57%	72%	96%	100%	100%	100%	95%	
% of Complaints responses to within 60 working days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PALS Received		369	334	280	249	247	218	177	259	232	316	283	218	180









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

What the information tells us

- The number of complaints received in January increased from 55 to 59.
- Response compliance is above performance targets for all response categories.

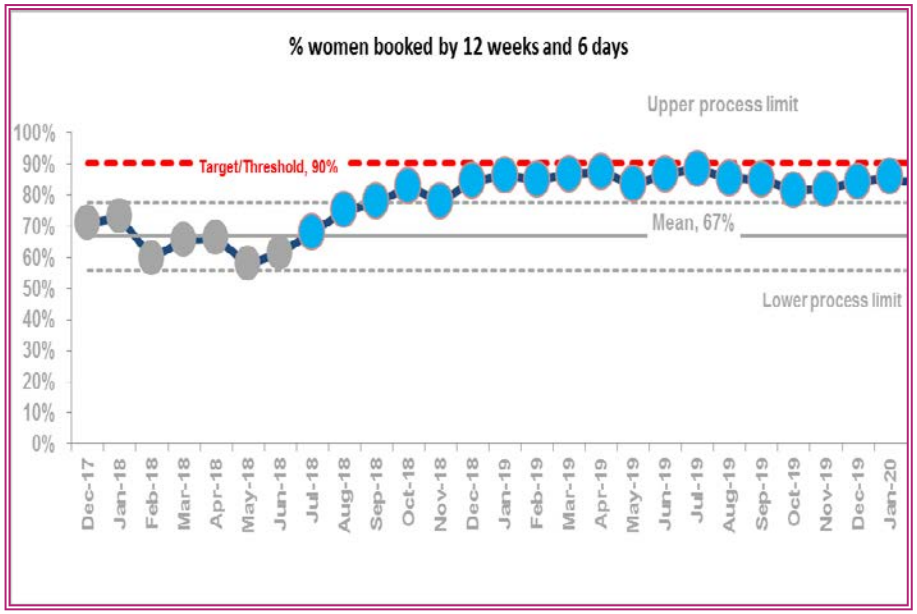
Actions and Quality Improvement Projects

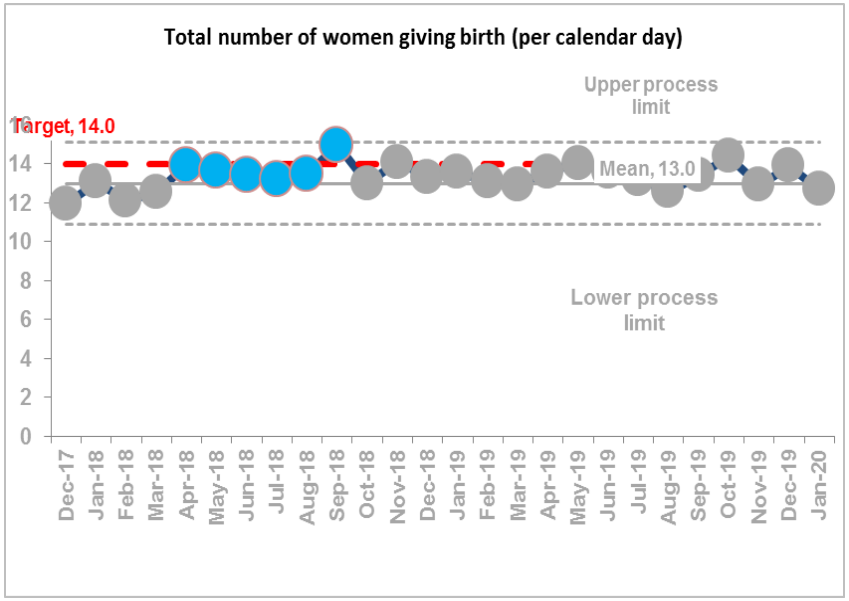
The daily complaints CommCell continues.

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

Maternity

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





What the information tells us

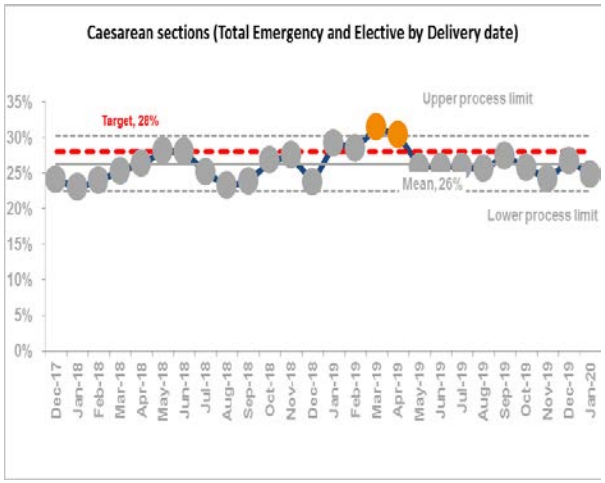
- The overall birth rate fell slightly in January, however remained within common cause variation.
- The number of women booking for maternity care was at the highest number since May 2019, and the percentage booked within12 weeks plus 6 days of pregnancy was at 82.5%, above the upper control limits.
- The percentage of births by caesarean section, including emergency caesareans, remained stable.
- The number of women sustained a 3rd or 4th degree tear dropped back to under 3% after a spike in December.

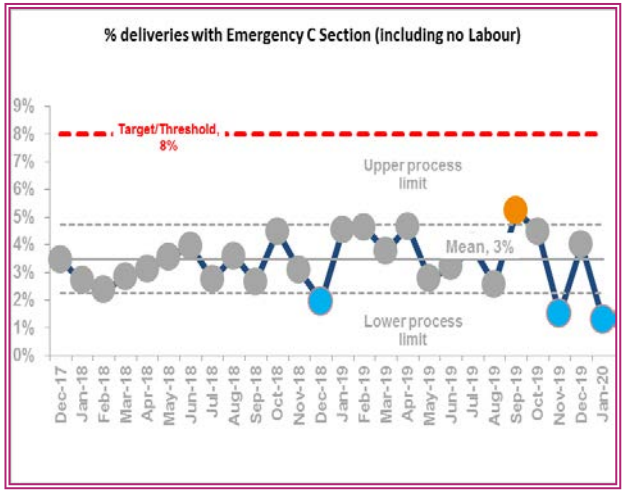
Actions and Quality Improvement Projects

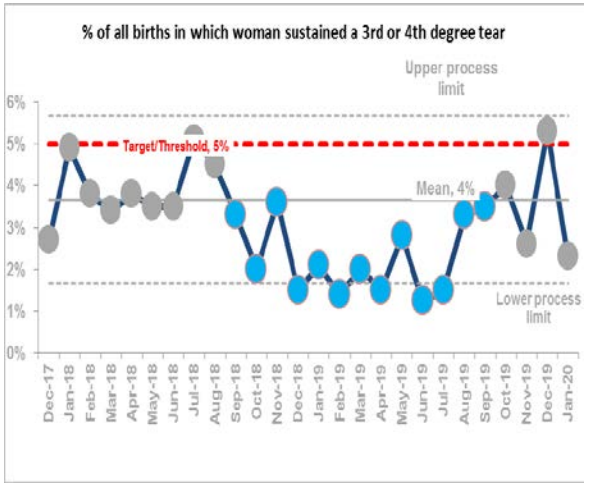
- The case notes of the women who sustained a 3rd or 4th degree tear in December are being reviewed to understand why the number exceeded the threshold limit.
- The percentage of women being booked by nine weeks and six days gestation fell to under 50% in month and work is being undertaken with the teams to improve this position.

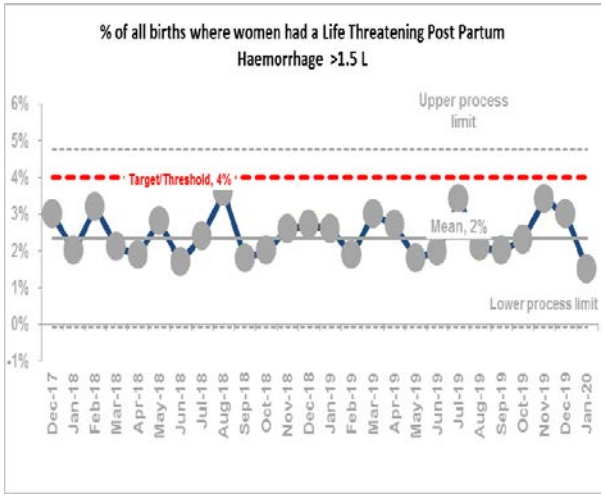
Maternity

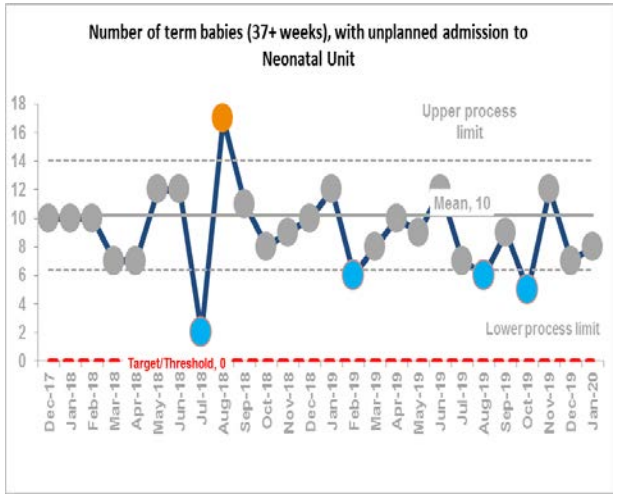
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance







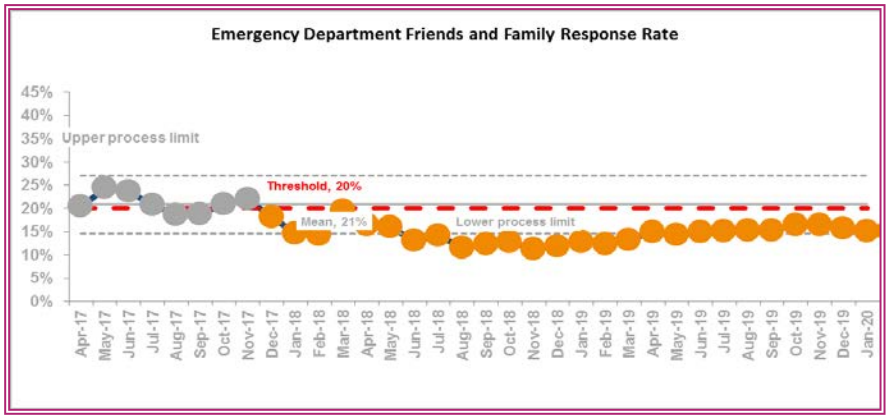


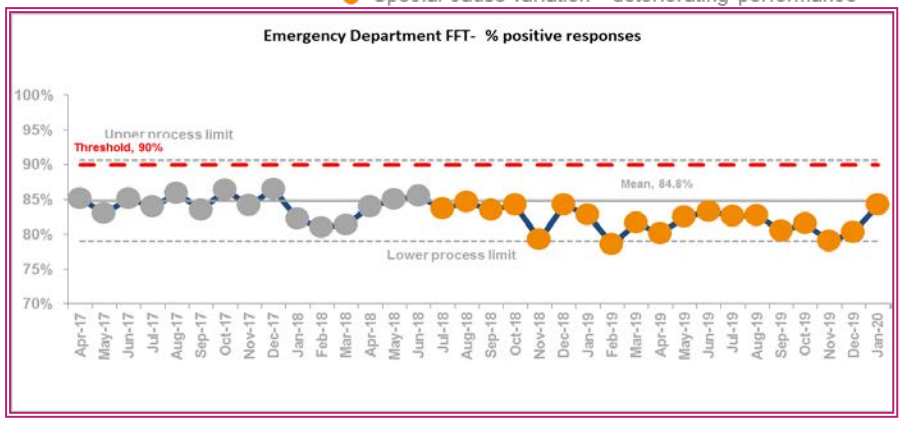


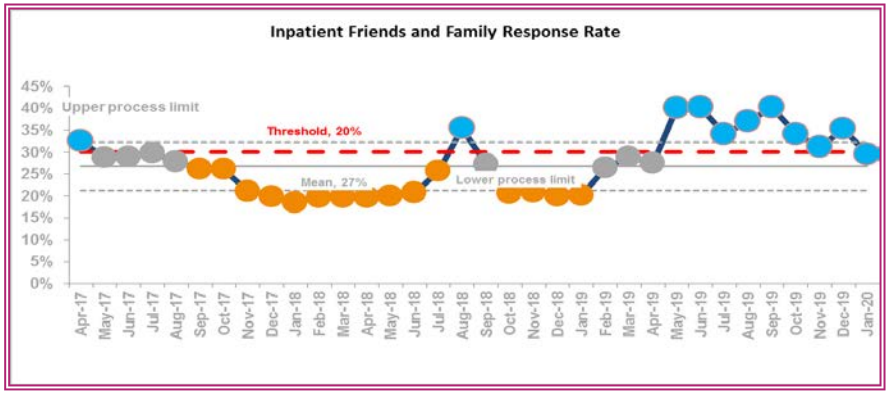
Outstanding care every time

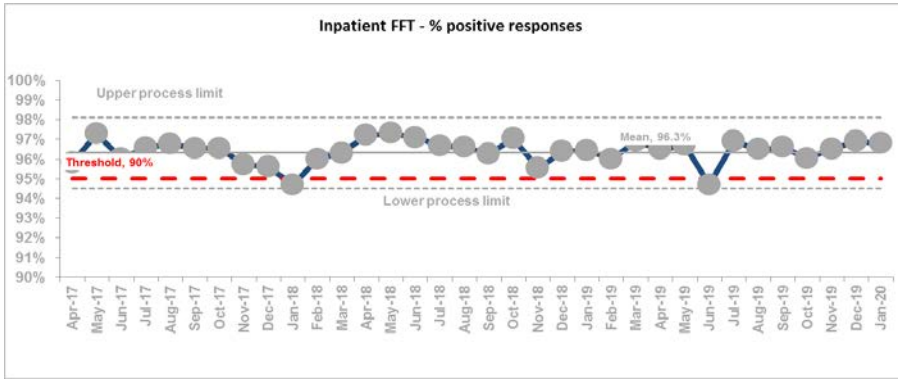
Friends and Family Test

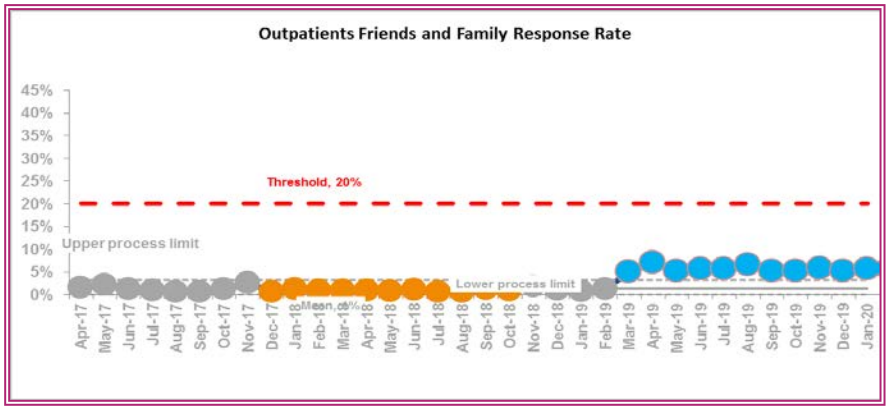
Special cause variation - improving performance
Common cause variation
Special cause variation - deteriorating performance

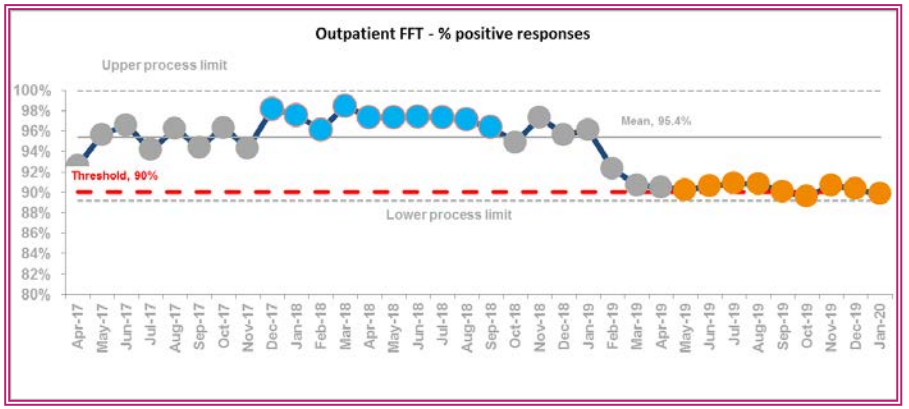






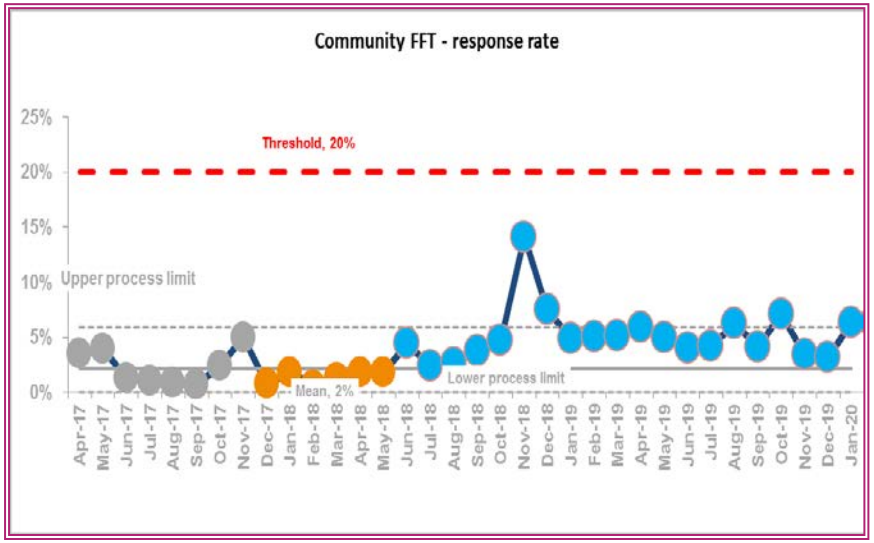


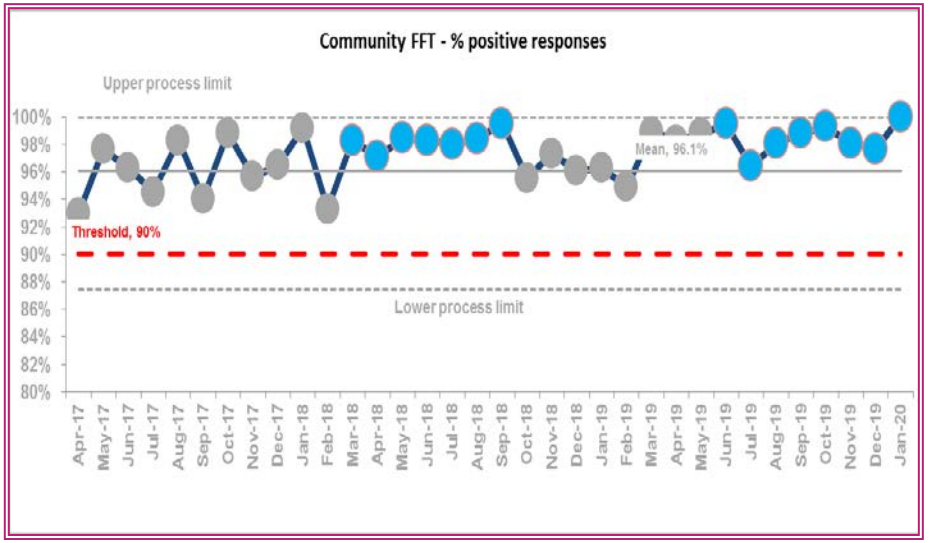


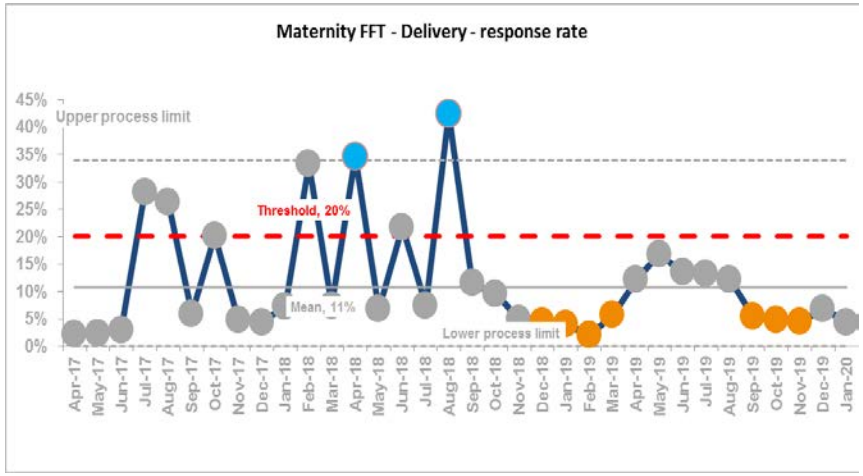


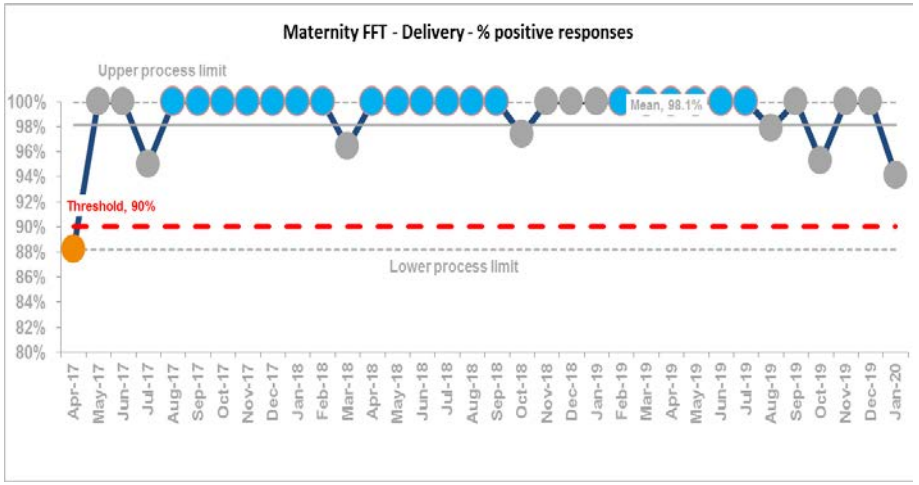
Friends and Family Test

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









Our Patient Perspective

Friends & Family Survey

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Emergency Department FFT - % positive responses	90%	82.8%	78.5%	81.6%	80.1%	82.5%	83.3%	82.6%	82.7%	80.5%	81.5%	79.0%	80.3%	84.2%
Inpatient FFT - % positive responses	95%	96.5%	96.0%	96.9%	96.5%	96.7%	94.7%	96.9%	96.5%	96.6%	96.0%	96.5%	96.9%	96.8%
Maternity FFT - Antenatal - % positive responses	90%				100.0%	90.0%	85.7%	100.0%		100.0%			100.0%	100.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	95.2%	100.0%	100.0%	94.1%
Maternity FFT - Postnatal Ward - % positive responses	90%	95.6%	95.7%	91.7%	96.4%	94.6%	98.0%	100.0%	98.3%	95.2%	100.0%	97.3%	88.0%	90.7%
Maternity FFT - Postnatal Community Care - % positive responses	90%		100.0%	100.0%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%
Community FFT - % positive responses	90%	96.3%	94.9%	98.9%	98.3%	98.8%	99.5%	96.4%	98.1%	98.8%	99.3%	98.1%	97.7%	100.0%
Outpatient FFT - % positive responses	90%	96.1%	92.3%	90.7%	90.5%	90.2%	90.6%	90.9%	90.8%	90.1%	89.6%	90.7%	90.3%	89.9%

What the information tells us

- The Emergency Department Friends and Family Test (FFT) – In the month of January, 84.2% of patients attending the emergency department would recommend the service to family and friends. This is above the lower process limit and the highest performance seen since October 2018.
- Maternity and Community FFT are above local thresholds in January and work continues to ensure patient responses improves. The London average response rate for Community is 4.4% and England is 3.9%.
- Our Outpatient recommended rate in January was 89.9% against a target of 90%. The response rate remains below target at 5.7% but has been consistently above 5% since March 2019.

Actions and Quality Improvement Projects

- Changes in Friends and Family (FFT) guidance will be implemented in April 2020. This guidance encourages patients to provide feedback throughout their care episode. In preparation for this and in line with guidance the wording of the questions and changes to the Trust systems are being implemented for launch in April 2020

Balanced Scorecard Approach

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

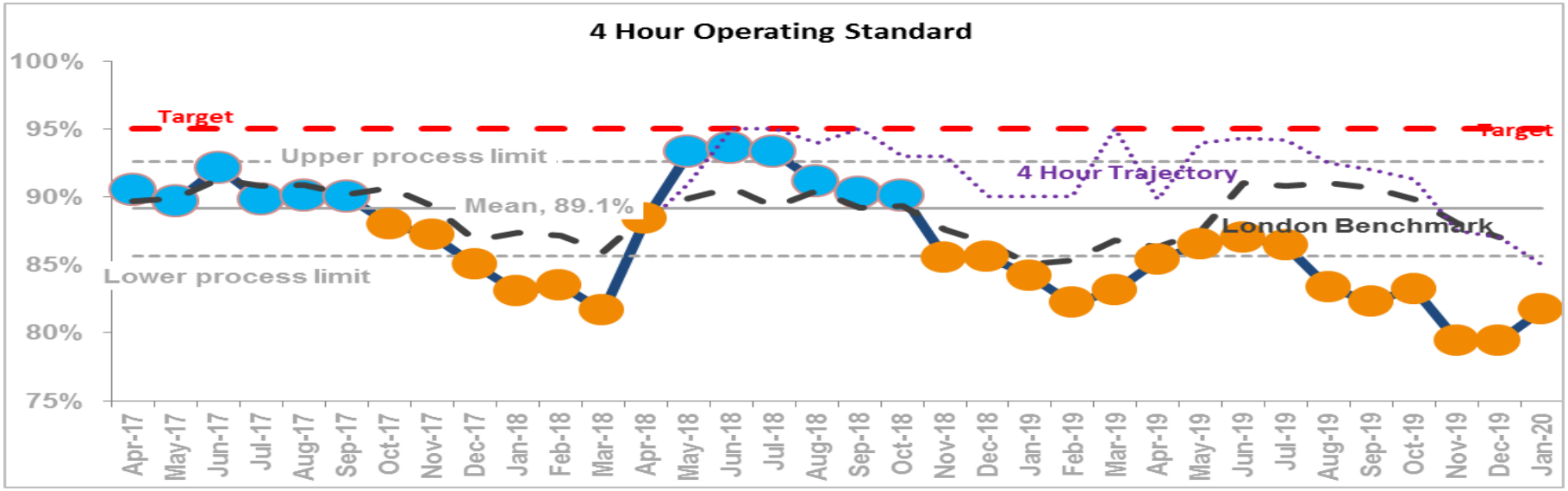
Key

Current Month

A Previous Month

Our Process Perspective

Emergency Flow



What the information tells us:

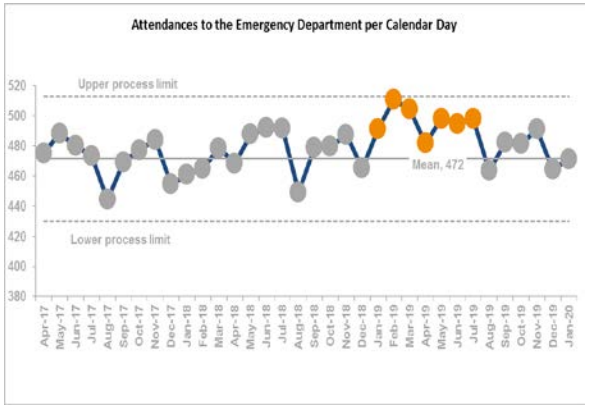
- The number of patients either discharged, admitted or transferred within four hours of arrival in the month of January was 81.7%, an improvement from December's position of 79.4%. Both admitted and non-admitted performance remains below the lower control limit and are lower compared to the same period last year, however, an improvement has been seen in the performance of non-admitted pathways.
- The number of overall attendances have remained within the upper and lower control limits and compared to the same month last year; the number of attendances have reduced by 4%. The emergency department has also seen a reduction in ambulance arrivals with the numbers attending in January below the lower control limit signifying special cause variation.
- In January, the Trust reporting eighteen patients waiting in the Emergency Department over twelve hours following a decision to admit.
- Bed occupancy for both Trust and AMU remains above the mean.
- The number of long length of stay patients has seen a step change in all 7, 14 and 21 days, reporting above the mean for the past seven months.
- London Ambulance Service (LAS) handover times performance has fallen across the London region with St George's performance remaining below the lower control limit with steady deterioration over the past six months.

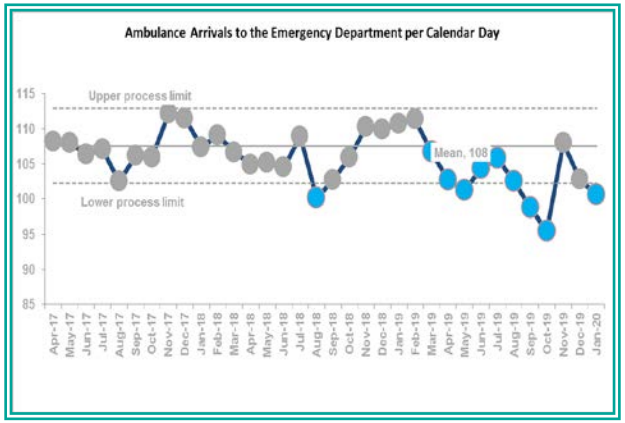
Actions and Quality Improvement Projects

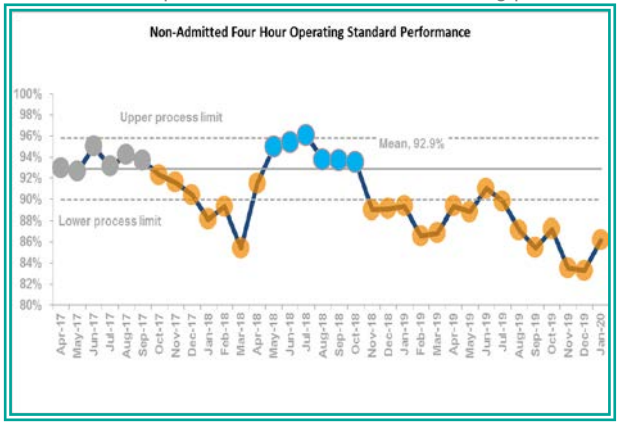
- Emergency Care Processes – standardisation of ED capacity & flow huddle agenda
- UCC Waits and Direct Access – Refinements of Rapid Assessment Zone (RAZ) Standard operating procedure. Additional GP cover to Tooting site agreed with commissioners and implemented
- Mental Health (ED) – Meeting undertaken between St George's Hospital and South West London & St. George's Mental Health Trust's management teams to review triage of mental health patients at ED front door
- Inter Professional Standards (IPS) – Five care groups identified on breach numbers as pilot IPS specialties – Medicine, General Surgery, Paediatrics, Orthopaedics & Stroke
- Flow – General Managers and Assistant General Managers are attending board rounds to offer support and take away internal delay actions

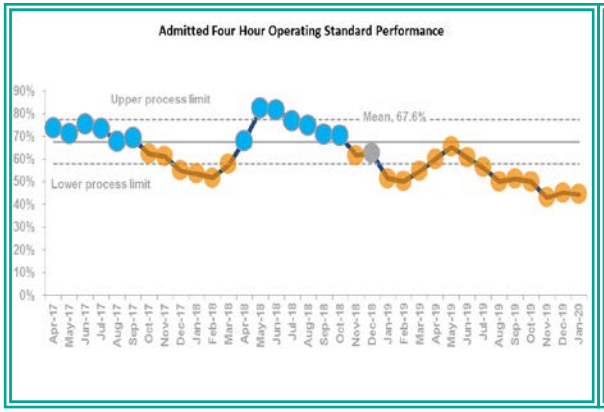
Emergency Flow

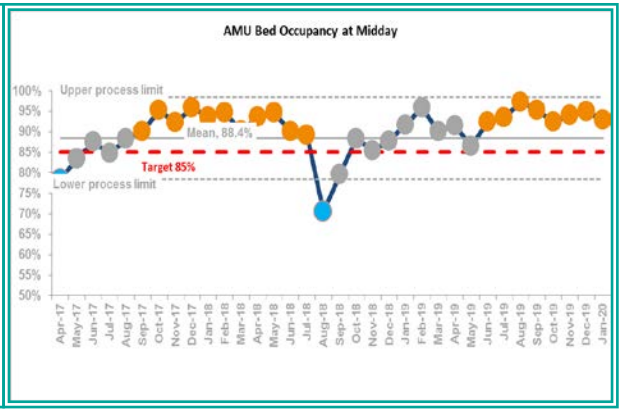
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

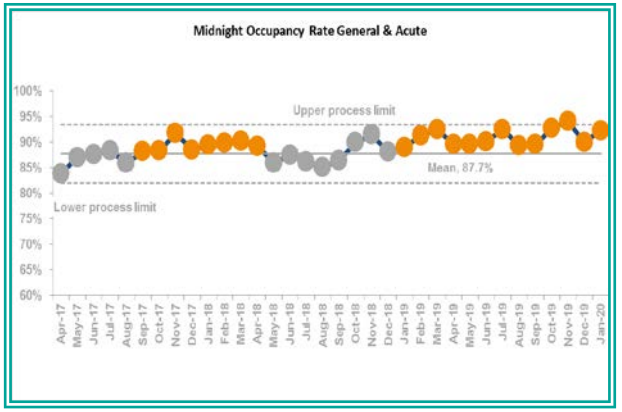


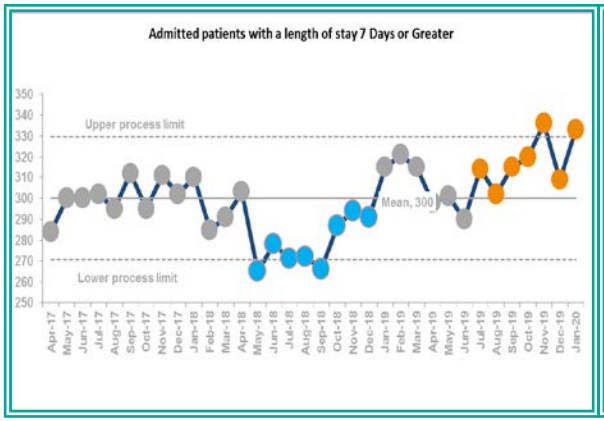


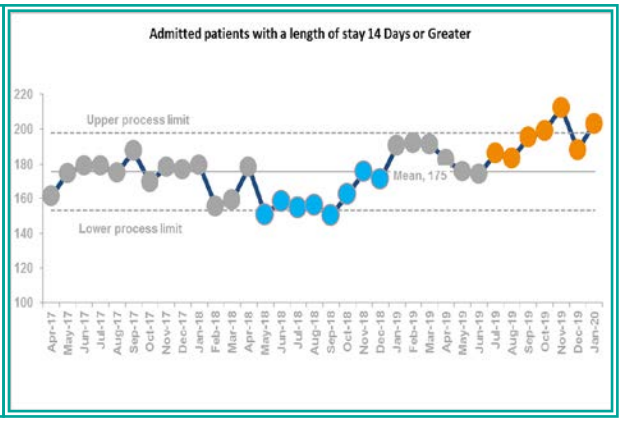


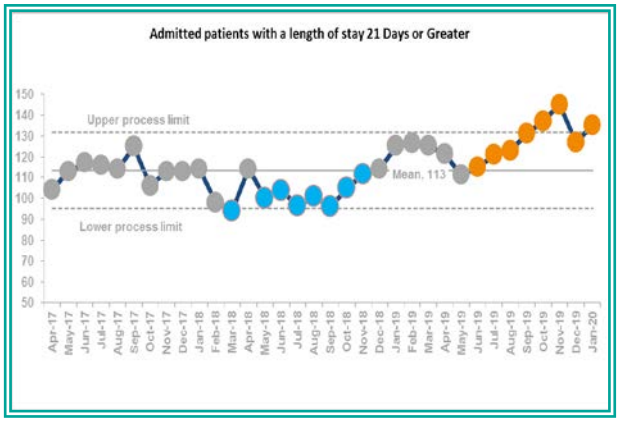






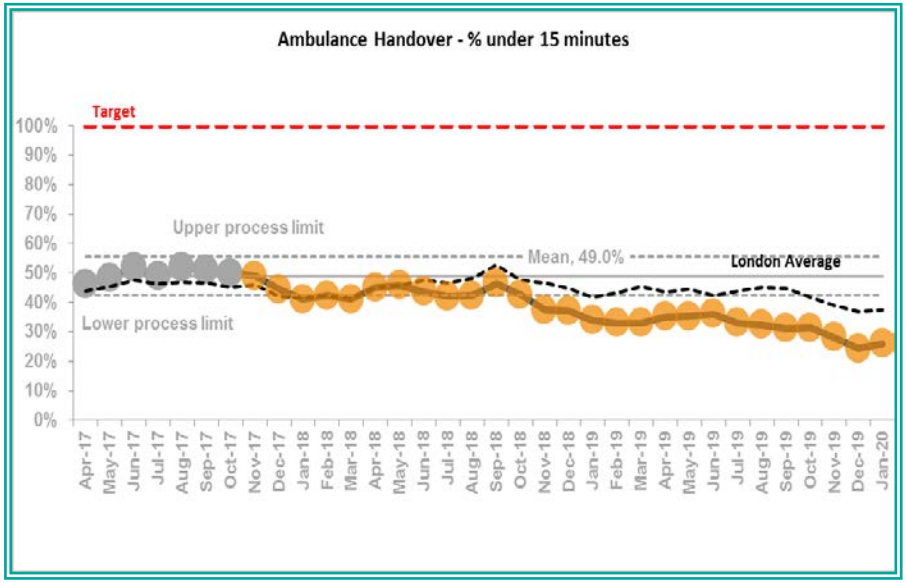


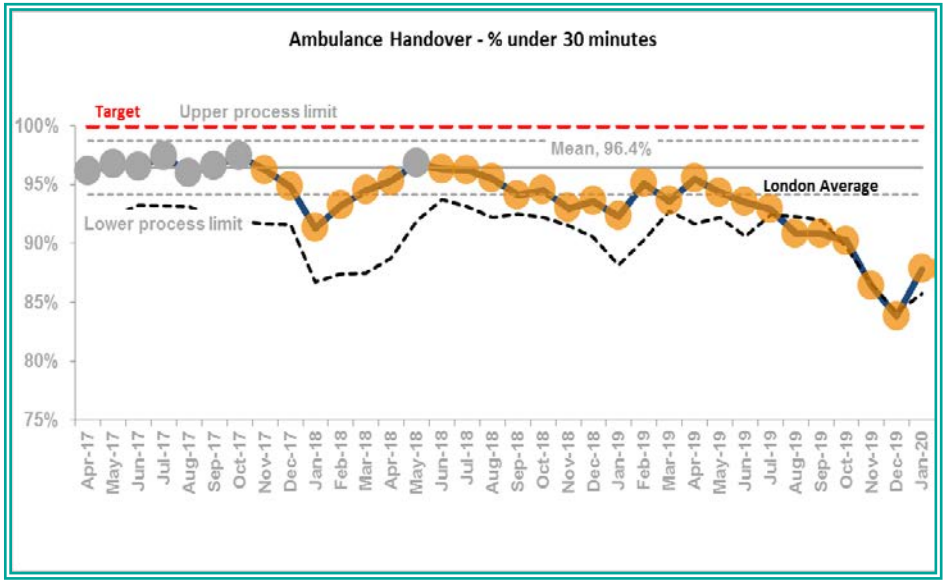


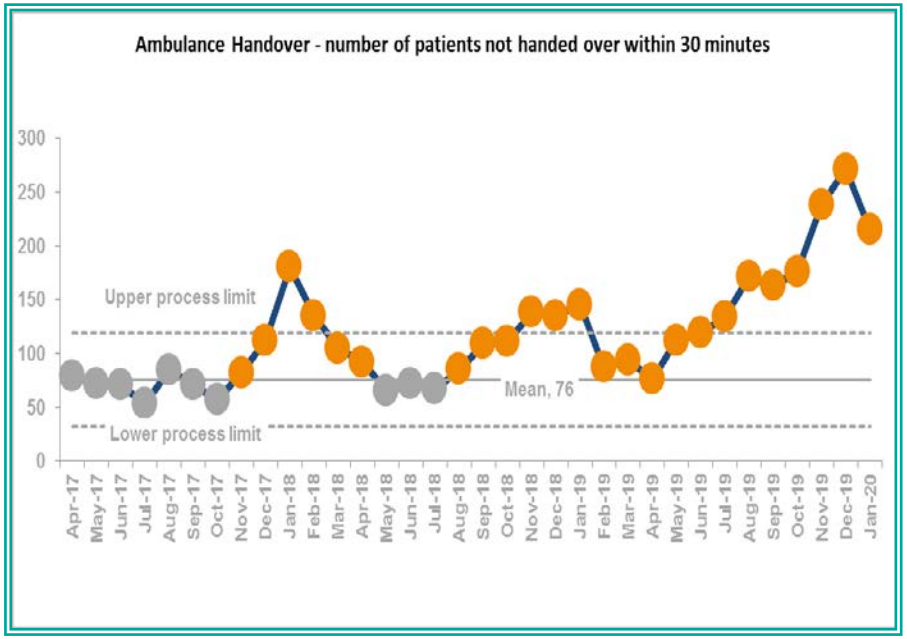


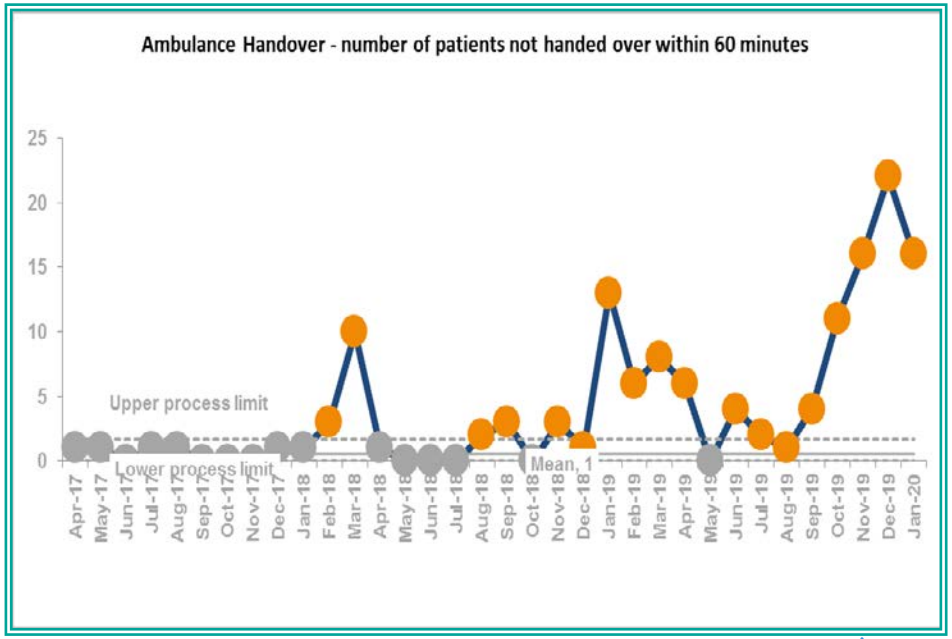
Emergency Flow

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

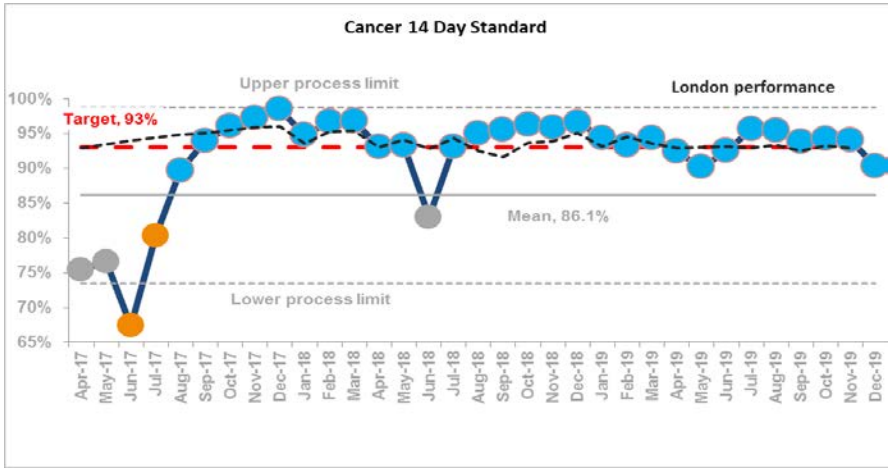


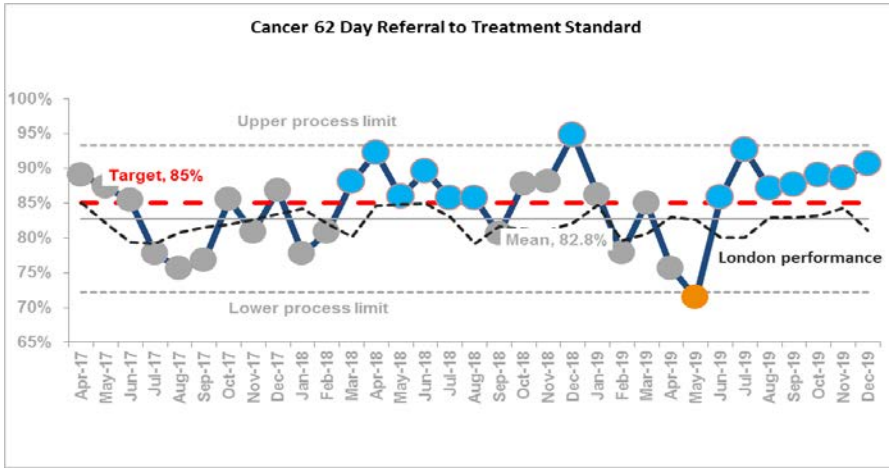






Cancer





What the information tells us

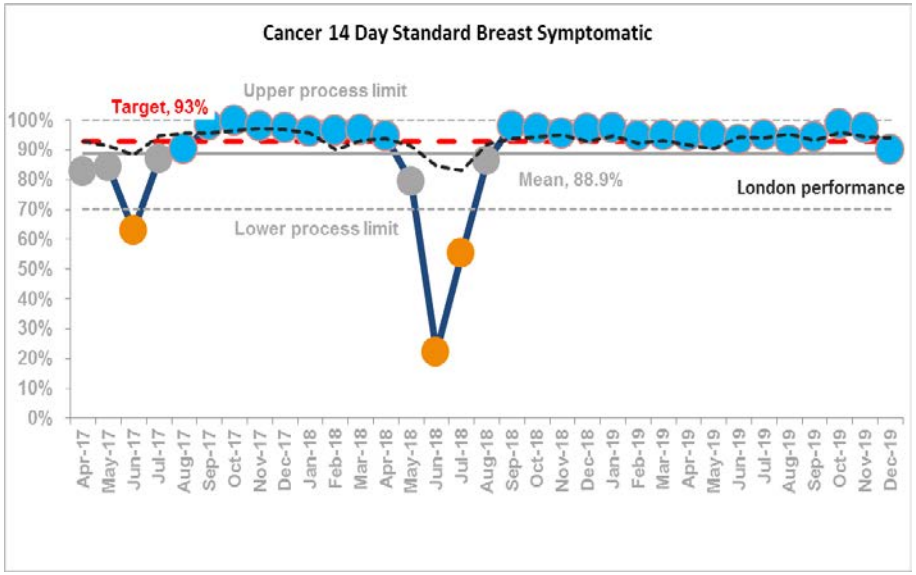
- The Trust met four of the seven cancer standards for the month of December, 14 day standard performance was under target reporting 90.3% and 62 Day standard remained compliant reporting 90.6%.
- Within the 14 Day Standard, six tumour groups were non-compliant against the 93% national target, these were Children's, Head & Neck, Lower Gastrointestinal, Lung, Urology and Upper Gastrointestinal. Overall Trust performance remains within the upper and lower control limits and in line with London performance. All tumour groups remain within upper and lower control limits with the exception of Lung and Upper Gastrointestinal where 14 day performance was below the lower control limit
- Performance against 62 days from referral was 90.3% in the month of December 2019 against the target of 85% with four tumour groups non-compliant (Gynaecology, Haematology, Head & Neck and Lower Gastrointestinal). All tumour groups remain within upper and lower control limits with no special cause variation seen with the exception of Haematology where performance dropped below the lower control limit.
- In the month of December, the Trust did not achieve the Cancer 62 Day Referral to Treatment Screening target of 90% for the second consecutive month reporting 86.4% although performance remains within the upper and lower control limit.

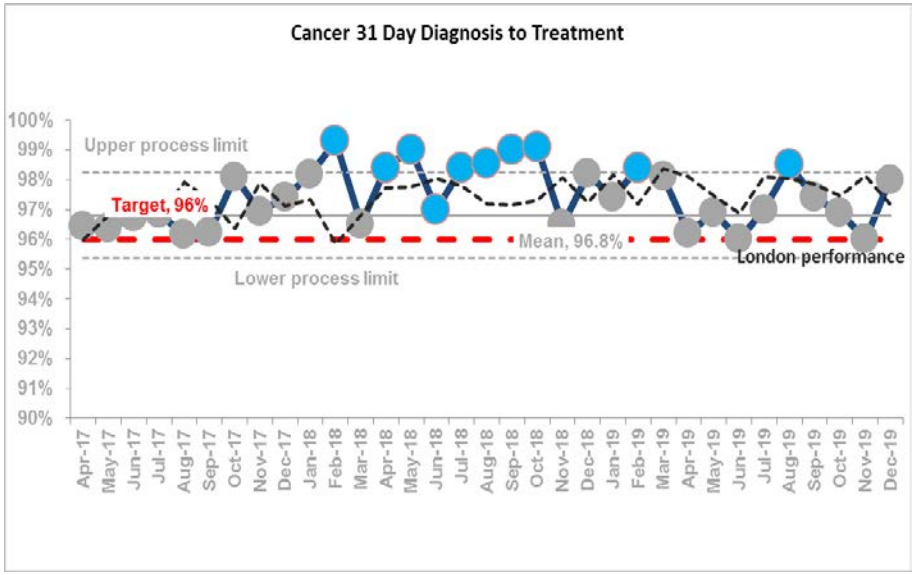
Actions and Quality Improvement Projects

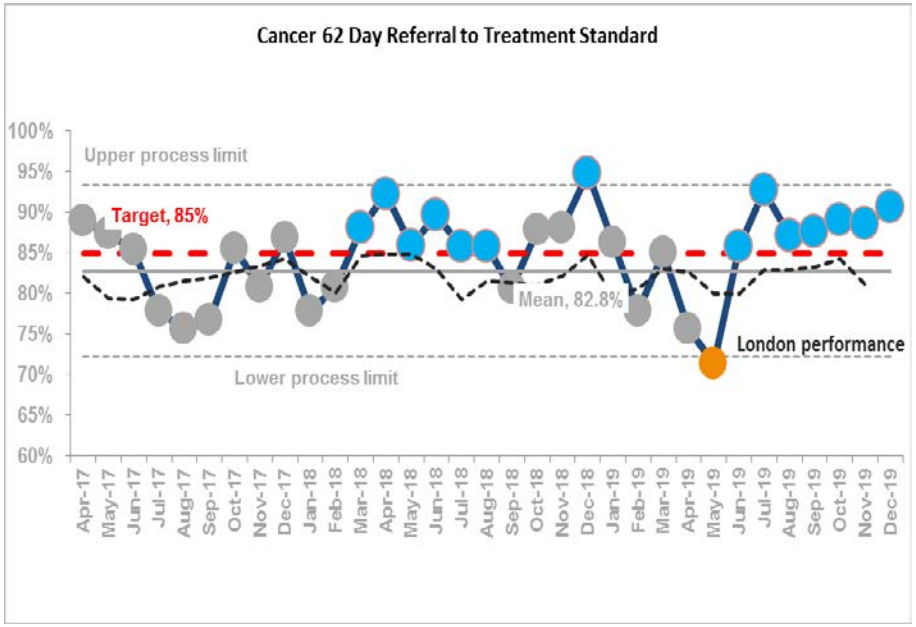
- All tumour types have given assurance that they will return to compliance and have their backlog cleared by third week in January and the beginning of February for breast symptomatic.
- Continued robust management of Appointment Slot Issues (ASI) list to ensure the right capacity is in place in January and pre planned for February and March 2020.
- All services have reviewed demand and capacity and will provide additional capacity where necessary.
- Targeted support and actions for Upper Gastrointestinal include expanded GP direct endoscopy services, endoscopy demand and capacity review, implementation of the Rapid Diagnostic Centre and Virtual triage slots to go live in February 2020.
- Targeted support and actions for Lower Gastrointestinal include supporting pathway redesign to increase straight to test and the implementation of the Rapid Diagnostic Centre

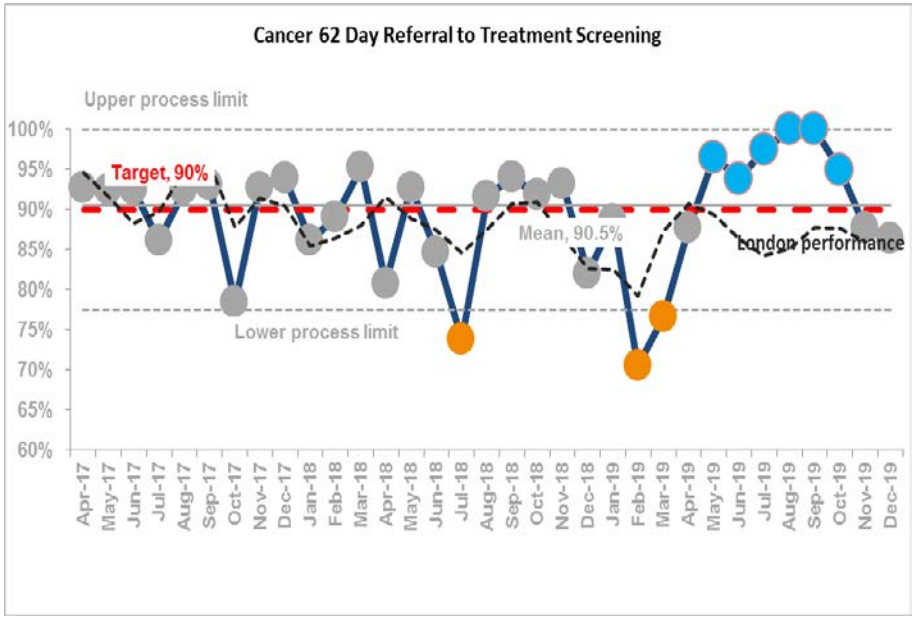
Cancer

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









Our Process Perspective

Cancer

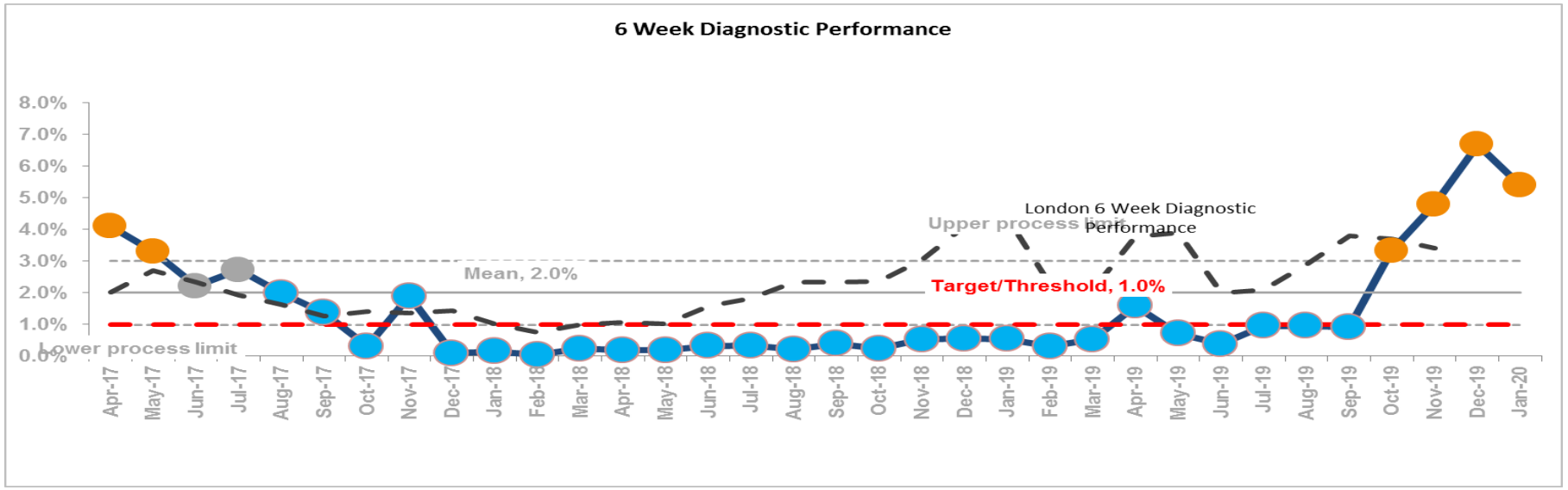
14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	No of Patients
Brain	93%	100.0%	100.0%	100.0%	-	100.0%	-	100.0%	-	100.0%	100.0%	-	-	-	0
Breast	93%	98.8%	97.4%	98.6%	97.9%	99.5%	96.3%	96.9%	95.4%	94.9%	95.9%	100.0%	97.0%	95.6%	180
Children's	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	4
Gynaecology	93%	95.9%	69.5%	65.3%	80.0%	75.0%	59.3%	78.0%	95.5%	97.2%	95.4%	97.6%	99.2%	99.0%	100
Haematology	93%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	100.0%	86.7%	95.2%	100.0%	100.0%	26
Head & Neck	93%	96.0%	98.5%	100.0%	99.3%	98.0%	97.8%	100.0%	98.9%	96.4%	96.6%	99.0%	96.6%	89.4%	170
Lower Gastrointestinal	93%	94.5%	97.2%	92.1%	94.5%	85.6%	91.1%	87.9%	93.7%	93.1%	92.8%	89.7%	91.5%	80.3%	269
Lung	93%	100.0%	93.3%	100.0%	96.9%	100.0%	95.6%	96.8%	95.7%	100.0%	97.1%	97.7%	100.0%	84.1%	44
Skin	93%	97.6%	97.1%	95.9%	97.6%	96.9%	95.5%	94.8%	96.0%	98.0%	91.8%	95.9%	91.0%	94.8%	327
Upper Gastrointestinal	93%	94.1%	91.8%	90.9%	83.5%	87.9%	70.2%	90.9%	95.1%	88.9%	87.2%	82.5%	88.1%	82.7%	98
Urology	93%	96.6%	94.5%	94.2%	92.2%	90.1%	95.4%	92.1%	93.8%	93.0%	97.0%	88.4%	95.6%	92.9%	127

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	No of Treatments
Brain	85%	100.0%	-	-	-	-	-	-	-	-	-	-	-	-	0
Breast	85%	100.0%	100.0%	82.4%	90.9%	83.3%	80.0%	87.5%	73.3%	88.6%	100.0%	100.0%	100.0%	100.0%	11.5
Children's	85%	-	-	-	-	-	-	-	-	100.0%	-	-	-	-	0
Gynaecology	85%	83.3%	88.9%	50.0%	100.0%	66.7%	66.7%	100.0%	100.0%	100.0%	100.0%	60.0%	100.0%	80.0%	2.5
Haematology	85%	100.0%	100.0%	100.0%	100.0%	30.0%	33.3%	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	80.0%	5
Head & Neck	85%	87.5%	46.2%	85.7%	80.0%	77.8%	40.0%	28.6%	80.0%	80.0%	75.0%	76.5%	76.9%	68.2%	11
Lower Gastrointestinal	85%	100.0%	100.0%	81.8%	66.7%	41.7%	100.0%	69.2%	83.3%	63.6%	90.0%	100.0%	87.5%	83.3%	6
Lung	85%	72.7%	80.0%	75.0%	70.0%	71.4%	100.0%	100.0%	91.7%	89.5%	60.0%	100.0%	66.7%	100.0%	4.5
Skin	85%	100.0%	92.3%	100.0%	89.7%	100.0%	75.8%	95.7%	100.0%	100.0%	78.9%	100.0%	89.5%	100.0%	11
Upper Gastrointestinal	85%	100.0%	0.0%	50.0%	60.0%	100.0%	20.0%	75.0%	100.0%	53.8%	66.7%	80.0%	50.0%	100.0%	2
Urology	85%	95.0%	89.5%	71.1%	88.9%	83.0%	75.8%	93.9%	100.0%	94.4%	100.0%	83.8%	87.8%	100.0%	12.5
Other	85%	-	0.0%	-	100.0%	-	-	100.0%	-	-	-	100.0%	-	100.0%	3

Diagnostics



What the information tells us

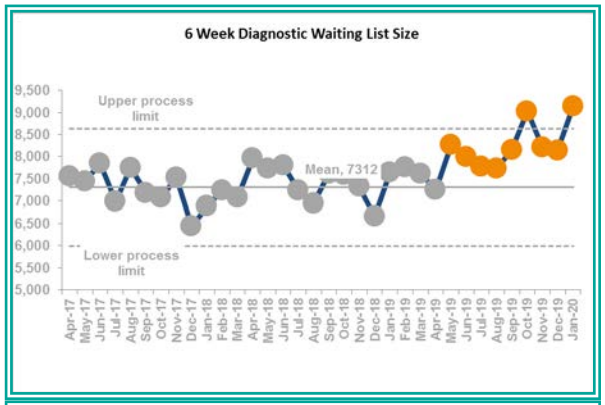
- In January, the Trust did not achieve the six week diagnostic standard with an adverse performance of 5.4% against a National Threshold of 1% and London performance of 3.4%. The total number of patients waiting greater than six weeks was 493, 9% less than the previous month.
- Compliance has not been achieved within four modalities (reducing from eight in December), with Echocardiography being the most challenged and performing above the upper control limit. Echocardiography has also seen an increase in waiting list numbers. This is due primarily to work reviewing the patient waiting list and ensuring any planned and non planned waits are being recorded appropriately.
- In the month of January, Neurophysiology have continued to be challenged reporting 9.6% of patients waiting greater than six weeks, this follows periods of challenged capacity both in Consultant capacity and administrative support within the service
- Endoscopy performance have seen an improved position achieving the 1% target in all modalities for the first time in eleven months.

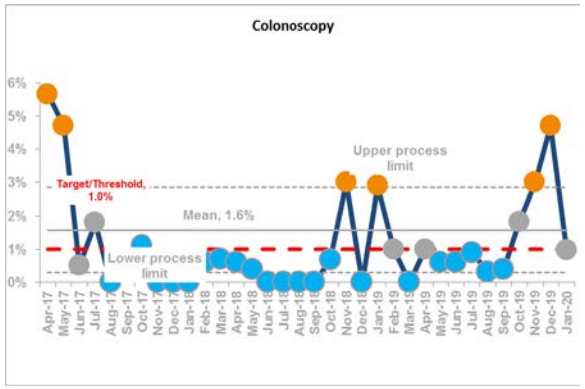
Actions and Quality Improvement Projects

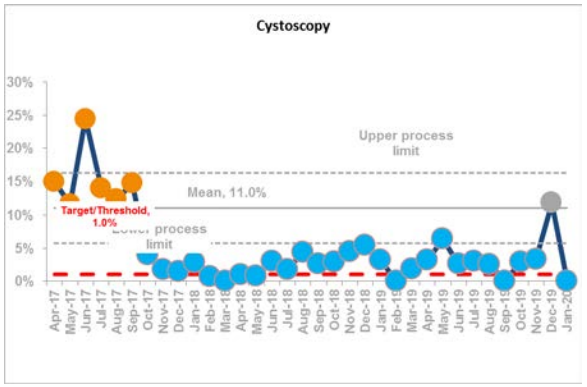
- **Echocardiography** - Performance trajectory for Echocardiography has been submitted to the Executive team with recommendations for long term impact and sustainability for the service including demand management projects. The patient waiting list continues to be reviewed and validated to ensure accurate reporting of planned and non planned patients. A service manager post will be dedicated to Diagnostics and RTT performance. Additional administrative resource has been requested to ensure that booking processes are robust and to ensure adequate capacity. A dedicated resource from transformation will lead on reviewing the current administrative and booking process. Insourcing has begun to bridge echocardiography capacity gap.
- **Neurophysiology** – The Trust have successfully recruited a locum Consultant (joint post with Croydon) with a start date in April. Administrative team are now fully established. Service is reviewing the booking process to see where any improvements can be gained.

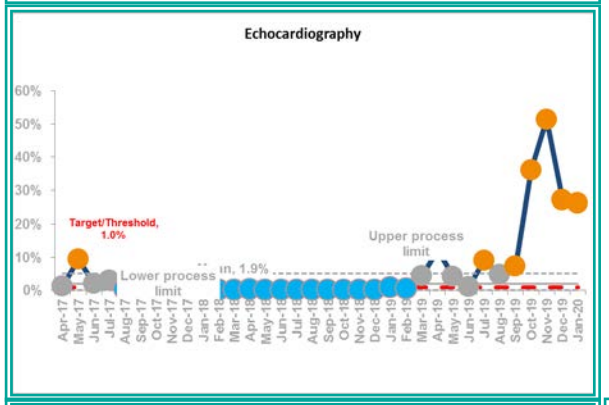
Diagnostics

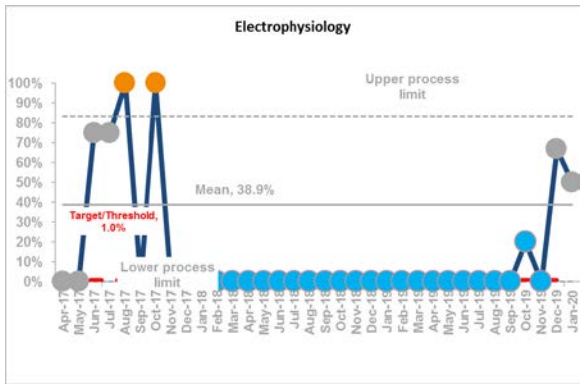
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

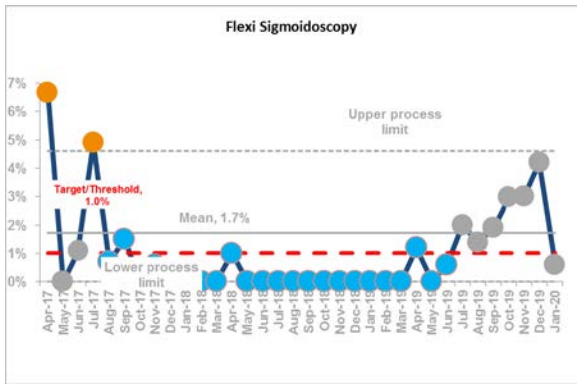


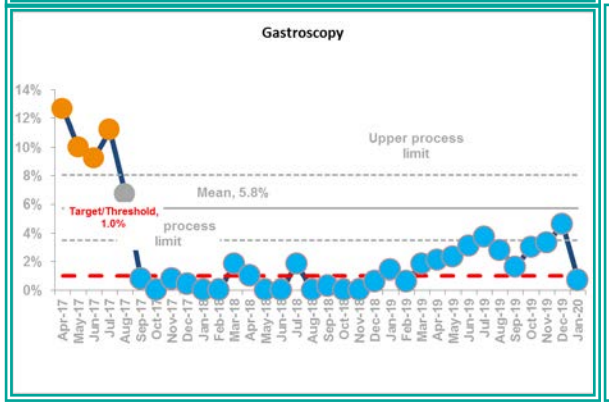


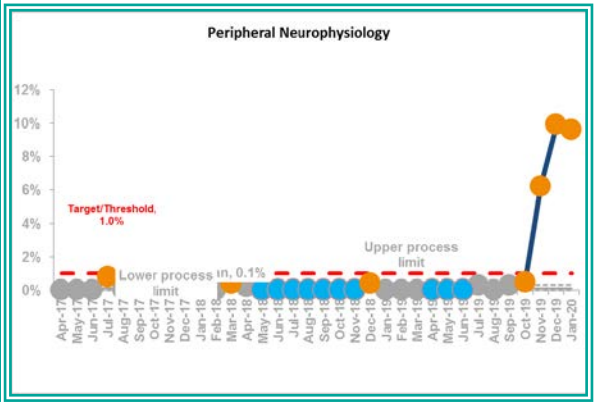


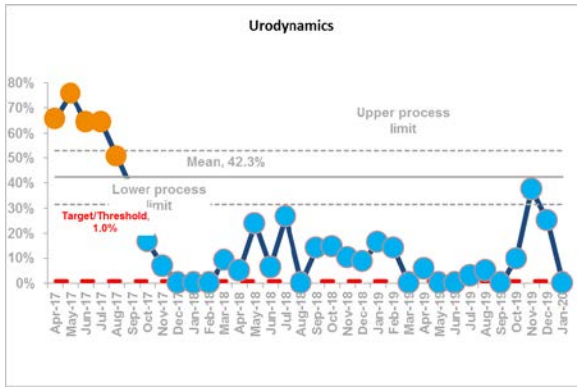






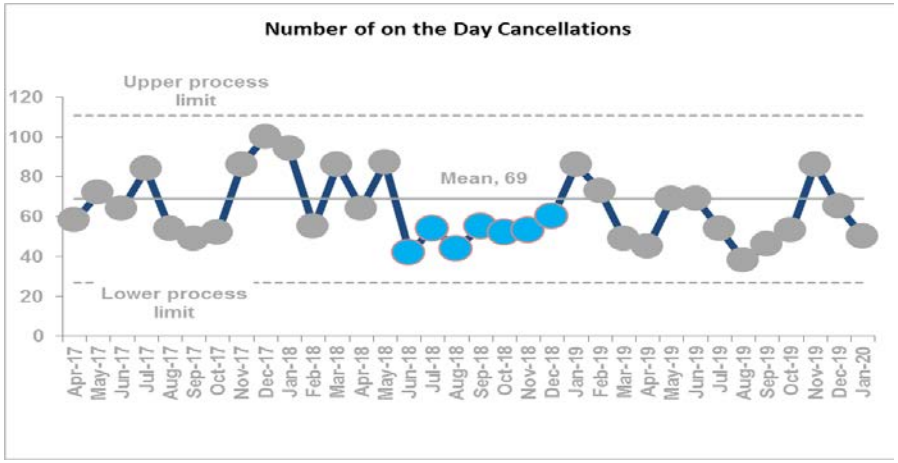


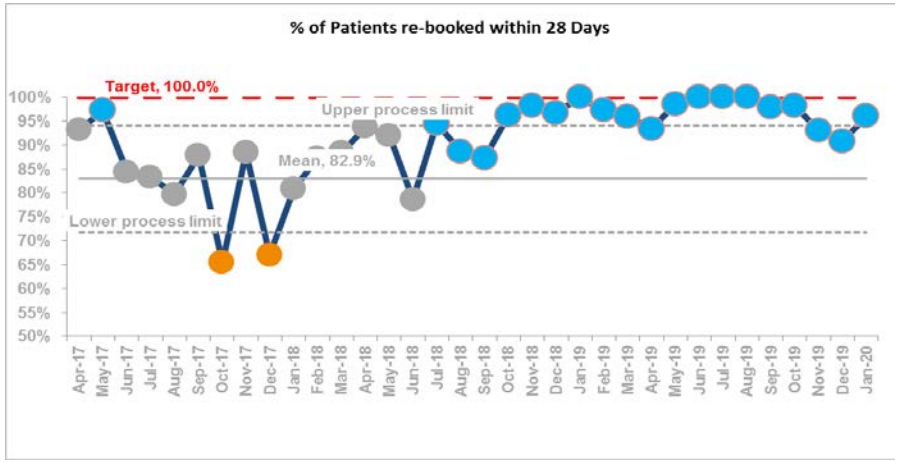




Our Process Perspective

On the Day Cancellations for Non Clinical Reasons





What the information tells us

- Performance remains within expected levels staying within the upper and lower control limits in both the number of on the day cancellations and the percentage of patients re-booked within 28 days.
- In the month of January, two patients were not re-booked within the 28 day time period due to capacity constraints.
- Compared to the same period last year the Trust has seen a reduction of 42% in the number of patients cancelled on the day of their operation for non-clinical reasons.
- The proportion of elective activity cancelled on the day is less than 1% in the month of January.
- The top three reasons for cancellations in the month of January were; Complication of previous case leading to timing issues and list overruns, no critical care beds available and emergency cases taking priority.

Actions and Quality Improvement Projects

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

Referral to Treatment

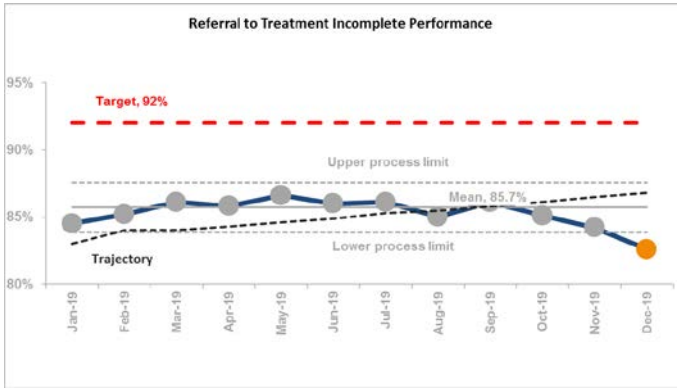
Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
RTT Incomplete Performance	92%	84.5%	85.2%	86.1%	85.8%	86.6%	86.0%	86.1%	85.0%	86.1%	85.1%	84.2%	82.6%
RTT Incomplete Trajectory		83%	84%	84%	84.3%	84.6%	84.9%	85.3%	85.5%	85.8%	86.1%	86.5%	86.8%
RTT Total Incomplete Waiting Lize Size		40,016	40,037	39,674	41,013	42,671	41,658	41,259	41,945	47,714	49,495	48,640	46,918
RTT Total Incomplete Waiting Lize Size Trajectory					39,890	39,880	39,870	39,860	39,850	39,840	39,830	39,820	39,810
Total waits greater than 18 weeks (inc 52Wk waiters)		5,921	5,929	5,515	5,812	5,717	5,820	5,739	6,305	6,651	7,353	7,701	8,183
Total waits greater than 18 weeks Trajectory				6,400	6,263	6,142	6,020	5,859	5,779	5,657	5,536	5,376	5,255
Total waits greater than 52 weeks	0	118	116	27	22	16	7	5	6	6	1	7	9
Total waits greater than 52 weeks Trajectory				31	23	16	9	5	5	5	0	0	0
RTT Incomplete Performance - Admitted		65.5%	65.5%	66.6%	65.3%	68.8%	68.7%	66.3%	63.7%	65.9%	65.3%	63.7%	61.40%
Total waits greater than 18 weeks - Admitted		1,563	1,563	1,428	1,511	1,459	1,494	1,523	1,655	1,643	1,686	1,719	1,876
Total waits greater than 52 weeks - Admitted	0	62	63	18	7	8	4	1	2	4	0	2	5
RTT Incomplete Performance -Non Admitted		87.7%	87.7%	88.5%	88.3%	88.8%	88.3%	88.5%	87.6%	88.3%	87.3%	86.4%	85%
Total waits greater than 18 weeks - Non Admitted		4,358	4,366	4,087	4,301	4,258	4,326	4,216	4,650	5,008	5,667	5,982	6,107
Total waits greater than 52 weeks - Non Admitted	0	56	53	9	15	8	3	4	4	2	1	5	4

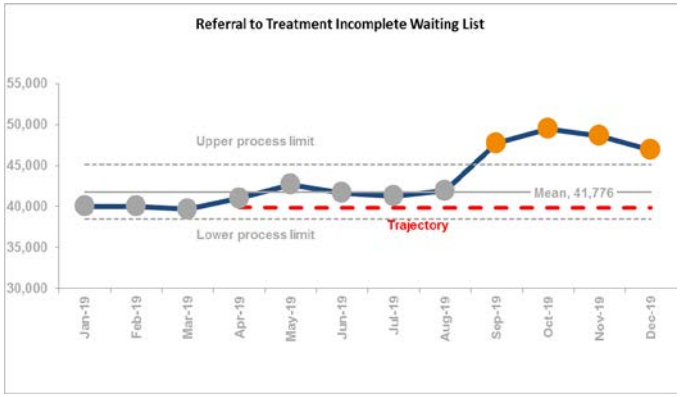
What the information tells us

- The Trust remains behind trajectory for incomplete Referral To Treatment (RTT) performance in December 2019. The submitted performance was 82.6% against a trajectory of 86.8%.
- The Total Patient Tracking List (PTL) size reported in December 2019 was 46,918 (inclusive of QMH pathways) against a trajectory of 39,810. The trajectory of PTL size was not adjusted to take into account the QMH patients migrated in September 2019. The QMH PTL size remains higher than planned.
- The Trust 52 week breach position deteriorated in December 2019 reporting nine patients waiting greater than 52 weeks (seven General Surgery, one Oral Surgery and one Cardiology).

Actions and Quality Improvement Projects

- Focused work on the management of patients on the continuing PTL (follow up waiting list). On 16th December 2019 there were a total of 15,035 patients on the continuing PTL, 7,150 (47.3%) did not have a next event booked. Service specific reviews have been taking place and continue throughout January 2020 to focus and action un-booked patients, this includes consultant, management and validation resource to either discharge or book patients. As of 15th January 2020 the continuing PTL position is now a total of 13,291 patients on the continuing PTL, 5230 patients (40%) remain un-booked. In short, it demonstrates that the Trust can reduce its overall PTL size by 1,744 patients in less than 4 weeks with targeted work to actually review each patient on its PTL.
- As a result of reviewing all un-booked patients on the continuing PTL (over and under 18 weeks) there will be a drop in performance for December 2019 however this will lead to longer term improvement and ensures our patients are appropriately being followed up.
- Revised RTT documentation circulated twice weekly to all operational teams.
- Revised access meeting structure from weekly to fortnightly offering more time to review report in detail.





Referral to Treatment

Specialty	Admitted		Non Admitted		Incomplete Pathway					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
General Surgery	267	46.8%	913	75.5%	814	366	1,180	69.0%	67	4
Urology	297	45.8%	1,415	93.4%	1,457	255	1,712	85.1%	27	0
Trauma & Orthopaedics	159	46.5%	1,926	87.1%	1,751	334	2,085	84.0%	6	0
Ear, Nose & Throat (ENT)	550	35.1%	2,458	82.9%	2,230	778	3,008	74.1%	49	0
Ophthalmology	0	-	477	88.9%	424	53	477	88.9%	1	0
Oral Surgery	8	50.0%	423	71.6%	307	124	431	71.2%	2	1
Neurosurgery	149	60.4%	2,105	79.1%	1,756	498	2,254	77.9%	26	0
Plastic Surgery	589	53.0%	928	7.0%	1,119	398	1,517	73.8%	34	0
Cardiothoracic Surgery	0	-	5	100.0%	5	0	5	100.0%	0	0
General Medicine	0	-	51	96.1%	49	2	51	96.1%	0	0
Gastroenterology	590	85.8%	2,472	87.7%	2,674	388	3,062	87.3%	8	0
Cardiology	924	74.6%	3,197	83.1%	3,346	775	4,121	81.2%	23	1
Dermatology	5	60.0%	3,277	86.7%	2,845	437	3,282	86.7%	4	0
Respiratory Medicine	8	87.5%	1,715	83.8%	1,445	278	1,723	83.9%	1	0
Neurology	34	94.1%	2,773	87.2%	2,449	358	2,807	87.2%	1	0
Rheumatology	1	100.0%	1,153	82.4%	951	203	1,154	82.4%	3	0
Geriatric Medicine	2	100.0%	91	95.6%	89	4	93	95.7%	0	0
Gynaecology	274	52.9%	2,157	89.1%	2,067	364	2,431	85.0%	8	0
Other	1,009	66.5%	14,516	84.6%	12,957	2,568	15,525	83.5%	136	3
Total	**4,866**	**61.4%**	**42,052**	**85.0%**	**38,735**	**8,183**	**46,918**	82.6%	**396**	**9**

- There are a number of specialties reported under speciality ‘Other’. This follows guidance set out in the documentation, “Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care” – produced by NHS England.
- The Trust 52 week breach position deteriorated in December 2019 reporting nine patients waiting greater than 52 weeks (seven General Surgery, one Oral Surgery and one Cardiology).

Balanced Scorecard Approach

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

Key

Current Month

A Previous Month

Our People Perspective

Workforce

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Trust Level Sickness Rate	3.2%	4.3%	4.0%	3.4%	3.1%	3.5%	3.8%	3.8%	3.5%	3.4%	3.7%	3.8%	4.0%	3.9%
Trust Vacancy Rate	10%	9.4%	9.3%	9.6%	9.1%	10.3%	10.5%	11.9%	12.8%	12.8%	9.3%	9.9%	11.2%	10.8%
Trust Turnover Rate* Excludes Junior Doctors	13%	17.1%	17.1%	17.5%	17.1%	17.4%	17.4%	17.5%	17.7%	17.7%	17.8%	17.6%	17.6%	17.4%
Total Funded Establishment		9,229	9,238	9,248	9,112	9,241	9,251	9,365	9,432	9,534	9,280	9,294	9,403	9,383
IPR Appraisal Rate - Medical Staff	90%	Data Unavailable				85.4%	84.5%	84.4%	85.7%	81.5%	83.9%	81.5%	83.6%	84.9%
IPR Appraisal Rate - Non Medical Staff	90%	70.9%	71.3%	70.4%	71.6%	72.5%	73.6%	73.3%	71.3%	70.4%	70.9%	72.3%	72.3%	72.0%
Overall MAST Compliance %	85%	89.3%	89.1%	89.4%	89.8%	90.6%	91.1%	91.2%	91.3%	90.6%	89.7%	89.7%	90.0%	89.7%
Ward Staffing Unfilled Duty Hours	10%	6.6%	6.7%	7.2%	5.7%	5.9%	6.1%	6.3%	5.4%	6.5%	6.1%	3.8%	5.3%	5.4%

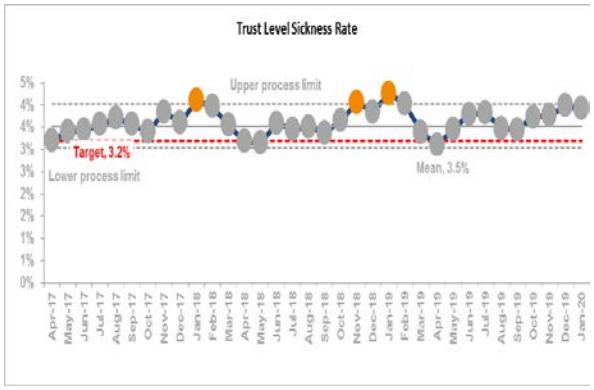
What the information tells us

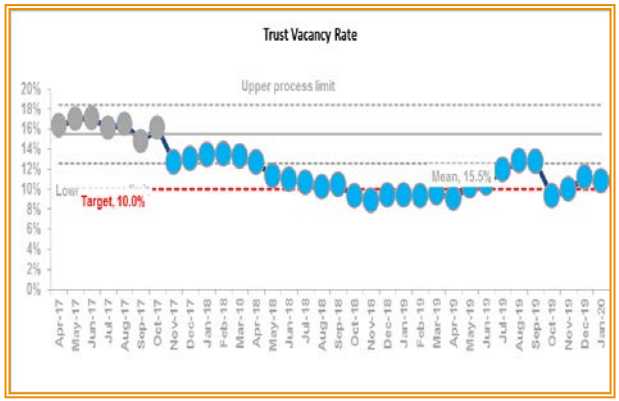
- Mandatory and Statutory Training figures was maintained at 89.7% in January.
- Medical appraisal rates currently stands at 84.9% an increase of 1.6% on last month and against a target of 90%.
- Non-medical appraisal performance remains similar to that of December at 72% against a 90% target and is below the lower control limits.
- The Trust's Total Funded Establishment and Trust Vacancy rate are both below the lower control limits.
- The Trust slightly exceeded the monthly agency target in January.

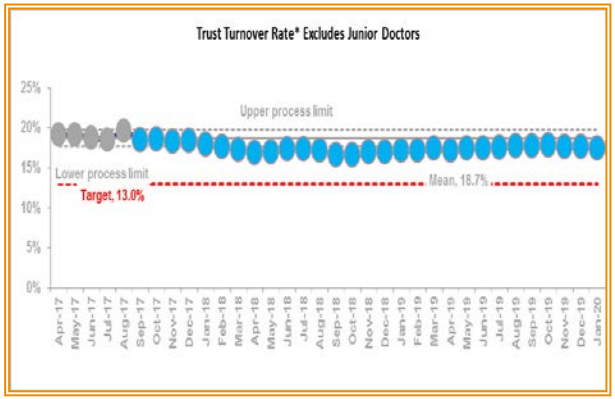
Actions and Quality Improvement Project
HR Managers will be meeting with Divisional Directors of Operations to discuss remedial actions to control agency costs.

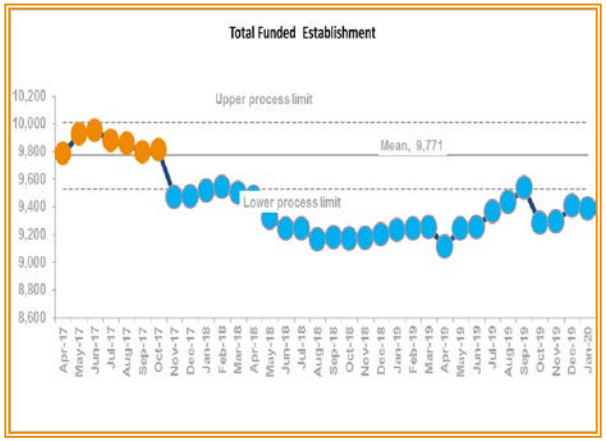
Workforce

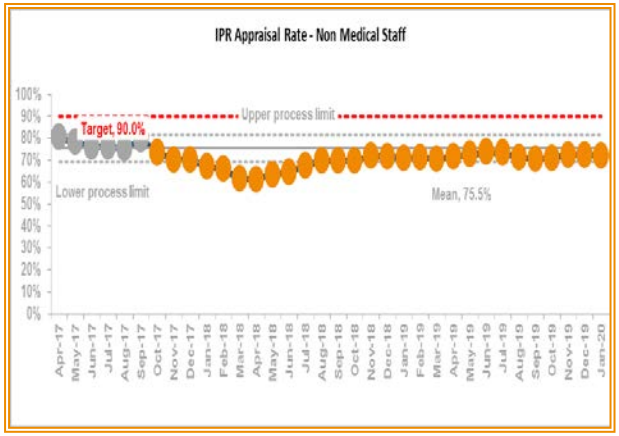
- Special cause variation - improving performance
- Common cause variation
- Special cause variation - deteriorating performance

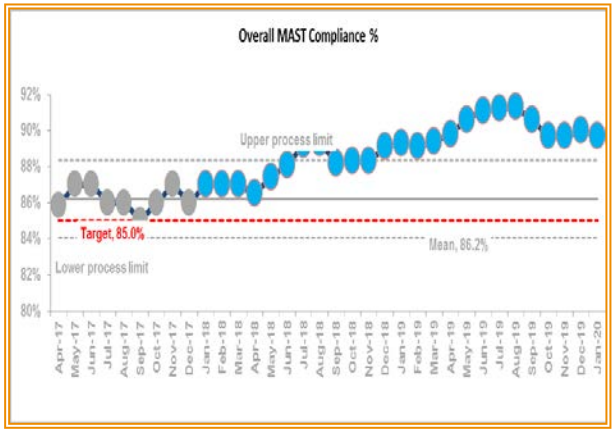


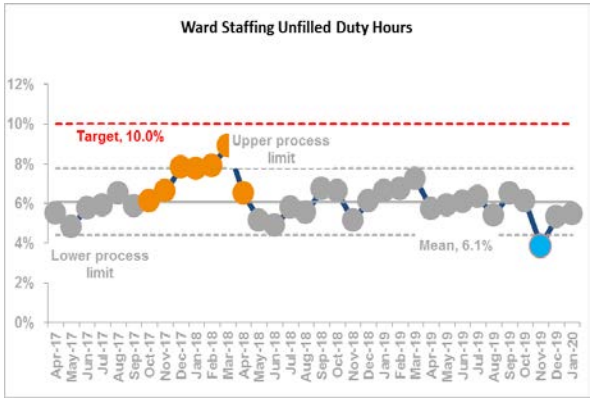






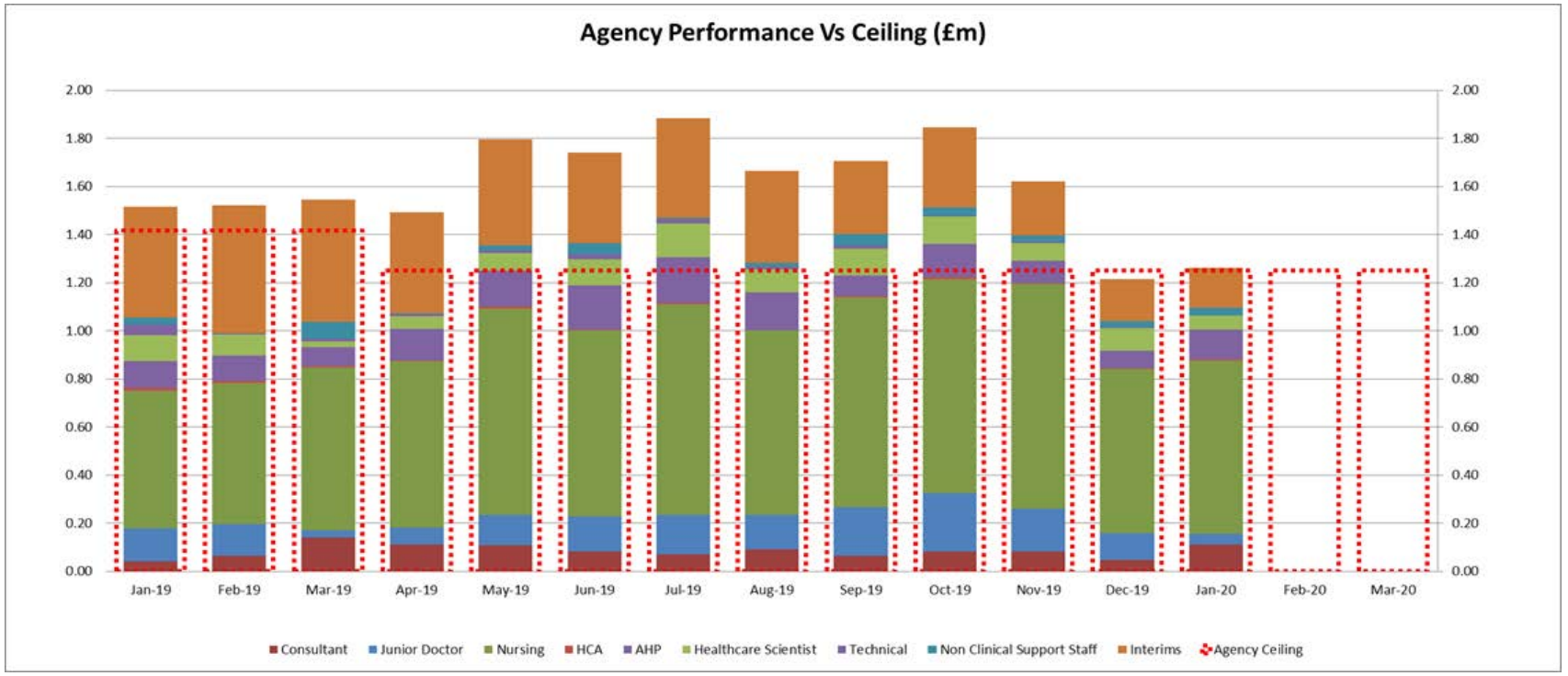






Our People Perspective

Agency use



- The Trust's total pay for January was £45.30m. This is £1.55m adverse to a plan of £43.75m.
- The Trust's 2019/20 annual agency spend target set by NHSI is £20.55m. There is an internal annual agency target of £15.00m.
- Agency cost in January was £1.26m or 2.8% of the total pay costs. For 2018/19, the average agency cost was 3.2% of total pay costs.
- For January, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.01m.
- Agency cost is £0.05m higher compared to December. This is in line with the forecast. There have been increases mainly in Consultant (£0.07m), AHP (£0.05m) and Nursing (£0.04m). This is partially offset by Junior Doctor (£0.07m) and Healthcare Scientist (£0.03m).
- The biggest areas of overspend were Nursing (£0.14m) and Consultant (£0.05m). The biggest areas of underspend were Interims (£0.13m).

Agency use

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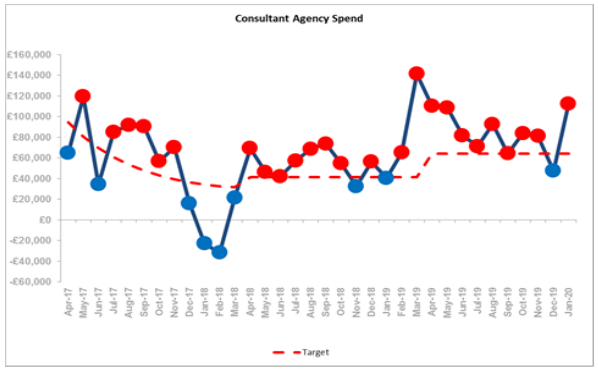
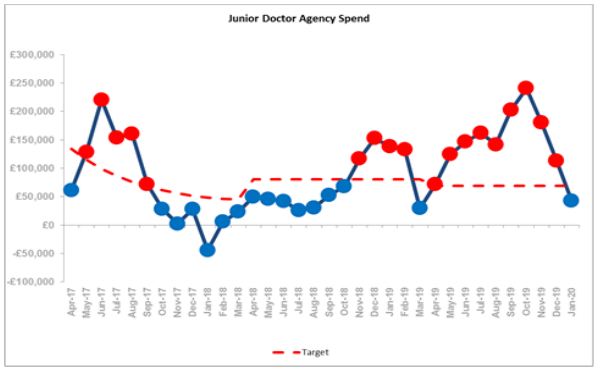
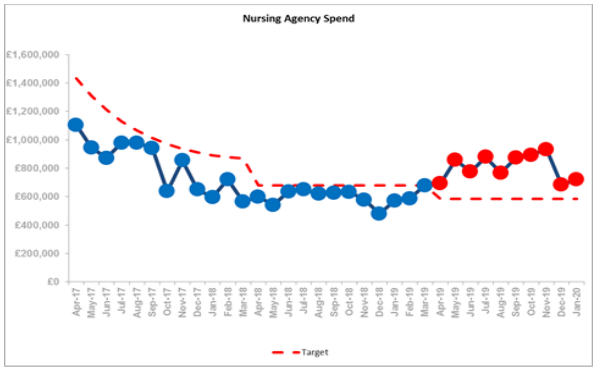
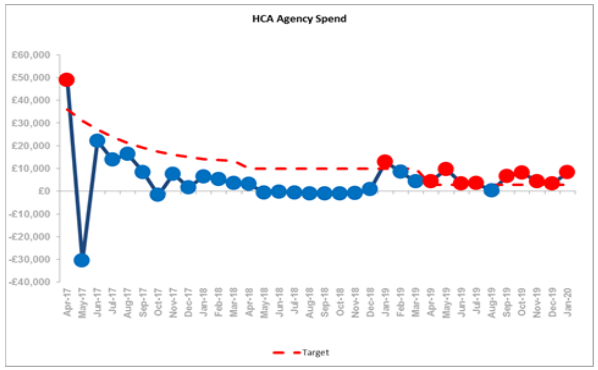
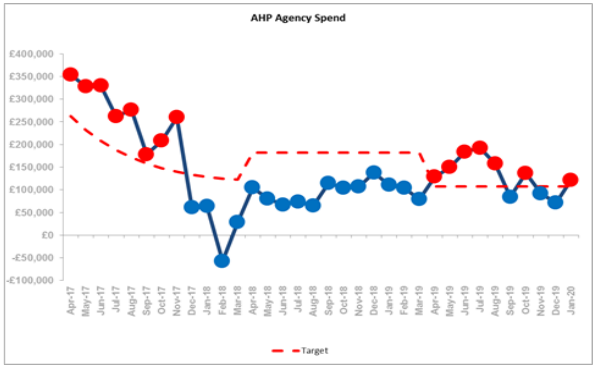
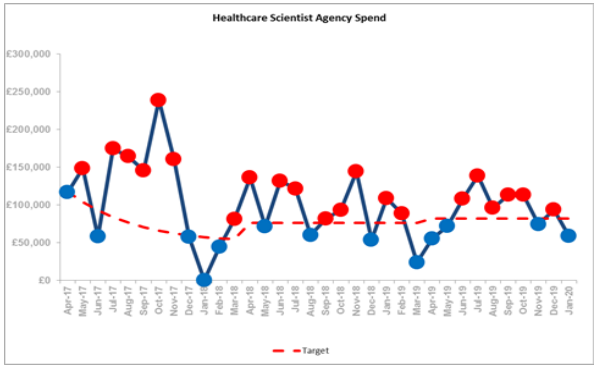


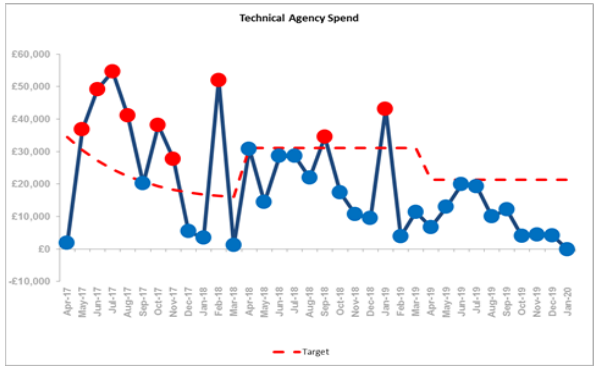


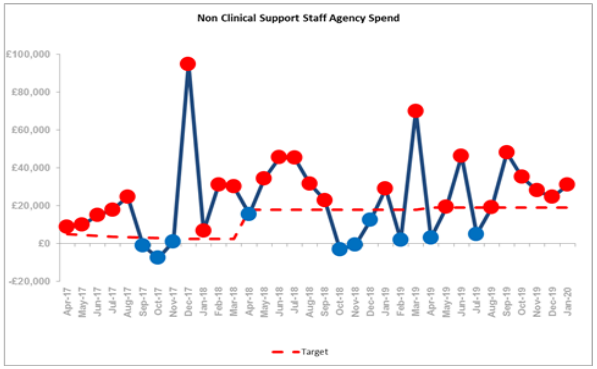


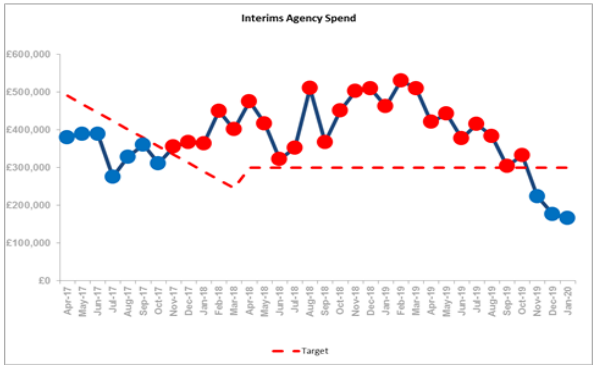






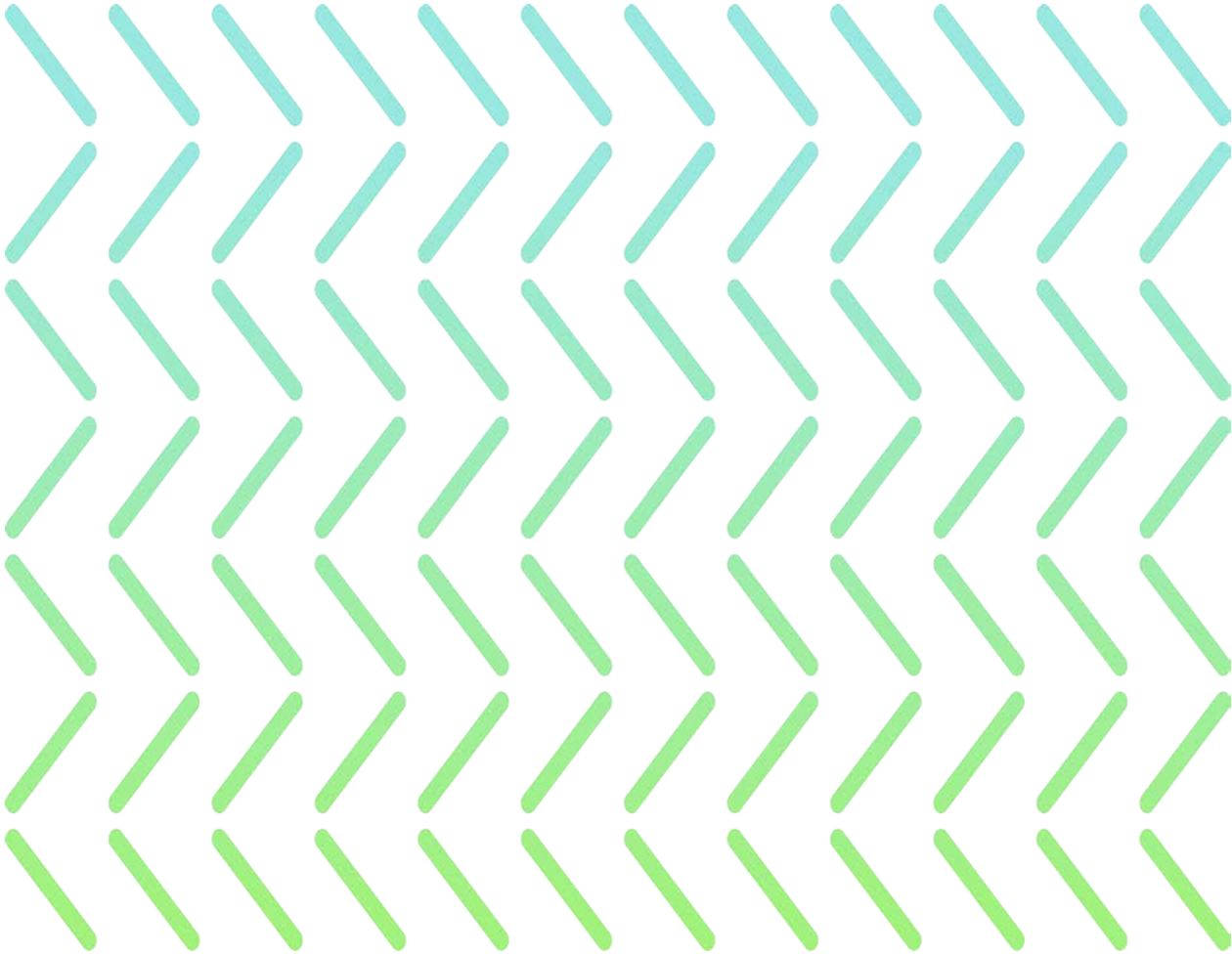




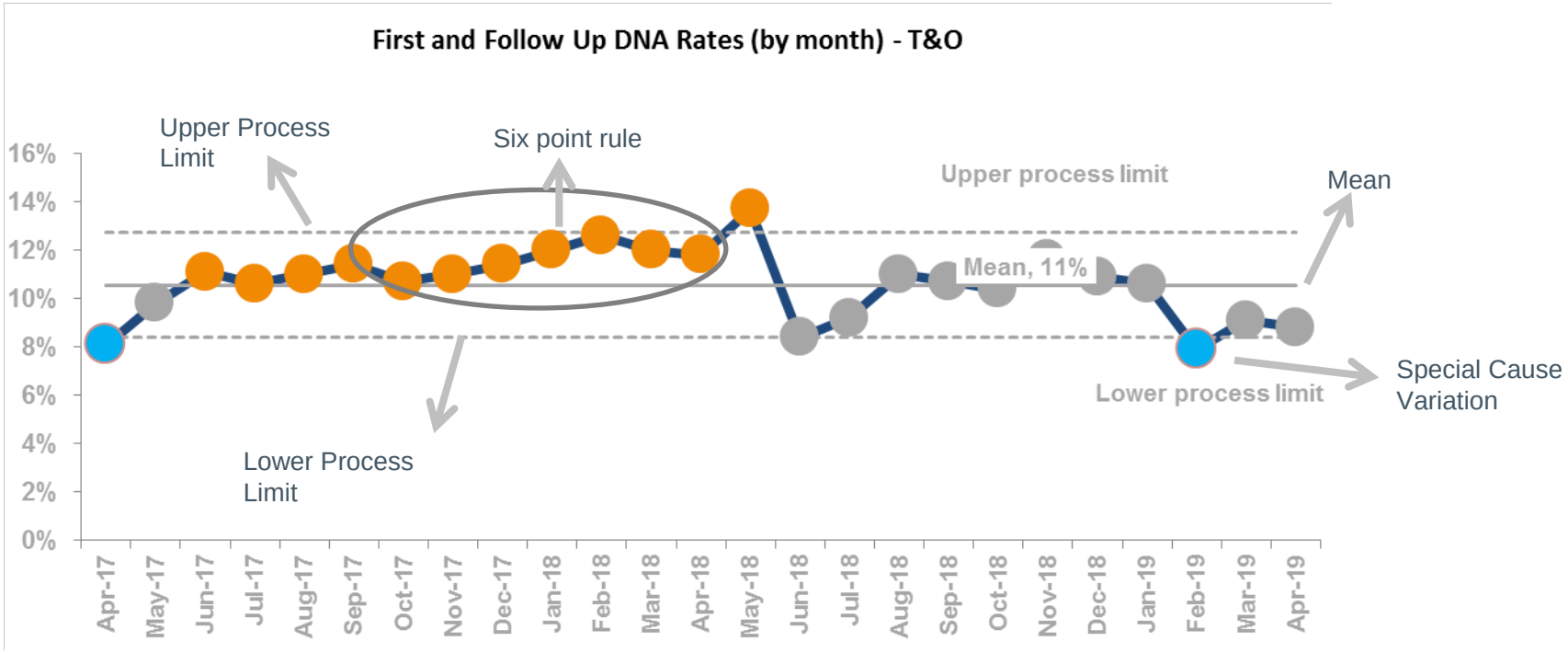


Our People Perspective

Appendix
Additional Information and Data Tables



Interpreting SPC (Statistical Process Control) Charts



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

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

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

Productivity Tables

First Outpatient Attendances (average per working day)

														First Outpatient Attendances per working day			
Directorate	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Attendances in the last month**	**2018-19 YTD**	**2019-20 YTD**	**Variance**	**Variance**
Cardiology, Cardiothoracic & Vascular Services	59	58	59	58	68	64	58	54	57	57	51	39	52	1,151	59	56	-3	-5.7%
Children's Services	50	47	46	42	50	45	43	39	44	46	48	34	43	954	46	43	-3	-5.5%
Neurosciences	94	81	75	86	82	88	82	72	77	86	84	69	80	1,749	81	81	-1	-1.2%
Renal & Oncology	26	25	24	25	25	27	25	24	26	24	24	21	24	517	26	25	-1	-3.9%
Specialist Medicine	148	147	148	148	158	159	155	131	147	144	138	120	139	3,059	143	144	1	0.7%
Surgery	268	264	278	250	252	269	253	243	235	228	231	191	224	4,926	270	238	-33	-12.1%
Womens Services	88	92	82	91	78	82	87	83	78	83	78	71	66	1,450	86	80	-7	-7.7%
T&O	53	54	51	52	51	54	53	42	56	51	53	43	49	1,071	55	50	-4	-7.8%
Other	39	33	32	60	60	62	59	52	66	78	74	61	68	1,488	37	64	27	71.5%
Total	**826**	**801**	**791**	**812**	**823**	**850**	**813**	**740**	**787**	**797**	**780**	**649**	**744**	**16,365**	**804**	**780**	**-24**	**-3.0%**

Follow-up Outpatient Attendances (average per working day)

														FollowUp Outpatient Attendances per working day			
Directorate	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**Attendances in the last month**	**2018-19 YTD**	**2019-20 YTD**	**Variance**	**Variance**
Cardiology, Cardiothoracic & Vascular Services	113	106	96	100	100	105	94	92	109	99	101	79	101	2,221	112	98	-14	-12.6%
Children's Services	83	84	70	78	82	78	72	70	73	81	82	59	74	1,617	79	75	-4	-5.5%
Neurosciences	124	118	101	121	118	122	107	103	99	114	119	95	119	2,626	115	112	-3	-2.5%
Renal & Oncology	238	223	230	242	229	221	219	211	222	235	226	197	229	5,040	230	223	-7	-3.1%
Specialist Medicine	528	537	526	573	538	544	528	483	504	534	533	466	553	12,162	509	525	17	3.3%
Surgery	382	350	335	317	331	327	321	291	306	325	332	264	341	7,504	355	316	-40	-11.2%
Womens Services	69	65	52	58	61	65	53	59	53	70	64	48	57	1,250	64	59	-5	-7.8%
T&O	86	85	76	82	79	81	75	70	77	77	82	63	82	1,796	83	77	-6	-7.6%
Other	91	92	87	119	121	125	125	104	109	132	136	106	128	2,820	91	120	29	31.7%
Total	**1,713**	**1,661**	**1,574**	**1,689**	**1,659**	**1,668**	**1,593**	**1,483**	**1,550**	**1,666**	**1,674**	**1,377**	**1,683**	**37,036**	**1,638**	**1,604**	**-34**	**-2.1%**

First to Follow-up Ratio

														First to FollowUp Ratio			
Directorate	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**	**2018-19 YTD**	**2019-20 YTD**	**Variance**	**Variance**
Cardiothoracic & Vascular Services	1.92	1.83	1.63	1.72	1.46	1.65	1.62	1.69	1.89	1.74	1.98	2.03	1.94	1.90	1.77	-0.12	-6.6%
Children's Services	1.66	1.79	1.52	1.85	1.64	1.73	1.69	1.82	1.64	1.76	1.71	1.74	1.72	1.73	1.73	-0.01	-0.3%
Neurosciences	1.32	1.46	1.35	1.40	1.44	1.39	1.30	1.43	1.29	1.33	1.42	1.38	1.49	1.41	1.39	-0.02	-1.8%
Renal & Oncology	9.15	8.92	9.58	9.68	9.17	8.06	8.76	8.70	8.45	9.79	9.42	9.38	9.54	9.06	9.10	0.04	0.4%
Specialist Medicine	3.57	3.65	3.55	3.87	3.41	3.41	3.42	3.67	3.42	3.71	3.86	3.88	3.98	3.57	3.66	0.09	2.7%
Surgery	1.43	1.33	1.21	1.27	1.31	1.21	1.27	1.20	1.30	1.43	1.44	1.38	1.52	1.32	1.33	0.02	1.2%
Womens Services	0.78	0.71	0.63	0.64	0.78	0.79	0.61	0.72	0.67	0.84	0.82	0.68	0.86	0.74	0.74	0.00	0.4%
T&O	1.62	1.57	1.49	1.58	1.55	1.51	1.43	1.65	1.38	1.51	1.55	1.47	1.67	1.53	1.53	0.00	0.1%
Other	2.33	2.79	2.72	1.98	2.02	2.03	2.11	1.99	1.65	1.69	1.84	1.74	1.88	2.46	1.89	-0.56	-23.0%
Total	**2.07**	**2.07**	**1.99**	**2.08**	**2.02**	**1.96**	**1.96**	**2.00**	**1.97**	**2.09**	**2.15**	**2.12**	**2.26**	**2.04**	**2.06**	**0.02**	**0.98%**

Productivity Tables

First and Follow-up DNA Rate

														Patients not attending rate		
Directorate	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	DNA patients in the last month	2018-19 YTD	2019-20 YTD	Variance
Cardiothoracic & Vascular Services	10.9%	10.3%	10.1%	9.0%	9.6%	9.8%	9.6%	8.5%	8.3%	8.5%	9.0%	9.3%	8.1%	259	10.6%	9.0%	⇩ -1.6%
Children's Services	10.9%	10.9%	10.2%	10.9%	12.3%	10.4%	11.1%	12.4%	11.1%	9.3%	10.4%	9.9%	8.0%	237	12.3%	10.6%	⇩ -1.8%
Neurosciences	10.3%	10.6%	11.0%	11.8%	11.9%	11.2%	10.1%	11.1%	10.2%	10.1%	9.4%	9.5%	8.0%	259	10.0%	10.3%	⇧ 0.4%
Renal & Oncology	9.7%	10.1%	9.4%	9.2%	9.9%	10.1%	8.2%	7.6%	7.9%	7.6%	8.3%	8.2%	7.2%	281	10.4%	8.4%	⇩ -1.9%
Specialist Medicine	12.3%	11.2%	10.8%	11.0%	12.8%	12.1%	10.2%	11.4%	11.1%	10.7%	12.0%	10.6%	9.8%	1,486	12.3%	11.2%	⇩ -1.1%
Surgery	10.4%	10.5%	10.4%	10.2%	10.3%	10.0%	8.8%	9.8%	8.8%	8.8%	9.2%	8.5%	7.5%	1,111	11.0%	9.2%	⇩ -1.8%
Womens Services	6.6%	7.4%	6.8%	8.0%	7.8%	7.8%	6.7%	7.4%	7.4%	6.6%	7.9%	8.1%	7.1%	409	8.2%	7.5%	⇩ -0.7%
T&O	10.6%	7.9%	9.1%	8.8%	10.7%	9.4%	9.3%	9.0%	10.5%	10.0%	9.8%	9.7%	8.1%	265	10.8%	9.5%	⇩ -1.3%
Other	12.9%	12.9%	14.3%	14.2%	13.4%	12.8%	12.6%	14.3%	14.8%	15.3%	17.6%	17.7%	14.7%	1,586	12.7%	14.7%	⇧ 2.0%
Total	**10.8%**	**10.5%**	**10.6%**	**10.7%**	**11.2%**	**10.7%**	**9.7%**	**10.6%**	**10.4%**	**10.1%**	**11.1%**	**10.7%**	**9.3%**	**5,993**	**11.0%**	**10.4%**	⇩ -0.6%

Elective & Daycase activity (average per working day)

Months	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	2018-19 YTD	2019-20 YTD	Variance	Discharges for month
Cardiology & Cardiac Surgery	14.7	17.2	16.2	12.0	13.3	15.4	13.7	13.6	15.6	14.3	15.6	10.2	14.2	15.4	13.8	-10.4%	313
Clinical Haematology	1.0	1.3	1.4	0.8	0.8	0.7	1.4	1.1	0.4	0.7	0.4	0.7	0.5	1.7	0.8	-56.4%	12
Diabetes & Endocrinology	2.0	1.6	1.8	1.8	2.7	1.9	1.6	1.6	1.9	1.3	2.5	1.4	1.4	1.8	1.8	-0.9%	30
Endoscopy & Gen Med	57.3	56.4	61.6	57.4	68.5	70.8	65.3	61.7	61.4	68.2	62.0	53.0	64.2	56.5	63.2	11.9%	1,413
Ear, Nose & Throat	9.5	7.9	7.9	8.5	8.3	8.9	8.3	7.5	9.4	8.5	7.8	6.4	7.8	8.3	8.1	-1.6%	171
General Surgery	10.7	10.5	12.8	8.1	7.1	8.5	7.2	6.7	7.6	9.0	6.8	6.0	7.5	10.0	7.5	-25.3%	164
Gynaecology and Obstetrics	11.0	10.8	10.4	9.9	10.8	10.5	10.3	8.8	11.0	10.0	10.5	8.2	11.1	10.4	10.1	-3.0%	245
Max Fax & Dental	6.7	7.2	5.4	6.1	7.3	7.2	6.5	5.8	6.8	5.8	6.5	4.0	5.8	6.5	6.2	-4.9%	128
Neurosurgery	8.2	9.3	10.5	8.8	10.3	9.1	8.1	8.5	8.0	9.0	8.1	7.5	7.3	9.1	8.5	-6.9%	162
Neurology	28.7	34.3	31.0	32.4	33.3	32.1	31.9	27.8	30.5	32.2	28.2	22.5	32.2	26.5	30.3	14.6%	709
Oncology	2.8	2.7	1.8	4.0	3.4	3.6	3.8	4.1	4.1	4.6	4.7	3.2	3.7	1.8	3.9	120.8%	80
Paediatric Medicine	10.5	12.5	11.9	12.9	12.3	12.6	11.2	10.5	13.0	11.8	10.1	11.9	12.2	10.2	11.9	16.7%	268
Paediatric Surgery	9.6	10.0	10.0	8.9	10.3	8.2	8.9	9.0	8.4	8.8	9.1	6.3	8.5	9.0	8.6	-3.6%	187
Pain Clinic	5.1	5.3	5.3	4.5	3.1	5.2	3.3	2.3	4.9	3.8	5.0	4.0	4.9	5.3	4.1	-22.6%	108
Plastic Surgery	17.1	17.4	16.5	15.0	19.3	18.5	15.1	16.6	17.5	18.0	17.2	14.4	18.0	17.6	17.0	-3.7%	395
Renal Medicine	3.2	5.2	3.7	4.3	6.5	5.1	4.3	5.5	5.2	5.6	6.7	4.5	4.4	4.8	5.2	9.4%	96
Trauma & Orthopaedics	7.7	8.5	6.4	7.3	8.0	9.2	6.0	6.1	6.0	5.6	8.5	5.6	7.3	7.1	7.0	-1.4%	161
Urology	13.4	14.8	13.2	15.8	13.0	13.7	14.1	12.6	15.8	13.6	13.8	10.0	12.1	12.9	13.4	4.2%	267
Thoracic Surgery	2.3	3.2	3.1	2.2	3.0	3.3	2.9	3.2	3.0	2.4	3.0	2.3	2.7	2.8	2.8	0.8%	60
Vascular Surgery	5.1	3.9	4.4	4.4	4.8	4.1	4.5	3.7	5.2	4.2	4.4	3.3	3.9	4.9	4.2	-12.7%	86
Other	6.5	6.6	4.2	7.5	7.4	8.6	9.3	9.4	11.2	10.5	17.0	12.9	15.0	5.7	10.9	90.1%	329
Grand Total	**233.1**	**246.3**	**239.4**	**232.3**	**253.7**	**256.7**	**237.8**	**226.0**	**246.9**	**248.0**	**247.9**	**198.3**	**244.7**	228.1	239.2	**4.9%**	**5,384**

Productivity Tables

Percentage of Daycase Activity

Months	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	2018-19 YTD	2019-20 YTD	Variance
Cardiology & Cardiac Surgery	51%	54%	54%	50%	49%	49%	50%	50%	56%	56%	55%	54%	54%	53%	52%	-0.5%
Clinical Haematology	57%	77%	45%	27%	17%	43%	52%	52%	0%	13%	10%	0%	0%	62%	24%	-38.7%
Diabetes & Endocrinology	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	89%	93%	100%	100%	98%	-2.3%
Endoscopy & Gen Med	99%	99%	98%	99%	97%	98%	97%	96%	97%	97%	98%	99%	99%	99%	98%	-1.1%
Ear, Nose & Throat	43%	39%	28%	39%	49%	37%	51%	42%	45%	47%	54%	49%	46%	45%	46%	1.1%
General Surgery	52%	51%	31%	42%	40%	36%	42%	42%	43%	53%	46%	61%	57%	46%	45%	-1.0%
Gynaecology and Obstetrics	75%	73%	74%	72%	72%	69%	68%	70%	76%	73%	76%	79%	78%	74%	73%	-1.3%
Max Fax & Dental	63%	55%	57%	56%	62%	62%	58%	52%	57%	57%	57%	52%	66%	55%	57%	1.4%
Neurosurgery	34%	30%	31%	26%	31%	28%	33%	32%	30%	25%	36%	27%	32%	34%	30%	-4.7%
Neurology	94%	95%	95%	96%	96%	95%	96%	95%	96%	97%	95%	96%	96%	94%	96%	1.3%
Oncology	79%	76%	65%	82%	79%	82%	82%	81%	67%	87%	87%	89%	85%	58%	82%	23.9%
Paediatric Medicine	94%	96%	94%	95%	96%	96%	98%	95%	94%	97%	95%	95%	97%	91%	96%	4.6%
Paediatric Surgery	84%	81%	84%	80%	85%	77%	80%	79%	85%	81%	78%	82%	79%	82%	81%	-1.0%
Pain Clinic	91%	93%	100%	92%	88%	92%	92%	100%	92%	99%	100%	90%	93%	93%	94%	1.3%
Plastic Surgery	78%	80%	75%	79%	79%	83%	85%	81%	85%	81%	80%	84%	83%	79%	82%	3.2%
Renal Medicine	81%	81%	73%	77%	81%	84%	72%	73%	75%	79%	81%	85%	55%	78%	78%	0.1%
Trauma & Orthopaedics	75%	71%	72%	63%	61%	69%	68%	66%	75%	78%	75%	66%	78%	64%	69%	4.9%
Urology	56%	52%	47%	58%	51%	50%	61%	54%	58%	55%	60%	53%	53%	52%	56%	3.8%
Thoracic Surgery	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%	0%	0%	0%	2%	0%	2%	0%	-1.3%
Vascular Surgery	52.7%	52.6%	48.9%	43%	52.5%	48%	48%	31%	57%	48%	47%	32%	48%	45%	45%	-0.1%
Other	92%	93%	84%	77%	76%	79%	86.9%	75%	74%	85%	70%	85%	81%	89%	79%	-10.0%
Grand Total	**78%**	**77%**	**75%**	**77%**	**78%**	**77%**	**79%**	**76%**	**78%**	**79%**	**79%**	80%	80%	76%	78%	2.1%

Productivity Tables

Theatre Utilisation

Main List Specialty	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Number of Patients in the last month
Cardiothoracic	72%	80%	74%	70%	70%	75%	70%	73%	75%	71%	81%	75%	80%	80
ENT	80%	76%	74%	75%	78%	72%	73%	82%	82%	75%	83%	76%	85%	149
General Surgery	78%	78%	82%	81%	80%	88%	80%	72%	76%	79%	76%	78%	79%	110
Gynaecology	79%	88%	74%	81%	71%	78%	84%	81%	84%	85%	77%	67%	84%	148
Neurosurgery	82%	78%	75%	79%	78%	78%	79%	79%	81%	76%	77%	82%	75%	150
Oral and Maxillo Facial Surgery	84%	67%	91%	61%	72%	84%	87%	67%	65%	84%	70%	74%	67%	32
Paediatric Dentistry	65%	68%	65%	58%	80%	64%	59%	74%	68%	48%	55%	51%	54%	36
Paediatric Surgery	76%	82%	74%	77%	79%	79%	80%	78%	80%	77%	81%	76%	79%	110
Plastic Surgery	74%	75%	69%	76%	87%	72%	74%	74%	69%	74%	72%	62%	65%	186
Renal Medicine & Surgery	66%	67%	83%	66%	88%	69%	79%	77%	77%	67%	64%	67%	61%	23
Trauma & Orthopaedics	81%	83%	90%	83%	81%	84%	88%	84%	74%	78%	77%	77%	83%	100
Urology	86%	82%	80%	79%	78%	79%	82%	77%	79%	78%	79%	83%	75%	193
Vascular Surgery	76%	82%	75%	68%	73%	74%	72%	67%	75%	73%	66%	75%	70%	72
Grand Total	**79%**	**79%**	**77%**	**77%**	**77%**	**78%**	**78%**	**77%**	**77%**	**76%**	**76%**	**76%**	**76%**	**1,389**

Theatre Average Cases per Session

Main List Specialty	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Cardiothoracic	1.5	1.7	1.4	1.5	1.6	1.6	1.6	1.6	1.6	1.3	1.6	1.5	1.7
ENT	1.9	1.6	1.6	1.7	1.9	1.9	1.8	2.0	2.0	1.9	1.8	1.9	1.7
General Surgery	1.8	1.7	1.6	1.8	1.8	1.6	1.5	1.7	1.4	1.4	1.2	1.4	1.4
Gynaecology	2.7	2.6	2.3	2.5	2.2	2.4	2.5	2.4	2.7	2.6	2.4	2.5	2.3
Neurosurgery	1.1	1.0	1.1	1.1	1.1	1.1	1.1	1.1	0.9	1.0	0.9	1.1	0.9
Oral and Maxillo Facial Surgery	3.7	3.1	4.0	2.7	3.1	3.4	3.2	3.0	3.0	3.6	2.6	2.8	3.0
Paediatric Dentistry	4.4	4.3	4.1	3.9	4.9	4.2	3.8	3.8	3.8	2.8	3.3	2.7	3.4
Paediatric Surgery	2.6	2.5	2.6	2.4	2.7	2.2	2.5	2.2	2.8	2.5	2.6	2.3	2.4
Plastic Surgery	1.9	2.0	2.1	1.8	1.8	1.7	1.8	2.0	1.9	1.6	2.0	1.7	1.8
Renal Medicine & Surgery	1.2	1.8	1.5	1.9	2.0	1.2	1.1	1.0	1.4	1.3	2.4	1.1	1.3
Trauma & Orthopaedics	1.9	1.9	1.9	1.8	1.8	2.0	1.7	1.8	1.7	1.7	1.7	1.7	1.5
Urology	2.0	2.0	2.0	2.0	2.1	2.1	2.1	1.8	1.9	1.9	2.0	1.7	1.8
Vascular Surgery	1.0	1.0	1.1	1.0	1.1	1.4	1.4	1.3	1.5	1.3	1.4	1.2	1.3
Grand Total	1.8	1.8	1.7	1.7	1.8	1.8	1.8	1.7	1.7	1.6	1.7	1.6	1.6

Productivity Tables

Elective Length of Stay

Directorate	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Discharges in the last month	Average length of Stay 2018-19 YTD	Average length of Stay 2019-20 YTD	Variance
Cardiothoracic	3.5	4.2	3.6	3.0	3.5	3.9	3.7	3.6	3.6	3.3	3.0	3.3	2.9	213	3.8	3.4	⇩ -12%
Children's & Women	3.8	2.7	3.0	2.4	1.9	2.0	2.2	1.9	3.8	5.1	1.6	4.7	2.8	106	2.6	2.8	⇧ 7%
Neurosciences	9.0	8.0	5.3	10.1	7.8	6.9	11.1	9.4	9.3	7.5	11.2	9.7	10.4	153	8.6	9.3	⇧ 8%
Surgery & Trauma	3.0	2.5	2.5	2.7	2.5	2.5	2.4	2.9	2.1	2.6	2.6	2.6	2.1	501	2.7	2.5	⇩ -8%
Grand Total	**5.4**	**4.7**	**4.7**	**3.8**	**3.5**	**3.5**	**4.1**	**4.0**	**3.5**	**3.9**	**3.9**	**4.3**	**3.6**	**973**	**4.8**	**3.8**	⇩ -20%

Non-Elective Length of Stay

Directorate	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Discharges in the last month	Average length of Stay 2018-19 YTD	Average length of Stay 2019-20 YTD	Variance
Acute Medicine	2.9	2.8	2.8	2.7	2.7	2.5	2.6	2.9	3.1	2.9	2.9	3.7	4.8	2,253	2.7	3.1	⇧ 14.86%
Cardiothoracic	7.6	9.7	11.7	10.2	12.3	9.1	11.2	8.1	10.7	10.3	9.6	9.5	8.2	146	8.4	9.9	⇧ 17%
Children's & Women	2.4	2.9	3.1	3.4	3.6	3.7	3.7	3.2	2.9	3.5	3.1	2.6	2.6	377	2.4	3.2	⇧ 34%
Neurosciences	10.8	13.5	9.3	9.5	11.9	6.8	9.9	10.3	8.6	11.2	12.4	10.1	10.2	201	9.6	10.1	⇧ 5%
Senior Health	12.5	11.1	11.2	12.7	12.6	10.2	12.6	10.6	16.6	18.4	23.3	16.0	24.1	30	10.1	15.7	⇧ 56%
Specialist Medicine	8.3	6.8	8.5	9.5	11.1	11.2	7.9	9.4	10.1	8.3	9.6	9.1	8.8	84	7.4	9.5	⇧ 28%
Surgery & Trauma	5.3	5.0	4.0	4.3	4.2	4.1	4.8	4.1	4.3	4.1	4.6	5.2	5.2	768	4.5	4.5	⇩ -1.8%
Therapeutics	12.3	25.3	11.3	11.0	22.5	23.0	14.1	7.6	12.6	18.0	8.3	12.2	15.1	15	12.2	14.4	⇧ 19%
Grand Total	**4.0**	**4.3**	**4.0**	**4.1**	**4.3**	**3.9**	**4.2**	**4.1**	**4.4**	**4.4**	**4.6**	**5.1**	**5.3**	**3,874**	**3.8**	**4.4**	⇧ 16%

Maternity

Definitions	Format	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Total number of women giving birth (per calendar day)	Number	14 per day	13.6	13.1	12.9	13.6	14.0	13.6	13.2	12.6	13.4	14.4	12.9	14	13
Caesarean sections (Total Emergency and Elective by Delivery date)	%	<28%	29.2%	28.5%	31.4%	30.4%	25.9%	25.9%	25.9%	25.6%	27.4%	25.7%	24.2%	26.7%	24.8%
% deliveries with Emergency C Section (including no Labour)	%	<8%	4.5%	4.6%	3.7%	4.7%	2.8%	3.2%	3.9%	2.6%	5.2%	4.5%	1.5%	4.0%	1.3%
% Time Carmen Suite closed	%	0%	0.0%	0.0%	0.0%	5.0%	0.0%	6.7%	0.0%	4.8%	1.7%	19.4%	11.7%	8.1%	1.6%
% of all births in which woman sustained a 3rd or 4th degree tear	%	<5%	2.1%	1.4%	2.0%	1.5%	2.8%	1.2%	1.5%	3.3%	3.5%	4.0%	2.6%	5.3%	2.3%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	%	<4%	2.6%	1.9%	3.0%	2.7%	1.8%	2.0%	3.4%	2.1%	2.0%	2.3%	3.4%	3.0%	1.5%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit	Number		12	6	8	10	9	12	7	6	9	5	12	7	8
Supernumerary Midwife in Labour Ward	%	>95%	98.4%	96.4%	95.2%	96.7%	98.4%	98.3%	100.0%	96.8%	96.7%	96.8%	96.7%	96.8%	96.8%
% women booked by 12 weeks and 6 days	%	90%	84.7%	86.6%	87.3%	83.3%	86.6%	88.4%	85.3%	84.9%	81.5%	81.7%	84.1%	85.7%	82.5%

Patient Safety

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Number of Never Events in Month	0	1	0	0	1	0	0	1	0	0	1	0	1	1
Number of SIs where Medication is a significant factor	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Number of Serious Incidents	=<8 month	6	6	4	3	7	7	2	4	1	3	1	6	4
Serious Incidents - per 1000 bed days	N/A	0.25	0.27	0.16	0.13	0.29	0.30	0.08	0.17	0.04	0.12	0.04	0.25	0.16
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.9%	96.5%	96.0%	96.1%	96.1%	94.6%	95.4%	95.3%	96.0%	96.8%	98.1%	96.5%	95.9%
Safety Thermometer - % of patients with harm free care (new harm)	95%	98.4%	98.6%	98.3%	98.3%	98.9%	98.0%	97.8%	98.7%	98.2%	98.3%	98.7%	98.2%	98.0%
Percentage of patients who have a VTE risk assessment	95%	95.9%	95.7%	95.5%	87.8%	88.2%	87.6%	93.8%	93.8%	93.9%	94.0%	94.7%	94.8%	96.1%
Number of Patient Falls	N/A	128	147	135	143	135	133	123	158	142	131	137	140	144
Falls (Moderate and Above Severity)	N/A	3	1	2	2	2	1	0	3	0	2	2	4	3
Number of patient falls- per 1000 bed days	N/A	5.31	6.57	5.38	6.08	5.63	5.75	4.99	6.58	6.03	5.25	5.57	5.87	5.78
Acquired Category 2 Pressure Ulcers	N/A	10	16	6	4	17	20	10	15	15	13	11	21	17
Acquired Category 2 Pressure Ulcers per 1000 bed days	N/A	0.42	0.72	0.24	0.17	0.71	0.86	0.41	0.63	0.64	0.52	0.45	0.88	0.68
Acquired Category 3 Pressure Ulcers		7	4	11	8	5	8	8	2	3	5	5	10	10
Acquired Category 3 Pressure Ulcers per 1000 bed days		0.29	0.18	0.44	0.34	0.21	0.35	0.32	0.08	0.13	0.20	0.20	0.42	0.40
Number of overdue CAS Alerts	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Complaints

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Complaints Received		92	84	101	108	102	96	96	88	81	88	79	55	59
% of Complaints responses to within 25 working days	85%	66%	55%	80%	72%	79%	78%	95%	100%	100%	100%	100%	100%	98%
% of Complaints responses to within 40 working days	90%	30%	64%	44%	56%	46%	57%	72%	96%	100%	100%	100%	95%	
% of Complaints responses to within 60 working days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PALS Received		369	334	280	249	247	218	177	259	232	316	283	218	180

Patient Priorities

Indicator Description	Threshold/ Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Number of 2222 calls / 1000 adult ordinary IP admissions		11.0	11.2	8.8	7.1	8.9	10.2	12.2	8.3	7.0	7.4	11.1	12.9	10.7
Number of Cardiac Arrests / 1000 adult ordinary IP admissions (to become avoidable cardiac arrests)		3.8	3.3	2.8	4.0	2.9	1.8	3.6	0.9	1.6	1.2	2.2	3.2	2.2
% of patients in ED with Red Flag sepsis receiving antibiotics within an hour (adults)	90%	94.5%	93.2%	88.3%	90.6%	91.4%	93.5%	87.2%	83.4%	90.3%	86.4%	89.5%	83.5%	82.0%
Compliance with appropriate response to EWS (adults)	100%	95.8%	87.3%	89.6%	92.7%	94.2%	92.9%	90.6%	93.9%	87.6%	86.8%	89.6%	89.0%	92.0%
Resuscitation BLS	85%	70.5%	71.5%	74.1%	76.2%	75.2%	76.0%	75.5%	75.9%	76.4%	77.8%	79.8%	81.3%	80.6%
Resuscitation ILS	85%	70.2%	69.3%	71.3%	72.1%	72.7%	72.0%	72.5%	69.2%	67.9%	67.7%	68.3%	71.7%	74.3%
Resuscitation ALS	85%	64.2%	67.0%	70.4%	72.7%	73.0%	73.5%	74.8%	59.1%	62.7%	64.4%	63.9%	66.9%	72.8%

Indicator Description	Threshold/Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Total Datix incidents reported in month		1,333	1,215	1,208	1,096	1,329	1,332	1,413	1,544	1,442	1,410	1,309	1,241	1,271
Monthly percentage of incidents of low and no harm					97.0%	97.0%	99.0%	97.0%	98.0%	97.0%	97.0%	96.0%	96.0%	data one months in arrears
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%				100.0%	92.0%	100.0%	97.0%	93.0%	97.0%	97.0%	98.0%	data two months in arrears	

Emergency Flow

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
4 Hour Operating Standard	95%	84.2%	82.2%	83.1%	85.4%	86.5%	87.0%	86.4%	83.3%	82.3%	83.2%	79.4%	79.4%	81.7%
Non-Admitted Four Hour Operating Standard Performance		89.3%	86.6%	86.8%	89.3%	88.8%	91%	89.8%	87.10%	85.43%	87.19%	83.50%	83.26%	86.17%
Admitted Four Hour Operating Standard Performance		51.4%	50.2%	54.6%	59.9%	65.3%	60.6%	56.3%	50.1%	51.30%	50.07%	43.13%	45.08%	44.49%
Patients Waiting in ED for over 12 hours following DTA	0	0	0	1	1	0	1	2	3	1	4	9	7	18
Attendances to the Emergency Department		15228	14296	15638	14446	15434	14836	15433	14363	14457	14916	14725	14383	14602
Ambulance Arrivals to the Emergency Department		3433	3117	3307	3081	3137	3129	3280	3176	2963	2959	3239	3186	3117
Ambulance Handover - % under 15 minutes	100%	33.9%	33.0%	33.0%	35.1%	35.2%	36.0%	32.9%	32.4%	31.1%	31.3%	28.0%	24.3%	25.9%
Ambulance Handover - % under 15 minutes (London Average)	100%	41.6%	43.1%	45.4%	43.5%	44.4%	42.3%	43.9%	45.0%	44.7%	41.7%	38.9%	36.8%	37.5%
Ambulance Handover - number of patients not handed over within 30 minutes	0	145	87	94	76	112	119	134	171	163	176	238	271	215
Ambulance Handover - % under 30 minutes	100%	92.3%	95.1%	93.6%	95.5%	94.3%	93.5%	92.9%	90.8%	90.8%	90.2%	86.4%	83.8%	87.8%
Ambulance Handover - % under 30 minutes (London Average)	100%	88.2%	90.3%	92.7%	91.7%	92.2%	90.6%	92.4%	92.3%	92.0%	89.6%	86.6%	84.1%	85.7%
Ambulance Handover - number of patients not handed over within 60 minutes	0	13	6	8	6	0	4	2	1	4	11	16	22	16
Admitted patients with a length of stay 7 Days or Greater		315	321	315	298	301	290	314	302	315	320	336	309	333
Admitted patients with a length of stay 14 Days or Greater		190	192	191	183	175	174	186	183	195	199	212	188	203
Admitted patients with a length of stay 21 Days or Greater		125	127	125	121	111	115	121	123	131	137	145	127	135
AMU Bed Occupancy at Midday	85%	91.7%	95.9%	90.1%	91.4%	86.5%	90.5%	91.3%	95.8%	94.0%	92.4%	94.1%	94.9%	92.9%
Midnight Occupancy Rate General & Acute		89.0%	91.3%	92.4%	89.5%	89.6%	90.0%	92.5%	89.3%	89.5%	92.8%	94.0%	89.9%	92.2%

Diagnostics

Indicator Description	Threshold	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
6 Week Diagnostic Performance	1%	0.5%	0.3%	0.5%	1.6%	0.7%	0.4%	0.95%	0.96%	0.92%	3.3%	4.8%	6.7%	5.4%
6 Week Diagnostic Breaches	N/A	41	24	40	115	59	31	74	74	75	300	393	544	493
6 Week Diagnostic Waiting List Size	N/A	7,649	7,754	7,622	7,247	8,274	7,992	7,772	7,737	8,153	9,025	8,205	8,142	9,138

Indicator Description	Threshold	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
MRI	1%	0.4%	0.6%	0.1%	0.3%	0.3%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.2%	0.4%
CT	1%	0.6%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.6%	0.2%
Non Obstetric Ultrasound	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	1.0%	0.1%	0.0%	0.0%	0.2%	0.0%
Barium Enema	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dexa Scan	1%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Audiology Assessments	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Echocardiography	1%	0.8%	0.4%	4.3%	12.1%	4.2%	1.0%	9.0%	4.7%	7.3%	36.1%	51.4%	27.1%	26.1%
Electrophysiology	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	66.7%	50.0%
Peripheral Neurophysiology	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.3%	0.5%	6.2%	9.9%	9.6%
Sleep Studies	1%	1.1%	0.8%	2.7%	4.6%	4.8%	1.4%	1.0%	0.9%	4.0%	3.0%	1.6%	0.5%	1.3%
Urodynamics	1%	16.3%	14.0%	0.0%	5.7%	0.0%	0.0%	2.9%	4.9%	0.0%	9.5%	37.5%	25.0%	0.0%
Colonoscopy	1%	2.9%	1.0%	0.0%	1.0%	0.6%	0.6%	0.9%	0.3%	0.4%	1.8%	3.0%	4.7%	1.0%
Flexi Sigmoidoscopy	1%	0.0%	0.0%	0.0%	1.2%	0.0%	0.6%	2.0%	1.4%	1.9%	3.0%	3.0%	4.2%	0.6%
Cystoscopy	1%	3.2%	0.0%	1.9%	3.2%	6.4%	2.6%	3.0%	2.6%	0.0%	3.0%	3.3%	11.8%	0.0%
Gastroscopy	1%	1.4%	0.6%	1.8%	2.1%	2.3%	3.1%	3.7%	2.8%	1.6%	3.0%	3.3%	4.6%	0.7%

On the Day Cancellations

Indicator Description	Target	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Number of on the Day Cancellations		86	73	49	45	69	69	54	38	46	53	86	65	50
Number of on the Day cancellations re-booked within 28 Days		86	71	47	42	68	69	54	38	45	52	80	59	48
% of Patients re-booked within 28 Days	100%	100.0%	97.3%	95.9%	93.3%	98.6%	100.0%	100.0%	100.0%	97.8%	98.1%	93.0%	90.8%	96.0%

Cancer

Indicator Description	Target	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	No of Patients
Cancer 14 Day Standard	93%	96.6%	94.4%	93.3%	94.4%	92.4%	90.2%	92.5%	95.6%	95.4%	93.8%	94.3%	94.0%	90.3%	1,345
Cancer 14 Day Standard Breast Symptomatic	93%	96.9%	97.4%	94.6%	94.7%	94.4%	94.9%	93.2%	94.9%	93.0%	94.3%	98.4%	97.4%	90.0%	269
Cancer 31 Day Diagnosis to Treatment	96%	98.2%	97.4%	98.4%	98.1%	96.2%	96.9%	96.0%	97.0%	98.5%	97.4%	96.9%	96.0%	98.0%	203
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	94.6%	97.9%	94.4%	96.2%	100.0%	95.7%	96.7%	100.0%	100.0%	100.0%	97.1%	96.8%	100.0%	33
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	101
Cancer 62 Day Referral to Treatment Standard	85%	94.8%	86.2%	77.8%	85.0%	75.6%	71.4%	85.8%	92.7%	87.1%	87.6%	89.0%	88.6%	90.6%	69
Cancer 62 Day Referral to Treatment Screening	90%	82.0%	88.7%	70.5%	76.6%	87.7%	96.5%	93.8%	97.4%	100.0%	100.0%	94.9%	87.7%	86.4%	22

Meeting Title:	**Trust Board**		
Date:	**27 February 2020**	**Agenda No**	**2.3**
Report Title:	**Cardiac Surgery Update**		
Lead Director	**Richard Jennings, Chief Medical Officer**		
Report Author(s):	**Steve Livesey, Associate Medical Director for Cardiac Surgery & Cardiac Surgery Care Group Lead**		
Presented for:	**(1) Assurance and (2) Information**		
Executive Summary	This paper provides assurance on the quality and safety of the Cardiac Surgery Service, and the on-going steps being taken to improve the service following the NICOR safety alerts (2018) and the findings of the independent review (Professor Bewick, July 2018). Since the last update to Trust Board (30 January 2020) the following key developments have taken place: • The most recent NHSE/I Single Item Quality Surveillance Group Meetings were held on 6 and 24 February 2020; no new quality concerns were raised at either meeting. • The External Mortality Review Panel report is awaited. • The Trust continues to communicate regularly with NHSE/I and the CQC and other regional and local stakeholders to provide assurance on the safety of the service and the improvements being made. • The Trust is engaging with the South London Cardiac Surgery Network Steering Group. This group meets on a monthly basis and last met on 14 February 2020. • The Trust is also a part of the South London Cardiac Surgery Clinical Leads Group meeting, facilitated by the Programme Manager for the South London Cardiac Network. • Safety update: an update on post-operative deaths and complications is provided. • The Trust's Cardiac Programme Risk Register remains unchanged.		
Recommendation:	The Board is asked to note the updated information on safety assurance and on-going actions.		
Supports			
Trust Strategic Objective:	• Treat the patient, treat the person • Right care, right place, right time • Champion Team St George's		
CQC Theme:	• Safe, Well Led		

Single Oversight Framework Theme:	• Quality of Care, Leadership and Improvement Capability		
Implications			
Risk:	As set out in the paper		
Legal/Regulatory:	The paper details the Trust's engagement with regulators on this issue.		
Equality and Diversity:	N/A		
Previously Considered by:	Trust Executive Committee Quality and Safety Committee	**Date**	19.02.2020 25.02.2020
Appendices:	None		

CARDIAC SURGERY UPDATE

1. PURPOSE

1.1 To update the Board on the information that provides assurance on the quality and safety of the Cardiac Surgery Service, and the on-going steps being taken to improve the service, since the last report received to the Board on 30 January 2020.

2. EXTERNAL ASSURANCES

2.1 The most recent NHSE/I Single Item Quality Surveillance Group Meetings were held on 6 and 24 February 2020; no new quality concerns were raised at either meeting.

2.2 The Trust is engaging with the South London Cardiac Surgery Network Steering Group, which is chaired by the Executive Medical Director for Clinical Strategy at Kings College Hospital Foundation Trust and Guy's and St Thomas' NHS Foundation Trust. This group meets on a monthly basis and last met on 14 February 2020.

3. INTERNAL ASSURANCES: SAFETY UPDATE

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

3.2 Since the last Trust Board paper received on 30 January 2020 there have been no inpatient deaths following cardiac surgery since the last paper to Board update. There have been no other incidents classed as moderate or severe harm following cardiac surgery since the last report to Trust Board.

4. EXTERNAL MORTALITY REVIEW

4.1 Following their receipt of the clinician responses to the Structured Judgement Reviews, the External Mortality Review Panel has provided the Trust with final versions of those Structured Judgement Reviews. The External Mortality Review Panel report is awaited.

5. EXTERNAL GOVERNANCE; UPDATE

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

6. CARDIAC SURGERY SERVICE RISK REGISTER; UPDATE

6.1 The risks rated as moderate and above on the Cardiac Surgery Service Risk Register have not changed since the last paper to the Board on 30 January 2020.

7. RECOMMENDATION

7.1 Trust Board is asked to note the updated information on safety assurance and on-going actions.

Meeting Title:	**Trust Board**		
Date:	27 February 2020	**Agenda No**	2.4
Report Title:	Learning from Deaths (Quarter 3) Report		
Lead Director:	Dr Richard Jennings, Chief Medical Officer		
Report Author:	Kate Hutt, Head of ME Office & Mortality Review Service		
FOIA Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The paper provides an overview of the work of the Mortality Monitoring Committee (MMC) and Learning from Deaths data for Q3 2019/20. It includes a summary of the independent reviews completed. The report summarises successes and areas for action in relation to implementation of the Learning from Deaths framework and the Medical Examiner system.		
Recommendation:	The Board is asked to: • Note and discuss the updated Learning from Deaths data; and • Note the update on the implementation of the Medical Examiner system in the Trust.		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	There is a potential risk that the without clearly defined processes that the response to concerns raised by the ME service will not be effectively managed and opportunities for learning will be missed. Prospective review of mortality has significantly decreased with transfer of previously key personnel into the new ME service, although the number of deaths reviewed still meets the Trust's original target. With the introduction of the ME service and appointment of a new Trust Lead for Learning from Deaths, it will be necessary to design and implement new processes going forward. The Learning from Deaths Lead, with the support of the Chief Medical Officer, will develop structures and processes to work very closely with Care Group Governance/Morbidity and Mortality Leads to make this process effective.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by CQC and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:			
Previously Considered by:	Patient Safety and Quality Group Trust Executive Committee Quality and Safety Committee	**Date**	19.02.2020 19.02.2020 25.02.2020
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

Learning from Deaths (Quarter 3) Report

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Board with an update on the work of the Mortality Monitoring Committee (MMC), focussing on information and learning identified through independent case record review of deaths for Q3 2019/20. An update on the delivery of requirements of the Learning from Deaths framework and the introduction of the Medical Examiner (ME) service is also detailed.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK AND NATIONAL STRATEGY

2.1 **Learning from Deaths – Ongoing Development**

The Chief Medical Officer has recently appointed a new Trust Lead for Learning from Deaths, Mr Ashar Wadoodi. Mr Wadoodi will begin in post in March 2020. This new role will be responsible for the implementation of the National Quality Board's framework for learning from deaths within the Trust, ensuring that opportunities to learn from cases and prevent repeat causes of harm are maximised; this role will interact closely with Care Group Governance Leads, and will provide an essential link to the Medical Examiner service.

As part of the action plan arising from the mortality governance review the strategy and aims of the Mortality Monitoring Committee are currently being reviewed. Additional actions have progressed over the last quarter, with the inaugural meeting of Care Group Governance leads taking place on 18th December. The intention is to develop a community of practice, which will help shape and support the delivery of effective local Mortality and Morbidity meetings, which will in turn contribute to the wider understanding of and learning from mortality across the trust. The Trust is currently in discussion with the Health Innovation Network (HIN) to explore whether the HIN can facilitate two communities of practice – for the Care Group Morbidity and Mortality Leads, and for a New Consultants' Forum. The HIN has valuable experience of supporting communities of practice for the South East London Cancer Network, which makes them well-placed to support this Trust in this initiative.

2.2 **Medical Examiner Service – Implementation**

The new ME office is located on the ground floor of Grosvenor Wing, next to Bereavement Services. Dr Nigel Kennea took up post as Lead Medical Examiner on 4th December and began scrutinising deaths in January. The service is being implemented in line with the national recommendation to do so in a phased way that minimises risk.

In December interviews for a number of additional MEs were held, with the Regional ME, Dr Mette Rodgers on the panel. Five applicants were successful and will be starting in post during quarter 4. The approved business plan allocated 14 Pas to the work of the Lead Medical Examiner and his team of Medical Examiners, which includes 12 PAs to provide a service for 52 weeks a year, with a further 2 PAs for leadership and reporting. Currently 9.25 PAs have been allocated and recruited to and it is anticipated that further recruitment will take place in 2020/21.

To support local implementation of this new service the Lead ME and Lead MEO have continued to liaise with a number of key stakeholders, including Lead MEs at local Trusts, the Regional ME and MEO, the Coroner and leads from the Registration Service.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 During October and November prior to taking up post as Lead ME, Dr Nigel Kennea continued to support mortality review processes. In December, fewer reviews were completed due to the reduced level of resource. With the introduction of the ME service and appointment of a new Trust Lead for Learning from Deaths it will be necessary to design and

implement new processes going forward. The Learning from Deaths Lead, with the support of the Chief Medical Officer, will develop structures and processes to work very closely with Care Group Governance/Morbidity and Mortlaity Leads to make this process effective.

As we move to 2020/21 the ME service is expected to scrutinise all in-hospital deaths; therefore, it may not be desirable to review such a high proportion under the Learning from Deaths framework. It will be important to define which cases are to be reviewed and to have in place reliable processes for identification, allocation of reviews and reporting.

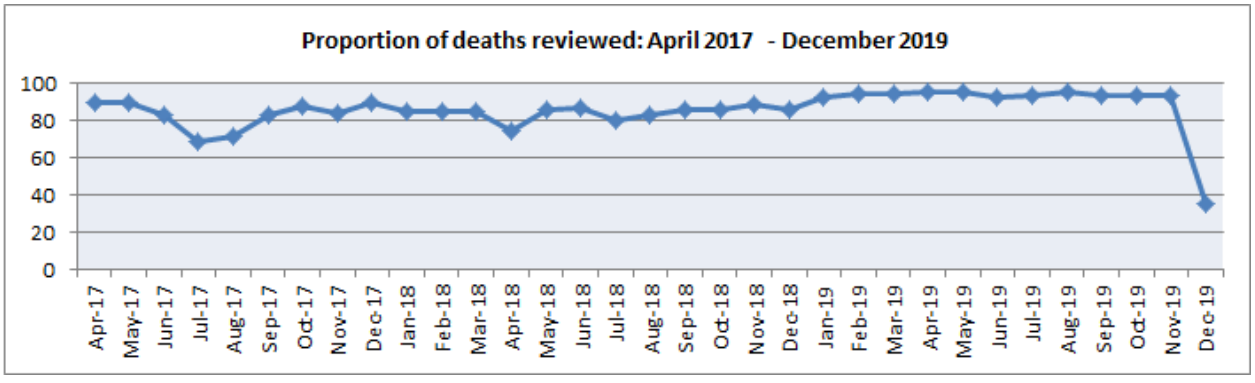
The following analyses include all deaths and do not consider deaths of patients with learning disabilities (LD) separately; however, this distinction between all deaths and deaths in people with LD is required for the national dashboard. Our data reported in the format of the National Quality Board (NQB) dashboard, which we have amended to reflect the local reviews of LD deaths, is shown in Appendix 1

Section 4.1 provides an overview of local scrutiny of deaths in patients with LD that have occurred during this report period.

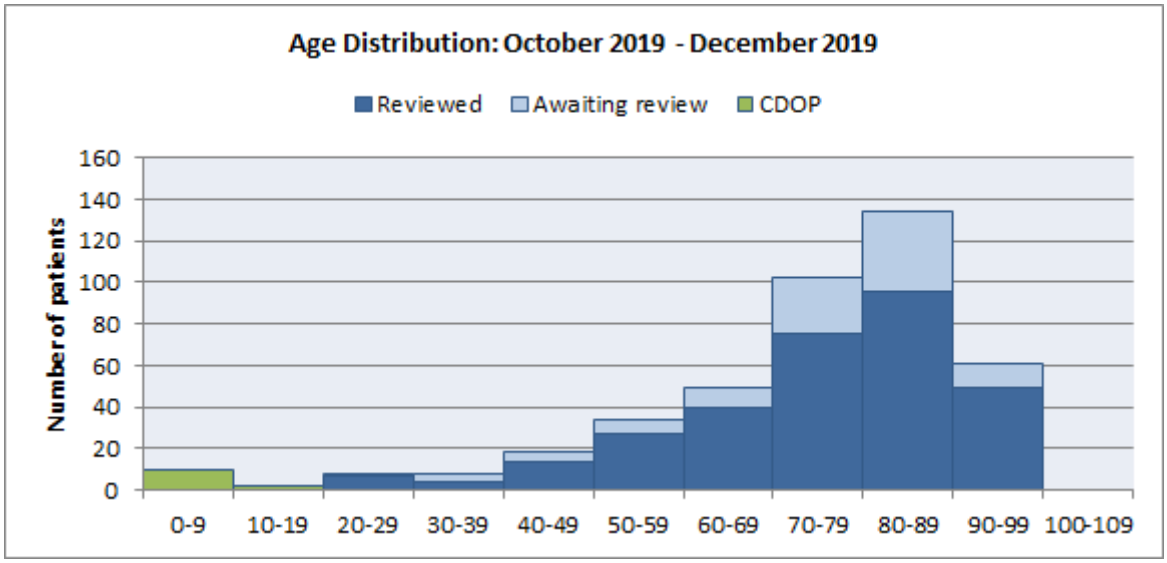
3.2 **Overview of October to December 2019**

Between October and December 2019 there were 426 deaths. Members of the Mortality Review Team reviewed 312, representing 73.2% of deaths. Although this is in excess of our target of 70%, it is a significant decrease on previous quarters. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel.

As we develop new ways of working between the ME service and the Learning from Deaths framework, we will need to revisit the target of 70 per cent which was set before the ME service was defined nationally. It will be necessary to define the reviews to be completed and to set a target for this group, rather than all deaths. It is anticipated that the deaths to be reviewed will include: patients with learning disabilities; patients with severe mental health diagnoses; deaths following elective admission; cases flagged by the ME as requiring review; deaths in services where a mortality signal is being investigated; and cases that may inform other improvement work. As we establish these new processes over the next few months it is likely that the proportion of deaths reviewed under the framework will remain somewhat lower than previously achieved, although it is intended that we continue to meet the Trust's internal target.

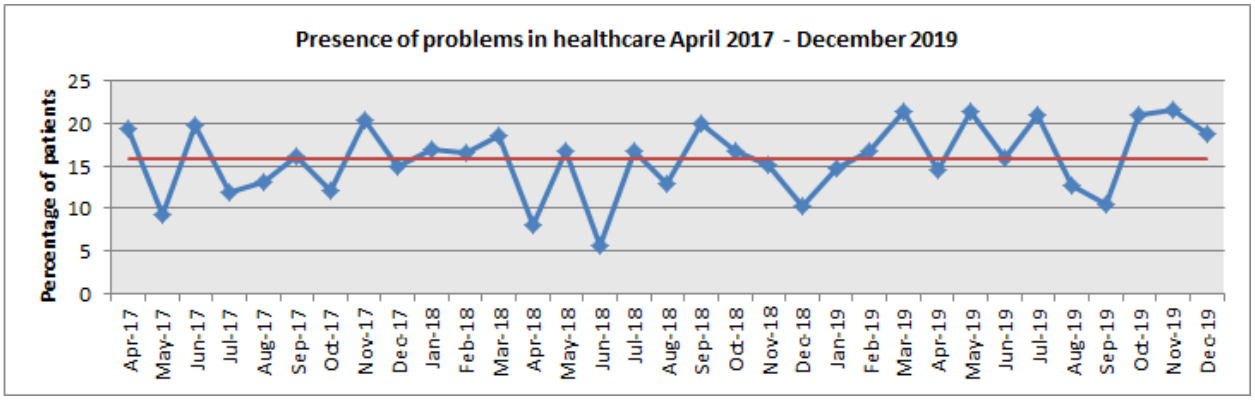


The age profile of deceased patients remains consistent, with the highest proportion of deaths in the 80-89 age group.

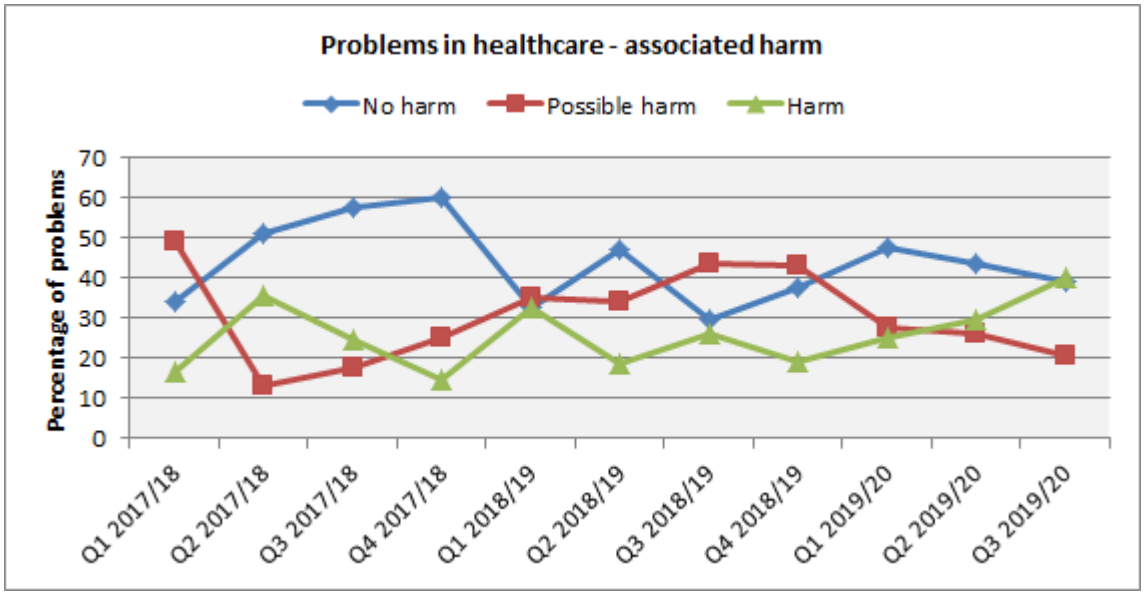


The structured judgement review methodology requires reviewers to identify problems in healthcare and to assess whether or not these have caused harm. The RCP define a number of problems in healthcare, as detailed in the tables below. Locally we have added 'Communication' to these categories. This quarter, one or more problems in healthcare were identified in 20.8% of the deaths reviewed, which is the highest proportion observed to date.

Problems in healthcare Q3 2019/20				
	Oct	**Nov**	**Dec**	**Total**
No	106	98	43	**247**
Yes	28	27	10	**65**
% with problems	20.9	21.6	18.9	**20.8**



The problems identified include recognised complications of treatment and not all are judged to have led to harm. This quarter the observed problems did not lead to harm in 39.0% of cases, possibly led to harm in 20.8% and did cause harm in 40.3%.This represents the highest proportion of harm reported to date.



This quarter the most common problem in healthcare identified by reviewers was those related to treatment and management plans with 20.8% reported being in this category. It should be noted that the number of problems differs from the number of deaths where a problem is observed. This is because a patient may have encountered more than one problem.

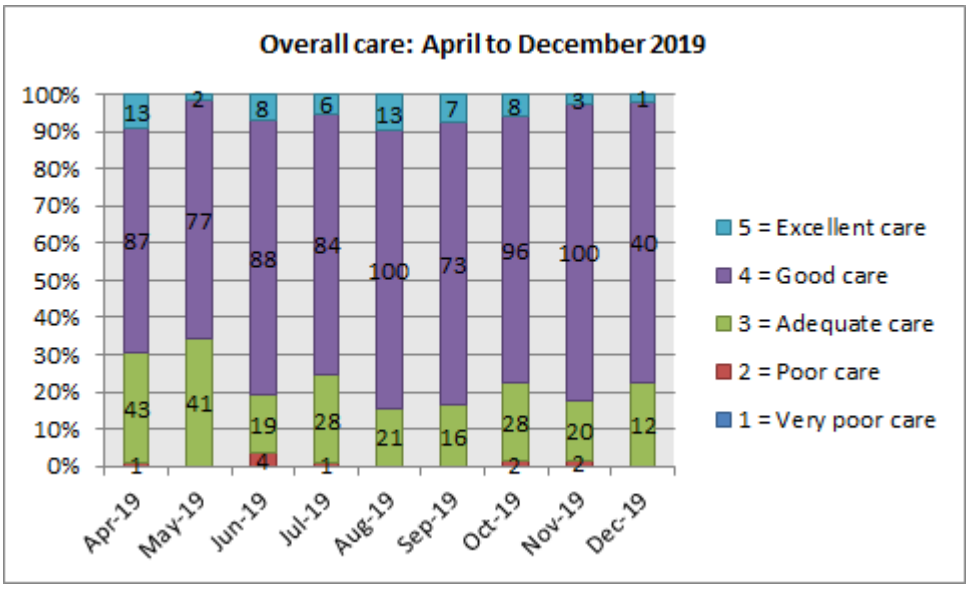
Problems in healthcare: Q3 2019/20	**No harm**	**Probably harm**	**Harm**	**Total**
Assessment, investigation or diagnosis	0	0	1	**0**
Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)	3	5	2	**10**
Related to treatment and management plan	5	0	11	**16**
Infection control	2	0	3	**5**
Operation/invasive procedure	3	2	8	**13**
Clinical monitoring	2	2	1	**5**
Resuscitation following a cardiac or respiratory arrest	1	0	0	**1**
Communication	9	3	3	**15**
Other	5	4	2	**11**
TOTAL	**30**	**16**	**31**	**77**

A judgement regarding avoidability of death is made for all reviews. As in previous periods, the large majority (97.4%) of deaths this quarter were assessed as definitely not avoidable. Two deaths were judged to be more than likely avoidable.

Avoidability of death judgement score: Q3 2019/20	Oct	Nov	Dec	Total
6 = Definitely not avoidable	131	120	53	**304**
5 = Slight evidence of avoidability	0	4	0	**4**
4 = Possibly avoidable but not very likely (less than 50:50)	1	1	0	**2**
3 = Probably avoidable (more than 50:50)	2	0	0	**2**
2 = Strong evidence of avoidability	0	0	0	**0**
1 = Definitely avoidable	0	0	0	**0**
TOTAL	134	125	53	**312**

Any death that the MMC review suggests may be avoidable, or where there is significant concern, is escalated immediately to the Risk Team to consider serious incident, or other, investigation. Any significant problem of care, whether or not it affected outcome, is highlighted to the clinical team for discussion and local learning.

An assessment of overall care is provided for each death. This quarter the majority of patients were felt to have received care that was either good or excellent, with 3.8% of care rated as excellent, 75.6% as good. Care was rated as adequate in 19.2% of cases and poor care was observed in 4 cases (1.3%). There were no cases that were rated as very poor care. All instances of poor care were raised with the clinical team for scrutiny and to provide feedback. Learning identified by the clinical teams related to the clarity and detail of documentation, clear consideration and agreement of treatment escalation plans and the need for junior staff to involve consultants out of hours. A number of brief examples are provided in section 4.3 to demonstrate the opportunities for learning identified through prospective mortality review and collaboration with clinical teams.



4.0 THEMES AND LEARNING

The following summary provides detail of some of the issues highlighted through the independent review of cases and MMC activity this quarter. Also included is a focus on the deaths of patients with learning disabilities.

4.1 Learning disabilities

All deaths that occur in patients with learning disabilities are submitted to the national Learning Disabilities Mortality Review Programme (LeDeR). The LeDeR reviews are co-ordinated by the CCG and our liaison with these colleagues continues to strengthen. We work together closely to share our local independent mortality reviews and in turn receive redacted copies of the LeDeR review. Regular reports from the LD team will be presented to MMC, a key feature of which will be analysis of the LeDeR reviews, identifying aspects of best practice and highlighting any areas for local learning and improvement. Of the reviews received, none have been assessed as avoidable; however, both the LD team and the MMC are committed to reviewing these assessments at a granular level in order to improve our service where necessary.

The mortality review team continue to carry out timely local review using our standard methodology. The table below summarises the deaths of patients with learning disabilities (LD) from the beginning of 2018/19 to the end of Q3 2019/20. In total there have been 23 deaths, with reviews completed for each. No avoidability was identified.

This quarter there have been 4 LD deaths, with each reviewed within one working day. No problems in healthcare were identified and the deaths were judged to be definitely not avoidable. Overall care was judged to be excellent in one case, good in two and adequate in one.

LD DEATHS **Avoidability of death judgement score**	**Q1 18/19**	**Q2 18/19**	**Q3 18/19**	**Q4 18/19**	**Q1 19/20**	**Q2 19/20**	**Q3 19/20**
TOTAL DEATHS	1	3	3	2	3	7	4
LOCAL REVIEWS COMPLETED	1	3	3	2	3	7	4
6 = Definitely not avoidable	1	3	3	2	3	7	4
5 = Slight evidence of avoidability	0	0	0	0	0	0	0
4 = Possibly avoidable but not very likely (< 50:50)	0	0	0	0	0	0	0
3 = Probably avoidable (> 50:50)	0	0	0	0	0	0	0
2 = Strong evidence of avoidability	0	0	0	0	0	0	0
1 = Definitely avoidable	0	0	0	0	0	0	0

4.2 Identification of Learning

During October and November there were a number of cases escalated for further review, including 22 cases referred to the service for local review and reflection. Ten of these were referred to draw attention to good practice, such as good documentation of patient and family communication, decision making and communication between teams.

Similar issues as those noted in previous reports have been highlighted for local consideration. These include the use of treatment escalation plans, decision making and documentation of resuscitation status, the management of end of life care, and the importance of good quality documentation.
For the first two months of the quarter the mortality review team continued to work collaboratively with other Trust governance processes; however as the level of reviews decreased markedly from that point, there has been less opportunity for joint working. In October and November there were 6 cases where the Mortality Review Team collaborated

with the Risk Team on mortality reviews. The two teams work together to share and triangulate information. Where the independent review team identify a potential issue this is highlighted to the Risk Team, either to consider carrying out a local investigation or to inform such an investigation. Independent reviews may be used to help inform the decision regarding the investigation to be undertaken and also to contribute to the investigation process. There were also five cardiac surgery deaths over the period, each of which was scrutinised by the mortality review team as part of the ongoing governance processes.

4.3 Examples of learning and reflection

Through timely review of a significant proportion of the deaths that occur within the Trust it is inevitable that opportunities for learning and reflection will be found. In these instances the reviewer provides feedback to the clinical team and often they respond with details of lessons learnt. A small selection of cases and the learning gained from them is summarised below.

- An elderly lady was brought directly to the Cath Lab following an out of hospital cardiac arrest. Sadly, the patient was admitted in extremis and died in the lab. The documentation available to the reviewer suggested that following the patient's death there had been difficulties related to the management of last offices. The Cardiothoracic Intensive Care Unit (CTICU) responded by carrying out a rapid investigation and concluded that the clinical record did not accurately reflect the effective joint working between teams in the Cath Lab, Coronary Care Unit (CCU) and CTICU. The feedback and subsequent investigation served as a reminder to those teams to ensure that more careful documentation is completed. It also led to discussion at the End of Life Steering Group to ensure that both divisions are aware of the complexity of managing deaths that occur in the Cath Lab and to clarify the provisions for end of life care and last offices by CCU and CTICU nursing staff.

- An elderly lady was admitted unwell to the Acute Medical Unit (AMU) unwell with hip pain. She was found to be tachycardic and treated for neutropenic sepsis. The reviewer made a positive observation that the patient was seen and reviewed by orthopaedics to rule out an acute T&O problem. The patient was treated for sepsis but continued to deteriorate and sadly arrested on the ward, at which point resuscitation was attempted. The reviewer raised questions about missed opportunities to discuss and document ceilings of care and resuscitation status. This observation was shared with the AMU team and also the General ITU team as they had reviewed the patient.

  The GITU team reflected on this feedback and concluded that the attempt at resuscitation might have been avoided with better planning. The case was discussed at the local M&M meeting for education.

  The AMU consultant leading the care for this patient explained the complexities that can be involved in reaching resuscitation decisions. He felt that the initial decision that the patient was for resuscitation had been appropriate, but that when the patient's condition changed out of hours an opportunity to consult with him, or the on-call Consultant, was missed. Had this consultation occurred it is possible that the earlier decision for CPR may have been changed. The case was discussed at the Acute Medicine M&M meeting with this learning identified.

5.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

5.1 Summary Hospital-level Mortality Indicator (SHMI) [source: NHS Digital]

The latest SHMI data, covering discharges from September 2018 to August 2019, was published on 16th January 2020. The Trust's overall mortality is categorised as lower than expected at 0.83; we are one of 14 trusts nationwide in this category. The SHMI for St George's site and Queen Mary's are both lower than expected at 0.84 and 0.35 respectively.

NHS Digital provides a SHMI value for a number of diagnosis groups, as detailed below. For these groups VLAD (variable life adjusted display) charts, which show the difference between the expected number of deaths and observed deaths over time, are also available. The latest information is summarised in the table below and shows that our mortality is either lower than, or in line with what would be expected for all the diagnosis groups analysed.

Diagnosis Group	SHMI value	SHMI banding
Cancer of bronchus; lung	0.57	Lower than expected
Secondary malignancies	0.75	Lower than expected
Pneumonia (excluding TB/STD)	0.80	Lower than expected
Urinary tract infections	0.72	Lower than expected
Gastrointestinal haemorrhage	0.76	As expected
Septicaemia (except in labour), shock	0.99	As expected
Fluid and electrolyte disorders	0.75	As expected
Acute myocardial infarction	1.22	As expected
Acute bronchitis	0.65	As expected
Fracture of neck of femur (hip)	0.80	As expected

5.2 Hospital Standardised Mortality Ratio (HSMR) [source: Dr Foster]

HSMR analysis: October 2018 – September 2019	Score	Banding
HSMR (all admission methods)	89.3	Lower than expected
HSMR: Weekday emergency admissions	87.5	Lower than expected
HSMR: Weekend emergency admissions	94.4	As expected

In addition to considering the high level data above, which is also reported in the Integrated Quality Performance Report, risk-adjusted mortality at both diagnosis and procedure group level is evaluated. There are currently investigations underway related to coronary angioplasty and acute myocardial infarction. The outcome of these investigations by the clinical service will be reported to the next meeting of the MMC in March.

Appendix 1: National Quality Board Dashboard – data to 30th September 2019

NHS St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - December 2019-20

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
148	133	52	125	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
422	363	308	342	2	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1188	1541	1032	1337	5	10

Time Series: Start date 2017-18 Q1 End date 2019-20 Q3

Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	52	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	0.6%	This Quarter (QTD)	2	0.6%	This Quarter (QTD)	4	1.3%	This Quarter (QTD)	300	97.4%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.1%	This Year (YTD)	4	0.4%	This Year (YTD)	6	0.6%	This Year (YTD)	19	1.8%	This Year (YTD)	1002	97.1%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping below.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	7	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
14	9	1	2	0	0

Time Series: Start date 2017-18 Q1 End date 2019-20 Q3

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	7	4	7	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
14	9	14	9	0	0

Meeting Title:	**Trust Executive Committee**		
Date:	27 February 2020	Agenda No.	**2.5**
Report Title:	Quarterly Transformation (Q3) Report		
Lead Director	James Friend, Chief Transformation Officer		
Report Author:	James Friend, Chief Transformation Officer Chris McAleer Head of PMO		
Presented for:	Information/Note		
Executive Summary:	This is the third quarterly report for 2019/20 setting out to the Trust Executive Committee the approach, progress and impact of the Transformation work. The Transformation Team have changed focus in Quarter Three to support operational colleagues in research, development and delivery of efficiency schemes as part of the drive to improve Use of Resources and to achieve their respective divisional forecasts. Whilst this means that Transformation opportunities, particularly in Ambulatory Care and Therapies, are now running slower than before, each opportunity being supported is being pursued using the Trust's improvement methodology. The team remains on financial budget and up to date with Mandatory Training and Appraisal benchmarks. We were delighted to reach 100% completion of the Staff Survey. The key risks to sustained delivery of Transformation remain IT system productivity and operational capacity. A plan for Transformation opportunities over the next two years has been collated with respective clinical and support service leaders.		
Recommendations:	The Board is asked to note the report.		
Supports			
Trust Strategic Objectives:	**Right Care, Right Place, Right Time** 9. Patient choice • *Aim: Ensure patients have access to high quality outpatient care, including by standardising outpatient pathways, supported by ICT, ensuring all activity is captured and reported* • *Aim: Offer patients greater choice in how they access acute specialties with alternative to face-to-face appointments* **Build a Better St. George's** 12. Strategy and engagement • *Aim: We will develop an organisational and clinical strategy that asserts St. George's position as a provider of local and world –reading specialist services* • *Aim: We will work with our partners and stakeholders to seek their views, so we address the challenges we face together* 13. Governance • *Aim: More engagement and involvement of patients, front line staff and partner organisations*		
CQC Themes:	• ***Effective*:** your care, treatment and support achieve good outcomes, help you to maintain quality of life and are based on the best available evidence. • ***Responsive*:** services are organised so that they meet your needs. • ***Well-led*:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight	• Strategic Change		

Framework Theme:			
Implications			
Risk:	None directly in this paper.		
Legal/Regulatory:	N/A		
Resources:	None requested in this paper.		
Previously considered	Builds on Trust Executive Committee Monthly Reports)	Date:	Nov, Dec 2019.
Appendices:	Appendix One – Quarterly Transformation Report to Board 22 January 2020.		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Quarterly Transformation Report
Quarter 3 Report

James Friend

Chief Transformation Officer

Quarterly Transformation Report

Summary

– The Transformation Team have changed focus in Quarter Three to support operational colleagues in research, development and delivery of efficiency schemes as part of the drive to improve Use of Resources and to achieve their respective divisional forecasts. Whilst this means that Transformation opportunities, particularly in Ambulatory Care and Therapies, are now running slower than before, each opportunity being supported is being pursued using the Trust's improvement methodology.
– The team remains on financial budget and up to date with Mandatory Training and Appraisal benchmarks. We were delighted to reach 100% completion of the Staff Survey.
– The key risks to sustained delivery of Transformation remain IT system productivity and operational capacity.
– A plan for Transformation opportunities over the next two years has been collated with respective clinical and support service leaders

Contents

Outstanding care every time

Highlights of Quarter 3 2019-20

- Voice reminders helped over 8,000 patients to attend their appointment via calls to their home phones and 325,000 text reminders were sent
- 158,000 outpatient follow-up and confirmation appointment letters were sent via Hybrid Mail
- 154 Urology Stones patients avoided having a wasted appointment
- 452 patients have been treated in the Gastroenterology and Liver Day Unit since June.
- The Electronic Queue Management project for the Emergency Department won Health Innovation Network funding of £9,928 and a prototype system has been developed
- 600 patients sent information about their symptoms to doctors before their consultation in ED through the edck.in pilot and this project won £5,000 at the Trust Dragons' Den competition.
- Funding was secured for an Estates feasibility study that will inform the Emergency Floor business case development
- 75% of services are now live with electronic rostering for Junior Doctors
- Maternity Continuity of Carer teams were able to book over 20% of women onto a Continuity Pathway

Outstanding care every time

Digital Transformation

Text Messaging

- Overall more than 325,000 text reminders were sent from October to December 2019, an increase of 25,000 from Q2.
- A two way text reminder service for theatres, ten days ahead of the appointment was launched in November with over 1,200 patients benefitting from this service. More than with 86,000 two way text messages were sent in the quarter.

Voice reminders

- Voice reminders were piloted with one way functionality to test the impact of responding patient call volumes on the Central Booking Service.
- Now launched, voice reminders have helped over 8,000 patients to attend their appointment via calls to their home phones. The service will expand to include mobile phones early in Q4. Sample analysis conducted in December indicates that a patient who hears a voice reminder is less likely to DNA their appointment (6%).

Hybrid Mail

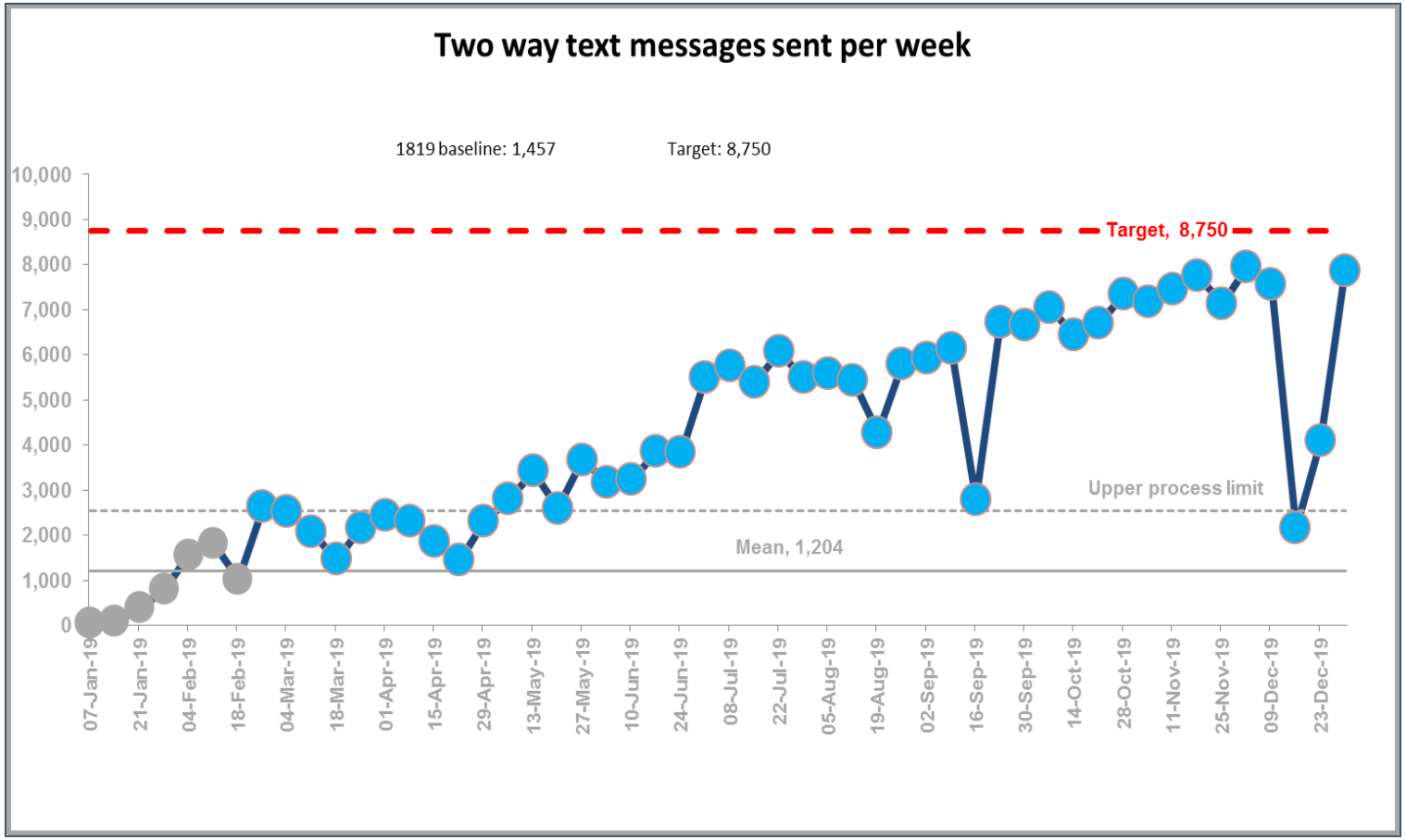
- 158,000 outpatient follow-up and confirmation appointment letters have been sent via Hybrid Mail in Quarter Three.
- The tender process to identify our new supplier has been commenced and due to complete in January.
- Specialty service teams have been able to reduce the printing and posting of an average of 2,600 patient letters per day which includes letters from the QMH site.

No wasted appointments

- 154 Urology Stones patients avoided having a wasted appointment in Q3 as the weekly reviews with the consultant continued to identify patients who needed a diagnostic test prior to attending on an outpatient basis (446 patients have benefited since the start of this project).
- Efficiency improvements to the process have been specified which will mean less clinical and administrative time is required to perform the consultant reviews.
- Trials are due to begin in other services including Cardiology and Orthopaedics following successful demonstrations to the clinicians.

Outstanding care every time

Key Improvement Indicators – Digital Transformation



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Patient Flow

Therapies

- The Allied Health Professional Day showed a variety of good local work and initiatives
- A demand and capaicty data review of the past year was used to challenge future reporting and progress has been made for improved reporting and patient tracking for Trauma and Orthopaedics and for Neurology, Neurosurgery and Neurorehabilitation

Ambulatory Care & Base Wards

- Since 10 June 2019, the Gastroenterology and Liver Day Unit has treated a total of 452 patients; evaluation shows the unit enabled up to 70% reduction in inpatient length of stay due with patients able to be discharged earlier and to return to the unit to complete their treatment
- Out of hours Rivaroxaban dispensing commenced in November 2019 in the AMU and AAA
- Two Multi-Agency Discharge Events were held to expedite inpatient diagnostic tests and assessments on the same day

Urgency

- The Electronic Queue Management project won Health Innovation Network funding of £9,928 and a prototype system has been developed; visible waiting times will improve patient experience and reduce Emergency Department (“ED”) frontline team interruptions
- The edck.in pilot enabled 600 patients to electronically send information about their symptoms to doctors before their consultation, saving valuable clinical time. The project won £5,000 at the Trust Dragons’ Den competition

Place

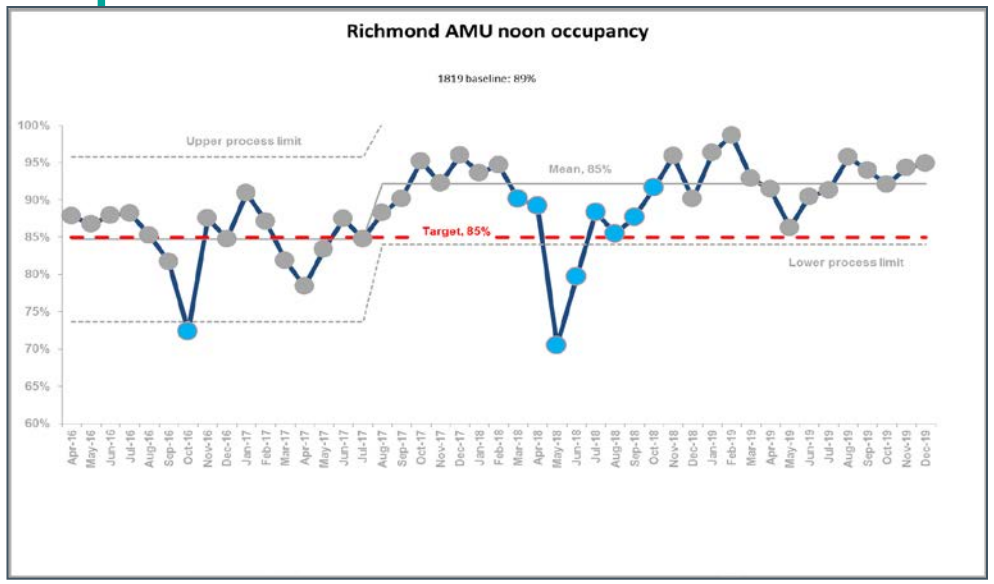
- A new standard operating procedure to enable GPs to refer directly to Nye Bevan Unit has been developed and will go live in February; this will avoid unnecessary patient re-assessment in the Emergency Department, reduce patient waiting time and improving Trust efficiency
- A Rapid Assessment Zone was launched in the ED to test the effect of putting senior clinical expertise earlier in patient pathway

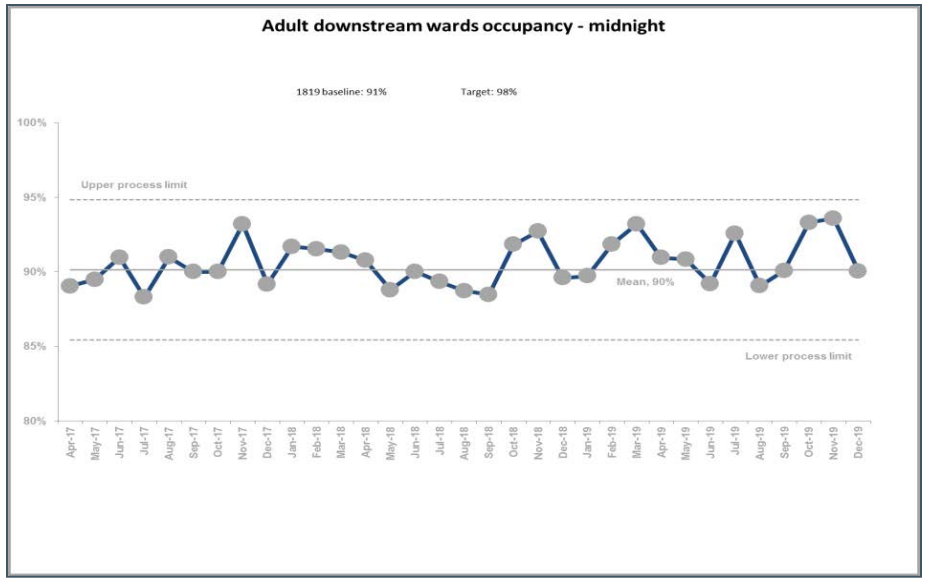
Emergency Floor

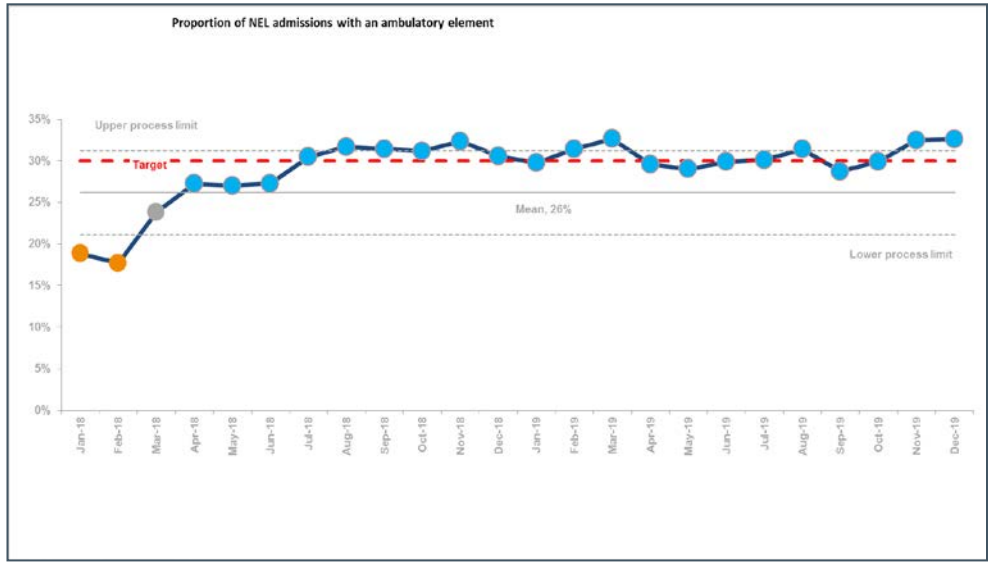
- A Clinical Reference Group has been agreed with Dr Jane Evans which will approve all aspects of the Emergency Floor
- Funding has been secured for an Estates feasibility study that will assess the ability of the St James Wing to take further development.
- Simulation modelling is being developed to ensure that the Emergency Floor will be future proof

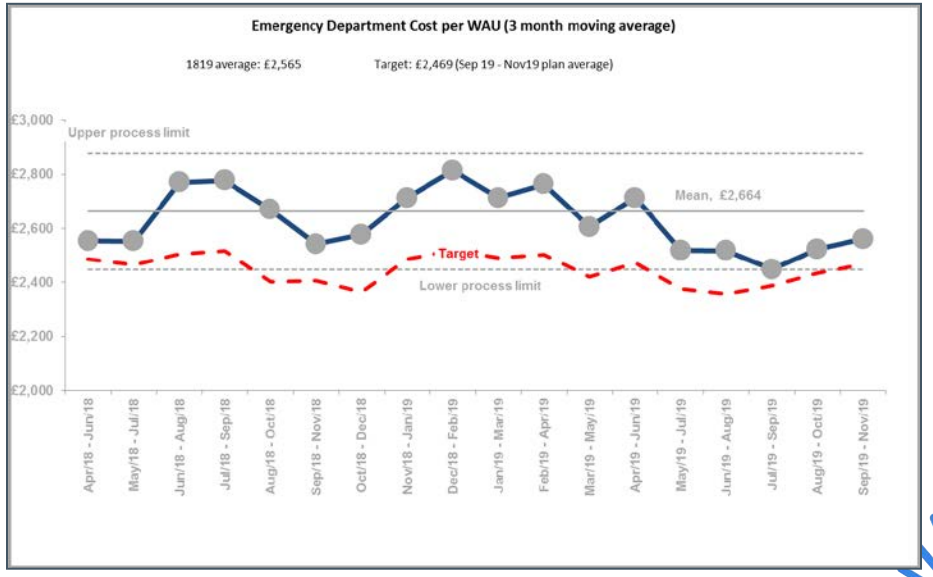
Outstanding care every time

Key Improvement Indicators – Patient Flow







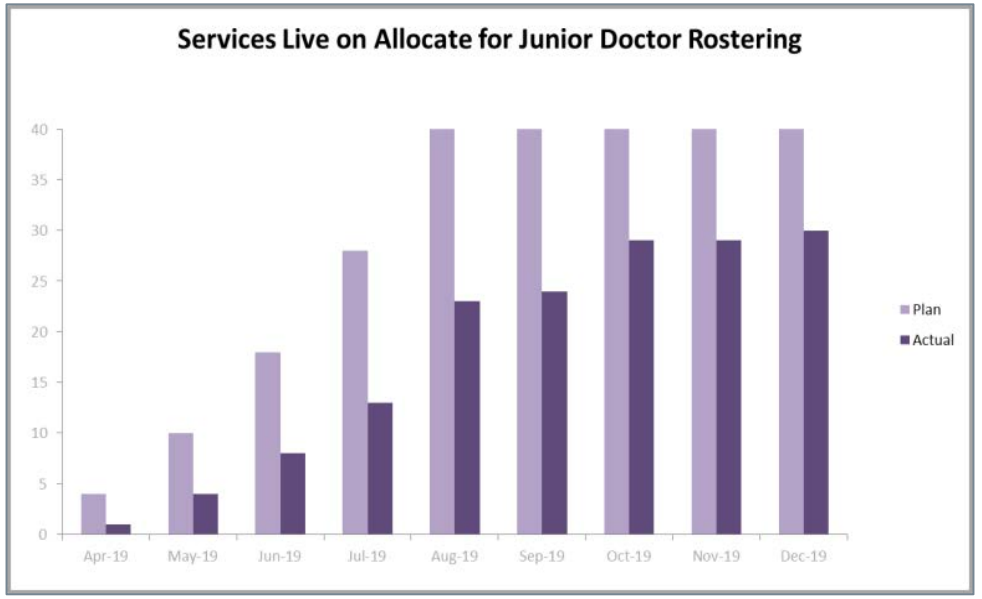


Outstanding care every time

Workforce Transformation

eRoster

- 5 more clinical services went live with eRosters for Junior Doctors during Quarter 3
- The roll out of Activity Manager (eRoster for Consultants) started
- The project has reviewed progress and lessons learned from the phase 1 of delivering eRoster for Junior Doctors. From this the Executive Sponsors have agreed revised objectives, by the end of March 2020 to:
    1. Complete the current implementation of Medics on Duty (Junior Doctors) and
    2. Deliver Activity Manager (Consultants) and
    3. Work to increase utilisation of eRoster to 37 priority services.
        - 20 of these services have also been identified as priorities for Medical Productivity Working Group.
        - An audit of utilisation has been completed, so engagement, training and support from the project team will increase to meet the needs of the services
- NHS England / Improvement delayed the decision on the eRoster capital bids until the end of January

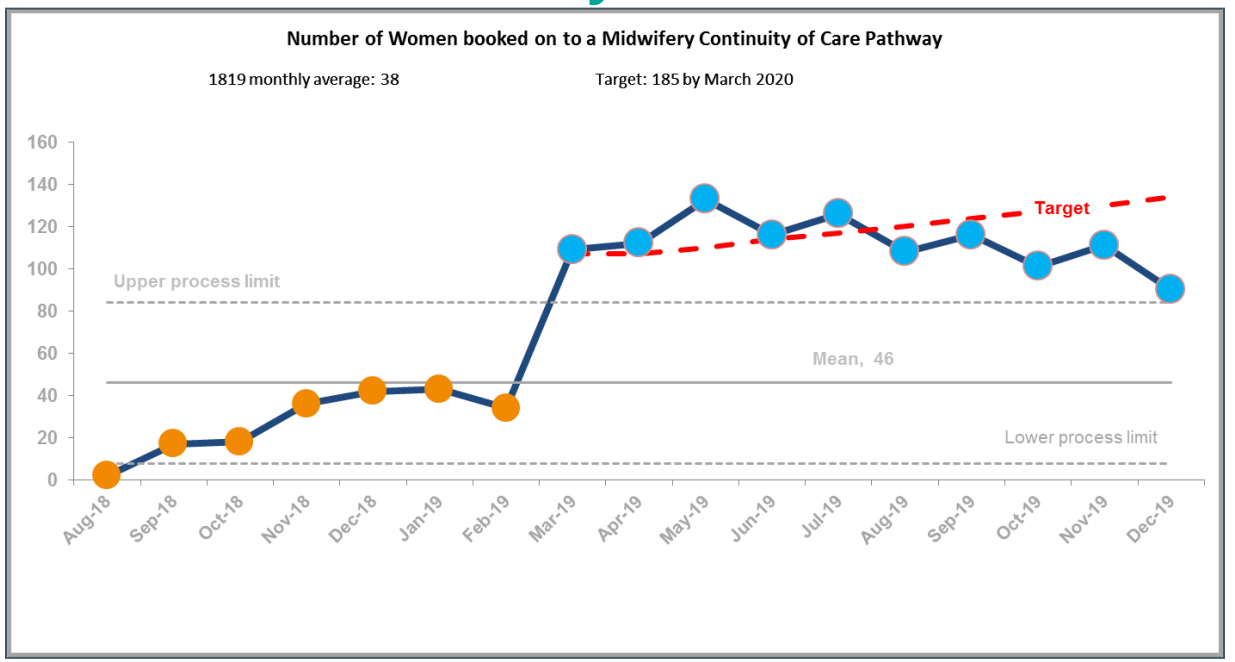


Outstanding care every time

Maternity Transformation

- Continuity of Carer teams were able to book over 20% of women onto a Continuity Pathway
- The New Beginnings Project was presented to the London Clinical Leaders Network, with positive feedback about both the content of the work and the co-design methodology
- The renovation of the Forget Me Not Bereavement Suite on Labour Ward has funding to proceed
- The Induction of Labour project has gained momentum with a Clinical Fellow joining the project team and support for increased outpatient induction given by the senior clinical staff
- Data quality improvements have been made to the Maternity Dashboard

Key Improvement Indicators – Maternity Transformation



Outstanding care every time

Ten Completed Plan Do Study Act Improvement Cycles

Outstanding care every time — St George's University Hospitals NHS Foundation Trust

Multi Agency Discharge Event – 19/09/2019

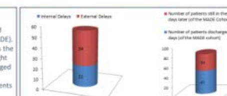
INTRODUCTION
In the past 18 months, St George's, in partnership with local health and social partners has completed four Multi Agency Discharge Events (MADE). These events are designed to help understand and improve flow across the local health system while ensuring we provide our patients with the right care, in the right place at the right time. In previous events, we discharged 35% of patients with length of stay over 7 days within three days after MADE. Previous events were run with two separate panels and all patients over 7 days length of stay were discussed.

AIMS (Plan)
MADE OBJECTIVES
Ward colleagues will present a list of inpatients who are identified as red today (when a patient receives little or no value adding acute care). One panel will be formed consisting of local health, social care and SGUH service leads, to ensure all key interventions happen without delay. Panel members will aim to resolve the delays to progress patient care during the event.

MADE WASH UP OBJECTIVES
- Identify recurring issues and solutions to minimise future occurrences
- To identify new opportunities for improvement
- To gain feedback on new style and format

INTERVENTION (Do)
- Panel members had place cards to identify their service
- Patients were identified by the ward teams based on red days
- One panel was formed
- Panel was co-chaired by Divisional Directors of Nursing and Governance from MedCard and Surgery Division
- Medcard wards presented their cases followed by Surgery and Neuro
- Ward liaison managers from MedCard gathered and identified issues from board rounds
- 81 patients across 32 wards were reviewed
- White board was used to collate themes and issues in real-time
- Internal and external service leads expedited actions in real-time
- Quick wash-up session was held to review the day to confirm outstanding actions and next steps

RESULTS (Study)
- All diagnostic tests were expedited (brought forward to that day or scheduled for the following day)
- Merton Borough had the largest number of delays related to Packages of Care (6/12) and nursing / residential home related delays (4/8)
- Merton reablement service were at capacity at the start of the day
- Three cases were escalated incorrectly as social referrals had been sent incorrectly



MAIN ISSUES IDENTIFIED ON THE DAY WERE
- Appropriate escalation to the Divisional Silver Bleep Holder
- Ward to ward transfer process (SGH – QMH)
- Incomplete and failed submission of social care notifications
- Lack of Homelessness team
- Equipment ordering process for interim placement (health vs. social)
- Placement out of borough – Identifying funding pathways on admission
- Lengthy screening time for Heathlands and Ronald Gibson House (RGH)
- System Partners were unable to login to their secured network

WHAT WENT WELL
- Introducing patients by borough important
- Action oriented as issues were resolved in real-time
- Real time collation of themes and issues
- Forging relationship across the health and social care system
- Ward teams empowered to self select complex cases
- One panel style preferred to two

CONCLUSION
- This MADE event structure and timing was felt to be much better than previous events. Ward Liaison manager approach to Medicine and Cardiac wards worked well therefore this approach should remain
- A number of patients had been previously discussed at the divisional led stranded patient meeting were represented to the panel as there had been limited or no progress
- Continuous training and educational sessions for frontline staff to raise awareness of process and existing services available across the system

NEXT STEPS (Act)
- Repeat MADE using the one panel format
  - Operational team to decide the frequency
  - System Partners to bring known complex cases to panel
  - Share the patients list with system partners ahead of the event
  - Provide access to secured wifi network for system partners
- Pursue business case to establish a dedicated homelessness team
- Review escalation process to Divisional Silver Bleep Holder
- Review current overseas patient discharge process to signpost clinical teams to next option for patients with no recourse to public funds
- Staff should follow training guide on how to submit care notifications
- Review the current stranded patient meetings to ensure appropriate escalation is in place, accountable officer has been allocated and actions are followed through
- Include all relevant discharge planning information when transferring patients to avoid further delays and duplication
- Review screening and response times for Heathlands and RGH
- Notification system should be reviewed to flag incomplete submissions

ACKNOWLEDGEMENTS:
All SGUHFT Staff and System Partners involved in providing care to patients
Thanks to all who participated in the MADE events
Jo Hunter – Divisional Director of Nursing and Governance, Medicine and Cardiovascular
Stephanie Sweeney – Divisional Director of Nursing and Governance, Surgery, Cancer, Neurosciences and Theatres
Laura Acquaye – Project Manger, Therapy Workstream – E: Laura.Acquaye@stgeorges.nhs.uk
Buddhi Pant – Programme Manager, Base Wards (Red2Green) & Ambulatory Care – E: Buddhi.Pant@stgeorges.nhs.uk

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St George's University Hospitals NHS Foundation Trust

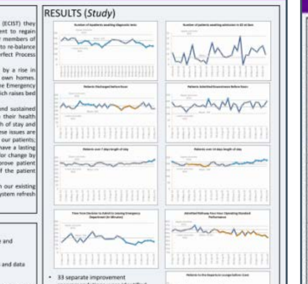
Perfect Process Week for Site Operations

INTRODUCTION
During a recent visit by the Emergency Care Intensive Support Team (ECIST) they suggested that St George's needs to do something significantly different to regain control of patient flow. Following conversations with a number of senior members of staff, ECIST and the Executive team have agreed a programme of action to re-balance capacity and operations across the Trust in an initiative called "The Perfect Process Week for Site Operations".
The Trust is currently facing significant operational difficulties, caused by a rise in patients staying for longer periods of time before returning to their own homes. Evidence has shown us that patients that wait more than four hours in the Emergency Department to be admitted then stay an additional day as an inpatient which raises bed occupancy once again.
These challenging times have left us with high occupancy rates, high and sustained escalation, patients in the "wrong" beds not best placed to deal with their health issues, crowding in assessment units, elderly care increases, longer length of stay and cancellations for elective surgery and outpatient appointments. All of these issues are detrimental to the excellent care and safety that we strive to provide for our patients; they also add further pressure on our staff, which if not contained will have a lasting and damaging effect on morale. This initiative aims to generate energy for change by doing things differently to support patient flow and consequently improve patient experience, safety and staff morale. The underlining principle is that if the patient needs to be admitted then it's: 'Right Bed, Right Patient, First Time'.
The "Perfect Process Week for Site Operations" is designed to re-launch our existing policy and escalation processes for managing the rhythm of the day – a system refresh ahead of winter.

AIMS (Plan)
- ✓ Effective running of the site meetings – with appropriate attendance and audience
- ✓ Clear agreed actions and ownership
- ✓ Efficient bed management process through use of electronic reports and data
- ✓ Focus on Trust surge capacity triggers and actions
- ✓ Launch of action cards for key roles
- ✓ Closer working between Emergency Department & Site Management to unblock delays
- ✓ Enable earlier discharge through improved use of departure lounge
- ✓ Reduce the numbers of extended and long stay patients
- ✓ Reduce the number of patients waiting for internal processes to be completed
- ✓ Reduce the time from Decision to Admit to Leaving Emergency Department
- ✓ Improve Admitted Pathway Four Hour Operating Standard

INTERVENTION (Do)
For the period 25th November to 29th November 2019, to run a "Perfect Process Week for Site Operations" event
- ✓ Site Meetings will be action oriented
- ✓ Daily action log will be collated, updated and tracked
- ✓ Site Head of Nursing will attend 2 hourly huddles within the Emergency Department
- ✓ Bed managers will use real time tableau reports to identify planned for discharges today
- ✓ Use of 'Today's Waiting Room' dashboard
- ✓ Ward colleagues to escalate all delays to Silver bleep holders
- ✓ Pilot of action cards for Silver bleep holders, Site Manager, Bed Manager and ED Patient flow coordinator
- ✓ Planning for tomorrow: discharges for tomorrow will be confirmed at 4pm each day with Ward Matrons
- ✓ Use of KPIs to measure impact - underpinned by the 5 guiding principles for effective site management, FOCUS (NHSI June 2019)
- ✓ Check data quality and accuracy of repatriation data
- ✓ Daily 'wash up' of the prior 24 hours at 0830hrs bed meeting
- ✓ Post week review to identify key successes and further areas for improvement

RESULTS (Study)



- 33 separate improvement recommendations were identified
- The time taken from Decision to Admit to admission reduced prior to the Perfect Process Week and this was sustained.
- Patients sent to the departure lounge by 11am also showed a sustained improvement trend

LIMITATIONS
- The Trust experienced a very challenging week with higher than normal numbers of long stay patients and high bed occupancy
- The hospital status resulted in difficulty in implementing all aspects of Perfect Process Week at the level of detail we set out to achieve
- Impact on the Trust was limited in terms of impact on some KPIs due to the intentional site team process focus for the week for example the external partner organisations were not included
- The resources available were limited and needed to involve a mix of skill sets to achieve maximum impact. Lead in time for the initiative needed to be longer.

CONCLUSIONS & NEXT STEPS (Act)
- Carry out review and refresh of the Trust full capacity protocol / triggers and actions
- Pilot an escalation dashboard (aligned with the above)
- Review of site management out of hours staffing
- Longer lead in time required for future initiatives to ensure staff are fully briefed and understand key measures, roles, responsibilities and outcomes
- Carry out a training needs assessment for the site team (bed managers) to assess needs in terms of IT, policies, guidance, reports – in particular use of Tableau
- Carry out a full review of the Transfer of Care Bureau with a focus on function, staffing model and the operational model
- Identify and assess IT systems that will support improvement opportunities for patient flow

ACKNOWLEDGEMENTS:
All staff involved in supporting "Perfect Process Week for Site Operations" PDSA event
MORE INFORMATION:
Buddhi Pant buddhi.pant@stgeorges.nhs.uk
Emilie Perry – Divisional Director of Operations for CWDT Division
Ian D Sparks – Site Manager

St George's University Hospitals NHS Foundation Trust

Local Safety Standards for Invasive Procedures (LocSSIPs) in Maternity

INTRODUCTION
The completion rates of Local Safety Standards for Invasive Procedures (LocSSIPs) is low across maternity, as illustrated in the table below.

[illegible table]

The implication of not completing these audit questions is potentially significant for patient safety and puts the Trust at risk given the potential for a Never Event of a retained swab.

The maternity notes have three separate pages where swab counts are recorded – third stage, perineum repair and LocSSIP audit. Accurate completion of these pages are audited on RaTE by the maternity governance team through completion of 60 separate questions. RaTE is the Trustwide on-line safety audit system.

AIMS (Plan)
To increase the rate of completion of LocSSIPs for perineal repair and instrumental delivery, to ensure patient safety. This improvement will be measured by the RaTE audit tool results

INTERVENTION (Do)
On-going audit of accurate completion of the LocSSIP, third stage and perineum repair pages of the maternity notes by the maternity governance team, but number of audit questions on RaTE reduced from 60 to 30. Five sets of notes audited per week.

Names of any staff making incomplete records recorded, and email sent to remind them to complete records accurately. If any names crop up twice, email sent to line manager to discuss further.

RESULTS (Study)
Audit of 23 cases in October showed that in 21.7% of cases, the number of swabs had not been accounted for. This was a small improvement compared to Q1 (30%) but still not the 100% accounted for that it should be.

Has the number of instruments and swabs used / not used POST procedure been accounted for?

Anecdotal evidence suggested that some of the forms were completed in full, but repetition across different pages meant not all questions were answered in all places and therefore audit failed. Emails sent to managers were well received, although some members of staff had left the Trust before action could be taken.

LIMITATIONS
Planned use of a flowchart leading to taking staff through capability management was not ratified by the maternity team ahead of this intervention.

CONCLUSIONS & NEXT STEPS (Act)
Review of three forms in the maternity notes is essential to ensure that staff are focussing on completing the most important fields to ensure safety.

RaTE audit question numbers need to be reduced further. Other areas that have higher scores on audit have fewer questions (Interventional Radiology use five).

Ratification of flowchart required to ensure that accurate completion of LocSIPP is given high profile amongst staff and managers.

ACKNOWLEDGEMENTS:
All staff involved in providing care to patients
MORE INFORMATION:

St George's University Hospitals NHS Foundation Trust

No Wasted Appointments – Urology Stones pilot

INTRODUCTION
As many as a third of Urology Stones Outpatient Clinic patients were arriving for their appointment without a diagnostic test that had previously been requested having been completed. This meant the consultant was not able to decide on the best course of action for the patient.
A fish-bone analysis found the common causes of the problem to be:
- The patient was not aware of test or did not attend the test
- The hospital did not schedule the test to occur before the outpatient appointment
- The appointment or test had been rearranged independently of the other

AIMS (Plan)
Develop a process to proactively identify these patients with enough time so that a test could be arranged and attended (or outpatient appointment delayed as backup) ensuring that when the outpatient appointment was attended the test results were available.
1. Specify and develop tableau report
2. Initiate weekly reviews with the consultant
3. Execute and record actions necessary to avoid patients having a wasted appointment
4. Document the steps to obtain the data and take action
5. Embed above into service management team

INTERVENTION (Do)
Report developed and weekly reviews began in April 2019.

Initially the project reviewed patients in the following week but quickly found that there was insufficient time to schedule a test so this was changed to reviewing appointments for three weeks time.

Consultant led reviews have continued at typically three per month, lasting between 30 minutes and an hour. Subsequent actions are normally completed by the project in 1-2 hours.

RESULTS (Study)
The project is able to identify patients and arrange a test or reschedule the appointment in most cases, improving patient experience and clinical efficiency. Nearly 300 appointments have been saved in six months.

RESULTS (Study)
Appointments saved:

However the project has not been able to resolve all the underlying issues and it is estimated that about 18% of urology stones patients will continue to fall into this error trap and require a manual intervention to avoid having a wasted appointment.

The project has specified an iClip change to improve the efficiency of this task. By adding a field / link to test when booking the follow-up outpatient appointment the report could auto generate a list of patients for the scheduling team to action.

LIMITATIONS
The varied root causes have many interdependencies and should be eliminated by the move to electronic Clinic Decision Outcome Forms and the associated Ordercomms.

CONCLUSIONS & NEXT STEPS (Act)
Review sessions provide an effective control to avoid the patient attending outpatients before the test is completed. The reviewed tests are not 'extra' since they are usually being brought forward but the act of rescheduling creates rework for diagnostic scheduling team.
To make this sustainable the recommended next steps are
1. Finalise report logic and set to auto generate lists for schedulers.
2. Train Urology service staff to pickup these actions.
3. Identify other services who might benefit from this process and roll out there.

ACKNOWLEDGEMENTS:
Marco Bolgeri – Urology Consultant
Romina Usai – Principle Information Analyst
MORE INFORMATION:
Matthew Pullar – Head of Process Redesign, Efficiency and Transformation, St George's University Hospital NHS FT
Dave Woodruff – Project Manager, St George's University Hospital NHS FT

St George's University Hospitals NHS Foundation Trust

Care Home Improvements in Wandsworth and Merton

INTRODUCTION
- For outstanding care, patients should be in the environment most appropriate for their assessment, for their treatment and for their care.
- When residents of Care or Nursing Homes are conveyed to the Emergency Department (ED) when they could have been more appropriately managed in that Home, this results in a busier and more congested Emergency Department than would otherwise be the case and places an often more vulnerable adult in an inappropriate and busy high activity environment.
- Similarly, when patients experience slower than optimal discharge to a Care or Nursing home this leads to them remaining in an acute hospital bed when they no longer require acute healthcare, to them being at risk of deconditioning and to the next patient needing the bed being unable to access that environment.

AIMS (Plan)
- Merton & Wandsworth CCGs (M&W CCGs) and St George's University Hospitals NHS Foundation Trust (SGHFT) have jointly agreed that a collaborative piece of work is required to better support Care and Nursing Homes to care for their patients in that Home environment.
- Existing support measures to prevent ambulance conveyance will be reviewed by a multi-organisational working group and alternative proposals discussed, reviewed and agreed at a workshop event.
- The resulting recommendations will be pulled into a Business Case for sign off by each organisations' internal governance processes.

INTERVENTION (Do)
- M&W CCGs and SGHFT will meet to confirm the intention to include the Care Homes work as part of the Place agenda.
- A director led, clinically engaged, multi-organisational workshop will then be arranged to review the existing pathways and processes and conveyance rates and outcomes compared to peer systems that use different processes and pathways.
- The working group will propose alternative processes, pathways and working practices as well as support systems to promote the non conveyance where appropriate and safe.
- Outside of the working group these proposals will be prioritised by M&W CCGs and SGHFT colleagues. This will be based on costs, outcomes and deliverability.
- The prioritised recommendations will be pulled into a jointly written Business Case which will move through each organisations' own internal processes.

RESULTS (Study)
- An agreement has been made between the M&W CCGs and the Trust to ensure that the specialist geriatrician supporting the Multidisciplinary Team meeting will call into the meeting at a designated time to assist in the completion of Co-ordinate My Care assessments.
- This negates the need to attend in person which can be time consuming.
- It is proposed that this will be the same for the Palliative care consultant input too.
- Consultants will not be completing the full Co-ordinate My Care assessments which the M&W CCGs are already paying the GP to do, but will provide the expert advice required where appropriate.

RESULTS (Study – What went well)
- Initial conversations with the M&W CCGs gave a very clear steer on what challenges existed. Specifically, the volume of care home conveyances to ED was impacting on the capacity within ED and often led to admissions for patients. This created an impetus for change.
- The proposed solutions from colleagues in both organisations were the same despite being given separately.

RESULTS (Study – What did not go well)
- The prioritisation of the work in people's diaries was not high and needed to fit in amongst other commitments and priorities.
- The different organisations had varying baseline understandings of what progress had been made at service level and what the existing and imminent pathways looked like.
- Whilst the Trust had developed a new service which allowed for a Geriatrician to be available to assist in the delivery of Co-ordinate My Care assessments, the M&W CCGs stated that they were not witnessing this or aware of it.

LIMITATIONS
- Progress was slowed by competing operational demands.
- Initial conversations with the M&W CCGs and the Trust had to be held separately due to lack of aligned availability between the clinical lead and the CCG lead.

CONCLUSIONS
- Although both organisations clearly understood the impact that these issues could have on Emergency Department flow, patient experience and the use of resources, the M&W CCGs and Trust were not aligned in their understanding of recent service developments.
- The joint approach to creating a business case / way forward led to a shared understanding of the existing plans and an agreement as to the service development required was made.
- A full joint business case was not required, given the commitment and resources already provided.
- The key learning point was around effective, ongoing communication regarding service development.
- Using defined measures of success to describe key operational performance indicators and sharing the tracking of these openly and transparently will be the basis of sustained delivery. This will also assist in identifying any further service development cycles required across Place during the post implementation review.

NEXT STEPS (Act)
- The service development planned for by the Trust will be implemented in order to try to reduce care and nursing home residents being conveyed by ambulance to the St George's Hospital site.
- Data collection to enable post implementation review against the agreed key performance indicators for Wandsworth and Merton Care and Nursing Home residents only:
  - Number of Co-ordinate my Care Assessment completed with Geriatrician support
  - Number of patients attending ED
  - Number of Non-elective admissions
  - Days lost to Delayed Transfer of Care for patients admitted

ACKNOWLEDGEMENTS:
MORE INFORMATION:

St George's University Hospitals NHS Foundation Trust

IMPROVING CONTACT RATE OF TELEPHONE APPOINTMENT CALLS

INTRODUCTION
Outpatient consultations via telephone are a priority laid out in the NHS Long Term Plan as an opportunity to "provide more convenient ways for patients to access advice and care"[1].

St George's currently provides 25,000 telephone consultations per year across a range of services and this is expected to steadily increase. The method to communicate with patients ahead of the call differs to that of a face to face consultation. The patients get a letter when the booking is made but crucially do not get a reminder closer to the date as in the past these had inadvertently caused patients to attend the hospital unnecessarily.

Clinicians making the calls anecdotally report that frequently patients don't answer the call and speculate that this is because they weren't expecting it or didn't want to answer a call from a number they don't recognise.

AIMS (Plan)
- Work with the clinicians who make the calls to design the wording and timing of a reminder message which would increase the likelihood of the call being answered, and the patient being prepared for the conversation.
- Reduce the number of telephone appointment calls which are attempted but not answered.
- Improve the uptake and effectiveness of telephone appointments in order to allow the Trust to make wider use of them.

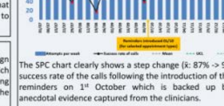
INTERVENTION (Do)
Pilot as a small trial to ensure no repeat of the issue where patients inadvertently attended the hospital.

Contact the clinicians who conduct the most telephone consultations invited to take part in the project (13 invited, 8 responded and agreed, the services include Paeds, Gynae, Gastro, General Surgery, Respiratory and Oncology).

The message was collectively agreed to be:
"This is St. Georges University Hospital in Tooting, John Smith has a Respiratory telephone appointment on 10/7/19 at 13:30. At **around this time** one of our clinicians will try to call this number, **the number they are calling from may be withheld**. Please ensure **you are in a comfortable place to take their call**. You do not need to attend the hospital for this appointment. Thanks."

INTERVENTION (Do)
Sections in **bold** were added at the direct request of a clinician in response to issues they perceived.
It was felt that the message should land 48 hours ahead of the scheduled call to give enough advanced warning yet still remain fresh in the mind of the patient.

RESULTS (Study)
Since 1st October, 740 patients have been reminded ahead of a telephone consultation; none of these patients inadvertently attended the hospital.



The SPC chart clearly shows a step change (x̄: 87% -> 91%) in success rate of the calls following the introduction of the new reminders on 1st October which is backed up by the anecdotal evidence captured from the clinicians.

"*Patients do mention that they get a text message reminder which definitely improves the number who answer*" T.Graham – Consultant General Surgery

[The call success rate data is derived using 'appointment outcome' as a proxy. There is some known inaccuracy since not all clinicians mark every failed call attempt as a DNA]

CONCLUSIONS & NEXT STEPS (Act)
Following this successful trial the reminders will be extended to cover more telephone and virtual clinics on an opt-in basis.

The results of this trial will be shared with clinicians and operational managers in services who do a high volume of none face to face activity. If this activity is telephone calls at the time scheduled in ICLIP then the project will recommend activating the reminders. If the activity differs (it is a notes review, or is made away from the scheduled time) then the project will work with the clinical/operational teams to see if a similar solution might help improve patient experience around these appointments.

[1] NHS Long Term Plan v1.2, Section 4. 1. 23 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

ACKNOWLEDGEMENTS: S.Parsons, N.Waters, A.Agneiska, E.Trayfoot, V.Sri Kantha, T.Graham, S.Haywood, D.Sharma. MORE INFORMATION: D.Woodruff or M.Pullar

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Outstanding care every time — St George's University Hospitals NHS Foundation Trust

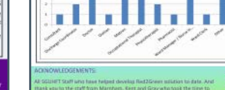
Impact of simulation to inform IT technical developments and deployment in clinical practice

INTRODUCTION
Introducing new technology into an existing organisation is a challenge. Studies show responses to innovation include: use as planned, rejection (up to 40%), partial use, workarounds, stress and breakdown (K.Eason 2014). Simulation allows organisations to understand how processes and systems work and how these would behave when the changes are implemented.
St George's University Hospital NHS Foundation Trust is committed to delivering the latest technology making it easier for staff to provide care safely and effectively.
A simulation session was completed to provide staff with an opportunity to test and develop the Red2Green module within iClip. Red2Green is a visual management system to assist in the identification of wasted time in a patient journey.

AIMS (Plan)
- Complete in depth user acceptance testing with three multidisciplinary teams (MDT): Gray ward, Marnham ward and Kent ward
- Testing to be completed within a simulation environment to replicate a huddle scenario
- Test 'what if' scenarios
- Ward teams to trial two technical solutions and provide feedback on preference, usability and shape future roll out requirements

INTERVENTION (Do)
- Meetings held with St George's Advanced Patient Simulation (GAPS) team to plan the simulation sessions.
- IT system testing took place to ensure iClip test environment was enabled within University building.
- IT trainers built mock wards consisting of 10 test patients per ward
- Senior Nursing leadership team (DDNGs, Heads of Nursing) were approached to identify participating wards from each division.
- Ward leaders locally agreed MDT attendance.
- One hour allocated to each ward to test two technical solutions.
- All staff signed consent forms to allow for video and audio recording of the session.
- Each team used their handover sheets to discuss patients who were currently on the ward. One team member physically entered the information.
- A total of 30 patients were discussed.
- 20 minutes to test each system per ward.
- Facilitated 15 minutes feedback per ward.
- Table top exercise to gain group feedback on solution A & solution B.
- QR Code provided to staff for feedback on the session.
- Follow up email and informal ward drop in to gain further feedback.

RESULTS (Study)
- 26% of staff were familiar with the existing technical system
- 23 staff members participated in the simulation session



RESULTS (Study)
- Staff reported they found the session useful
- 33% completed the survey monkey post simulation
- 84% of staff rated the simulation session as very good or good

"*Both systems are fairly equal in terms of technical usage, I can see there will be more flexibility in usage with the second system and the text is larger. The large list of options is only a problem if the board round is going too fast and it's members don't give time to select the correct option - if everyone knows we have to select options and what options there are then it will be ok.*"

- Staff reported the use of real patients was beneficial
- All staff felt the session provided them with an opportunity to ask questions
- The sessions ran to time, however staff provided mixed feedback regarding the length of testing time. 29% felt time was insufficient

"*As a pharmacist clinically the session may not have applied to me however was good to understand new potential discharge processes.*"

LIMITATIONS
- Length of session felt to be too short
- Staff were unable to take more than one hour away from the wards
- Staff did not use the supporting technology to combine live and test environment deferring to use of paper handovers
- Not all staff could see the screen
- PC mirrored to a replica whiteboard during the simulation session which is not a like for like version of daily events during a board round / huddle
- While representation from staffing groups was diverse not all professions felt the session topic was relevant to them
- iClip test environment limited the resemblance to clinical practice i.e. short cut navigation to landing page not enabled to suit board round format

CONCLUSION & NEXT STEPS (Act)
There was good attendance and engagement at the simulation session. Teams were unanimously clear on the preferred technical solution, which has informed development.
Simulation methodology provided an opportunity to blend IT process change with clinicians into an existing system. The recommendation would be for ICT to review their current IT deployment process and utilise simulation methodology. Simulation provides an opportunity to combine IT expertise along with clinical and operational requirements. This will optimise clinical engagement and system change success. Using simulation as a method of learning and development would need to be reflected in clinical training and education priorities alongside GAPS team.

ACKNOWLEDGEMENTS:
All SGUHFT staff who have helped develop Red2Green solution to date. And thank you to the staff from Marnham, Kent and Gray who took the time to participate in testing.
Buddhi Pant- Programme Manager St George's University Hospital NHS FT
Laura Acquaye – Project Manager St George's University Hospital NHS FT
Matthew Pullar – Head of Process Redesign & Efficiency St George's University Hospital NHS FT
Matthew.Pullar@stgeorges.nhs.uk

Outstanding care every time — St George's University Hospitals NHS Foundation Trust

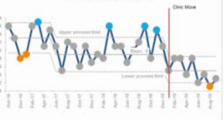
Frailty Rapid Access Clinic move from Queen Mary's Hospital to St George's AAA Unit

INTRODUCTION
- Rapid Access Clinic (RAC) was established in October 2016 with Wandsworth CCG as part of the Acute Frailty Pathway (AFP)
- The AFP intends to provide an alternative to emergency department presentation and acute admissions
- RAC offers rapid access to geriatrician assessment, investigation and possibly admitted to a rehabilitation inpatient unit at Mary Seacole ward (MSW)
- Patients are referred from primary care. Clinic capacity is a maximum of two referrals per day, five days a week with the exception of public holidays.
- In week referrals varied from seven patients to zero, which resulted inconsistent and inefficient use of consultant time
- Increased demand winter 2018 combined with staffing pressures placed a strain on the ability to provide other services at SGH

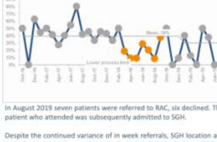
AIMS (Plan)
- Move the clinic location from Queen Mary's Hospital Roehampton to St George's Hospital Tooting
- Improve efficiency of clinical time provided by consultants.
- Provide consultants with the ability to access urgent diagnostics in line with same day emergency care guidelines
- Enable direct access to specialty services on site
- Develop a flexible workforce to provide clinic cover
- Identify patients via OPAL who could be discharged from ED/CDU with RAC follow up to prevent admission

INTERVENTION (Do)
- RAC was relocated January 2019 to SGH Tooting site within the Acute Assessment Area (AAA), ground floor St James' Wing
- Joint planning to manage the move took place with partners; CCG, Transport lead and community services
- Communications were sent via the CCG to primary care to inform practices of the site move
- Referral pathway and criteria remained the same
- Consultants screened all referrals prior to acceptance and booking
- Changes were made to the transport booking system, whereby patients and/or GPs are required to book their transport to attend the clinic
- RAC hours of operation remained the same

RESULTS (Study)
Of those referred 84% were seen in RAC, 10% were rejected and 3% Did Not Attend (DNA)



RESULTS (Study)
Overall only 4% of patients were referred to an acute hospital
Below graph depicts the percentage of patients admitted to MSW overall



In August 2019 seven patients were referred to RAC, six declined. The one patient who attended was subsequently admitted to SGH.

Despite the continued variance of in week referrals, SGH location allowed consultants to release time back into clinical duties within SGH. Identification of OPAL patients from ED/CDU with RAC follow up did not occur.

LIMITATIONS
- Issues were identified with the transport booking process.
- Referral process was not redesigned to account for the clinic move and the ensuing internal process changes. This did not impact upon the number of referrals from primary care.
- AAA environment is not suitable for RAC patients; accessible toilets, loud and busy environment
- Impact of supporting workforce at QMH was not mirrored in AAA. There was limited support for blood tests, feeding and toileting of patients
- Geographical change in clinic location may have impacted on attendance; however no change seen in referral source
- RAC based within AAA takes away from from acute medicine utilisation
- Methodology of capturing data has not been consistent
- Patient feedback has been limited by low responses. Prior to the service move focused patient feedback was not captured

CONCLUSION & NEXT STEPS (Act)
A reduction in referrals is evident since January 2019, however there are a number of contributing factors including location and transport. In addition to this, the consultant team changed the screening process to reduce the number of inappropriate referrals.

Both staff and patient feedback has concluded that AAA is not the right environment to deliver comprehensive geriatric assessment and treatment.

Next steps will be to review the outcomes jointly with Wandsworth CCG and outline a proposal for relocation of RAC away from AAA. Within the proposal consideration of patients needs from the clinic as well as environmental considerations such as dementia friendly and accessibility should be pivotal. Ensuring the clinic reflects a multidisciplinary model will promote a holistic approach to patient care. Engaging with our primary care colleagues to refine referral criteria and pathway will inform future plans.

ACKNOWLEDGEMENTS:
All SGUHFT Staff involved in the deliver of care within rapid access clinic
Gaggandeep Alg – Consultant Geriatrician, St George's University Hospital NHS FT
Joanna Preston – Consultant Geriatrician, St George's University Hospital NHS FT
Bernadette Kennedy – Therapy Lead for Community Services

St George's University Hospitals NHS Foundation Trust

Falls Improvements in Wandsworth and Merton

INTRODUCTION
- The existing Integrated Falls and Bone Health service provided by St George's University Hospitals NHS Foundation Trust (SGHFT) was at risk of being decommissioned following a CCG approved Business Case which proposed a change to the commissioned model from its historical prevention service (directed at injurious falls) to a rapid response and falls prevention model.
- SGHFT felt that appropriate clinical and system partner engagement had not been undertaken and that the proposed changes would have a significant and detrimental impact on service delivery, quality and performance. A formal challenge was issued to the CCG.
- There was an agreement to convene a meeting whereby the CCG agreed to listen to the challenge. SGHFT proposed an alternative collaborative leadership approach to develop a new whole system approach with multi-organisational engagement and whole system agreement in how things should develop and progress.

AIMS (Plan)
- To reach agreement on a whole system vision and purpose for Rapid Response and Falls transformations and an operational whole system plan.
- To reach agreement on the contractual and financial implications of these transformations and ensure all organisations are transparent and in agreement regardless of which organisation may benefit.
- To result in reduced Falls conveyances and admissions to acute hospital bed bases in real terms and / or in comparison to peers.
- To result in better case finding, data management and monitoring and patient care across the system for the Wandsworth population who Fall.

INTERVENTION (Do)
- Initial meetings to be held with CCG and SGHFT Directors to agree the trialling of Falls through the new Place system.
- A series of initial listening exercise 'new Business Case' development meetings will be arranged with senior CCG colleagues, SGHFT, Local Authority and Third sector to agree a shared purpose and commitment.
- A series of multi-organisational Task and Finish (T&F) groups will take place focussed on writing a new joint business case for Falls. This will be reviewed at the Director level Business Case development meetings before being passed through each organisations own governance processes for sign off.
- The Business Case development meetings are looking for the completion of four key stages at a rate of one key stage each week:
  1. Multi-organisational agreement on the challenges using data where possible and appropriate. Due for sign off week commencing 28.10.19.
  2. Multi-organisational agreement on the remedial actions to be undertaken and why those actions as opposed to others using a decision making matrix highlighting the performance and outcomes impact as well as finance. Due for sign off week commencing 04.11.19.
  3. Multi-organisational agreement on the owners and timescales for those actions. Due for sign off week commencing 11.11.19.
  4. Multi-organisational agreement on the contractual and finance implications resulting from remedial actions as well as which organisation each implication will impact upon and to what extent. Due for sign off week commencing 11.11.19.

RESULTS (Study)
- The work undertaken has led to the development of a joint CCG and Trust Business Case for a new Falls service.
- The business case identifies the benefits to patient outcomes and finances and also identifies which organisation will benefit from the gains being made or which organisation will be responsible for the costs incurred.
- The progress made on the development of this business case has led to an improved working relationship between the CCG and Trust team involved.
- Specific multi-organisational task and finish groups that were held focussed largely on those key items intended (noted in the Intervention section) and agreement was achieved across all organisations and teams on what the challenges were, what the remedial actions were, who owned these, what the timescales for delivery were and what the financial impacts were (along with which organisation had what impact).

RESULTS (Study – What went well)
- The complex and sensitive start point for this work could have resulted in duplication, gaps and non-agreement as to the right thing to do for our patients, but taking time to ensure that people were clear on the goals via the T&F Group helped.
- This ensured that each person (not just each organisation) was in agreement with:
  1. The current challenges being experienced.
  2. The proposed resolutions for each of those challenges.
  3. The owner and timescales for delivery for each of those remedial actions.
- The result was an agreement between CCG and Trust colleagues on each of points 1-3 above and a single business case across both organisations.

RESULTS (Study – What did not go well)
- The complex and sensitive start point for this work made for a slow start to the work which impacted on all consequential dates.
- The sensitivities also meant that some meetings took longer than they would normally have required.
- The original Business Case for this work was already written in a CCG template. This meant that the new joint Business Case for the work retained the CCG format and the format has not yet been reviewed by the Trust's Investment Decision Group.
- The early progress of this work went via a CCG-led Benefits Realisation Group as opposed to any groups within the Trust.
- Given that the work was not starting from scratch, the meetings often needed to deviate from the agenda to ensure that we were covering everything required and that every voice and point was made and heard.
- Earlier identification of the project management resource requirement for the work could have enabled better planning for that resource to have been in place.

LIMITATIONS
- The negative starting point of the Rapid Response and Falls work, which resulted in a formal challenge by the Trust to the CCG, made this a much more challenging piece of work that required leadership, difficult conversations and a system effort to do differently. However success despite this start is encouraging for future work.
- The lack of a jointly agreed template to use across the system was restrictive.
- The lack of an agreed governance process causes confusion. The CCG-led, but multi-organisational Benefits Realisation group is one avenue for sign-off, whilst the Trust-led, but multi-organisational Frailty Board is another.

CONCLUSIONS
- The start point was less than ideal and required a significant effort to recover the position of trust and readiness for change.
- The fact that this work has resulted in a joint business case (regardless of organisational template) is very positive.
- Colleagues involved approved of the joint development process and the linear approach that the multi-organisational T&F group took.
- There is a need for a single multi-organisational Benefits Realisation Group (BRG) to oversee Business Case development.

NEXT STEPS (Act)
- The Business Case for the work is undergoing a slight revisions to give greater clarity on the financial benefits resulting from the work and where specifically they come from.
- The Business Case has been recommended in principle by the BRG for progressing through individual organisations' governance processes and the progress towards a collaborative approach has been noted by the BRG.
- Final sign off of the business case by the Trust's Investment Decision Group and the relevant CCG board is required. The cross organisational implementation plan will require further system sign off from additional partners in health and social care.
- A designated project manager needs to be identified to oversee implementation of the service, including data collection to enable post implementation review against the agreed key performance indicators for Wandsworth and Merton patients only:
  - Number of patients attending ED following a fall
  - Number of patients conveyed by ambulance to ED following a fall, having had paramedic or other Health Care Professional assessment
  - Number of Non-elective admissions for patients following a fall
  - Length of acute hospital stay for patients admitted non-electively following a fall
  - Number of patients admitted following a fall who are discharged to rehabilitation or intermediate care beds

ACKNOWLEDGEMENTS:
MORE INFORMATION:
Sandy Keen
Bernadette Kennedy
Michael Kaiser

St George's University Hospitals NHS Foundation Trust

Improvements in Accessing Post-Acute Care in Wandsworth and Merton

INTRODUCTION
- There are currently multiple referral methods, templates and at least 17 different forms for acute staff to have to complete and intrinsically adhere to in order to access post-acute care for a patient.
- Any missing information or errors in completion of a referral can lead to delays.
- Once referrals have been made, access to the selected care can still be slow and have a multi-stage process meaning patients remain in acute hospital beds long after their acute health care requirements and provision have ended.
- The delays to patients' discharge actively facilitates the deterioration of patients' health and condition.
- The delays to discharge cause bed occupancy to be higher than necessary, and accessing the beds from the Emergency Department (ED) to be slow, to the detriment of Four Hour Operating Standard performance.

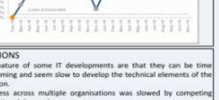
AIMS (Plan)
- The aim is to develop a business case for an agreed single referral process to post-acute care, or in the worst case, a vastly reduced number of processes, forms and templates.
- The Business Case should have clearly agreed Key Performance Indicators (KPIs).

INTERVENTION (Do)
- Initial meetings will be arranged with local authorities and Clinical Commissioning Groups (CCGs) to garner their input / support to a remedial plan and their buy in from the start.
- A strong emphasis will be placed throughout this process on the fact that this development is not about blame but is about trying to move forward from the current norm to develop processes that are better for our patients.
- The initial meetings will discuss and highlight the numerous referral methods from an acute setting to post-acute hospital care and why this causes delays.
- This will also be the start point of a subsequent, less senior working group which will focus on developing remedial actions to streamline the referral processes. Examples of best practice from peer groups will be highlighted as recommendations of potential resolutions and the recommendation of a single referral process, true discharge to assess and trusted assessor models will be promoted.
- In terms of the IT solution itself, a separate improvement cycle and post implementation review will be completed which will highlight the plan and results including the mapping out of referral requirements from eight health and social care localities, trialling the template and developing a reporting system linked to the discharge dashboard.

RESULTS (Study – What went well)
- The IT based solution to the multiple referral routes and templates has been developed in partnership with involvement from the operational and IT teams.
- The IT solution will not only have the capacity to reduce the number of referral routes and templates, but also pre-populate a majority of the fields required for any given referral.
- Of the 33 fields the single electronic referral requires, it will automatically pre-populate 24 of these.

RESULTS (Study – What did not go well)
- Meetings with local authority partners have not yet occurred and will be required in order to secure their support for the use of the new referral system.

RESULTS (Study)
- The single referral form has now been tested internally but is not yet rolled out as a pilot.
- The form is out for consultation with system partners and support exists in principle from CCG colleagues.
- As expected, there has been no movement in the proportion of Discharge Notifications sent before Noon:



LIMITATIONS
- The nature of some IT developments are that they can be time consuming and seem slow to develop the technical elements of the solution.
- Progress across multiple organisations was slowed by competing operational demands.
- The absence of a multi-organisationally based Task and Finish Group means that ad hoc meetings have to be set up.

CONCLUSIONS
- This work is not yet completed and requires ongoing developments by the Trust which continue to progress.
- Support from commissioners exists for the continued development and implementation of this solution once developed (subject to demonstrations) and some middle grounds may be required to be agreed by organisations in order to achieve single format forms.

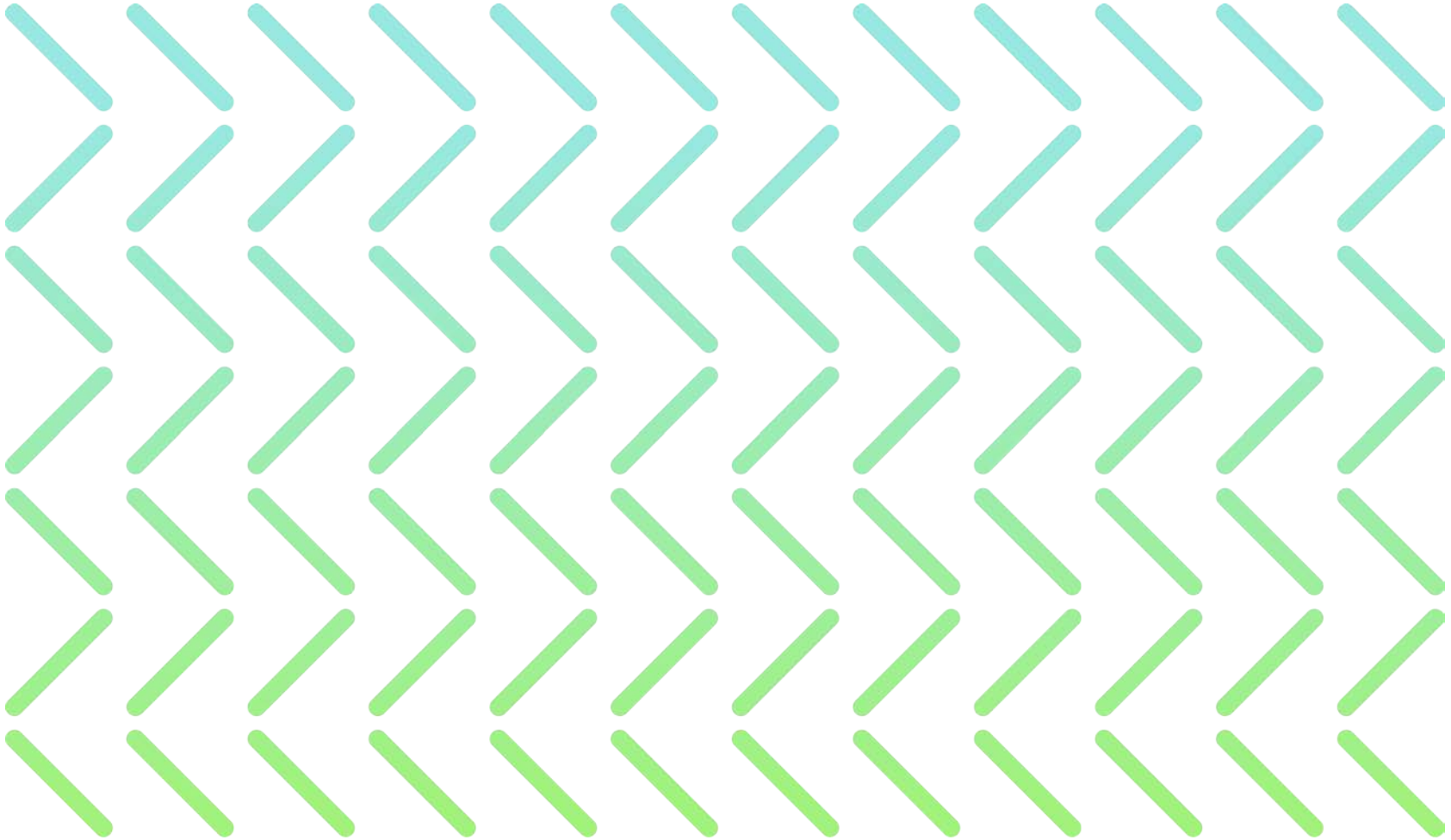
NEXT STEPS (Act)
- Ongoing conversations to be held with commissioners and local authorities as to the implementation of the system.
- Agreement required on which services to pilot it with.
- There is a need to develop a Place Based Benefits Realisation Group which will act as a Clearing House to oversee the development and implementation of system-wide solutions such-as this.
- Data collection will be required to enable post implementation review against the following proposed KPIs:
  - Number of referrals sent to health services (broken down by CCG) and the proportion rejected including rejections due to missing information, poor completion or misdirection.
  - Number of referrals sent to local authorities (broken down by authority) and the proportion rejected.
  - Processing time from form started to completion and the proportion of Discharge Notifications issued before Noon.
  - Time from referral to discharge.
  - Of the patients discharged with a referral sent, the number of readmissions within 30 days from discharge.

ACKNOWLEDGEMENTS:
Laura Acquaye, Project Manager, St George's University Hospitals NHS Foundation Trust
Matthew Pullar, Head of Process Redesign, Efficiency and Transformation, St George's University Hospitals NHS Foundation Trust
MORE INFORMATION:
Michael Kaiser

Upcoming Plan Do Study Act Cycles

Already underway for Quarter 4

- Transferring patients to Queen Mary's
- edck.in
- Ear Wax Pathway
- Multi Agency Discharge Event
- Place Based Transformation Business Case Development
- Sepsis
- Atkinson Morley ward facilities
- Mitie contract review
- Rapid Assessment Zone
- Medical Productivity and Model Hospital



Outstanding care every time

Meeting Title:	Trust Board Meeting		
Date:	27 February 2020	**Agenda No.**	**3.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Harbhajan Brar, HR & OD Director		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	This paper sets out the key risks and issues reviewed by the Committee at its meeting on 18 February 2020 including commenting on assurance to the Board on key risks allocated to the Committee. The overall message is of continuing progress on a number of fronts with no new risks to be brought to the attention of the Board, and no change to existing risk ratings. In relation to the NHS Staff Survey, the Trust's results remain below the NHS average overall although there has been a discernible improvement in staff endorsement of the Trust as: a place to be treated; a place to work; and a place where patient focus was a top priority - all improving by around four percentage points. This is encouraging, particularly as the rate of improvement is twice that achieved across the NHS whole. However the Committee noted with some disappointment that there had been only a very limited reduction in the proportion of staff reporting discrimination from colleagues or managers. Of real concern was the fact that the proportion of Trust staff reporting discrimination from patients, service users and visitors, rose from 11.2% of staff to 11.8%. It is clear from the discussion in Committee that this is a real issue for many of our staff and a very debilitating feature of their working experience. Management were clear that they adopt a zero-tolerance approach to this and would support any member of staff who does experience such behaviour. We spent some time discussing possible further actions to address this and management agreed to revert with additional proposals at our next meeting. This is an increasing issue across the NHS as a whole.		
Recommendation:	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 Committee meeting held on 18 February, and a very full Agenda.

The areas of focus at this month's meeting were: a detailed briefing on the Culture Change Programme; a review of the results of the NHS Staff Survey; a reconciliation of the two measures of the Trust's staffing establishment; an update on progress on this year's Diversity and Inclusion Action Plan and a proposal for next year's D&I priorities; and a review of two draft Pay Gap reports, one dealing with Gender Pay and the other with Ethnicity Pay. We also received a briefing on the Trust's preparedness for any Corona Virus cases, with a particular focus on our handling strategies for our staff.

The results of the Staff Survey were broadly encouraging, although the Trust still remains below the NHS average overall. Whilst there is clear progress in many areas, engagement and sentiment levels in some segments of the Trust's workforce (e.g. BAME, staff with disabilities etc.) are at real risk of remaining low, and of those staff being left behind. We have strategies and actions in place to help address this, but we will need to maintain focus. The improvement in the survey results overall, whilst welcome, must not detract from the very real need to concentrate on our culture, engagement and inclusion work. The good news is that this is being maintained and we are setting a clear expectation of further progress. The bad news is that a material and increasing proportion of our staff report having experienced discrimination from patients, service users and visitors. Management were clear that they adopt a zero-tolerance approach to this and would support any member of staff who does experience such behaviour. We spent some time discussing possible further actions to address this and management agreed to revert with additional proposals at our next meeting. This is an increasing issue across the NHS as a whole.

That said, the overall message is of continuing progress on a number of fronts with no new risks to be brought to the attention of the Board. We noted a number of impending changes within the senior leadership team, and a shift of responsibilities to enable other individuals to step up into roles on an interim basis. We expressed our appreciation to Tom Shearer and Rob Bleasdale, who had stepped into the roles respectively of Chief Financial Officer and Chief Nursing Officer and who had made to time to attend, and contributed well to the meeting.

2. Key points:-

Board Assurance

The Committee has five Trust level risks[1] allocated to it as part of the Board Assurance Framework. The Committee recommends that the risk ratings for these remain as currently set.

Theme 1 - Engagement

Staff Survey – we spent a significant part of the meeting being briefed on the results of the 2019 NHS Staff Survey, and specifically the results for the Trust compared to 2018. In summary, the results demonstrated continued progress in many areas but also some areas of continuing concern. The Trust's results are still below the NHS average.

In relation to the three key 'place' questions, there has been solid progress over the last year, with staff endorsement of the Trust as: a place to be treated; as a place to work; and as a place

[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.

where patient focus was a top priority - all improving by around four percentage points. This is encouraging, particularly as the rate of improvement is twice that achieved across the NHS whole.

However, whilst acknowledging the progress being made, we had a detailed discussion of the areas that the survey tells us we need to maintain focus on. We looked closely at three 'discrimination' questions. Responses on two[2] of these had improved, but that improvement was only modest. In relation to a third discrimination question, relating to experiencing discrimination from patients, service users and visitors, the percentage reporting having experienced this rose from 11.2% of staff to 11.8%. It is clear from the discussion in Committee that this is a real issue for many of our staff and a very debilitating feature of their working experience. We agreed that the Trust needed to sharpen its response to such actions, and executive management have committed to revert with further proposals to address this. We accepted that this is a complex issue to manage, but this should not stop us acting to support our staff and provide a safe working environment. We will follow up at our next meeting, at which point we will also be reviewing management's analysis of the 1,200+ comments generated by staff responding to the survey.

Medical Engagement – we received a short report from Richard Jennings on the results of the recent Medical Engagement Survey. This suggested that engagement was still well below the NHS average (and only modestly higher then when a similar assessment was undertaken in 2016). There were particular challenges at each end of the seniority spectrum – consultants and junior doctors. Engagement was highest when doctors considered their immediate team, and lowest when considering the Trust as a whole. Richard is reviewing the detailed results and will revert with a final assessment, and the Trust's proposal to address this. We take the results of this every bit as seriously as the Staff Survey, as having our medical workforce on board is critical to implementing the service and efficiency improvement sought.

Diversity and Inclusion - Lisa Childs has been seconded from Epsom and St Helier to work with the Trust over the last six months on Diversity and Inclusion (and specifically race equality and disability equality). Lisa reported on progress against the Trust's project plan during that period, and also laid out a proposed Action Plan for the next financial year. Progress to date was encouraging, and a number of actions are now on target and well on the way to completion by year-end. There were no concerns arising as a result of the Committee's review of this. The proposed Action Plan for 20-21 was reviewed and endorsed, and this will now be consulted upon more widely within the Trust. With the end of her secondment coming shortly, this was Lisa's last meeting and we thanked her for the work she had undertaken.

Discriminatory Application of Disciplinary Process - At a previous meeting, we had asked that more detailed analysis be undertaken of a sample of disciplinary cases to ensure that the decisions made and actions taken in relation to BAME members of staff were (a) consistent with those taken in relation to white staff, and (b) consistent with Trust policies. The analysis and conclusion was presented to the Committee. The Review, of 30 cases, concluded that there was consistency across both areas. Importantly, however, the review noted that there was not always clear and demonstrable use of the Trust's internal pre-disciplinary checklist, or of a consistent approach between different HR advisers. The pre-disciplinary checklist had been created specifically to help ensure consistency of treatment, and consistency of decision-making as to which situations warranted use of disciplinary proceedings. The Review therefore recommended that the protocol be used in all cases, and the Committee accepted and endorsed that recommendation. Harbhajan Brar agreed to action this.

Pay Gaps - Sion Pennant-Williams introduced two Pay Gap reports, each with a snapshot date of 31 March 2019. The Gender Pay Gap Report is now in its third year, so we are able to show changes over time. This will also be the second year we have published an Ethnicity Pay Gap

[2] Q14, acting fairly in relation to career progression / promotion, up from 72.3% to 73.4%, and Q15b, experiencing discrimination from a manager, team leader or colleague, down from 12.9% to 12.6%.

review so we can see the changes since prior year, although neither yet amounts to trend data. The overall result of both reports disappointingly show little movement in the overall Pay Gaps, but certainly some early indicators of positive change in gender pay.

As well as reviewing the gender pay gap generally, the Committee focussed on two areas. The impact that the shift to a *financial* long service award had had on the bonus gap, and the beginnings of a positive shift in the proportion of female consultants receiving a local Clinical Excellence Award. The Committee discussed ways to separate these factors from the underlying data, and Sion has since re-run the Reports to reflect the specific impact of each of these.

The ethnicity pay gap report showed that BAME employees are under-represented at the higher bands and over-represented at the lower bands, and that overall there is a pay gap in favour of white staff. The data suggests that the pay gap disproportionately affects Black/Black British employees, who make up 16% of our total workforce. The implication is that the cause of the pay gap may run deeper than simply under-representation of overall BAME employees in the higher pay bands. The Diversity and Action Plan for 20-21 is critical in helping to start to correct this.

Theme 3 - Workforce Planning and Strategy

Tom Shearer and Sion Pennant-Williams reported back on work they had been undertaking to reconcile the Agresso and ESR totals for the Trust's establishment. This demonstrated that a closer reconciliation could be achieved and, other than for the period at the very beginning of each financial year, this would be undertaken routinely in future. We anticipate this coming through in future reporting from HR and finance where very similar staff establishment totals should be reported.

We reviewed a number of **workforce statistics** for January, most of which were trending broadly steady. Although the agency fill rate had moved up marginally in the month, we noted that agency spend remained below the Trust's own cap.

Theme 4 – Compliance.

Freedom to Speak Up – we received a progress report from Liz Wood on the Trust's Guardian programme, and noted that the processes appeared to be working, with concerns being raised and escalated. We deferred consideration of where the Guardian should report into the Trust, to enable a full options assessment to be made.

Committee Effectiveness – we reviewed the results of the effectiveness review. Whilst these were generally supportive of the shift to a more assurance-focussed approach, there were a number of pointers to ways we could sharpen our meeting management and ensure we maximised our effectiveness. We will action these.

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

22 February 2020

Meeting Title:	Trust Board		
Date:	27 February 2020	**Agenda No**	**3.1.1**
Report Title:	Gender Pay Gap		
Lead Director/ Manager:	Harbhajan Brar, Chief People Officer		
Report Author:	Sion Pennant-Williams, Workforce Intelligence Manager		
Presented for:	Assurance/Approval		
Executive Summary:	The Trust has a legal requirement to produce an annual gender pay gap report based on a snapshot date of the 31 March each year. This report must be submitted to the Government and published on the Trust's public website. The gender pay gap as at the 31 March 2019 (the snapshot date for reporting) is 14.83% mean and 7.85% median. The 4 pay quartiles show a higher proportion of males in the highest and lowest pay quartiles, despite the workforce being predominantly female. The mean pay gap has increased by just over 1% since the previous year. Examination of the pay gap within the different payscales shows that there is little difference in the average hourly rates until band 9. Similar to previous years the reason for the pay gap lies primarily within the medical and dental staff group, primarily in the Junior Doctor and Consultant pay grades. The mean gender pay gap for bonuses is 42.5% and the median is 66.67%. This figure has seen a large increase since the previous year. This is due to the inclusion of low value long service awards which were primarily paid to female staff, whilst the Clinical Excellence Awards were of much higher value and were primarily paid to males Consultants, though it looks like more female Consultants are starting to receive these.		
Recommendation:	The Board is asked to note that: • Note the contents of the report and offer any comments; and • The Workforce & Education Committee considered this report on 18 February 2020 and the Committee's reflections were included in the Committee's Board Report under agenda item 3.1; and • Agree, subject to reflecting any matters raised by the Board, that the report could be published on the Trust's public website.		
Supports			
Trust Strategic Objective:	Build a better St George's		
CQC Theme:	Leadership & Engagement		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	Submit is data to the Government and publish the report on public website.		
Resources:	N/A		
Equality and Diversity:	This report addresses equality and diversity issues related to gender pay inequalities.		
Previously Considered by:	Trust Executive Committee Workforce & Education Committee	**Date:**	19/02/2020 18/02/2020
Appendices:	N/A		

Gender Pay Gap Report
Data as at 31 March 2019

1.0 PURPOSE

1.1 Provide initial findings of the gender pay gap.

1.2 Generate discussion as to how to respond to these findings.

1.0 BACKGROUND

2.1 As per the legal requirement, an annual gender pay gap based on a snapshot date of the 31st March each year has to be produced and the figures submitted to the Government. This report shows the data from the 31st March 2019.

2.2 It was expected that discussions within this meeting may shape the report further.

2.0 ANALYSIS

3.1 There is a mean pay gap of 14.83% and median pay gap of 7.85% between male and female staff.

3.2 Female employees are under-represented in the Upper Pay Quartile, and also in many of the higher-paid payscales.

3.3 The pay gap lies mainly within the medical staff group which has the highest pay gap at both consultant and non-consultant level.

3.4 There is a mean bonus pay gap of 42.5% and median pay gap of 66.67% between male and female staff.

3.5 1.68% of all female staff are paid bonuses compared with 5.43% of all male staff.

3.8 This year saw the inclusion on Long Service Awards in the bonus pay gap, as employees now receive a voucher for £50 rather than a crystal bowl. These low value bonuses that were paid primarily to females have massively increased the bonus pay gap.

3.9 The other bonuses paid were to consultants in the form of Clinical Excellence Awards and Distinction Awards. These high value bonuses to were paid primarily to males, though there are more new entry females receiving these bonuses than there were in previous years.

4.0 IMPLICATIONS

Risks

4.1 Reputational risk
Impact on staff turnover, higher dissatisfaction levels on staff surveys and FFT
Negative impact on customer care

Legal/Regulatory

4.2 The Trust is required to submit is gender pay gap data to the Government and publish the report on its public website.

Resources

4.3 N/A

Equality & Diversity

4.4 This report addresses equality and diversity issues related to gender pay inequalities.

5.0 RECOMMENDATION

The Board is asked to note that:

5.1 Note the contents of the report and offer any comments; and

5.2 The Workforce & Education Committee considered this report on 18 February 2020 and the Committee's reflections were included in the Committee's Board Report under agenda item 3.1; and

5.3 Agree, subject to reflecting any matters raised by the Board, that the report could be published on the Trust's public website.

Gender Pay Gap Reporting 2018/19

Introduction

The Equality Act 2010 (Gender Pay Gap Information Regulations 2017) requires all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website. This report captures data as at 31st March 2019.

St George's University Hospitals NHS Foundation Trust employs over 8,500 staff in a number of staff groups, including administrative, medical, nursing, and allied health roles. All staff except for medical and Very Senior Management (VSM) are on Agenda for Change payscales, which provide a clear process of paying employees equally, irrespective of their gender.

What is the gender pay gap?

The gender pay gap is the difference between the average hourly earnings of men and women – this is not the same as equal pay, which is concerned with men and women earning equal pay for the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. Instead the gender pay gap highlights the imbalance of pay across an organisation. For example, if an organisation's workforce is predominantly female yet the majority of senior positions are held by men, the average female salary could be lower.

What do we have to report on?

The statutory requirements of the Gender Pay Gap legislation is that each organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payment

Definitions of pay gap

The **mean pay gap** is the difference between the pay of all male and female employees when added up separately and divided by the total number of males, and the total number of females in the workforce.

The **median pay gap** is the difference between the pay of the middle male and middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

Who is included?

All staff who were employed by St George's and on full pay on the snapshot date (31st March 2019) are included. Bank staff who worked a shift on the snapshot date are included. Consultant Additional Programmed Activities (APA's) are included, but general overtime pay and expenses are excluded.

Employees who are on half or nil absence or maternity leave, hosted staff (e.g. GP Trainees) and agency staff have not been included.

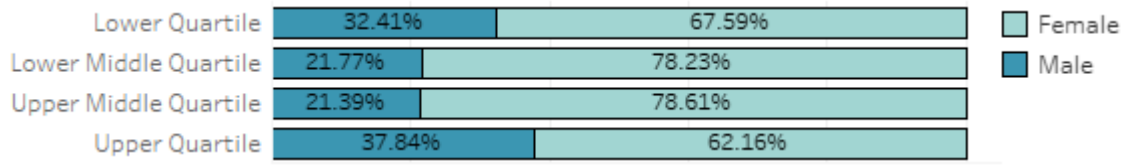
Bonus pay is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. This therefore also includes CEA's and also Distinction Awards. Recruitment & retention payments (RRP's) are only included if they are a one-off payment at the start of recruitment, not if they are continuous. Workplace vouchers that are paid in addition to basic salary should be included, but not if they take the form of a salary sacrifice arrangement.

Background

This is the third gender pay gap report produced. Our last Gender Pay Gap report was in March 2019 based on snapshot data from 31st March 2018. The findings were:

- Our mean pay gap was 13.61%
- Our median pay gap was 4.96%
- Our mean bonus pay gap was 12.25%
- Our median bonus pay gap was 17.19%

The total workforce was comprised of 73% female and 27% male. The pay quartile split was as follows:

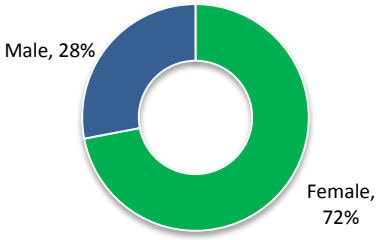


Further analysis of this data revealed that although most of the higher bands had a higher proportion of males than the overall Trust composition, the gender gap lay primarily within the Medical & Dental staff group, specifically the Consultant role. If this staff group was excluded from the calculations then the pay gap would actually have been in favour of females.

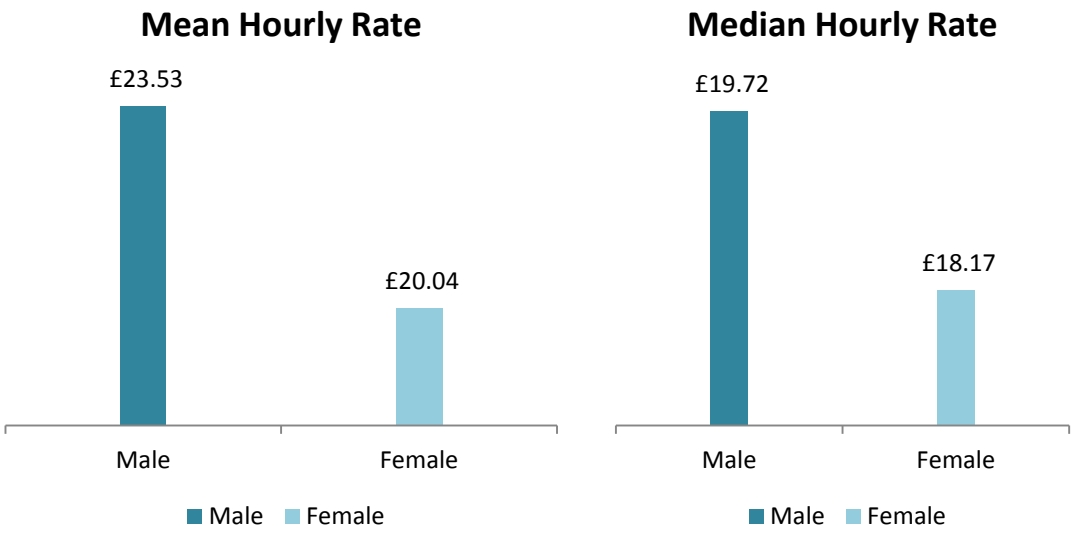
The only bonuses that paid within this period were to Medical Consultants. It was noted that although 55% of Consultants were male, 64% of bonuses had been paid to males whereas 45% of Consultants were female and just 36% of bonuses had been paid to females.

Trust Gender Profile (based on headcount)

St George's University Hospitals NHS Trust, as is typical of the NHS, has a higher proportion of females to males in its workforce – of the 8,947 staff counted as part of the gender pay gap reporting, 6,423 were female compared to 2,524 male:



Gender Pay Gap

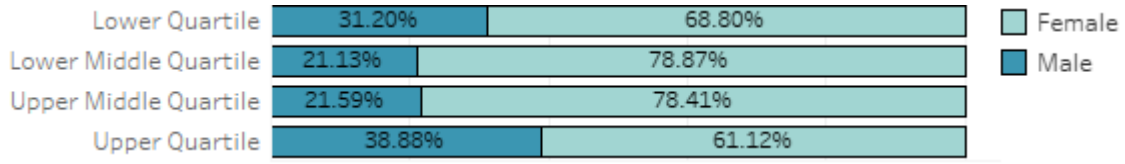


Mean gender pay gap– 14.83%
(2017/18 – 13.61%)

Median gender pay gap – 7.85%
(2017/18 – 4.96%)

The above figures show that the mean hourly pay for males is £3.49 higher than that of females, which is a gap of 14.83%. Male median pay is £1.55 higher than females, which is a gap of 7.85%.

Pay quartile split:



What does this mean?

Both the mean and median pay gaps have increased since the previous year. To understand where this increase has occurred in the mean pay gap it is helpful to look at the differences in each band.

Mean Pay Gap

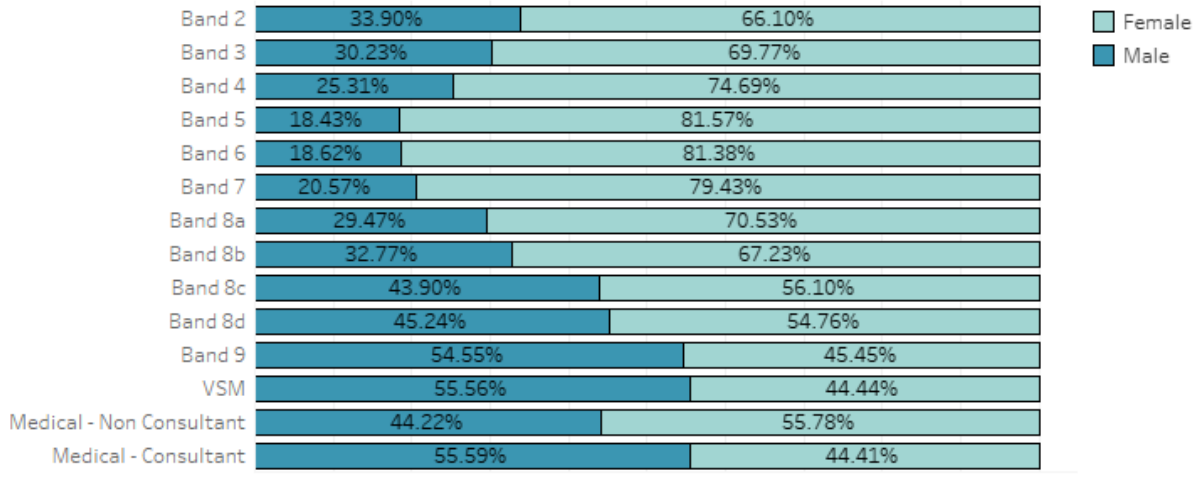
To determine the cause of the mean pay gap is it worthwhile examining the gender composition and pay gaps in each individual pay grade. This is shown in the following table, with the higher average pay by gender highlighted in green.

Grade	No. of male staff	No. of female staff	Male Hourly Rate*	Female Hourly Rate*	Difference	Gap†	2017/18 Gap†
Band 2	458	893	12.10	12.17	-0.07	-0.56%	-1.03%
Band 3	195	450	12.16	12.00	0.16	1.34%	1.00%
Band 4	162	478	13.12	13.36	-0.23	-1.78%	-2.90%
Band 5	261	1,155	16.67	16.86	-0.19	-1.15%	-1.06%
Band 6	288	1,259	20.71	20.63	0.08	0.40%	-1.89%
Band 7	231	892	23.42	23.68	-0.27	-1.15%	-0.55%
Band 8a	112	268	27.92	27.30	0.62	2.21%	0.90%
Band 8b	39	80	32.43	32.13	0.30	0.92%	1.39%
Band 8c	18	23	36.36	36.27	0.08	0.23%	-0.02%
Band 8d	19	23	43.17	42.64	0.53	1.22%	1.28%
Band 9	6	5	51.72	53.00	-1.27	-2.46%	-3.86%
VSM	10	8	69.93	67.88	2.05	2.94%	3.63%
Medical - Non Consultant	325	410	28.51	26.74	1.77	6.20%	7.17%
Medical - Consultant	333	266	48.91	46.79	2.12	4.33%	3.94%

*refers to the mean hourly rate

† negative values mean that the difference and the gap are favourable to females

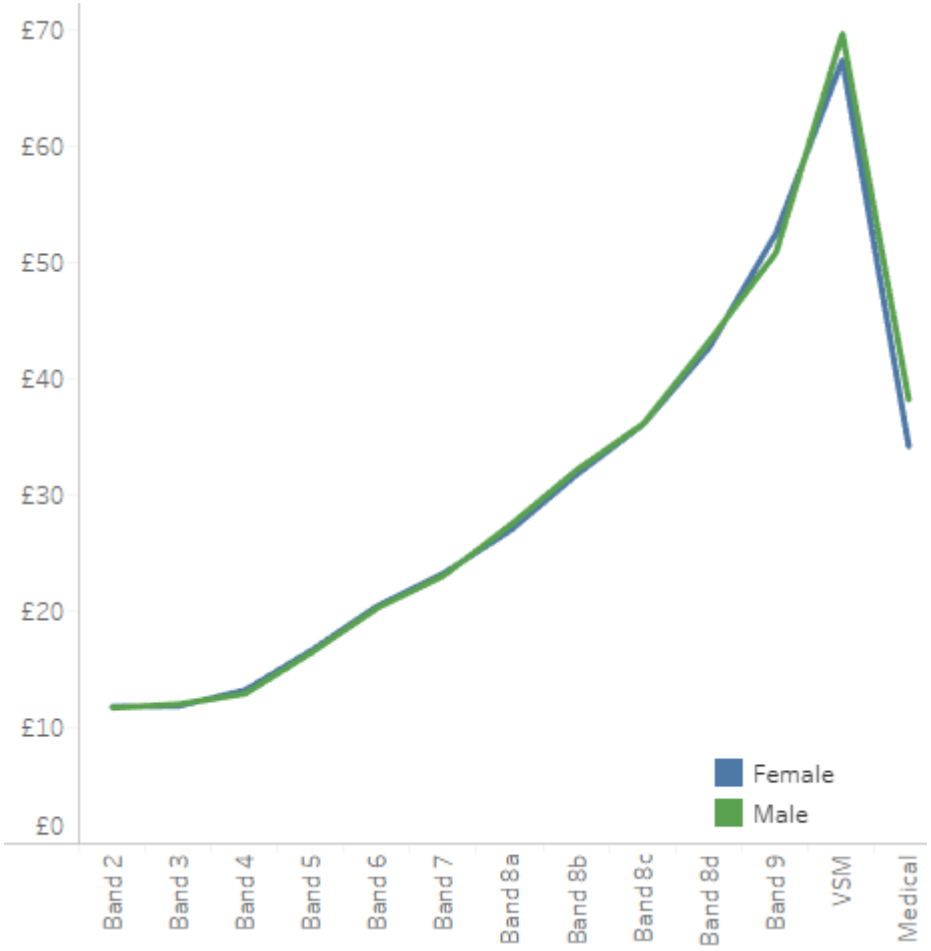
Gender split by band – based on headcount:



The mean gender pay gap has increased by just over 1% in the last year. The table above shows where the changes are in each grade – however there have been no significant changes over the year. The gap in some cases have narrowed, in other cases it has increased – this is part of the constant movement of the Trust staff profile, which remains fairly consistent. In the majority of grades the pay gap is less than 2%, but where it is higher than 2% tends to be in the higher grades where male staff are over-represented. In the past 2 years the

proportion of females in band 9 and VSM has increased, most notably in the VSM grade which has gone from 37.5% in March 2017 to 44.44% in 2019.

The following graph shows the mean hourly rate for each grade by gender. It shows that they are more or less the same, with the only noticeable divergents occurring at the higher bands.



The above graph shows that the biggest gap in hourly pay is in the medical staff group, and as with previous years it is this pay gap that is the most significant. Although the gap has narrowed in the non-Consultant group, at 6.2% it is still significant and there is a £1.77 difference in average hourly pay. The pay gap has increased for Consultants and there is a £2.12 difference in hourly pay. The medical staff group consists of 1,334 staff and so these differences are notable and once again this is where the overall pay gap lies. If medical staff are removed from the overall total then the gender pay gap would be 1.32% in favour of females.

Medical Staff

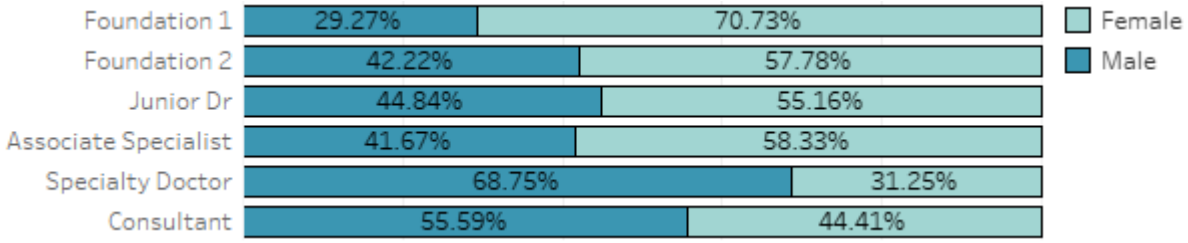
Medical staff group comprises of all trainee to Consultant roles. The pay gap for Medical staff as a whole is is 10.82% (up from 11.43% last year) - males get paid on average £4.20p/h more than females. The proportion of male to female staff is 49.33% to 50.67%.

Band	No. of male staff	No. of female staff	Male hourly rate*	Female hourly rate*	Difference	Gap†	2017/18 gap†
Foundation 1	12	29	14.97	14.86	0.11	0.76%	1.11%
Foundation 2	19	26	17.91	17.80	0.12	0.65%	1.45%
Junior Dr	278	342	29.27	28.02	1.25	4.26%	6.24%
Associate Specialist	5	7	39.23	44.96	-5.73	-14.60%	2.63%
Specialty Doctor	11	5	37.37	29.22	8.15	21.82%	-0.95%
Consultant	333	266	48.91	46.79	2.12	4.33%	3.94%

*refers to the mean hourly rate

† negative values mean that the difference and the gap are favourable to females

Gender Split by Medical Role – based on headcount



Consultants

St George's had 599 consultants in post on 31st March 2019. It was noted in the 2016/17 report that Medical Consultants are one of the highest paid roles in the Trust, and are eligible to receive clinical excellence awards (CEAs) and Additional Programmed Activities (APAs) which are consolidated into the basic pay calculations.

There are more male consultants than female (respectively 56% male to 44% female). Male Consultants were paid on average £2.12 p/h more than female Consultants, and this gap has increased since 2017/18 when it was 3.94%.

Non-Consultants

The pay gap for Foundation level Doctors has narrowed slightly since 2017/18, so the gap is now less than 1% for both level 1 and level 2. The proprtion of females to males in level 2 has also increased from 53% female to 58%, which suggests that more female are going into doctor training.

The Trust has over 600 junior doctors, and they are the most numerous of the medical roles. The overall pay gap for Junior doctors has decreased from 6.24% to 4.26%, and although there is a higher proprtion of females in this role, male Junior Doctors are paid on average £1.25 p/h more than female Junior Doctors. Male Junior Doctors are getting more basic pay than female Junior Doctors, with 71% of male Junior Doctors

being in the overall upper quartile compared with 61% of females. There are 10 spine points on the basic Junior Doctor payscale, and males tend to be on the higher points which suggests that males are continuing the training for longer and that females are dropping out or taking longer to complete their training, possibly taking a break to start a family.

Median Pay Gap

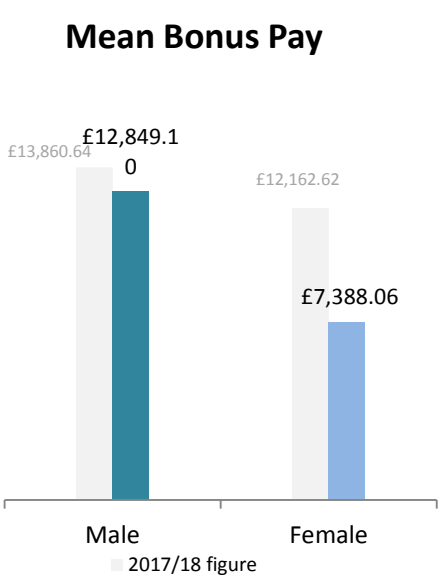
The median is based on the hourly rate that is in the middle when lined up from lowest to highest. Keeping in mind that the Trust profile is 72% female to 28% male, females are over-represented in the middle quartiles, whilst slightly under-represented in the lower quartile. However in the upper quartile males are over-represented at 39%, which has increased slightly from 38% last year and 37% the previous year. The proportion of males and females in each quarter is shown below:

	Males	Females
Lower Quartile	27.81%	24.10%
Lower Middle Quartile	18.58%	27.26%
Upper Middle Quartile	19.18%	27.37%
Upper Quartile	34.43%	21.27%

The highest concentration of males is in the upper quartile, whereas this is where the lowest concentration of females sits. We can see that this disproportionately high number of males in the Upper Quartile is affecting where the median gap is – adding the percentages from the lowest we can see that the median male hourly rate will be in the Upper Middle Quartile, whilst for females it will be in the Lower Middle Quartile.

It is worth noting however that the overall median figure for hourly pay across the Trust regardless of gender is £18.42, which is much close to the female figure of £18.17 than the male figure of £19.72.

Bonuses

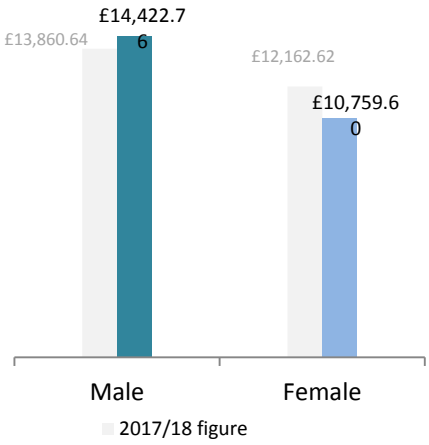


Mean gender pay gap – 42.5%
(2017/18 12.25%)

Median gender pay gap – 66.67%
(2017/18 17.19%)

The recipients of the long service awards have previously been gifted a crystal bowl and therefore haven't been included in the figures for bonus awards. However they now receive a voucher for £50 and so this is classed as a monetary value and as such are classed as a bonus and have been included in the calculations. As the Trust profile is 72% female most of these were given to female staff. The other bonuses paid in the time frame (1st April 2018 to 31st March 2019) were to medical Consultants in the form of CEA's and Distinction Awards. These were paid mainly to males, and have a much higher value. This has caused a dramatic increase in the bonus pay gap since last year. We know from previous analysis that the main issue in the provision of bonuses is that the CEA's are typically paid more to males than females, therefore although it is this higher pay gap that we will have to report on to the government, the following analysis will look at the bonus pay gap with the long service awards excluded.

Mean Bonus Pay (excluding long service awards)



Median Bonus Pay (excluding long service awards)

Mean gender pay gap – 25.4%
(2017/18 12.25%)

Median gender pay gap – 36.11%
(2017/18 17.19%)

Aside from the Long Service Awards the only bonuses paid were the distinction awards and Clinical Excellence Awards, both paid only to Consultants. Focussing just one these both the mean and the median pay gaps have doubled since last year, Only 6 Distinction Awards were paid (4 to male Consultants and 2 to female Consultants) compared to 190 CEA's so this analysis will focus on the CEA's. Whilst this initially looks alarming, both previous gender pay gap reports have noted that the Consultant role has traditionally been male dominated and so males will be getting higher paid CEA's as they will have worked up the Clinical Excellence Award scale over the years. It has been noted in previous reports that there is no quick fix to this as these high value bonuses will be getting paid for several years, until the Consultants leave or retire. However last year the Trust committed to encouraging female Consultants to apply so that in time the balance can be redressed, and in 2018/19 there are 7 females Consultants who were not paid a CEA in the previous year and are now on CEA Level 1, compared with just 3 males. This suggests that the encouragement has been successful and that more females are applying for the CEA – but because they are on the lower paid first level this will bring both the mean and the median bonus pay for females down, thereby increasing the bonus gender pay gap.

Another encouraging sign is that the proportion of females now receiving CEA's in the lower age range has increased, suggesting a positive change for addressing the bonus pay gap in the future:

2017/18:

Age Range	Female	Male
31-40	80%	20%
41-50	36%	64%
51-60	35%	65%
61-70	33%	67%

2018/19:

Age Range	Female	Male
31-40	86%	14%
41-50	42%	58%
51-60	34%	66%
61-70	0%	100%

Including the Long Service Awards there were a total of 245 bonuses paid in the period. 108 of these were to females, which is 1.68% of the total female employees in the Trust. In comparison 137 were paid to males, which is 5.43% of the total male employees in the Trust. Excluding the Long Service Awards 1.15% of the total female employees in the Trust and 4.83% of total male employees were paid a bonus.

When compared with the proportion of male Consultants to female Consultants, 62% of bonuses were paid to males when they make up 56% of the role. 38% were paid to females, who make up 44% of the role.

Year on Year

Though we are unable to determine trends with 3 years' worth of data, the figures for each metric over the year are presented here for reference.

	2016-17	2017-18	2018-19
Mean Pay Gap	13.94%	13.61%	14.83%
Median Pay Gap	2.11%	4.96%	7.85%
Mean Bonus Pay Gap	15.05%	12.25%	25.40%
Median Bonus Pay Gap	15.36%	17.19%	36.11%
% males getting bonus	5.28%	4.98%	4.83%
% females getting bonus	1.08%	1.11%	1.15%

Comparison

At the time of writing 22 Trusts had published their gender pay gap results for 2018-19. Seven of these Trusts had reported a lower mean pay gap than St George's, and fourteen had a higher mean pay gap. Similarly 10 Trusts reported a lower median pay gap, and 11 Trusts reported a higher median pay gap.

* These figures will be updated nearer to publication when more Trusts have submitted their figures.

Progress and Next Steps

There is still a higher proportion of males in the higher paid roles than females when comparing with the general Trust proportion, however the balance at band 9 and VSM is nearly equal and the pay gap has decreased. There is still a significant pay gap at Consultant level which is again primarily due to males getting paid more for CEA's than females, though the number of females receiving CEA's is increasing. This should eventually reduce the pay gap, though this will not start happening in the near future as they will need to work their way up the levels.

The Trust will soon publish its Diversity and Inclusion Action Plan for 2020/21 which has a specific action for the Trust Women's network group around reducing the Gender Pay Gap, though the next Gender Pay Gap report will be for the snapshot date 31st March 2020 so this may not have an impact until the following Gender Pay Gap report in 2021.

Meeting Title:	Trust Board		
Date:	27 February 2020	**Agenda No**	**3.1.2**
Report Title:	Ethnicity Pay Gap		
Lead Director/ Manager:	Harbhajan Brar, Chief People Officer		
Report Author:	Sion Pennant-Williams, Workforce Intelligence Manager		
Presented for:	Assurance		
Executive Summary:	The Trust voluntarily produced and published the first Ethnicity Pay Gap report to complement both the mandatory Gender Pay Gap report and the Workforce Race Equality Standards (WRES) report. The ethnicity pay gap as at the 31st March 2019 (the snapshot date for reporting) is 11.23% mean and 11.64% median. The 4 pay quartiles show a higher proportion of white employees in the highest pay quartile, and a higher proportion of BAME staff in the lowest pay quartile. There has been little change from the previous year – the largest pay gap still affects Black/Black British employees who are paid on average £5.27 an hour less than white employees, comprising of a mean pay gap of 23.74%. Again this is primarily due to a lack of Black/Black British employees in the higher pay bands of the admin and clerical staff group.		
Recommendation:	The Board is asked to note that: • Note the contents of the report and offer any comments; and • The Workforce & Education Committee considered this report on 18 February 2020 and the Committee's reflections were included in the Committee's Board Report under agenda item 3.1; and • Agree, subject to reflecting any matters raised by the Board, that the report could be published on the Trust's public website.		
Supports			
Trust Strategic Objective:	Build a better St George's		
CQC Theme:	Leadership & Engagement		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	This report addresses diversity and inclusion issues related to ethnicity pay inequalities.		
Previously Considered by:	Trust Executive Committee Workforce & Education Committee	**Date:**	19/02/2020 18/02/2020
Appendices:	N/A		

Ethnicity Pay Gap Report

1.0 PURPOSE

1.1 Agree to publish on the Trust external website

2.0 BACKGROUND

2.1 The Trust voluntarily produced and published the first Ethnicity Pay Gap report to complement both the mandatory Gender Pay Gap report and the Workforce Race Equality Standards (WRES) report

2.2 Data is a snapshot from 31st October 2019

3.0 ANALYSIS

3.1 There is a mean pay gap of 11.23% and median pay gap of 11.64% between white and BAME staff. The mean pay gap has barely changed over the year, however the median pay gap has doubled.

3.2 An increase in the number of BAME employees since the previous year is the primary reason why the median pay gap seen such an increase.

3.3 BAME employees are over-represented in the lower pay quartiles and under-represented in the higher pay quartiles.

3.4 There is a pay gap in favour to white staff for all the different ethnic groups except that of Chinese/Other.

3.5 The largest pay gap is between white staff and Black/Black British staff – this discrepancy is mainly found within the admin and clerical staff group.

4.0 IMPLICATIONS

Risks

4.1 Reputational risk
Impact on staff turnover, higher dissatisfaction levels on staff surveys and FFT
Negative impact on customer care

Legal Regulatory

4.2 N/A

Resources

4.3 N/A

Equality & Diversity

4.4 This report addresses equality and diversity issues related to ethnicity pay inequalities.

5.0 RECOMMENDATION

The Board is asked to note that:

5.1 Note the contents of the report and offer any comments; and

5.2 The Workforce & Education Committee considered this report on 18 February 2020 and the Committee's reflections were included in the Committee's Board Report under agenda item 3.1; and

5.3 Agree, subject to reflecting any matters raised by the Board, that the report could be published on the Trust's public website.

Ethnicity Pay Gap 2018/19

1. Background

Although not yet mandated to do so, in March 2019 St George's produced its first Ethnicity Pay Gap report alongside its second Gender Pay Gap report. This showed that on average white employees were paid £2.37 an hour more than Black, Asian and minority ethnic (BAME) employees.

As figures were collated for the 2018/19 Gender Pay Gap, to be published in March 2020, the information for ethnicity was also collated and the findings are detailed in the following report.

As this is the second year we are reporting on this we can compare the figures with the previous year. However it is important to note that two sets of data do not comprise a trend. If the figures have improved or deteriorated then we can try to determine why, but this is not necessarily a major cause of concern or celebration.

2. What we are reporting on

The figures are produced in the same format as the gender pay gap figures, and so we have calculated:

- The mean basic pay gap
- The median basic pay gap
- The proportion of White and BAME staff in each quartile pay band

The mean pay gap is the difference between the pay of all white and BAME employees when added up separately and divided by the total number of white and BAME employees in the workforce.

The median pay gap is the difference between the pay of the middle white employee and the middle BAME employee, when all of the employees are listed from the highest to the lowest paid.

Though part of the gender pay gap reporting, this report does not include figures for the bonus pay gap i.e. the difference in how many white and BAME staff receive bonus payments.

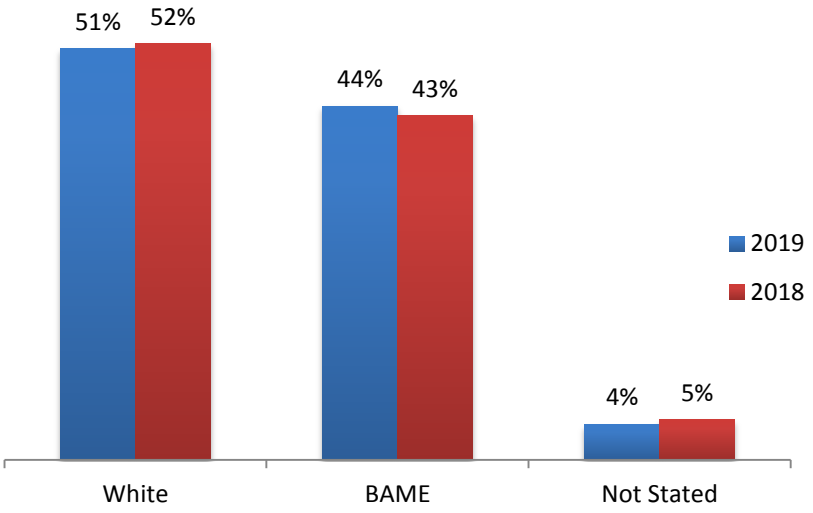
3. Who is included?

All staff who were employed by St George's and on full pay on the snapshot date (31st March 2019) are included. Bank staff who worked a shift on the snapshot date are included. Consultant Additional Programmed Activities (APA's) are included, as are Clinical Excellence Awards (CEA's). The calculations exclude overtime pay and expenses.

Employees who are on half or nil absence or maternity leave, hosted staff (e.g. GP Trainees) and agency staff have not been included.

4. Trust Ethnicity Profile (based on headcount)

At the snapshot date St George's University Hospitals NHS had 4,597 white employees and 3,955 BAME employees. There are also 395 employees whose ethnicity is unknown. This is a slight decrease in white employees and slight increase in BAME employees than in 2018:



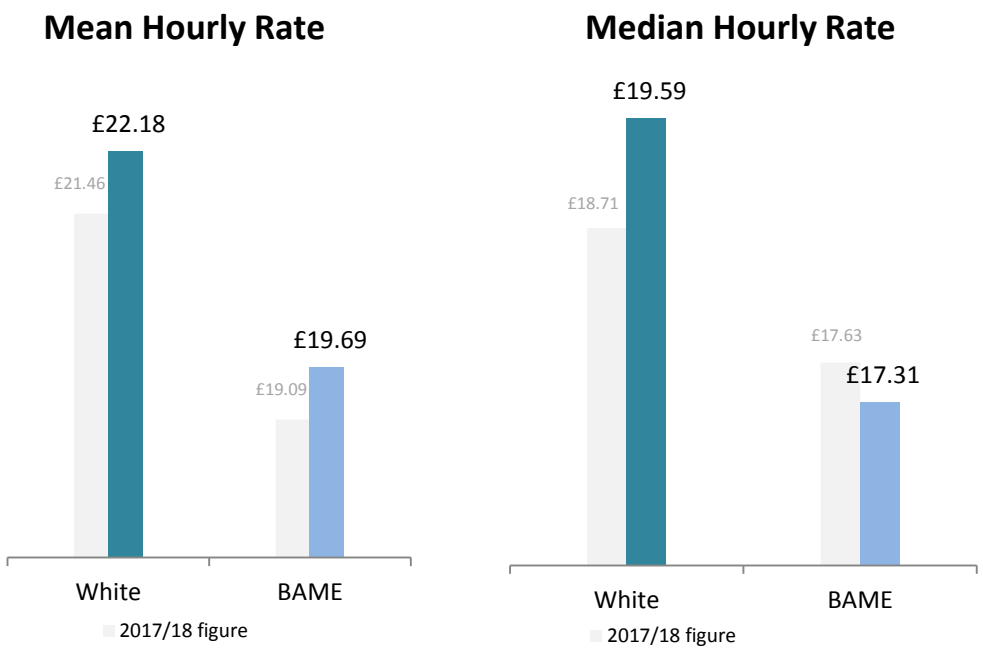
Whilst the Trust has a 97% complete set of ethnicity data for substantive staff, there are a number of gaps for bank staff which the pay gap data includes. However some of these gaps have been addressed over the year and the number of 'unknowns' have reduced, and so the data set for 2018-19 is 96% complete.

5. Ethnicity Pay Gap

Ethnicity	MEAN Hourly Rate	MEDIAN Hourly Rate
White	22.18	19.59
BME	19.69	17.31
Difference	2.49	2.28
Pay Gap %	**11.23%**	**11.64%**

The mean hourly pay for white employees is £2.49 higher than that of BAME employees, which is a gap of **11.23%**, The median pay for white employees is £2.28 higher than BAME employees, which is a gap of **11.64%.**

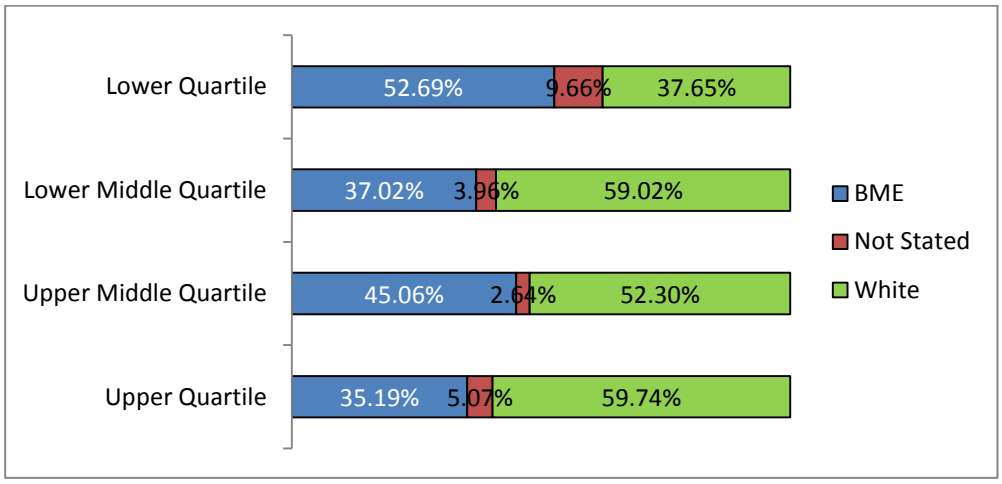
In 2017/18 the mean hourly pay for white employees was £21.46 and £19.09 for BAME employees. This was a difference of £2.37 an hour and a pay gap of 11.04%. The median hourly pay for white employees was £18.71 and £17.63 for BAME employees. This was a difference of £1.08 an hour and a pay gap of 5.77%.



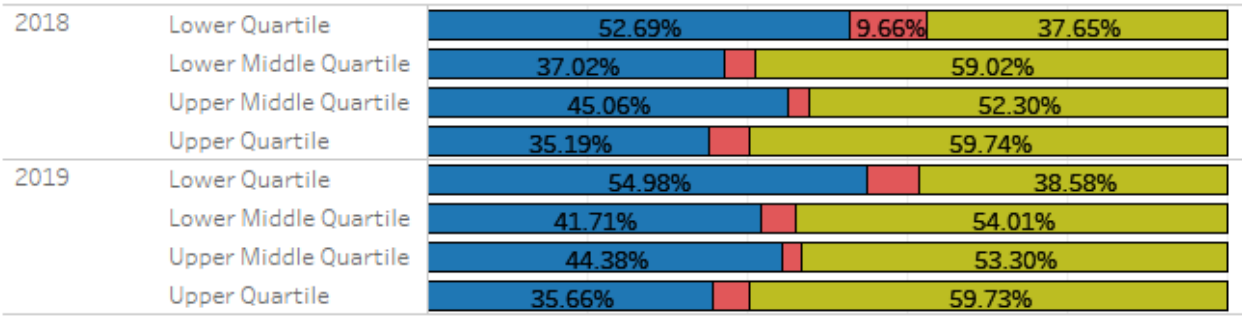
The average hourly rate for white employees increased by £0.72, which represented a 3.25% increase. For BAME employees it increased by £0.60, which represented a 3.05% increase. However the median hourly rate increased by £0.88 for white employees (a 4.49% increase), but actually fell by £0.32 for BAME employees, a decrease of 1.85%.

6. Pay Quartile Split

6.1. By Quartile



Given that BAME employees comprise of 44% of our workforce, they are clearly over-represented in the lower pay quartile and under-represented in the upper pay quartile. Comparing the data with the previous year, there has been increases in the proportion of BAME employees in the lower and lower middle quartiles.



6.2. By grade

Comparing the number of employees in each grade from last year can help explain the increase in the median pay gap:

	2017/18		2018/19	
Grade	**White**	**BAME**	**White**	**BAME**
Band 2	463	766	460	807
Band 3	259	316	264	349
Band 4	312	262	320	290
Band 5	818	632	685	687
Band 6	744	695	825	694
Band 7	741	321	734	361
Band 8a	259	96	278	94
Band 8b	84	23	88	28
Band 8c	49	7	32	9
Band 8d	29	3	38	4
Band 9	12	1	10	1
VSM	13	2	15	3
Medical	710	464	740	494
Total	**4493**	**3588**	**4489**	**3821**

There has been a notable increase in BAME employees at the lower bands compared with white employees. As the median looks at the middle figure when lining up the staff from lowest paid to highest, having an increase in BAME employees at lower bands is bound to have an impact, and this is why the median pay gap has increased. However this is not necessarily a negative. We have 233 more BAME employees then last year, whilst the number of white employees is basically unchanged. New staff will typically be on the bottom of the scale so they will earn less than existing employees. The issue of over-representation of BAME employees in lower bands and under-representation in higher bands is not to be ignored, but this does suggest that we are recruiting higher numbers of BAME employees who with the right training and development opportunities can progress up the career ladder in St George's and in time can help address this imbalance.

Grade	No. of White staff	No. of BAME staff	White Hourly Rate*	BAME Hourly Rate*	Difference	Gap⁺	2017/18 Gap⁺
Band 2	460	807	12	12.3	-0.23	-1.88%	-1.10%
Band 3	264	349	12.2	12.1	0.08	0.64%	-0.44%
Band 4	320	290	13.5	13.2	0.27	2.02%	2.79%
Band 5	685	687	16.4	17.3	-0.95	-5.80%	-7.80%
Band 6	825	694	19.7	21.8	-2.13	-10.82%	-10.14%
Band 7	734	361	23.6	23.8	-0.22	-0.93%	-1.34%
Band 8a	278	94	27.3	28.2	-0.86	-3.15%	-2.39%
Band 8b	88	28	32.4	31.6	0.85	2.62%	2.71%
Band 8c	32	9	36.7	35.1	1.55	4.22%	1.12%
Band 8d	38	4	43.1	41.2	1.83	4.25%	7.00%
Band 9	10	1	52.4	51.6	0.80	1.53%	7.66%
VSM	15	3	68.5	71.6	-3.10	-4.52%	-9.14%
Medical	740	494	76.2	74.3	1.90	2.50%	3.61%

If we break the figures by band it shows that the pay gap is in favour of BAME employees in bands 2, 5, 6, 7, 8a, and VSM. Compared with last year's figures the gap has narrowed in some bands, most notably in bands 8d and 9, and increased in others such as band 8c. The pay gap remains in favour of BAME employees at VSM level despite them being severely under-represented. This gap has narrowed over the year.

6.3. By different ethnic groups

Number of employees:

Asian/Asian British – 1,685 (18.33%)

Black/Black British – 1,479 (15.72%)

Chinese/Other – 454 (4.8%)

Mixed Race – 337 (3.65%)

Not Stated – 395 (5.33%)

White/White British – 4,597 (52.18%)

Ethnicity	Mean Hourly Rate	Median Hourly Rate
White/White British	22.18	19.59
Asian/Asian British	21.21	18.90
Difference	0.97	0.69
Pay Gap	**4.36%**	**3.52%**
Pay Gap 2017/18	3.93%	-2.13%
Black/Black British	16.91	14.65
Difference	5.27	4.94

Ethnicity	Mean Hourly Rate	Median Hourly Rate
Pay Gap	**23.74%**	**25.23%**
Pay Gap 2017/18	23.78%	25.40%
Chinese/Other	22.99	21.85
Difference	-0.81	-2.25
Pay Gap	**-3.67%**	**-11.50%**
Pay Gap 2017/18	-3.96%	-12.57%
Mixed Race	19.77	17.21
Difference	2.40	2.38
Pay Gap	**10.84%**	**12.15%**
Pay Gap 2017/18	11.72%	12.89%

Looking at the figures broken down by the different ethnic groups can help identify if any groups are particularly affected. There is a small pay gap between Asian/Asian British employees and White employees – the mean pay gap has increased, and the median has reversed from being in favour of Asian/Asian British employees to being in favour of White employees.

As with the previous year is it the second largest BAME group – Black/Black British – which has the largest pay gap, at 23.75% for the mean figure. This means that white employees get paid on average £5.27 an hour more than black employees.

It is therefore beneficial to examine the pay gap for Black/Black British employees by staff group:

Staff Group	No. of White/White British staff	No. of Black/Black British staff	White/White British Hourly Rate	Black/Black British Hourly Rate	Difference	Gap	2017/18 Gap
Add Prof Scientific and Technic	337	86	19.98	16.69	3.29	16.46%	14.51%
Additional Clinical Services	318	371	13.43	12.84	0.59	4.41%	3.39%
Administrative and Clerical	951	359	17.85	13.90	3.96	22.15%	23.58%
Allied Health Professionals	532	35	21.14	19.83	1.31	6.19%	11.42%
Estates and Ancillary	152	70	13.86	13.04	0.82	5.93%	4.69%
Healthcare Scientists	168	55	24.01	23.01	1.00	4.16%	2.90%
Medical and Dental	740	54	37.10	33.48	3.62	9.75%	0.16%
Nursing and Midwifery Registered	1399	449	20.82	20.37	0.45	2.17%	0.70%

The pay gap has increased in the Medical and Dental staff group from 0.16% to 9.75%. Whilst this is a steep increase, the small number of Black/Black British employees in this staff group compared to white employees means that the pay gap is prone to wild variation. It is also worth noting that the number of Black/Black

British employees in this staff group has increased from 34 to 54, so this group will have more entry level employees who will be on lower pay, but it is also showing more representation which can only balance the pay gap in future years.

As with 2017/18 there is a large gap in the admin and clerical staff group, where white employees get paid on average £3.96 more than black employees comprising a pay gap of 22.15%. This is primarily where the overall pay gap lies, so it is worth looking at the pay differences of this staff group by pay band:

Band	No. of White/White British staff	No. of Black/Black British staff	White/White British Hourly Rate	Black/Black British Hourly Rate	Difference	Gap	2017/18 Gap
Band 2	185	96	11.68	11.50	0.18	1.52%	5.23%
Band 3	131	83	11.94	11.67	0.28	2.31%	0.58%
Band 4	234	96	13.50	13.13	0.37	2.72%	3.48%
Band 5	100	37	15.70	16.17	-0.46	-2.96%	-4.75%
Band 6	68	17	19.72	19.46	0.26	1.34%	-4.23%
Band 7	75	17	22.39	22.64	-0.25	-1.12%	0.78%
Band 8a	55	6	27.12	27.32	-0.20	-0.75%	-0.67%
Band 8b+	91	5	43.02	31.72	11.30	26.26%	19.46%

It is clear that the pay gap is primarily because of severe under-representation of black employees at senior level, with only 5 at band 8b or above. The pay gap has increased from 19.46% to 26.26% over the year. Considering that Black/Black British employees are our second most populous BAME group, and that admin and clerical employees make up 50% of all roles at 8b and above, this will be where a large part of our ethnicity pay gap comes from.

7. Progress

Within the past 12 months the Trust has set out its Diversity and Inclusion Strategy and formed a BAME network group with an executive team sponsor.

More recently we have introduced BAME recruitment panel representatives and there is a requirement that all recruitment panels for posts of 8a and above should have someone from a BAME background on the panel.

8. Conclusion

We have already identified and reported in the Workforce Race Equality Standard (WRES) that BAME employees are under-represented at the higher bands and over-represented at the lower bands, so it should come as no surprise that we have a pay gap in favour of white staff.

However the data suggests that the pay gap disproportionately affects Black/Black British employees, who make up 16% of our total workforce. The implication is that the cause of the pay gap may run deeper than simply under-representation of overall BAME employees in the higher pay bands.

9. Next steps

The Trust will soon publish its Diversity and Inclusion Action Plan for 2020/21 which has a number of specific actions around ensuring the Trust operates on a fair basis for BAME staff in terms of recruitment and development.

Meeting Title:	**Trust Board**		
Date:	**27 February 2020**	**Agenda No**	**3.1.3**
Report Title:	**Medical Engagement Scale (MES) Survey**		
Lead Director	**Richard Jennings, Chief Medical Officer**		
Report Author(s):	**Richard Jennings, Chief Medical Officer**		
Presented for:	**(1) Information and (2) discussion**		
Executive Summary	To establish a current baseline for medical engagement, the Trust conducted a Medical Engagement Scale (MES) Survey during September and October 2019. The Trust previously completed an MES survey in 2016 and this has allowed for the opportunity to compare the results of the two surveys. A lot of doctors responded to the 2019 survey – 567, compared to 353 in 2016. About three quarters of those who responded were consultants. Key observations from the 2019 MES survey results: • Overall, medical engagement is much lower than we would wish. There is, however, a definite improvement since the survey conducted in 2016. The improvement is modest, but it is very consistent across all areas, and shows us that medical engagement can improve. • The level of engagement varies between staff groups within the doctor body. • The level of engagement varies between Care Groups. • Doctors with managerial and leadership responsibilities are on the whole more engaged than those who are not in such roles. • Doctors feel very highly engaged with their own immediate Care Groups, in marked contrast with the relatively low level of feeling of engagement with Divisions, or with the Trust as a whole. The Trust created summary slides of the MES survey to send out to all doctors, these are appended to this paper. The Trust has received quality special measures funding for external resource to support the trust to develop a medical engagement improvement plan; this is explored in more detail in this paper.		
Recommendation:	The Board is asked to discuss the MES survey summary results and the proposal for the development of a medical engagement improvement plan.		
Supports			
Trust Strategic Objective:	• Champion Team St George's		
CQC Theme:	• Safe, Well Led		
Single Oversight Framework	• Quality of Care, Leadership and Improvement Capability		

Theme:			
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	N/A	**Date**	N/A
Appendices:	1. St George's summary slides of the MES survey, shared with the medical workforce on 6 January 2020		

Medical Engagement Scale (MES) Survey

1. BACKGROUND TO THE MEDICAL ENGAGEMENT SCALE (MES) SURVEY

1.1 To establish a current baseline for medical engagement, funding was received as part of the quality special measures bid to enable the Trust to conduct a Medical Engagement Scale (MES) Survey during September and October 2019.

1.2 The MES survey was developed in 2008 by Applied Research Ltd for use for a project conducted by the NHS Institute for Innovation and the Academy of Medical Royal Colleges around enhancing engagement in medical leadership.

1.3 MES surveys have now been used by 19,500 members of medical staff across over 120 trusts; this provides a large and useful benchmark database.

1.4 MES surveys were developed to measure how connected doctors feel to their colleagues, and management teams – at both divisional and trust level. MES surveys specifically help organisations establish:

- If doctors think there is a sense of common 'purpose and agreed direction' in planning and delivering services
- Whether doctors think a Trust has a 'collaborative culture' that allows opportunities to discuss issues and problems at work with all staff groups
- How 'valued and empowered' doctors feel.

1.5 MES surveys ask standardised questions, but bespoke questions can be added by individual Trusts. We asked:

- How 'engaged' doctors feel with their Care Group, Division and the wider Trust.

1.6 Doctors of all grades who were employed by the Trust were invited to complete the survey and the results of the survey were collected independently by the company Engage to Practice Ltd.

1.7 The Trust has previously completed an MES survey in 2016 and this has allowed for the opportunity to compare the results of the two surveys.

2. PURPOSE

2.1 The MES survey has been discussed at the Workforce and Education Committee (WEC). Although the Board would have received information about the MES survey through the regular WEC report, the Board has not previously received a report regarding the MES survey. This report provides a summary of the survey results and also provides details of the way in which the Trust is going to engage our doctors and other staff to co-create a plan to improve medical engagement over the next year and beyond.

3. SUMMARY OF MES SURVEY RESULTS

3.1 It is worth noting that a lot of doctors responded to the 2019 survey – 567, compared to 353 in 2016. About three quarters of those who responded to the 2019 survey were consultants.

3.2 The 2019 MES report highlights a number of areas that are in the 'low relative engagement band' or the 'lowest relative engagement band' and we have a long way to go in getting to a place in which all of St George's doctors feel really engaged with the Trust.

3.3 However, there is some definite improvement since the survey conducted in 2016. The improvement is modest, but it is very consistent across all areas (there is an upward trend in the majority of the different scales (43 out of 46)) and shows us that medical engagement can improve.

3.4 The level of engagement varies between staff groups within the doctor body – this survey tells us that consultants feel less engaged, as do Foundation Year doctors, but middle grade doctors on the whole feel more engaged.

3.5 There is also variation between Care Groups. There are a few Care Groups that are quite highly engaged, whereas others are more mixed, and others remain quite disengaged.

3.6 We can also see that doctors with managerial and leadership responsibilities are on the whole more engaged than those who are not in such roles. However, it should be noted that following receipt of the MES report for the Trust, the CMO had a further discussion with Professor Peter Spurgeon, (Project Director on the 'Enhancing Engagement in Medical Leadership' project that produced the MES Survey) and during this discussion Professor Spurgeon observed that although those with a management responsibility were more engaged than their colleagues, their levels of engagement weren't as good as would be expected. This will need to be explored further in the workshops used to develop the medical engagement project plan.

3.7 Doctors feel very highly engaged with their own immediate Care Groups, in marked contrast with the relatively low level of feeling of engagement with Divisions, or with the Trust as a whole. This is to an extent a positive finding, and will be an important factor in the trust being able to provide safe and effective care to patients whilst maintaining the improvements in quality and safety that were recognised in the CQC's report of December 2019.

4. NEXT STEPS

4.1 It is important that we use 2020/21 to build on the improvements we have already started to make, and to get to the point where doctors feel much more positively engaged with the organisation.

4.2 In 2019 we started to work to develop communities of practice and to increase the visibility of senior medical leaders in the Trust, both were highlighted as areas for improvement in the MES report. The Trust is currently in discussion with the Health Innovation Network to explore whether it can facilitate two communities of practice. The Health Innovation Network has valuable experience of supporting communities of practice for the South East London Cancer Network, which makes them well-placed to support this Trust in this initiative.

4.3 In 2019 the Trust also completed the recruitment process to the internal change team to lead the St George's 'Culture and Leadership Programme', which uses the programme framework developed by NHSI. Several doctors were recruited as part of the change team. Two staff member posts are part funded (50%) to provide more substantial leadership to this programme, one of who is a medical trainee. This will be an important programme for change at the Trust over 2020/21.

4.4 The Trust has also received funding from the special quality measures funding to engage *2020 Delivery* (public service consultancy firm) to support the Trust to co-develop a plan for improving medical engagement, drawing on the findings of the MES survey and the additional insights gathered throughout the course of the engagement events. This plan will be one that the medical workforce can own and feel motivated to drive forward.

4.5 *2020 Delivery* was recommended as they have a strong track record of delivering similar projects. As a firm that only works with public sector organisations they can provide a team who work very well with clinicians and consistently receive excellent feedback about the quality of their engagements.

4.6 *2020 Delivery* has developed a proposal that uses a combination of planned workshops, individual 1:1s and also an approach to reach the less-easy-to reach staff who may not be inclined to engage with workshops - 2020 Delivery has experience of using social media to help achieve this.

4.7 Engagement will primarily be with doctors, but other professions (nurses, AHPs, managers etc.) will also be drawn in to develop the medical engagement plan.

4.8 *2020 Delivery* will help plan and facilitate workshops, but they are clear that these workshops need to be visibly attended and led by Trust senior leaders.

4.9 The project plan developed by *2020 Delivery* means that workshops and 1:1s will be held throughout April (allowing 6 weeks' notice for doctors) and that the plan will be developed and reviewed by the Executive Team in early May.

4.10 It is proposed that a further report with details of the co-created medical engagement plan is brought to the Board meeting in July 2020.

Medical Engagement Scale (MES) survey

Richard Jennings
Chief Medical Officer

Date 06.01.2020

Introduction

What is the MES survey?

- The Medical Engagement Scale (MES) was originally developed by Applied Research Ltd in 2008 and used in the 'Enhancing Engagement in Medical Leadership' project conducted by the NHS Institute for Innovation and the Academy of Medical Royal Colleges.

- To date, MES surveys have been undertaken by 19,500 members of medical staff across over 120 Trusts, providing a large normative database against which results from individual Trust can be benchmarked.

- Medical engagement is very important – it is about how connected doctors feel to their colleagues, and management teams – at both divisional and Trust level, and how involved doctors are in key decisions.

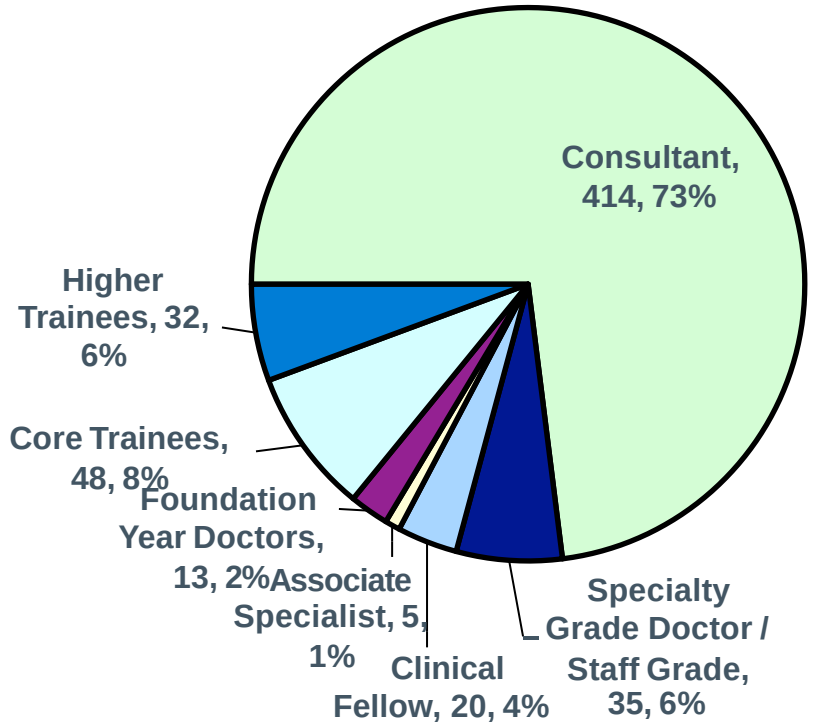
- The Trust first completed an MES survey in 2016. To provide feedback as to the current relative levels of medical engagement, the Trust received funding from NHS Improvement, our regulator, to complete a follow-up MES survey.

- Doctors of all grades were invited to participate in the survey over the course of September and October 2019.

Response rate
Composition of the response sample

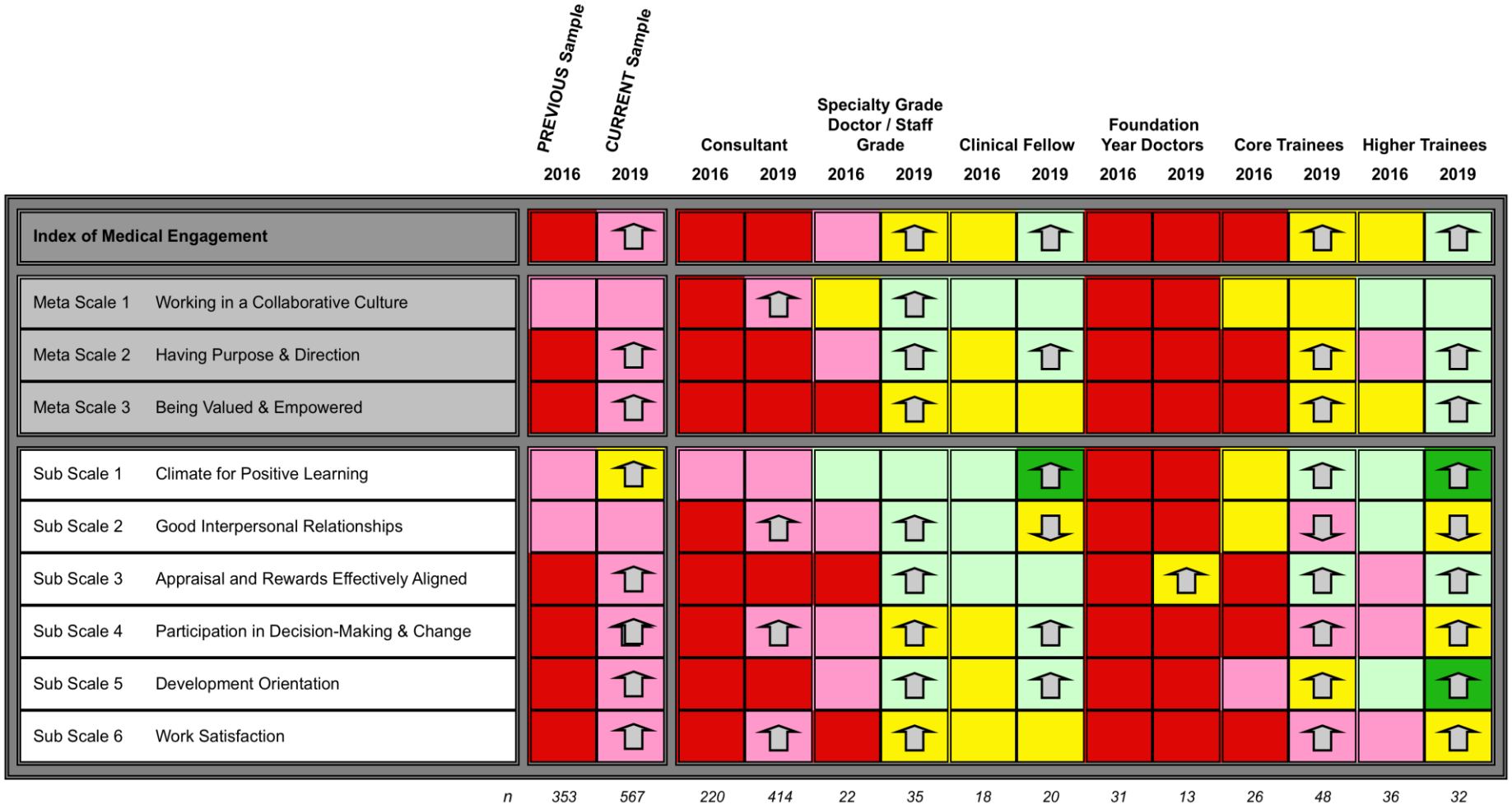
- Higher total response rate in 2019 (n=567) compared to the survey conducted in 2016 (n=353).

Graph 1: Composition of the response sample by grade



Overall picture
Comparison between survey results in 2016 and 2019

Chart 1: Comparison between the results of the MES completed in 2016 and the MES completed in 2019

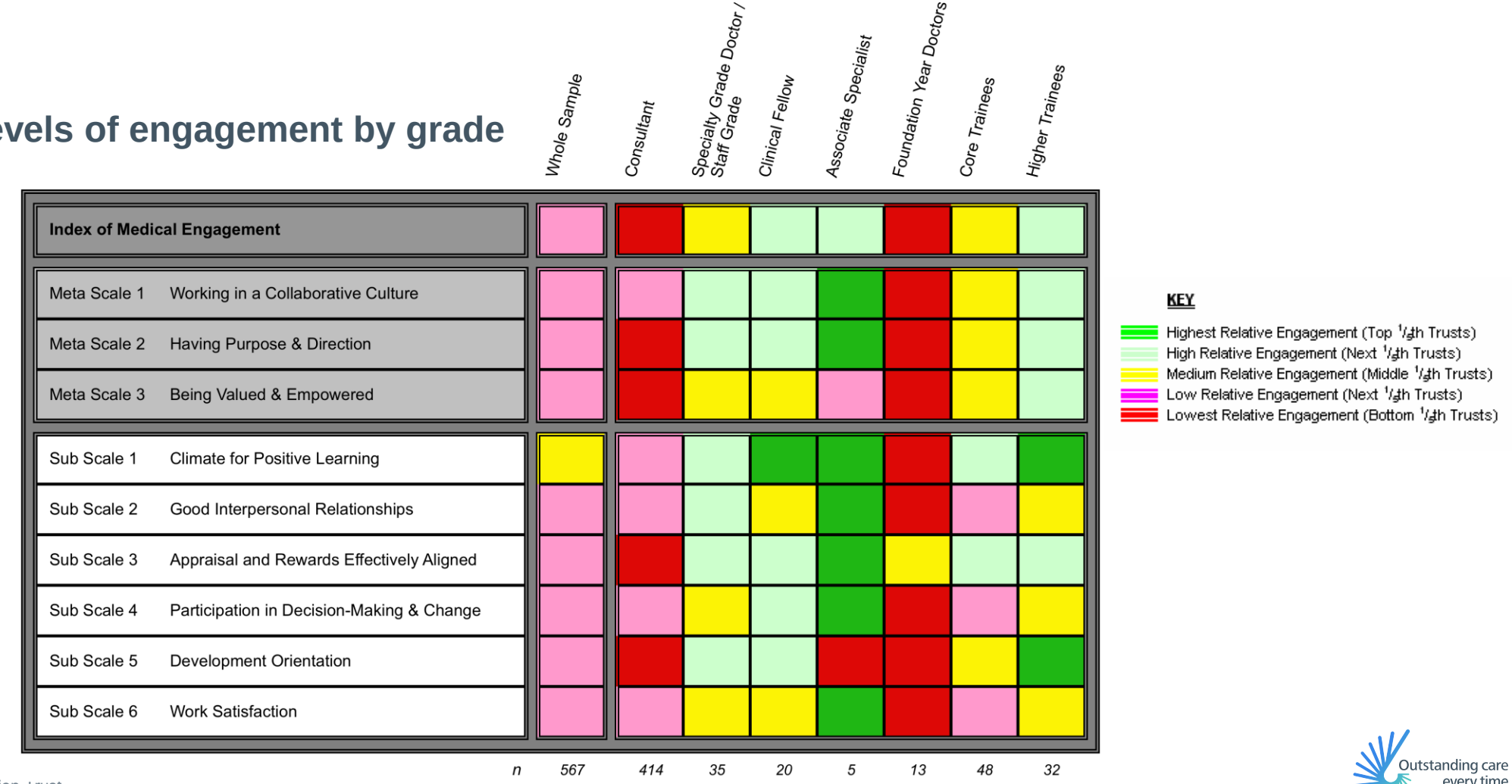


When comparing the results of the MES completed in 2016 and the MES conducted in 2019, there is an upward trend in the majority of the different scales (43 out of 46).

Engagement by grade

- As Chart 2 below shows, when compared to the normative national database, both consultants and foundation year trainees have given responses which are in the low or the lowest engagement bands. In contrast, SASG doctors, clinical fellows and higher trainees have given responses that are in the high or highest engagement bands.

Chart 2: Average levels of engagement by grade



Outstanding care every time

Engagement by speciality

Highly engaged specialities

- Clinical infection (n=6)
- Dermatology / Lymphoedema (n=5)
- Neurology / Neurosciences (n=32)
- Stroke (n=8)
- Vascular Surgery (n=5)
- General Practice (n=29)

Specialities with mixed responses

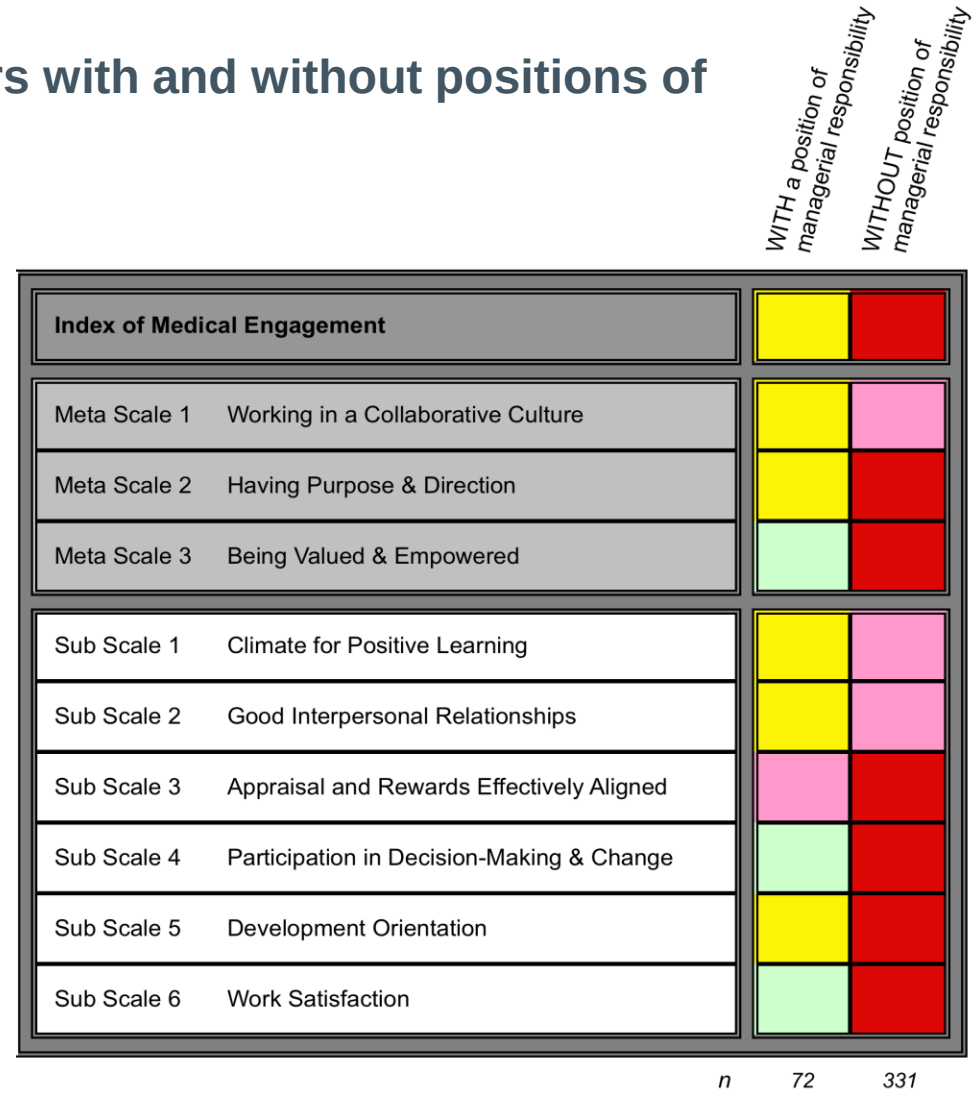
- Clinical Care / ICU (n=40)
- Diabetes / Endocrinology (n=6)
- ENT & Audiology (n=16)
- Gynaecology (n=8)
- Paediatric Medicine / Surgery (n=47)
- Radiology (including Clinical Genetics) (n=26)
- Clinical Genetics (n=6)

Strongly disengagement specialities

A&E medicine (n=27)
Acute medicine (including senior health)(n=37)
Anaesthetics (n=80)
Cardiology / Cardiac Surgery (n=18)
Gastroenterology / Endoscopy (n=13)
General Surgery (n=15)
Haematology (n=16)
Neonatal Unit (n=10)
Oncology and palliative (n=11)
Pathology (n=10)
Plastic Surgery (n=15)
Renal (n=8)
Respiratory (n=7)
Thoracic Surgery (n=5)
Trauma and Orthopaedics (n=13)
Urology (n=7)
Specialties with 4 or less respondents(n=16)
Other / no answer (n=15)

Engagement - comparison of engagement of doctors with and without management responsibilities

Chart 3: Engagement of doctors with and without positions of managerial responsibilities

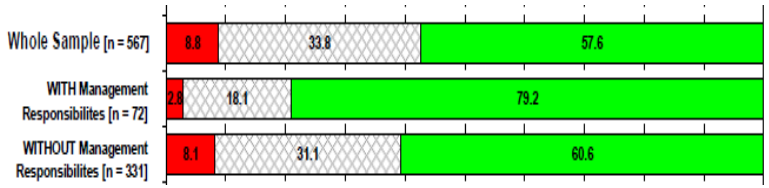


When comparing the relative engagement of doctors with a management responsibility to those without, it is evident that there is a significantly higher level of engagement amongst those with a position of managerial responsibility.

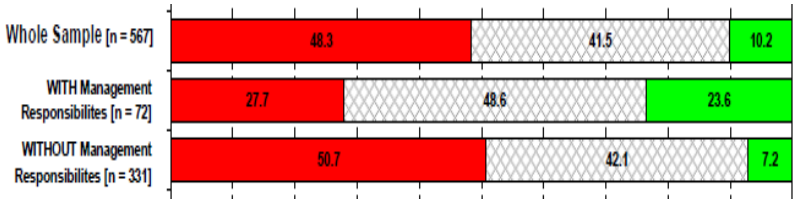
Three local questions

The questions in the MES survey are fixed, regardless of the Trust being surveyed, but local questions can be added, and we added these three:

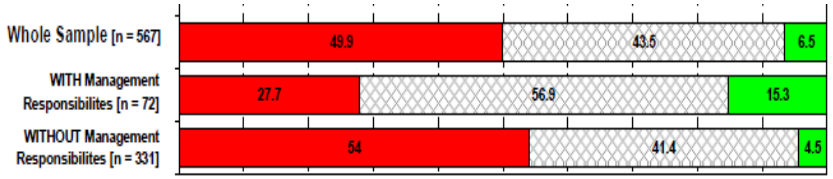
How engaged do you feel with your colleagues in your own clinical department or care group?



How engaged do you feel with your Division?



How engaged do you feel with the Trust?



These three local questions were devised to allow us to compare how connected doctors feel to their own clinical area/care group, compared with how connected they feel to their division or with the wider Trust.

These results show that the majority of doctors are highly engaged with their own department, but only a small percentage of doctors have this level of engagement for their division or the Trust as a whole.

Summary of free text comments

Relationship with management

In the comments about relationship with management there is a general consensus that there is a lack of communication between senior managers and frontline clinical staff, and that there is a lack of opportunity for senior managers to listen to frontline staff. Some areas, however, such as neurosciences are highlighted as examples of good practice).

Patient care

Comments relating to patient care describe feeling that care is being delivered to the detriment of staff well-being, particularly in regard to achieving metrics. A lack of appropriate support services and medical equipment is also highlighted by a number of comments.

Staff support

In the comments about staff support there were a number of issues raised about the need to improve infrastructure, but also the need to involve and communicate these improvements with clinical staff. A number of comments suggested drop-in sessions to hear concerns. There were also comments about the need for more opportunities for medical staff from across the Trust to meet and connect.

Medical Directors

The comments focussed on the need for more engagement opportunities between clinicians and those with senior clinical leadership roles, and the importance of visibility for the Medical Director and senior clinicians.

Consultant role

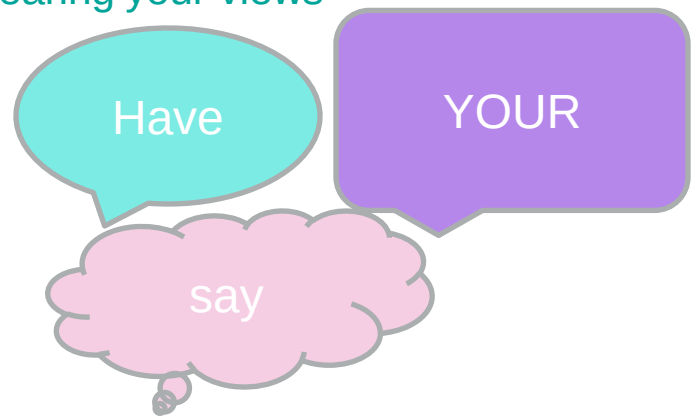
The comments around the consultant role highlighted the need for a better support systems for consultants, including opportunities for consultants from across different areas to meet. There were a number of comments stating the need for regular forums for consultants and the senior clinical leaders.

Engagement issues

A number of people commented that they felt very engaged with their immediate colleagues, across the multidisciplinary team, but there was not the same sense of engagement with the wider Trust. Some people commented that the strategic direction of the Trust is not influenced by clinicians.

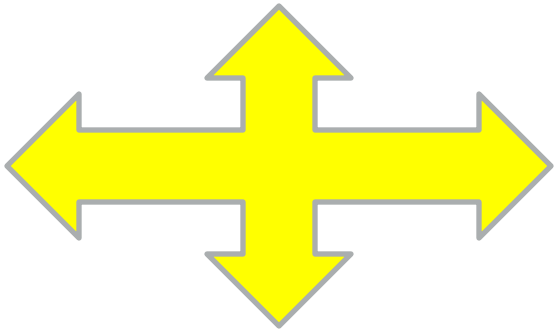
Next steps

Hearing your views



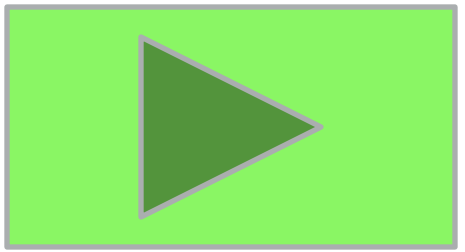
We will be holding a number of facilitated sessions in the New Year (giving you 6 weeks' notice of the sessions) to enable us to understand better how you feel things can be improved.

Co-designing a plan



I would like to use the opportunity of the facilitated sessions to enable you all to be involved with the plan going forward to help to improve medical engagement across St George's.

Putting it into action in 2020 and beyond



I would like the agreed plan to be put into action from 1st April 2020 and for progress to be regularly reviewed.

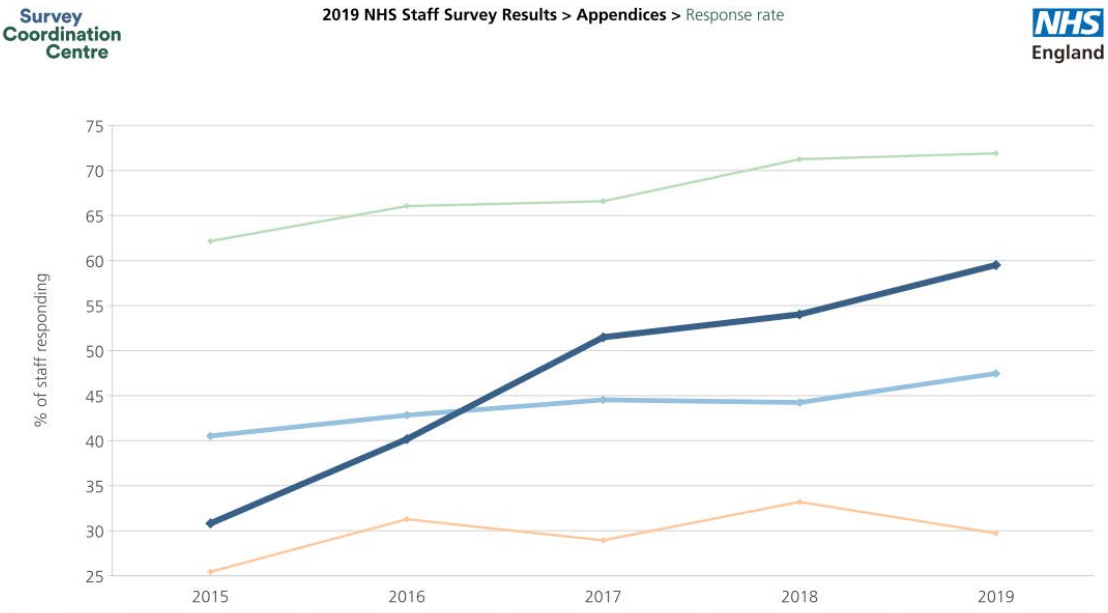
Meeting Title:	Trust Board		
Date:	27 February 2020	**Agenda No.**	**3.2**
Report Title:	NHS Staff Survey Results 2019		
Lead Director/ Manager:	Harbhajan Brar, Chief People Officer		
Report Author:	Harbhajan Brar, Chief People Officer		
Presented for:	Assure		
Executive Summary:	The purpose of this paper is to provide the Board with an overview of the NHS Staff Survey results for 2019, which was published nationally on the 18th February 2019. The result of the survey was shared with staff members. The report identifies possible keys areas of focus, which once fully analysed will be built into our refreshed staff engagement plan for 2020/21.		
Recommendation:	The Board is asked to note that: • The Workforce & Education Committee considered this report on 18 February 2020 noting that whilst there was still a long way to go things were moving in the right direction. The Committee's reflections were included in the Board Report under agenda item 3.1; • The results of the 2019 NHS staff survey and the next steps which include completing a detailed analysis of the results and the comprehensive free text responses; and • The Trust would incorporate key actions in the Staff Engagement Plan for 2020/21.		
Supports			
Trust Strategic Objective:	To have a committed, skilled and highly engaged workforce who feel valued, supported and developed and who work together to care for our patients.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	No specific risk		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee Workforce & Education Committee	**Date:**	05/02/2020 18/02/2020
Equality Impact Assessment:	None		
Appendices:	**Annex A: Message from Andrew Grimshaw, Acting Chief Executive: NHS staff survey results – what you told us**		

St George's 2019 NHS Staff Survey Results

1. Background

1.1 NHS Staff Survey questionnaires were sent out to 8518 members of staff (all eligible staff) with 4923 staff returning the survey. This was a 59.5% response rate, which is higher than last year's response rate of 54%.

1.2 The median response rate for Acute NHS organisations (85 in group) in 2019 was 47.5%



	2015	2016	2017	2018	2019
Best	62.2%	66.0%	66.6%	71.3%	71.9%
Your org	30.8%	40.2%	51.5%	54.0%	59.5%
Median	40.5%	42.8%	44.5%	44.2%	47.5%
Worst	25.4%	31.3%	28.9%	33.2%	29.7%

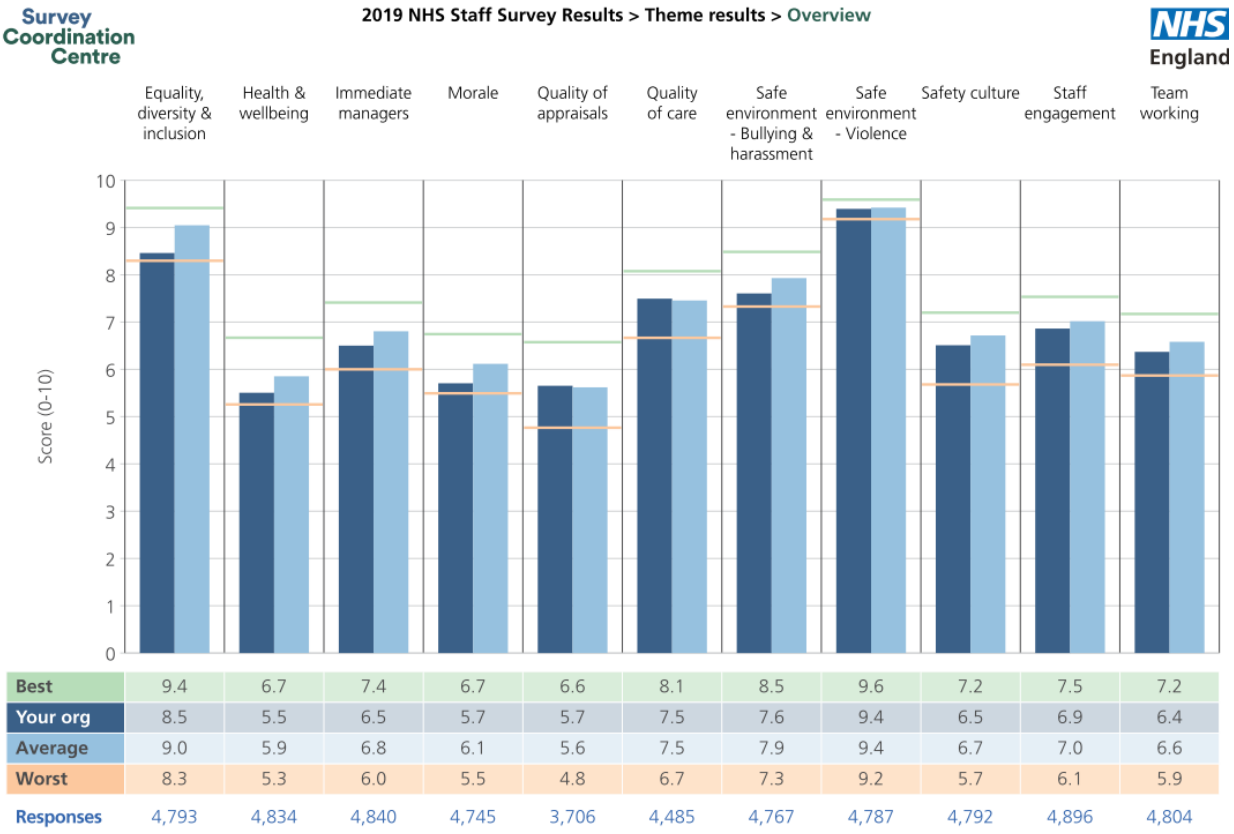
1.3 In terms of a historical (Picker) comparison to 2018, we are:

- Significantly better on 17 questions
- Significantly worse on 3 questions
- No significant difference on 70 questions

1.4 In terms of (Picker) comparison with the average for similar Trusts, we are

- Significantly better on 6 questions
- Significantly worse on 64 questions
- No significant difference on 20 questions

1.5 The NHS Staff Survey analysis the data across 11 key themes, the St George's results as compared to the best, average and worst organisations is as follows:-



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	8.5	5.5	6.5	5.7	5.7	7.5	7.6	9.4	6.5	6.9	6.4
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	4,793	4,834	4,840	4,745	3,706	4,485	4,767	4,787	4,792	4,896	4,804

1.6 The top 5 scores compared to average & most improved from last year are shown below

Score	Top 5 scores (compared to average)	Score	Most improved from last survey
75%	**Q19F.** Appraisal/performance/ review: training, learning or development needs identified	52%	**Q23C**. I am not planning on leaving this organisation
12%	**Q11g**. Not put myself under pressure to come to work when not feeling well enough	61%	**Q21c.** Would recommend organisation as place to work
65%	**Q10b**. Don't work any additional paid hours per week for this organisation, over and above contracted hours	77%	**Q21a.** Care of patients/service users in organisations top priority
27%	**Q19b**. Appraisal/review definitely helped me improve how I do my job	54%	**Q18c.**Would feel confident that organisation would address concerns about unsafe clinical practice
38%	**Q19c.** Appraisal/performance review. Clear work objectives definitely agreed	43%	**Q6c**. Relationships at work are unstrained

1.7 The bottom 5 scores compared to average & least improved from last year are below:

Score	Bottom 5 scores (compared to average)	Score	Least improved from last survey
74%	**Q14.** Organisation acts fairly: career progression	65%	**Q10b**. Don't work any additional paid hours per week for this organisation, over and above contracted hours
44%	**Q23b**. I am unlikely to look for a job at a new organisation in the next 12 months	41%	**Q11d**. In last 3 months, have not come to work when not feeling well enough to perform duties
52%	**Q23c**. I am not planning on leaving this organisation	69%	**Q20**.Had training learning or development in the last 12 months
81%	**Q19a.** Had appraisal/KSF review in last 12 months	56%	**Q11c**. Not felt unwell due to work related stress in last 12 months
66%	**Q28b**. Disability: organisation made adequate adjustment(s) to enable me to carry out work	92%	**Q18a**. Know how to report unsafe clinical practice

1.8 Whilst the results demonstrate that we are still below the average when compared to other similar organisations, we have shown an:-

- Improvement in 52 of 90 questions = 58%
- Deterioration in 15 of 90 questions = 17%
- No change in 23 of 90 questions = 25%

2. The 3 'Key Questions'

2.1 We have seen improvement on all three of the three key NHS questions:-

- With most staff saying that they would be happy with the standard of care if a friend/relative needed treatment by St Georges. This has risen **from 68% to 72%** which is higher than the NHS average of 71%.
- With more staff saying they would recommend St George's as a place to work, going **up from 57% in 2018 to 61% in 2019**.
- With more staff saying that the care of patients/service users by St George's is one of our top priorities, **up from 73% in 2018 to 77% in 2019**.

		Historical					Organisation type	
		2015	2016	2017	2018	2019	Average	Organisation
Q21a	Care of patients/service users is organisation's top priority	71%	69%	74%	73%	77%	77%	77%
Q21b	Organisation acts on concerns raised by patients/service users	68%	65%	70%	68%	70%	72%	70%
Q21c	Would recommend organisation as place to work	55%	52%	59%	57%	61%	63%	61%
Q21d	If friend/relative needed treatment would be happy with standard of care provided by organisation	71%	70%	73%	68%	72%	71%	72%
Q22a	Patient/service user feedback collected within directorate/department	89%	88%	87%	85%	88%	91%	88%
Q22b	Receive regular updates on patient/service user feedback in my directorate/department	58%	58%	61%	61%	61%	61%	61%
Q22c	Feedback from patients/service users is used to make informed decisions within directorate/department	54%	55%	59%	56%	59%	59%	59%
Q23a	I don't often think about leaving this organisation	-	-	-	38%	40%	45%	40%
Q23b	I am unlikely to look for a job at a new organisation in the next 12 months	-	-	-	42%	44%	53%	44%
Q23c	I am not planning on leaving this organisation.	-	-	-	48%	52%	59%	52%

3. Free Text Analysis

3.1 We have received all 1277 lines of free text comments and this is now being analysed by Pickers for key themes.

3.2 In addition, we have also received locality information which will now enable us to review the data by directorate and division, by staff group, age, disability, ethnicity, gender, sexuality, and religion.

3.3 The results of these reviews will feed into the review of our current Engagement Plan.

4. Workforce Race Equality Standard

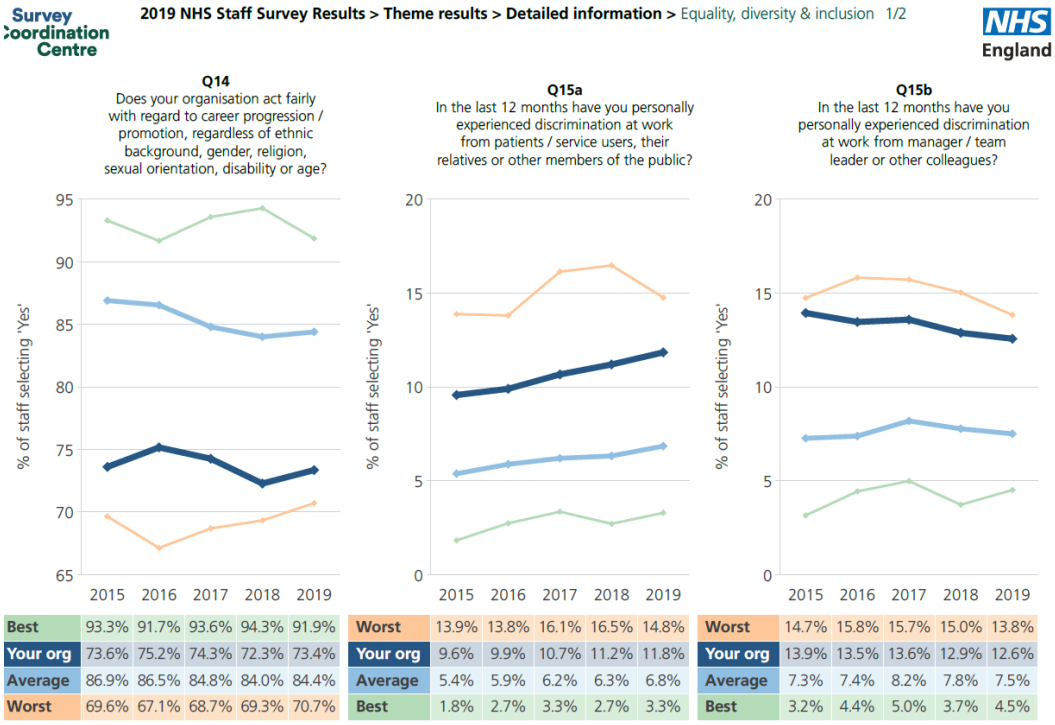
4.1 There are three key questions from the NHS staff survey that will feed into the 2019 WRES report and in all three questions, our BAME staff have scored us lower (as in previous years) than their white counterparts, so there is still much more work to be done in this area.

Question topic	Q	Description	Organisation Overall	White (n=2640)	BME (n=1915)
Q14		Organisation acts fairly: career progression	74%	83%	63%
Q15a		Not experienced discrimination from patients/service users, their relatives or other members of the public	88%	93%	83%
Q15b		Not experienced discrimination from manager/team leader or other colleagues	88%	91%	84%

4.2 The 2019 BAME scores have seen an improvement for:-

- Q14, 63% going up from 59.6% in 2018

- Q15b 84% going up from 80.9%, in 2018
- Q15a has seen a deterioration 83% going down from 84.5% in 2018.



	2015	2016	2017	2018	2019
Best	93.3%	91.7%	93.6%	94.3%	91.9%
Your org	73.6%	75.2%	74.3%	72.3%	73.4%
Average	86.9%	86.5%	84.8%	84.0%	84.4%
Worst	69.6%	67.1%	68.7%	69.3%	70.7%

	2015	2016	2017	2018	2019
Worst	13.9%	13.8%	16.1%	16.5%	14.8%
Your org	9.6%	9.9%	10.7%	11.2%	11.8%
Average	5.4%	5.9%	6.2%	6.3%	6.8%
Best	1.8%	2.7%	3.3%	2.7%	3.3%

	2015	2016	2017	2018	2019
Worst	14.7%	15.8%	15.7%	15.0%	13.8%
Your org	13.9%	13.5%	13.6%	12.9%	12.6%
Average	7.3%	7.4%	8.2%	7.8%	7.5%
Best	3.2%	4.4%	5.0%	3.7%	4.5%

4.3 Preliminary analysis of the BAME scores do show a marked difference between ethnicities, with Asian/Asian British being the most engaged and Black/Black British being the least engaged of the BAME ethnicities.

5 Picker Analysis

5.1 As part of the Picker Staff Engagement report, they have identified as number of key areas for action and they include:-

Issues to address

Q14. Organisation acts fairly: career progression

Q23b. I am unlikely to look for a job at a new organisation in the next 12 months

Q23c. I am not planning on leaving this organisation.

Q19a. Had appraisal/KSF review in last 12 months

Q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work

5. Recommendations

The Board is asked to note that:

- The Workforce & Education Committee considered this report on 18 February 2020 noting that whilst there was still a long way to go things were moving in the right direction. The Committee's reflections were included in the Board Report under agenda item 3.1;

- The results of the 2019 NHS staff survey and the next steps which include completing a detailed analysis of the results and the comprehensive free text responses; and

- The Trust would incorporate key actions in the Staff Engagement Plan for 2020/21.

Annex A

Message from Andrew Grimshaw, Acting Chief Executive: NHS staff survey results – what you told us

Dear all,

The NHS staff survey results are being published today, and the purpose of this message is to let you know how we got on.

You can access a copy of the detailed results here (INSERT LINK) – and these will be published online later today, alongside the results for all Trusts.

Message from Andrew Grimshaw, Acting Chief Executive: NHS staff survey results – what you told us

Response rate

The survey ran from October to November last year, and nearly 60% of you (4923 staff) found the time to fill it in. Thank you, as we know it can be challenging to find the time.

In 2016, only 40% of staff completed the survey – so we've come a long way since then, although ideally, we'd like to hear from even more of you.

A high response rate is a positive sign - but the real importance is in finding out what you think is working well; and what we need to do better.

Where we have improved

Overall, the results show we are making steady progress in some areas, and there are positives to build on. But equally, the rate of improvement is not happening as quickly as we would like.

For example, 61% of you said you would recommend the Trust as a place to work. This is up from 57% in 2018, so good news, but still clearly nowhere near where we would want it to be.

77% of you said that the care we provide for patients is the organisation's top priority. This is an improvement on 73% compared to 2018, but again, this needs to be much higher if we truly do want to provide outstanding care, every time.

There are other positives in the report; in particular how you feel about your manager, and the support they provide.

Scores relating to managers are generally up on previous years. For example, appraisals are being carried out in a way that you feel is beneficial; although the same survey tells us that appraisal rates are not where they should be.

Areas for further work

Despite progress in some areas, the results show that we need to do a lot more to make St George's a truly outstanding place to work.

For example, too many of you still feel under pressure to work additional hours over and above those you are contracted to do; and only just over half of you (56%) had not felt unwell due to work related stress in the previous 12 months.

The survey results also tell us we can do more to value each other, and encourage one another; and that opportunities for flexible working are not where they should be.

So what happens next?

As you would expect, we will be looking in detail at the results, and seeing what further work we need to do in specific areas.

I would also urge you to discuss the results with each other, as well as your teams and departments – 4923 of you completed the survey this time around, so we need to take them really seriously, both as individuals but as members of Team St George's.

We all want to make St George's better, and we have already embarked on a number of exciting projects – such as our Culture Champions initiative – to help us address some of the long-standing challenges we face.

However, the results published today show that there is a huge amount still to do – but it is a challenge I know we are all up for.

Meeting Title:	**Trust Board**		
Date:	27 February 2020	**Agenda No**	**4.1**
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 20th February 2020.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee (Core) – February 2020

The Committee met on 20 February 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, SWL Procurement, SWLP Four Trust Partnership, SWLP Well-Led Review, Technical Releases, the Digital Strategy and a Committee Effectiveness report.

Committee members discussed the BAF risks on finance and ICT although noting no change in risk scoring. The Committee noted performance in Diagnostics, Cancer, RTT and Emergency Flow as well as outlining recovery processes in each area. The Committee discussed current financial performance in view of the forecasted year end position, as well as the implications for the annual plan in 2020/21. **The Committee wishes to bring the following items to the Board's attention:**

1.1 Finance & ICT Risks – the Acting Chief Financial Officer (ACFO) and the Chief Information Officer (CIO) gave verbal updates on their respective BAF risks. They noted no change in risk scoring following more detailed updates in previous months.

1.2 Diagnostics Performance – the Chief Operations Officer (COO) observed the continued challenge in Diagnostics performance in January, where 5.4% of patients had a Diagnostic wait over 6 weeks compared with a target of 1% (and London performance of 3.4%). She noted particular work required in Echocardiography waits, and that the plan to move to compliance by May 2020 remained on track. The COO also outlined the other services that required improvement to recover the position. The Committee noted this update.

1.3 The COO noted that in a mandated audit of performance reporting processes, a discrepancy was discovered in classification of some patients in the waiting list which has now been rectified. The Committee noted the improvements in processes in this area, and the intention to proactively review, where possible, other areas in future.

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 81.7% in January, which is adverse to the Trust's trajectory in the month, although better than December's performance of 79.4%. The COO noted the current situation with respect to long stay patients, and the focus required in this area. The Emergency Care Intensive Support Team (ECIST) is working with the Trust for the next 12 weeks to review current processes that take place at the Trust and share / support national best practice with the Trust. The Committee remained disappointed with the current performance but welcomed the update whilst noting that more work and continued focus was needed.

1.5 Cancer Performance – the COO noted that the Trust met 4 of the 7 Cancer performance targets in December, with challenges caused in some standards by the booking process for patients over the Christmas period and patient choice. She noted that this pattern appeared to be impacting into January and February although reviewing the position with the General Manager for Cancer gave her confidence that performance would recover for March. The Committee noted this update.

1.6 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in December of 82.6% was below the incomplete target trajectory of 86.8%, and the number of 52 week waits of 9 was more than the trajectory of 0. The size of the waiting list (including QMH patients) was 46,918 patients. The Committee noted the work being done to reduce the 52 week wait patients to 0 by March 2020.

1.7 Activity Update – the performance against activity targets was discussed, where underperformance was noted on Outpatient and Elective activity with a particular focus on cases per session. The Committee noted the importance of deep dives in these areas as the Trust moves into 2020/21, in view of the feedback given in the Committee Effectiveness survey.

1.8 Financial Performance – the ACFO noted performance to date at Month 10 was adverse to plan by £3.4m (which was in line with the £9m adverse forecast), showing a £39.8m Pre-PSF/FRF/MRET deficit. The Committee noted the current cash requirements in view of the expected year end position and details of the expected expenditure against the £5.4m extra capital funding in 2019/20 made available.

1.9 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 Committee noted that clinical division's forecasts were adverse solely owing to pass through income not matching expenditure owing to the block contract.

1.10 2020/21 Planning Update – the ACFO introduced the Committee to the paper providing an update on the financial plan for 2020/21. The Committee noted the financial gap internally and across the sector that needed to be addressed, as well as the important work being undertaken on Consultant job plans.

1.11 SWLP Well-Led Review – the Chief Strategy Officer (CSO) introduced a paper on the SWLP Well-Led Review, noting the recommendations suggested. The ACFO noted that some recommendations have already been implemented.

1.12 Technical Releases – the ACFO outlined some of the financial implications following the publishing of the national annual planning guidance.

1.13 SWL Procurement Business Case – the Associate Director of Procurement (ADP) introduced the Full Business Case for a SWL Procurement Partnership. The Committee recommended for the preferred option to be approved at Trust Board.

1.14 SWLP Four Trust Partnership – the Managing Director- SWLP (MD-SWLP) introduced the paper highlighting progress on extending the pathology partnership in South West London to include Epsom & St Helier University Hospitals NHS Trust.

1.15 Digital Strategy – the CIO introduced the paper on the 5 year Digital Strategy, noting the public engagement undertaken. The Committee welcomed the progress and recommended the strategy to the Trust Board.

1.16 Committee Effectiveness report – the ACFO noted the outcome of survey completed by committee members on the committee's effectiveness. The committee welcomed the suggestions on further deep dives in key areas as evidenced in activity reporting this month.

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,
February 2020

Meeting Title:	**Trust Board**		
Date:	27 February 2020	**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 20 February 2020.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee (Estates) – February 2020

This Part 2 FIC meeting has been set up on a monthly basis to provide more comprehensive assurance on Estates risks in the Trust. Good progress continues to be made and the Committee agreed to review in March whether Estates matters should revert to consideration within the regular FIC (Core) meeting agenda. Once achieved, the Committee thought that introducing a quarterly thematic focus on a particular aspect of Estates and Facilities would be helpful to support continued FIC assurance.

The February 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 detailed report from the Authorised Engineer (AE) for Ventilation and noted the efforts ongoing to standardise the format of these reports.

Other Committee discussion focussed particularly on progress on Capital Projects (Procure-22 (P22) contract), the Mitie contract performance, Violence and Aggression, and Fire Safety.

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

1.1 AE Report on Ventilation – the Committee received a detailed and positive AE report on Ventilation and noted the significant improvement in risk rating (from 16 to 6). The improved rating was due in part to the progress of works on the McEntee isolation ward and to the wider improvements made to plant rooms, inspections and matters of HTM compliance. Given the significant jump in rating the Committee agreed that it would be valuable to perform a further check against the previous report to ensure that all improvements were properly embedded.

1.2 AD Report – Divisional Overview - the DDE&F highlighted key updates from the division, including progress on the Estates Strategy and the efforts to improve divisional engagement. Good progress continues on fire safety and a Fire Strategy Group has been established that will meet for the first time later this month. A formal Health & Safety action plan has also been produced which has been presented to EMG and shared with Staff Side. The Committee discussed the importance of the Estates Strategy and recognised the particular challenges given the dynamic nature of wider SWL discussions that will impact upon the estate plans for the Tooting site. It was suggested that one way forward may be to produce a site remediation plan for the critical refurbishments required alongside a modular plan for specialist facilities. The Committee noted that a Board seminar focussing on Estates Strategy will be held on 17 March and welcomed the opportunity to engage more fully with this work as it progresses.

1.3 AD Report - Estates - the Committee noted the progress on infrastructure survey work and the focus on fully utilising funds available for maintenance by financial year end. There remains a backlog of maintenance jobs which the Committee has previously heard are now prioritised and grouped to enable the most efficient resolution. There remains a concern however that the backlog will not reduce significantly with the resources currently available.

1.4 AD Report - Facilities - the DDE&F introduced an update on the Mitie contract. The Committee noted the progress on the catering element and proposed changes in the cleaning model which are to be trialled and results reviewed. Good communications have been established with the nursing teams which are helpful in quickly identifying issues and practicable means of resolving them.

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 implications of delay and underspend in 2019/20 against the overall capital programme, and the balance of expenditure required in 2020/21. The Committee also discussed the progress made in responding to the Coronavirus outbreak, with a 'POD' being set up in the Bence Jones Portacabin for screening patients to ensure that they do not present at A&E. The Committee welcomed the positive feedback from Public Health England on the trust's response to the virus.

1.6 AD Report- Medical Physics & Clinical Engineering – the DDE&F introduced a paper reporting on this domain. The Committee welcomed the good grip in this area.

1.7 AD Report- Fire, Health & Safety –The AD Health & Safety (ADHS) discussed his paper updating the committee on Fire, Health & Safety. The Committee welcomed the continued good progress in this area and the good understanding that has been developed of the risks involved. The comprehensive discussion at the recent Risk Management Executive on this topic was noted.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee (Estates) on 20 February 2020 for information and assurance.

Tim Wright
Lead Non-Executive Director, Estates
February 2020

Meeting Title:	**TRUST BOARD**		
Date:	**27 February 2020**	**Agenda No.**	**4.3**
Report Title:	**M10 Finance Report 2019/20**		
Lead Director/ Manager:	Tom Shearer, Acting Chief Financial Officer		
Report Author:	Michael Armour, Head of Finance - Reporting		
Presented for:	Update		
Executive Summary:	The Trust has reported a deficit to date in M10 of £39.8m which £3.4m adverse to the Pre-PSF/FRF/MRET plan. Within the position, income is favourable to plan by £6.9m, and expenditure is overspent by £10.3m. CIP performance to date is £33.2m which is £1.0m adverse to plan. The Trust has recognised £23.8m of PSF/FRF/MRET funding YTD to Month 10. This leaves £3.3m of PSF/FRF not achieved as the Trust did not deliver the M10 YTD Pre-PSF/MRET/FRF plan. The Trust is currently unsure on whether this income will be received at present, although discussions with NHS Improvement are positive. The financial forecast submitted at M9 shows an expected £9.0m adverse variance to the Pre-PSF/FRF/MRET plan.		
Recommendation:	The Board is asked to note the Trust's financial performance to M10.		
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		

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Financial Report Month 10 (January 2020)

Trust Board - Feb 20

Chief Finance Officer

27th February 2020

Executive Summary – Month 10 (January)

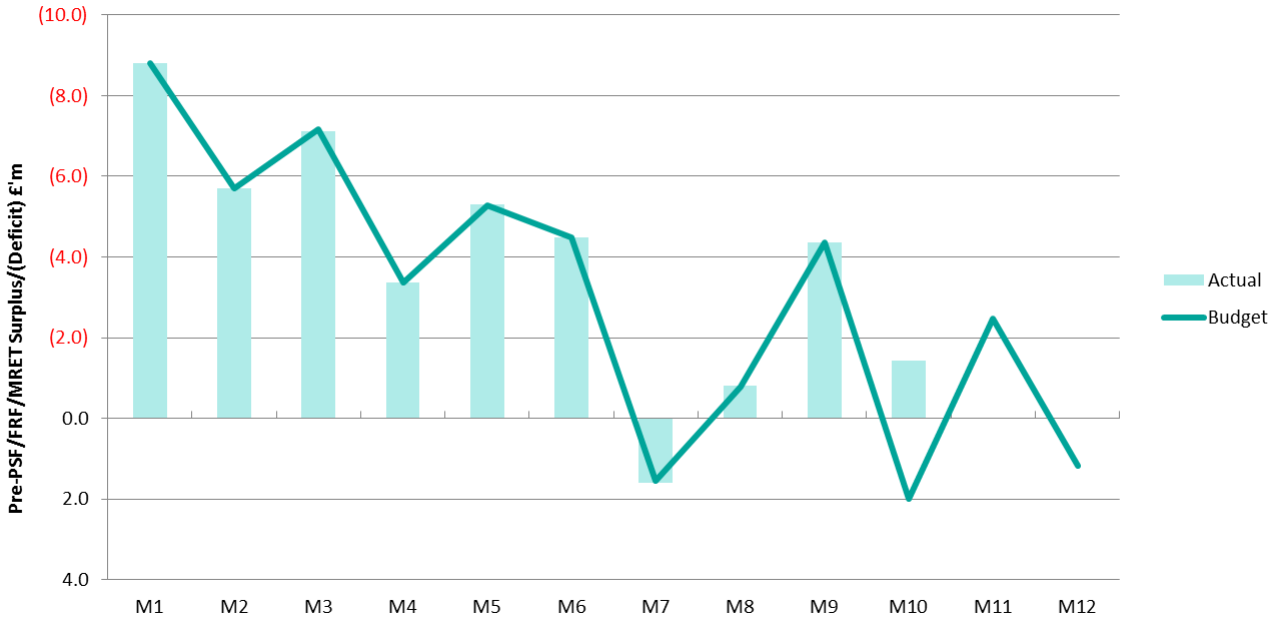
Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	**The Trust is reporting a Pre-PSF/MRET/FRF deficit of £39.8m** at the end of January, which is **on £3.4m adverse to plan**. Within the position, income is favourable to plan by £6.9m, and expenditure is overspent by £10.3m. **M10 YTD PSF/MRET/FRF income of £23.8m** in the plan has **been achieved** in the Year-to-date position, which is £3.3m adverse to plan. **£5.5m of this is MRET which is expected to be received in all scenarios. The remaining £18.2m relates to the Q3 YTD portion of PSF/FRF.** **This leaves £3.3m of PSF/FRF not achieved** as the Trust did not deliver the M10 YTD Pre-PSF/MRET/FRF plan. The Trust is currently unsure on whether this income will be received at present, although discussions with NHS Improvement are positive. **£0.5m of Prior Year PSF** is included in the position following a re-allocation of the General PSF after finalisation of annual accounts.	£3.4m Adv to plan	On plan
Income	Income is reported at £6.9m favourable to plan year to date. SLA income is £5.0m over plan, mainly due to decreased Challenges and excluded Drugs and Devices which are offset in non-pay. Non-SLA income is £1.9m favourable to plan, which is mainly owing to Private Patients and R&D income.	£6.9m Fav to plan	£7.4m Fav to plan
Expenditure	Expenditure is £10.3m adverse to plan year to date in January. This is caused by Non-Pay adverse variance of £5.3m, related to pass-through income, and Pay adverse variance of £5.0m across Medical and Nursing staff groups.	£10.3m Adv to plan	£7.3m Adv to plan
CIP	The Trust planned to deliver £34.2m of CIPs by the end of January. To date, £33.2m of CIPs have been delivered; which is £1.0m adverse to plan. Income actions of £8.0m and Expenditure reductions of £25.2m have impacted on the position. A £2.6m gap remains in Green schemes identified against the £45.8m target.	£1.0m Adv to plan	On plan
Capital	Capital expenditure of £35.7m has been incurred year to date. This is to plan. The current month YTD position is £32.3m and the previous month YTD position is £32.3m.	£35.7m To plan	£32.3m To plan
Cash	At the end of Month 10, the Trust's cash balance was £3.5m. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.	£0.5m Fav to plan	£0.1m Fav to plan
Use of Resources (UOR)	At the end of January, the Trust's UOR score was 4 as per plan.	UOR score 4	UOR score 4

Contents

Outstanding care every time

1. Month 10 Financial Performance

			Full Year Budget (£m)	M10 Budget (£m)	M10 Actual (£m)	M10 Variance (£m)	M10 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Pre-PSF/FRF/MRET	**Income**	SLA Income	676.7	59.5	59.0	(0.5)	(0.9%)	562.7	567.6	5.0	0.9%
		Other Income	160.3	13.4	13.5	0.1	0.6%	134.1	136.0	1.9	1.4%
	Income Total		**837.0**	**72.9**	**72.5**	**(0.5)**	**(0.6%)**	**696.7**	**703.6**	**6.9**	**1.0%**
	Expenditure	Pay	(533.4)	(43.7)	(45.3)	(1.6)	(3.5%)	(447.2)	(452.3)	(5.0)	(1.1%)
		Non Pay	(305.5)	(24.2)	(25.6)	(1.4)	(5.9%)	(256.0)	(261.6)	(5.6)	(2.2%)
	Expenditure Total		**(838.9)**	**(68.0)**	**(70.9)**	**(3.0)**	**(4.4%)**	**(703.3)**	**(713.9)**	**(10.6)**	**(1.5%)**
	Post Ebitda		(35.8)	(3.0)	(3.0)	0.0	0.3%	(29.9)	(29.5)	0.3	1.1%
Pre-PSF/FRF/MRET Total			**(37.7)**	**2.0**	**(1.4)**	**(3.4)**	**(171.2%)**	**(36.4)**	**(39.8)**	**(3.4)**	**(9.3%)**
PSF/FRF/MRET			34.7	3.8	0.6	(3.3)	(85.6%)	27.1	23.8	(3.3)	12.1%
Total			**(3.0)**	**5.8**	**(0.9)**	**(6.7)**	**115.0%**	**(9.4)**	**(16.0)**	**(6.7)**	**(71.3%)**
Prior Year PSF			0.0	0.0	0.0	0.0	0.0 %	0.0	0.5	0.5	0.0 %
Grand Total			**(3.0)**	**5.8**	**(0.9)**	**(6.7)**	**115.0%**	**(9.4)**	**(15.5)**	**(6.2)**	**(65.9%)**



Trust Overview

- Overall the Trust is reporting a Pre-PSF deficit of £39.8m at the end of Month 10, which is £3.4m adverse to plan.
- **SLA Income** is £5.0m ahead of plan, after adjustment for block contract values. There remains a large level of estimation within the M10 income position due to delays in coding in some specialties.
- **Other income** is £1.9m over plan, which is owing to Private Patient and R&D income.
- **Pay** is £5.0m overspent across Medical and Nursing staff groups.
- **Non-pay** is £5.6m overspent, mainly related to pass-through income.
- **PSF/FRF/MRET Income** is adverse to plan by £3.3m at M10 YTD, at £23.8m. The Trust has not met the pre-PSF/FRF/MRET control total target of a £36.4m deficit and so has not received the Q4 portion of PSF/FRF.
- **Prior Year PSF** of £0.5m is included in the position. This is the trust's element of the Post Accounts PSF adjustment for 2018/19.
- **CIP delivery** of £33.2m is £1.0m adverse to plan. Delivery to plan is:
  - Non-pay £1.2m favourable
  - Income £1.0m favourable
  - Pay £3.2m adverse

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2. Month 10 YTD Analysis of Cash Movement

	M10 YTD Plan £m	M10 YTD Actual £m	YTD Variance £m
Opening Cash balance	**3.2**	**3.2**	**(0.0)**
Income and expenditure deficit	(9.8)	(16.5)	(6.7)
Depreciation	20.5	20.5	0.1
Interest payable	10.0	10.0	0.0
PDC dividend	0.0	0.0	0.0
Other non-cash items	(0.1)	(0.3)	(0.2)
Operating surplus/(deficit)	**20.6**	**13.7**	**(6.9)**
Change in stock	1.2	(0.8)	(2.0)
Change in debtors	15.1	23.2	8.1
Change in creditors	(45.1)	(23.6)	21.5
Change in provisions	(0.8)	(0.7)	0.0
Net change in working capital	**(28.8)**	**(1.9)**	**27.6**
Capital spend (excl leases)	(20.7)	(20.7)	(0.0)
Interest paid	(8.5)	(8.5)	0.0
PDC dividend paid/refund	0.0	0.0	0.0
Interest Received	0.2	0.2	0.0
Investing activities	**(29.0)**	**(29.0)**	**(0.0)**
Revolving facility - repayment	0.0	0.0	0.0
Revolving facility - renewal	0.0	0.0	0.0
WCF borrowing - new	21.1	2.0	(19.1)
Capital loans	23.3	23.3	0.0
Loan/finance lease repayments	(7.5)	(7.8)	(0.3)
Financing activities	**36.9**	**17.5**	**(19.4)**
Cash balance 31.01.20	**3.0**	**3.5**	**0.5**

M01-M10 YTD cash movement

- The cumulative M10 I&E deficit is £16.5m, a £6.7m underperformance to plan. (*NB this includes the impact of donated grants and depreciation which is excluded from the NHSI performance total).
- Within the I&E deficit of £16.5m, depreciation (£20.5m) does not impact cash. The charges for interest payable (£10.0m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating surplus" of £13.7m.
- The operating surplus variance from plan is £6.9m.
- Working capital is better than plan by £27.6m. This favourable variance comprises of £8.1m higher on debtors and £21.5m lower on creditors excluding capital creditors. The change of stock level is £2.0m worse than the plan.
- The Trust has borrowed £11.6m to fund the YTD deficit and repaid £6.9m.
- The Trust has received £23.3m for capital loan. The working capital borrowing is £19.1m lower than the YTD plan. The Trust has requested a drawdown of capital loan in February of £1.9m with an interest rate of 1.55%. Although the Trust can borrow up to £21.1m, however due to the phasing of the I&E at month 10, we have not requested any loans since June. The Trust would have had to repay any excess as the maximum loan cannot exceed £12.8 at the year end. The previous slide outlines the expected working capital drawdowns before the end of the year.

January cash position

- The Trust achieved a cash balance of £3.5m on 31st January 2020, £0.5m higher than the £3m minimum cash balance required by NHSI and in line with the forecast 13 week cash flow submitted last month.

3. Balance Sheet as at Month 10

Balance Sheet	Mar-19 Audited Account (£m)	M10 YTD Revised Plan (£m)	M10 YTD Actual (£m)	M10 YTD Variance to Plan (£m)
Fixed assets	**390.5**	**405.9**	**405.9**	**0.0**
Stock	**7.8**	6.5	8.5	2.0
Debtors	**101.9**	87.2	79.1	(8.1)
Cash	**3.2**	3.0	3.5	0.5
Creditors	**(126.7)**	(95.3)	(116.3)	(21.0)
PDC div creditor	**0.0**	0.0	0.0	0.0
Int payable creditor	**(1.2)**	(2.3)	(2.8)	(0.5)
Provisions< 1 year	**(0.5)**	(0.4)	(0.4)	0.0
Borrowings< 1 year	**(57.6)**	(187.5)	(177.9)	9.6
Net current assets/-liabilities	**(73.1)**	**(188.8)**	**(206.3)**	**(17.5)**
Provisions> 1 year	**(1.0)**	(0.5)	(0.5)	0.0
Borrowings> 1 year	**(284.3)**	(194.3)	(183.6)	10.7
Long-term liabilities	**(285.3)**	**(194.8)**	**(184.1)**	**10.7**
Net assets	**32.1**	**22.3**	**15.5**	**(6.8)**
Taxpayer's equity				
Public Dividend Capital	**133.4**	133.4	133.4	0.0
Retained Earnings	**(213.4)**	(223.2)	(229.9)	(6.7)
Revaluation Reserve	**110.9**	110.9	110.9	0.0
Other reserves	**1.2**	1.2	1.2	0.0
Total taxpayer's equity	**32.1**	**22.3**	**15.5**	**(6.7)**

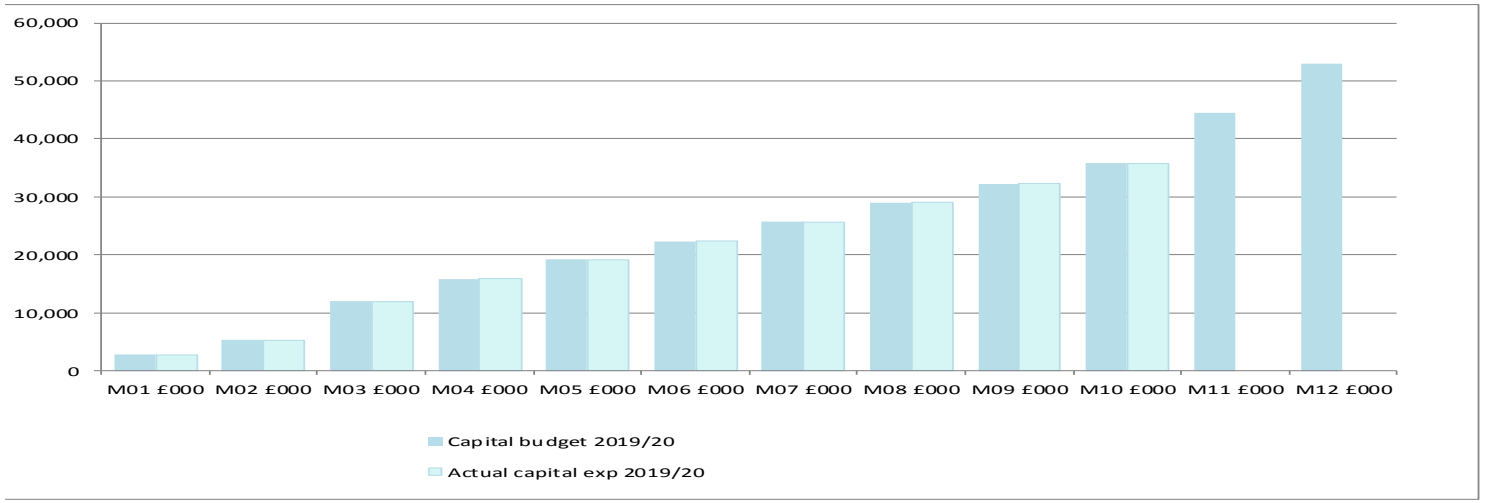
M10 YTD Balance Sheet

- Fixed assets are £0.7 higher than the plan. This includes depreciation charges and capital spend to month 10
- Stock is £2m higher than plan, mainly due to an increase in pharmacy area.
- Debtors is £8.1m better than plan in month and has reduced by £22.8m from March 2019. Target reduction of £ 18m by year end is being actively pursued
- The cash position is £0.5m higher than planned. Cash resources are tightly managed at the month end to meet the £3.0m minimum cash target.
- Creditors are £21.5m higher than plan in month 10, this includes interest payable creditors. However have been reduced by £8.8m since March 2019.
- £23.3m of capital loan was received as at January subject to an interest rate of 1.55%. The Trust has requested drawdown of capital loan in February of £1.9m with the same interest rate as in January.
- The Trust requested and received working capital loan of £11.6m in April and May to fund the current year deficit as per submitted plan. No loan has been drawn since June, although more is expected in February and March.
- The deficit financing borrowings are subject to an interest rate 3.5%

4. Capital programme 2019/20 – M10 update

COMMENTARY

- The bid that the Trust submitted for £27.2m capital funding to NHSI has been approved for investment to address a number of critical risks in the IT and estate infrastructure.
- In addition to this capital bid the Trust has Internal capital of £15.1m and a total capital spend of £53.057m for 2019/20.
- The Trust has spent £35.774m YTD as at M10, which is to plan and includes a £9.8m accrual for commitments to date.
- Trust continues to exert tight control over capital expenditure, approving requisitions for all projects included in the bid.
- The Trust received additional funds of £158k for HSLI in month 6.
- The Trust received additional funds of £168k for Imaging in month 10.
- The Trust received confirmed notification of receiving an Emergency Loan funding of £5.4m in month 10.
- Budgets have been allocated to cost centres with reviews continuing each month of the actual spend against the forecast.



Outstanding care every time

Meeting Title:	Trust Board		
Date:	27th February 2020	**Agenda No**	**5.1**
Report Title:	Education Strategy 2019-2024		
Lead Director	Richard Jennings , Chief Medical Officer		
Report Author:	Sarah James, Associate Director Workforce, Education and Development Kath Brook, Strategy and Planning Manager		
Presented for:	Approval		

Executive Summary:

The education strategy 2019-2024 is one of a number of supporting strategies being developed by the Trust in order to support deliver of the ambitions set out in the Trust Strategy 2019-2024.

The development of the education strategy has been informed and shaped by engagement with staff, patients and the public and via working group with representatives from professional staff groups. Particular note should be taken of the following information in appendix 1 which has informed the education strategic priorities for 2019-24:

- Slides 8-10: Progress to date against the Trust key education priorities
- Slide 11: National and local implications for education
- Slide 12: Our strengths, weaknesses, opportunities and threats
- Slide 13: Feedback from our staff, patients and partners

A Board seminar was held on December 2019 and the feedback provided has been incorporated in the final strategy draft:

Board seminar feedback	**Slide number**
Increase the aspirations of the strategic priorities and clearly articulate the vision	16 & 17
Support for training opportunities to be offered to all staff, minimising variations across staff groups	19
Encourage the local community into the Trust, consider how we draw people in and outreach to our communities	21

Given the breadth of issues, challenges and opportunities facing the Trust now and in the future, the education strategy has focussed on five strategic priority areas which have the potential to deliver the biggest impact within the 5-year timescale, see slides 18-22 for details. These are:

1. We will be the leading NHS organisation for education and development in South West London collaborating with other employers and education providers
2. We will provide opportunities to all our staff to develop and progress in ways that support fulfilling personal, professional and career development, embracing principles of well-being, equality and diversity.
3. We will provide accessible and innovative ways of learning and teaching by keeping up to date with emerging advances in clinical practice, digital and artificial intelligence, supported by the use of new technologies
4. We will ensure education provision is flexible to adapt to changing innovations in the workforce, developing robust governance around the

	scope and remit of new roles. 5. We will provide high quality education opportunities to ensure our staff have the skills and knowledge to deliver safe and outstanding care Our strategy will culminate in: *As a 'learning organisation' we will inspire our staff to reach for excellence and deliver outstanding care, every time.* *We will be the leading NHS organisation for education and development in South West London.* *We will achieve this by becoming a system leader in emerging innovation and technologies driving teaching and learning, fit for a future health service* Dedicated investment will be required to deliver the ambition detailed in this strategy. Current income streams will be priorities to support the strategic vision i.e. Health Education England's new personal development allowance and apprenticeship levy. Income generation in areas of training provision and access to facilities will be maximised. Wider partnership working will be optimised i.e. St George's Charity, who currently fund a number of initiatives A new Associate Medical Director for Education has been appointed and will take up post in April 2020. This post has been vacant for a number of months; the new post holder will assist in driving forward the year 1 priorities.
Recommendation:	The Trust Board is asked to: i) Review the draft strategy 2019-2024 and approve ii) Note the dependency of the Workforce, Digital and Estates Strategies to deliver the outcomes
Supports	
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring:** staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)

Implications			
Risk:	▪		
Legal/Regulatory:	N/a		
Resources:	N/a		
Previously Considered by:		**Date:**	
Appendices:	A. Education Strategy 2019-2024 B. Equalities Impact Assessment C. Quality Impact Assessment D. Stakeholder Engagement		

Appendix D - Stakeholder Engagement

The following groups were engaged in developing the education strategy

Stakeholder	How have contributed
Staff Groups: • Allied Health Professionals • Advanced Clinical Practitioners • Physician Associates • Nursing and Midwifery • Healthcare Scientists • Medical • Clerical and Administration • Pharmacy	Steering group meetings and /or individual meetings occurred with representation from each of the staff groups listed and together they have contributed to: • Scoping the education strategy • Identify current, future challenges for their relevant staff group • Identifying potential solutions • Review and testing and refining of the emerging strategy
Joint Strategic Board	Presentation at the 14th November meeting
Trust Board	Board Seminar 4th December
Council of Governors	Presentation at the 17th December meeting
Trust staff	Staff engagement event at St George's 28th Oct Staff engagement event at QMH 8th Jan Online staff engagement Survey – December 2019 to February 2020
Midwifery Service	Staff engagement at senior leaders meeting 13th February
Public and Patient Groups	Engagement event 21st October
People Management Group	Discussion and Review 20th January Discussion at Patient and Public Engagement Group 29th October
Workforce and Education Committee	Discussion and Review 18th February

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Education Strategy 2019 – 2024

February 2020

Contents

Introduction

St George's is globally renowned as a centre of excellence and one of UK's largest teaching hospitals. Our staff are our most valuable assets. As a '*learning organisation*' will inspire our staff to reach for excellence and deliver outstanding care, every time.

Delivering outstanding care, every time

Our strategy for 2019-2024

Our vision is to provide outstanding care, every time for our patients, staff and the communities we serve.

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

Strong foundations

To provide outstanding care, every time

- We will provide outstanding care, every time
- We will provide the right care, in the right place, at the right time
- We will invest in our staff
- We will manage our funding and spending, and invest in our future
- We will improve our buildings and hospital estate
- We will make sure our staff and patients have access to the digital technology and information they need, when and where they need it

Excellent local services

To provide excellent local hospital services for the people of Wandsworth and Merton

- We will provide planned care that fits around our patients' lives using the latest technology
- We will provide more same day emergency care

Closer collaboration

To work with others to provide health services for people across south west London

- We will work with our partners to provide care closer to patients' homes
- We will work with neighbouring hospitals to make sure patients get the care they need
- We will work with others to meet the changing needs of our ageing population

Leading specialist healthcare

To provide specialist healthcare for the people of south west London, Surrey, Sussex and beyond

- We will continue to be the main provider of specialist services for our region, including as the major trauma centre
- We will be a major centre for cancer, children's and neuroscience services
- We will take part in commercial opportunities that enable us to invest more in NHS care
- We will develop tomorrow's treatments, today, through innovation, research and training

1. Our collaboration with St George's University of London will continue to offer opportunities for innovation, education and research supporting excellent patient care.

2. We will invest in a safe culture of learning together in multi-professional teams that nurtures talent, embraces diversity, inspires to reach personal and professional developmental goals.

3. We will develop leaders who champion continuous quality improvement for safe care of our patients.

4. We will become a system leader in emerging technologies driving teaching and learning, fit for a future health service.

5. We will expand mutually beneficial partnerships with regional healthcare organisations, schools, patients and learners supporting a community of learning

Stakeholder engagement

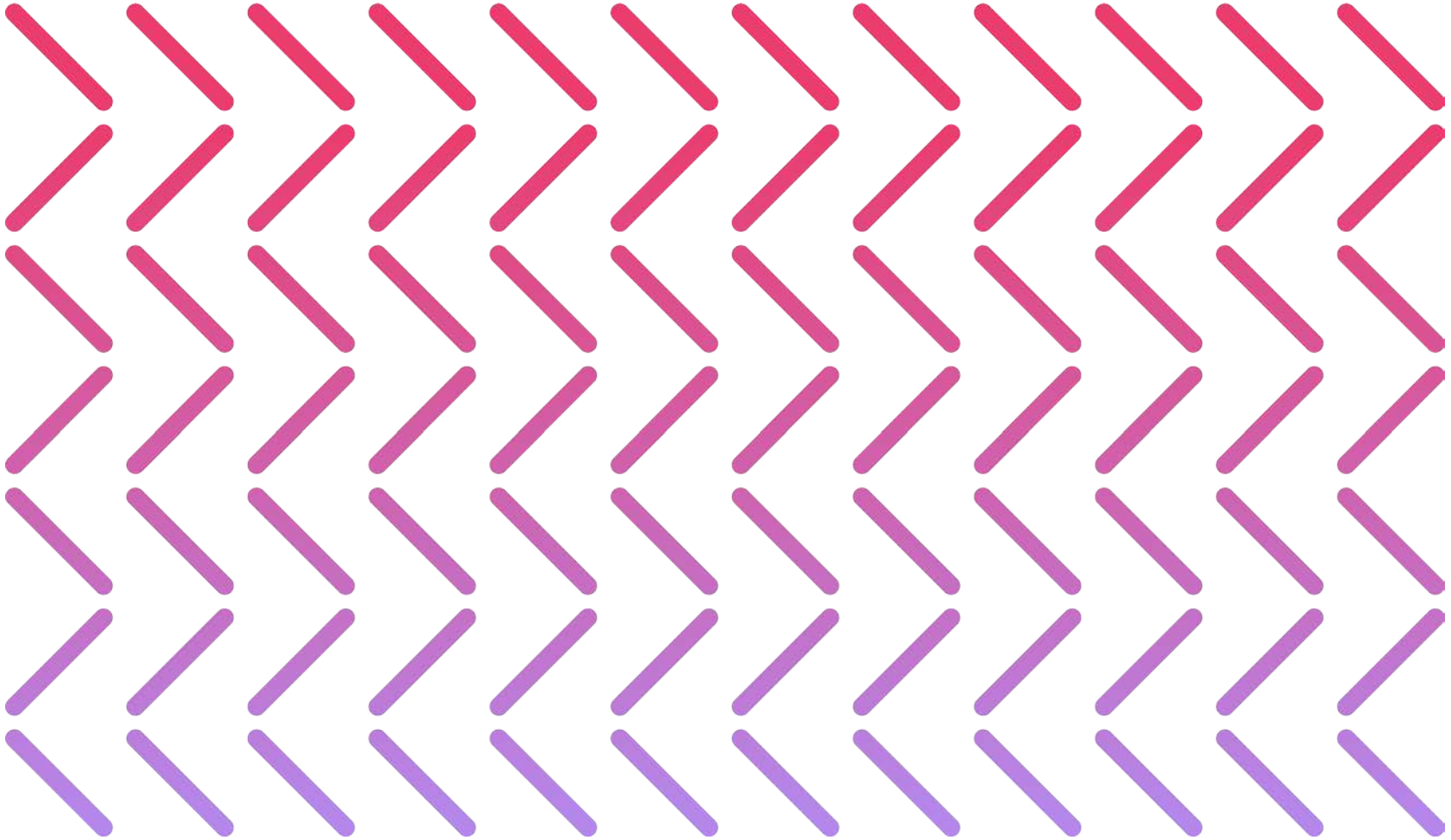
In developing this strategy, we:

- Formed a strategy steering group with leads from all staff groups
- Leads supported direct engagement with their staff groups
- Held staff engagement events at St George's and Queen Mary's Hospital sites
- Carried out a staff engagement survey
- Engaged with a range of patient groups
- Engaged with the Joint Strategic Board (joint board between St George's University Hospitals and St George's, University of London)

We also reviewed:

- NHS Staff Survey results for 2019
- Leavers survey
- 2019 General Medical Council National Trainee Survey results
- St George's University of London student survey results
- Health Education England funding streams
- Medical Engagement Scale (MES) survey 2019

Where we have come from, and where we are now



Context: Where we are now

The Trust as a leader in education:

- We partner with **St George's University of London** (SGUL) to train in
  Medicine, Biomedical Science, Healthcare Science, Physiotherapy and Radiography
  Undergraduate courses (foundation level) in Healthcare Practice, Paramedic Science and Breast Imaging
  Postgraduate training for a wide range of clinical specialties
  Local education provider for a wide range of clinical specialties
- We partner with **Kingston University** to train in a wide range of Allied Health Professional degrees
- We have partnered with **South Thames College** and Westminster Kingsway to provide a level 4 apprenticeship in mammography and pharmacy
- We provide placements for **Project Search** students (young people with disabilities)
- We provide over 600 **work experience** placements annually
- We provide undergraduate placements and pre-registration training for nursing, midwifery, pharmacy and allied health professional students from a variety of universities, our main partner is Kingston
- We are the **Lead Employer** for the South West London consortium for **Trainee Nursing Associates**
- Pharmacy provides training to 20 **postgraduate trainee pharmacists** and Pharmacy Technicians annually

The Trust as an employer:

- We offer **Apprenticeship routes** into employment
- All staff have an **annual performance development** review
- **Training and development** for our staff, including access to **simulation facilities**
- We provide employment and training for a range of Clinical Scientists
- We train clinical staff for Royal College Fellowship (such as Radiologists).
- We support a wide range of postgraduate and **Continuing Professional Development** opportunities
- We support staff to transition into **new or enhanced roles** such as Advanced Clinical Practitioners, Prescribing Pharmacists, Nursing Associates
- We provide education and training courses to the open market
- We provide **education for patients**
- We will provide Parity of Esteem training across both sites in conjunction with South West London and St George's Mental Health NHS Trust
- Through our **Leadership Academy** we provide comprehensive programmes at every level of the leadership journey including Masters programme
- **Quality Improvement** is embedded into our Leadership Academy programmes
- We have an established trained accredited **coaching** and mentoring service for staff
- We have established a trained accredited **mediation and workplace conflict resolution service**

Key education priorities that have emerged in the last few years

Undergraduate

- Increased placements for non-medical learners
- Supportive student experience across all professions
- Enhanced quality of supervision
- Improve formal and informal teaching

Postgraduate Education

- Enhancing the quality of clinical placements (*General Medical Council & National Education & Training survey results)*
- Supporting Local & Regional Faculty Groups
- Enhancing well-being & supported return to practice
- Excellent induction, sustainable workload and rotas

Future Workforce

- Meeting public sector target of employing 2.3% of the workforce as apprentices
- Our partnerships with local schools and Further Education Institutions
- Our work experience offering

Careers & Continuing Personal Development

- Good progress in delivering Nursing Associates
- New emerging workforce e.g. Physician Associate, Advanced Clinical Practitioner, Independent Prescribing Pharmacists.
- Progress with higher level apprenticeships

Parity of Esteem

- Ensure staff have confidence and competence in addressing patients mental health as well as physical healthcare needs.
- Supporting training in Dementia

Development Pathways

Embedding:

- Healthcare support worker pathway
- Band 5 Career Pathway
- Bands 5-7 Career pathway
- Band 5 Development Programme
- Leadership Academy
- Quality Improvement

- The areas of focus have arisen iteratively from issues identified at the Workforce and Education Committee, Nursing Board, and from external requirements from the Department of Education, Department of Health, and Health Education England, over the past three years
- We need to ensure that in those areas we are doing well, we mainstream activity so it becomes ‘business as usual’ e.g. our collaboration across South West London as the pilot site for Trainee Nursing Associates
- For the areas that we are making less progress we need to understand the reasons behind this and how these can be addressed in the future strategy e.g. ensuring that all clinical staff have appropriate supervision, embedding learning to improve safety and quality of care provision through our education offering
- We need to consider those priorities which will help deliver our future workforce strategy 2019-24

Progress against the Trust's key education priorities

Education priorities	Overall progress	Key development areas to address:
Undergraduate Education		
Increase in placement provisions for non medical students	Increased nursing placements by 25% achieved September 2019	• Recruitment to undergraduate nursing programmes • Business case for nurse apprentices to be developed
Providing a positive student experience across all professions	Increased recruitment to Clinical Teaching Fellow posts with roles in Medicine, Surgery, Paediatrics, Cardiology and Emergency Medicine. Clinical Teachers for student nurses, Trainee Nursing Associates, and midwives. Improved medical student feedback cycle via the Joint Undergraduate Committee.	• Sustainability when Clinical Teaching Fellow is absent • Upskilling all nursing staff with new Nurse and Midwifery Council standards • Supporting education faculty development • Reflecting education roles and designated education time through job planning
Postgraduate Medical Education		
Positive and Improving General Medical Council Trainer and Trainee Surveys Achievement of Key Performance Indicators; Overall satisfaction, Patient Safety, Educational and Clinical Supervision, Workload	Trainees report positively for educational supervision and clinical supervision, with the Trust ranking 3rd highest in London for these areas	• Rota gaps impacting negatively on trainees educational experience and quality to be addressed, in part, through the development & use of new roles within the workforce • Sustainability of improvements implemented through General Medical Council action plans

Progress against the Trust's key education priorities

Education priorities	Overall progress	Key development areas to address:
Career Pathways and Continuous Personal and Professional Development		
Progress with higher level apprenticeships	7 staff on Level 7 Leadership programmes 24 more to start March 2020 on Clinical Leadership 4 on Level 7 Finance	Off the job training time In 2018 – 2019, 50 % of newly qualified nurses in one of the clinical divisions had an allocated Preceptor (supervisor), by 2021 this will be 100% Facilitate horizontal as well as vertical career development, providing opportunities for generalists to work across a range of settings and across organisational boundaries, as well as those who are progressing vertically and aspire to be specialists and in leadership roles
Parity of Esteem		
The NHS parity of esteem agenda means that patients should be able to access services which treat both mental and physical health conditions equally and to the same standard.	Training Needs Analysis complete Training Programmes designed Joint post with South West London & St. George's Mental Health Trust Mental Health in Cancer Care simulation programme	Mental health training framework for all staff Continuity of Trust lead post-holder (currently fixed term post) Work with partners to understand how this is appropriately covered in the undergraduate syllabuses. (It is a core part of Trainee Nursing Associate course and placements)
Development Pathways		
Recognise personal and career development is very important to our staff	Healthcare Support Worker development pathway Band 5 Newly Qualified Nurse Development Pathway Bands 5-7 Development pathway Band 5 accredited Development Programme from Kingston University Ward Manager Leadership development	Affordability of the development programme for all Newly Qualified Nurses. Leadership development pathway at all levels

Progress against the Trust's key education priorities

Education priorities	Overall progress	Key development areas to address:
Educate the Workforce of the Future		
Meeting the public sector target of employing 2.3% of the workforce as apprentices	Currently 0.6% of the workforce are employed into apprenticeships	• All band 2 posts to be ring-fenced as potential apprentice positions. • Availability of a supporting infrastructure for the recruitment, support for managers, and pastoral care of apprentices
Our partnerships with local schools and Further Education Institutions	Partnership with South Thames College to provide mammography apprenticeship Opened discussions with South Thames College about new Technical education level qualifications	• Placements for Technical education level students (alternative to existing A levels) • More partnership working on widening participation opportunities
Our work experience offering	Joint Widening Participation scheme (30 places) 600 places offered per year 7 places for learning disabled students via Project Search	• As above
Career Pathways and Continuous Personal and Professional Development		
Good progress in delivering Nursing Associates	8 qualified in post. A further 35 are in progress and 21 due to commence in March 2020.	• Health Education England would like the Trust to increase provision, the issues will be supervision and placements.
Establish training pathways for the new emerging workforce e.g. Physician Associate, Advanced Clinical Practitioner, Non-medical Independent Prescribers	Governance systems established or in development for Advanced Clinical Practitioners and increase in numbers being trained Commenced establishment of pathways for Independent Prescribing Pharmacist	• Career pathway for Physician Associates, Advanced Clinical Practitioners, Independent Prescribing Pharmacists to be developed further

National and Local Implications for Education

NHS Long Term Plan 2019 details the need for:

- Education and Workforce development to offer:
  - improved development opportunities, motivating staff to remain within the NHS
  - equip staff with the skills to operate at advanced levels of professional practice to meet patients' needs of the future
- Local Maternity Systems delivering recommendation from the National Maternity Review: Better Births, to champion a culture of multidisciplinary learning

Interim NHS People Plan 2019 identifies the need to:

- Make the NHS the best place to work, retaining staff
- Improving leadership culture
- Tackling the Nursing workforce shortage challenge
- Delivering 21st Century care
- Develop new operating models for workforce

National Patient Safety Strategy 2019

- New national standards and guidance to support continuous improvement in patient safety
- The Strategy builds on 2 foundations: ***a patient safety culture*** and ***a patient safety system***
- Details future requirements for new digital technologies to support learning and a new ***training and education safety framework*** for the NHS

South West London Health & Care Partnership priorities:

- Ambition to make South West London a great place to work, attracting and growing talent
- Designing sector workforce and education needs e.g. sector business case for apprentices

Health Education England priorities

- Increase in nursing and midwifery placements for an extra 5000 (25%) undergraduate places nationally in 2019-20, rising to 50% by 2024
- Increase in numbers of Trainee Nursing Associates to meet national target of 7500 in 2020
- Introduction of a personal development allowance of £1,000 over 3 years for nurses, midwives and AHPs from April 2020

National changes to Education

- New technical level qualifications in health available from 2020 (equivalent to A level's, requiring 45 days work placement per student per year)
- More apprenticeship frameworks available, SGUH will focus on clinical leadership
- Route to Qualified Registered Nurse for Nursing Associates via apprenticeship
- The Topol review- an independent report on behalf of the Secretary of State for Health and Social Care, highlights recommendations around technology in work and in learning, supporting efficiencies in training and quality of care provision
- Expansion of multi-professional credentialing e.g. Advanced Clinical Practitioner

St George's University NHS Foundation Trust

- Our focus on improving quality and safety has seen our CQC inspection rating improve from ***Inadequate in 2016 (placed in quality special measures)*** to ***Requires Improvement in 2019 (with a recommendation to be removed from quality special measures)***
- In April 2019 the Trust launched its new Clinical Strategy 2019-2024, detailing how we will continue to deliver 'outstanding care every time'
- Workforce and Digital strategies approved by Board in 2019, Quality and Safety Strategy approved by Board in January 2020, all driving improved quality of care provision, all requiring element of education for staff
- Staff and leavers survey results indicate staff join us for development opportunities and leave us if they don't get them

Outstanding care every time

Strengths, Weaknesses, Opportunities and Threats Analysis - from stakeholder feedback

Strengths

- We offer lots of education opportunities across SGUL/SGUH
- We have a university and hospital at the same site, broader group of specialities is our unique selling point
- Our Trust has Integrated Education Services
- We have clinical academic groups (link to research strategy)
- We have a good reputation for education e.g. simulation resources in the Trust
- We have a long history of promoting a patient safety culture through fixed and mobile educational activities across the workforce.
- Education is prioritised in the direction of travel for the organisation
- We have improved Personal Development Reviews compliance rates across trusts
- We offer entry routes into nursing - via the Nursing Associate role
- We have received an Excellence in Education Awards and Preceptor/Mentor of the Year awards
- We have committed Practice Educators and Clinical Teachers
- We have excellent partnership working with SGUL and Kingston University e.g. Joint Undergraduate Committee

Opportunities

- We can offer training for new and extended roles e.g. Allied Health Professional's to become Advanced Clinical Practitioners
- We can strengthen our profile to support 'employer of choice'
- We have opportunities to develop more 'in-house' training /courses with the university, cost effective, accredited
- We can further develop our inter-professional education
- We can attract a local workforce to meet the population needs-external presence in schools, colleges and universities to develop SWL education hub
- We can develop the role of the digital platforms to support learning
- We can develop talent management & succession planning, supporting equality of access
- We can development of the mentorship programme and career development programme for admin staff
- We can improved staff satisfaction and Trust survey results
- We can increase apprenticeship training
- We can focus on primary and community nurse training e.g. support Roehampton University, attract into acute settings
- We can develop and expand principles of a SWL skills training passport – e.g. midwifery
- We will support the new pharmacy integrated training year by hosting placements

Weaknesses

- There is disparity with supervision and funding for medical & non-medical staff, with staff expressing feelings of inequality
- We are not maximising the use and benefit of the apprenticeship levy
- It is challenging to release nursing workforce other than for mandatory training (vacancies and cost) due to capacity
- There is limited vision and coordination to bring together strategy & identifying gap, no previous education strategy
- There is limited access and communication of opportunities for Allied Health Professionals
- Horizon Scanning – need to be better at this (links to Long Term Plan)
- We offer no academic 'stamp' – accreditation for in-house training
- We need to educate beyond 'St George's' – too inward looking
- SGUL Simulation labs are underutilised with a limited scope of practise
- Our current IT infrastructure can not support our education ambitions
- There is a lack of Education Centre availability and other teaching space
- Not all staff have annual Personal Development reviews (80% against a target of 100%)
- We need to consistently embed the process for learning from incidents and best practice across the organisation

Threats

- Our financial constraints
- Culture shift does not happen
- Consistency of 'System' and Governance around supporting different professionals e.g. structured medical trainings vs support for other professionals
- Impact on staff recruitment and retention because of limited training opportunities
- Unable to respond timely to support staff in the changing model of care delivery
- Poor student and trainee experience, with risk to losing funding
- Parity of Esteem Training (between physical and mental health), currently project needs longer term workforce solution

Engaging with our staff, patients and partners

In developing this strategy we engaged with a range of staff, patients, partners and the public. Common themes highlighted across these groups as core principles for inclusion in the strategy were, **education should be accessible to all staff; the way we educate needs to evolve with emerging innovations; external partnership working is required to ensure education supports the workforce of the future**.

Staff Feedback

- **Culture** - education must be viewed as a priority and to enable **ALL** staff to access this equitably
- The **Environment** in which to teach and learn needs to be fit for purpose
- There should be easily accessible information on education opportunities
- Ensure that **Simulation Based Learning is accessed by Inter-professional teams**
- Embed further education for **safety and continuous improvement**
- Review the **style of education** from 'classrooms' to more innovative models of development
- Utilise the retiring workforce to **retain expert knowledge**
- Provide **equitable access** to training pathways across existing and emerging workforce
- **Value the students** we have, in order to retain them post graduation
- Opportunity to develop St George's University of London/the Trust as the **education hub** for South West London
- We have opportunities for **income generation** using our clinical expertise

Patients, Partner and Public Feedback

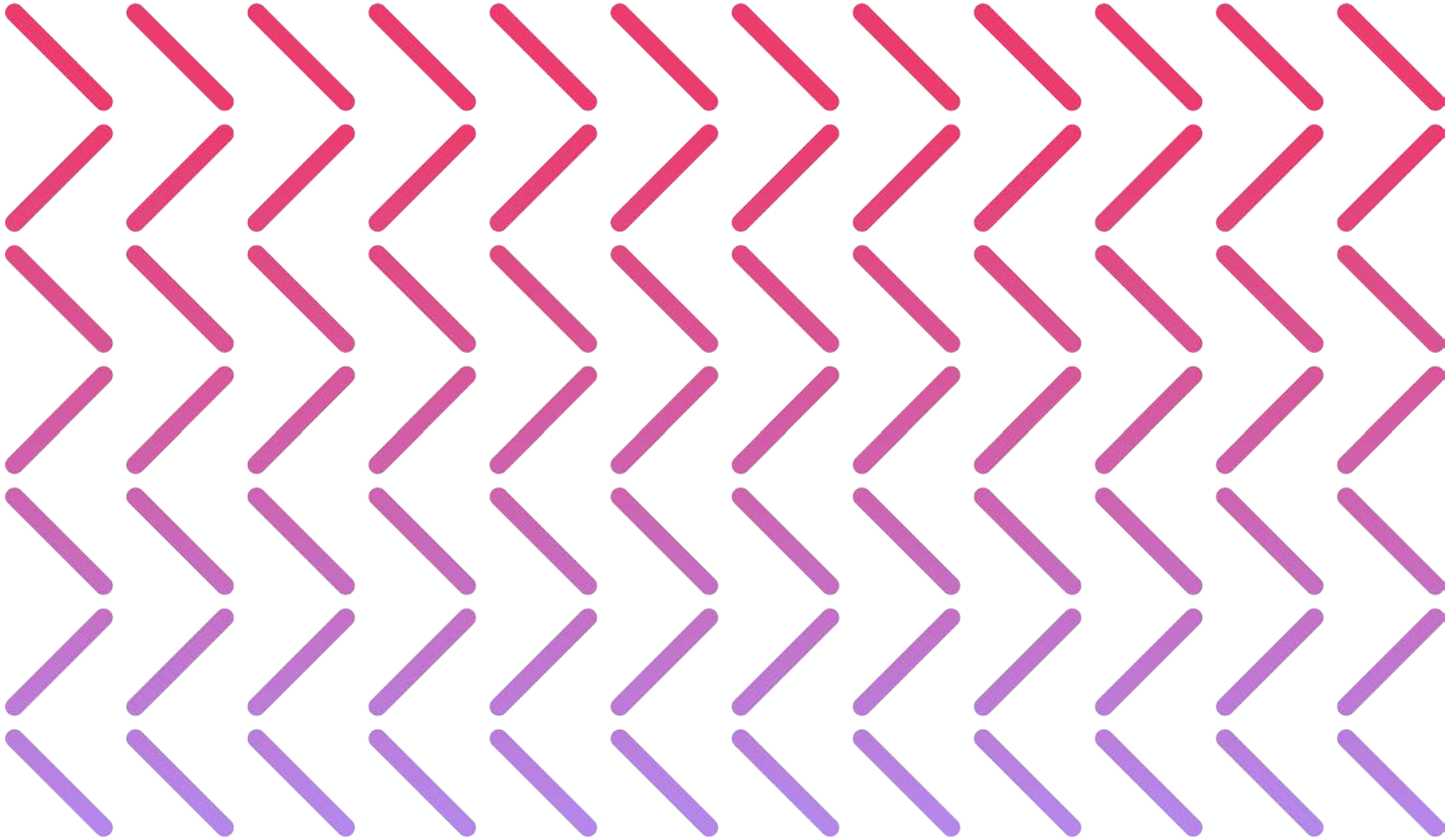
- **Leadership culture** needs to value and encourage development for all staff
- **All** staff should be encouraged to develop
- **Mentoring/coaching** should be available to all staff
- **Talent Management** opportunities to be available for clinical and non clinical staff; we need to train and retain our staff
- We should maintain our exemplar position with **Trainee Nursing Associates**
- There are **opportunities to reach out to the wider community** through work experience offerings
- There are **opportunities to reach out into South West London** health and social care organisations to provide **mutual development** opportunities
- Higher Education Institutes need student volumes to make courses viable; we should take a **coordinated approach across South West London** with the new emerging training needs
- Departments should be able to reap the benefits from **income generation**

Emerging themes for this strategy

A number of common themes have been identified through engagement and data analysis which are areas for the strategy to consider, and our priority areas for the 5 years emerged from these.

- Safety
- Funding
- Joint education across SW London
- Continuing Personal & Professional Development opportunities
- Links to Further *(college)* & Higher *(university)* Education Institutes
- Student/trainee experience
- Career pathways
- Apprenticeships
- Innovation in new ways of learning
- Educating for new roles
- Income generation

Where we go next



Our vision 2019-2024:

Outstanding care every time

As a '*learning organisation*' we will inspire our staff to reach for excellence and deliver outstanding care, every time.

We will be the leading NHS organisation for education and development in South West London.

We will achieve this by becoming a system leader in emerging innovation and technologies driving teaching and learning, fit for a future health service.

Strategic education priorities for 2019 – 2024

1. We will be the leading NHS organisation for education and development in South West London collaborating with other employers and education providers.

2. We will provide opportunities to all our staff to develop and progress in ways that support fulfilling personal, professional and career development, embracing principles of well-being, equality and diversity.

3. We will provide accessible and innovative ways of learning and teaching by keeping up to date with emerging advances in clinical practice, digital and artificial intelligence, supported by the use of new technologies.

4. We will ensure education provision is flexible to adapt to changing innovations in the workforce, developing robust governance around the scope and remit of new roles.

5. We will provide high quality education opportunities to ensure our staff have the skills and knowledge to deliver safe and outstanding care.

Education Priorities – where we will focus action

Strategic Priority	**We will be the leading NHS employer for education and development in South West London collaborating with other employers and education providers**
Why is it important?	The South West London Workforce Board aspires to make South West London a great place to work. Our vision is **to be seen among the leaders in South West London** as an innovative and high quality education partner.
What we will focus on	• We will establish a vehicle (e.g. St George's Education Academy) which will provide system leadership, investment, infrastructure and governance for excellence in healthcare education and training, in partnership across South West London • We will enhance and embed the joint work with South West London and St George's Mental Health Trust to build workforces in both Trusts who are competent in **physical and mental health needs of our patients** in line with the Parity of Esteem national agenda • We will further develop the opportunities across South West London to run training programmes e.g. Local Midwifery Service Network to review and establish a central course function supporting access to specialist training and efficiency of provision • The pharmacy service will continue to implement the new model of Primary Care Network pharmacy training and recruitment, at pace over the next few years to ensure as a system we have a skilled and sustainable workforce • While working with partners to **develop new models of care**, we will ensure our staff have the appropriate training and education to meet the emerging outreach model of care e.g. first contact practitioners- physiotherapists, other allied health professional and pharmacists • We will work across South West London to **support more apprentices by utilising** the money in the **Apprenticeship Levy.** We will 'gift' up to 25% of the levy into the health and social care system, specifically to smaller organisations such as GP practices and Care Homes, if appropriate • We will **maintain our status as an Education Provider Organisation** for Apprenticeships. The Trust Breast Screening Apprenticeship programme is our first apprenticeship being provided to both internal and external apprentices • We will work with the **Acute Provider Collaborative** to ensure there are sufficient numbers of students to make the courses viable for universities and colleges to run, such as radiology, sonography and radiography • We will bid for **Lead Employer** status from Health Education England for further medical training specialities (we are the Lead Employer for 500 GP Trainees in South London currently). This means that the doctors in training have a better experience and that the Trust is able to increase income.

Education Priorities – where we will focus action

Strategic Priority	**We will provide opportunities to all our staff to develop and progress in ways that support fulfilling personal, professional and career development, embracing principles of well-being, equality and diversity.**
Why is it important?	Key to success is St George's as a Trust where all staff are **supported in their personal, professional career developmen**t. This will attract excellent staff, retain those who want to progress, support those who are struggling.
What we will focus on	• We will **prioritise getting the 'basics' right,** to establish the foundation for an optimal learning environment i.e. the estates infrastructure, accessible e- learning, central learning directory of all education opportunities (SGUH/SGUL) • We will guarantee **all** staff, both non clinical and clinical, have an individual **Personal and Professional Development plan** • We will encourage and expect all **staff to actively participate** in their own Personal and Professional Development plan, as well as contributing to the learning of others • We will continue the expansion of the **Leadership Development Programmes** to cover all staff groups, supporting the inclusive open and engaged culture we strive for • We will enable **protected time for staff development** and **supervision** to support career development, in line with the Trust Workforce Development Policy • We will **maximise opportunities for staff to access training,** above mandatory requirements, by optimising use of funding e.g. Health Education England specialist funding, education grants and income generation • We will enable protected time for experienced staff to **supervise and support newly qualified** registrants e.g. ensuring organisational parity with medical supervision processes • All undergraduate and post graduate students/trainees will be provided with the appropriate **educational supervision** in line with Health Education England and National regulatory guidance e.g. General Medical Council, Nursing Midwifery Council**,** Health Care Professional Council with a continuing programme of development for supervisors and assessors • We will **increase visibility of education income back to departments that provide education support**. Consultant job planning will review all education provision by consultants to align education income with education provision • We will continue to **work collaboratively with St George's University London** to raise the prestige of education roles to attract and retain high quality educational leaders • We will ensure our educators are supported to deliver **high quality and an effective learning experience** e.g. Practice Development Nurses/Midwives and Clinical Teaching Fellows to complete a teaching qualification

Education Priorities – where we will focus action

Strategic Priority	**We will provide accessible and innovative ways of learning and teaching, keeping up to date with emerging advances in clinical practise, digital and artificial intelligence , supported by the use of new technologies**
Why is it important?	We need to offer staff **career progression** that motivates them to stay within the NHS and, just as importantly, equips them with the skills to operate at advanced levels of professional practice and to meet patients' needs of the future. Our education strategy needs to **optimise the range of evolving methodologies** which best meet learners needs.
What we will focus on .	• We will make access to the training directory, course bookings and e-learning accessible remotely and on mobile phones, aligning with the Trust Digital Strategy • We will develop teaching/learning approaches aligned to **technology advances,** supported through the IT strategy and funding opportunities • We will prioritise the use of **safe experiential learning through simulation and technology**, allowing people to learn in a safe environment rather than being put in high risk situations or completing procedures too early in their training • We will maximise the use of and access for non-medical staff to **St. George's Advanced Patient Simulation & Skills Centre** in order to learn from and with each other through inter-professional learning replicating the working environment • We will maximise opportunities for **mobile education** – using appropriate mobile technologies (patient simulators) and various educational tools providing training in clinical and non clinical settings e.g. mental health awareness for porters and security staff with actors • We will continue and **promote shared learning and innovation** using all available tools tailored to specific communities of practice, e.g. the principles of the e-learning nursing skills development programme for Neurosurgical Ward to be replicated in other clinical areas, in-house Coaches and Mediators to support and supervise each other

Education Priorities – where we will focus action

Strategic Priority	**We will ensure education provision is flexible to adapt to changing innovations in the workforce, developing robust governance around the scope and remit of new roles.**
Why is it important?	In 5 years time the current workforce model will not be fit for purpose due to shortages in core staffing e.g. doctors. The Trust needs to grow and develop non medical clinical staff to **future proof our workforce**. To achieve this we need to ensure education and on-going professional support is robust across this new workforce
What we will focus on:	• We will **source appropriate educational provider partners** to develop a critical mass of the emerging workforce in order that these roles have the intended benefits to patient care e.g. nursing associates • We will utilise the Apprenticeship Levy to **train more qualified professionals,** where due to national shortages there is a need for us to 'grow our own' from the Trusts' existing workforce or local community e.g. occupational therapy and speech and language therapy • In line with the Workforce Strategy, we will ensure that staff have protected time whilst in a training role • We will develop **programmes of continued professional development post qualification** from trainee roles, for our staff in new roles e.g. Physician Associates, Advance Clinical Practitioners (allied health professional and nursing) • We will support our non-medical workforce to obtain the advanced clinical practice and non medical prescribing qualifications • As the non-medical workforce increases with advanced clinical skills, we will work with services to review the educational needs of the emerging Multi Disciplinary Team models e.g. consultant pharmacists undertaking the accountable professional role verse traditional doctor remit. • We will **develop robust governance around the scope and remit of new roles** • We will promote and **celebrate excellence in emerging new roles** through internal communication channels, national awards and collaboration with national professional bodies • We will **expand our work experience offering to the local community** by providing placements to meet the needs of the new technical level qualification (alternative to A levels), and in-reach to schools to encourage uptake of apprenticeship opportunities e.g. pharmacy technicians, with long term benefits for recruitment at SGUH

Education Priorities – where we will focus action

Strategic Priority	**We will provide high quality education opportunities to ensure staff have the skills and knowledge to deliver safe and outstanding care**
Why is it important?	To deliver *'outstanding care every time'* our staff need access to high quality training and development opportunities. This will ensure staff have the skills and knowledge to deliver safe and outstanding care. We need to build a culture where learning for improvement is embraced across the organisation and built on evidence-based education, supported by robust governance systems
What we will focus on:	• We will **build a culture where learning for improvement is embraced across the organisation,** supported by the Trusts' workforce, quality and safety strategies • We will build on **evidence-based educational programmes**, capturing best practice examples and shared learning from incidents, complaints, complements and feedback from Friends and Family survey results • We will collaborate with the national patient safety team, local systems and regulators to broaden and deepen training, ensuring readiness to implement the **new Patient Safety Incident Response Framework** • We will **embed consistently safety and quality improvement training across all staff educational programmes**, to ensure every member of our staff has access to patient safety and quality improvement training (appropriate to role); from ward/department to board (this will be above current mandatory training requirements) • We will **design educational activities** that can be delivered as efficiently and effectively as possible, using technology-enhanced learning and encouraging collaboration, these will be **co-designed with staff and patients** e.g. our bespoke human factors training programme • Where possible, **patient safety training will be delivered in multidisciplinary teams** and across patient pathways to reflect the way services are delivered. This will help staff learn about safety alongside others in a collaborative manner e.g. our weekly Flow Coach programme and 'Big Room' events to share best practice and learn together • We will **develop an Education Quality Framework** to evaluate training and assure quality/impact on improved patient care

Delivering our education vision - approach to implementation

- We recognise delivering this strategy will require dedicated time and investment. The strategy sets the direction of travel. Time scales will be detailed in implementation plans.

- It is acknowledged there are a number of co-dependencies to the pace of delivery, specifically investment and wider support strategies implementation. The delivery of the education strategy will have a direct impact on the successful implementation of the workforce strategy and vice versa.

- The ambition, speed of implementation and investment in the Digital and Estates supporting strategies (both to be approved at Trust Board in March) will impact on the ability to deliver the Education Strategy i.e. improvement in the teaching environment and the digital platform for training and learning.

- Dedicated investment will be required to deliver the ambition detailed in this strategy. Income streams will be priorities to support the strategic vision i.e. Health Education England's new personal development allowance and apprenticeship levy. Income generation in areas of training provision and access to facilities will be maximised. Wider partnership working will be optimised i.e. St George's Charity currently fund a band 5 development programme, work place mental health training and staff wellbeing initiatives.

- In 2019/21 we will build on what we already have started and ensure that we maximise the opportunities e.g. expanding the number of staff accessing development through the apprenticeship levy, support newly qualified registrants through protected supervision time.

- Implementation plans will be produced for each of the five priorities areas which will set out in detail the actions needed, clear targets, Key Performance Indicators and an accountable owner.

- We will establish working groups to drive and support implementation with clear time line for delivery.

- The operational delivery will be managed through the People Management Group through to Trust Executive Committee. The governance of the plans will rest with the Workforce and Education Committee which reports into the Trust Board.

EQUALITY IMPACT ASSESSMENT FORM

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Education Strategy 2019-2024	Strategy	Sarah James Associate Director of Workforce and Kath Brook Strategy and Planning Manager	New strategy	17/01/2020

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

Richard Jennings, Chief Medical Officer
Harbhajan Brar, Chief People Officer

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

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

1.3 Are there any associated objectives?

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

The strategy will focus on five key areas for 2019/24:

1. We will be the leading NHS organisation for education and development in South West London collaborating with other employers and education providers
2. We will provide opportunities to all our staff to develop and progress in ways that support fulfilling personal, professional and career development, embracing principles of well-being, equality and diversity.
3. We will provide accessible and innovative ways of learning and teaching by keeping up to date with emerging advances in clinical practice, digital and artificial intelligence, supported by the use of new technologies

4. We will ensure education provision is flexible to adapt to changing innovations in the workforce, developing robust governance around the scope and remit of new roles.
5. We will provide high quality education opportunities to ensure our staff have the skills and knowledge to deliver safe and outstanding care

1.4 What factors contribute or detract from achieving intended outcomes?

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

- Availability of investment (either by the Trust or through other organisations such as Health Education England)
- Digital infrastructure – for enhanced learning methodologies, and overview of opportunities
- Estates – availability and quality of training facilities, and ease of booking
- Ability and capacity to support students in quality placements
- Ability and capacity for staff to be able to educate others
- Ability and capacity for staff to be released for development opportunities

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

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

- Commits to providing development opportunities for all roles within the Trust therefore provide all members of staff with the support they need for continual leaning and with the education to progress their career

- Ensure that we look to provide work experience opportunities to our local community, including the new Technical level qualification, and continue to support young people with learning disabilities become work ready through supporting Project Search

- As part of the plan the Trust will ensure that processes for applying for and approving funding for education are equitable and transparent

Without some changes, there remain negative impacts:

- Investment is needed to the Education Centre to become DDA compliant (a ground floor classroom needs to be configured as there is no access to the 1st floor classrooms other than stairs)

- Fewer development opportunities for staff in support roles where there is a higher concentration of BAME staff

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

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

The areas identified with negative impact can be addressed by:

- Investment linked to the Estates Strategy and income generation from educational activities

- The associated education implementation plan will seek to enhance opportunities for

support staff by learning from best practice, and monitoring take-up.

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

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

1.8 What are your monitoring arrangements for this policy/ service

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

Education data is submitted as part of the Workforce Race Equality annual return.

1.9 Equality Impact Rating [low, medium, high]

Low.

2.0. Please give you reasons for this rating

The proposed strategy should have a positive impact on equalities, as set out in this assessment. There will be further opportunities to ensure that this potential positive impact is delivered as the Trust moves into implementing the education strategy, and monitoring progress.

The process of drawing up more detailed education implementation plans, and then monitoring progress against them, will also afford further opportunities to identify and prevent/mitigate any unintended negative impact on equalities.

CLINICAL AND QUALITY IMPACT ASSESSMENT-EDUCATION STRATEGY

Risk Description (see guidance tab for examples)	QIA Criteria Associated to Risk: Patient Safety	Patient Experience	Clinical Effectiveness	Non-Clinical Other	Current risk Impact 1-5	Current risk Likelihood 1-5	Current risk score (1-25)		Mitigating Action (see guidance tab for examples)	Residual risk Impact 1-5	Residual risk Likelihood 1-5	Residual risk score (1-25)		Positive Impact / Benefit
Quality sustainability- Increased risk of potential reduction in service quality experienced by patients- with the increase in national mandated protected time for medical staff and the ambition of the education strategy for improved access to training for wider staff groups, there is a risk to quality of care provision due to the impact on service capacity to deliver face to face care if staff released for training	PS	PE	CE		3	3	9	M1	model of education and training developed to fit around service needs-i.e. trainning in the work place with use of mobile technologies	2	2	4	B1	positive impact on retention as staff accessing education opportunities
								M2	implementation plans to be aligned to a gradual increase in protected time and aligned with safe service provision demands				B2	improved quality of care through increased training provision to staff
								M3	medical rota reviewed and training build into it, with new e Rostering system implementation				B3	
								M4	forward planning to ensure 2-3 months notice for training opportunities to enable rostering of safe staffing levels				B4	
								M5	where back fill to release staff is required, bank staff or agency staff from approved framework providers will be used				B5	
Workforce Sustainability- Reduction in education and learning development opportunities for staff and, or staff teams i.e. in ability to release staff to attend apprentice training which requires 20% time off job, or lack of bespoke courses to train the workforce needed for the future	PS		CE		2	3	6	M1	partnership working with key providers to influence course development	2	2	4	B1	workforce for the future requirement of the Trust developed
								M2	developing bespoke in-house training courses to increase accessibility to a wider cohort e.g. ward based, e learning				B2	training needs meet the bespoke requirement of SGUH
								M3	Aligned to workforce strategy funding to double run roles to support new post development in 20/21				B3	Improved flexibility of work force through better utilisation of clinical skills across all Trust sites
								M4	annual training needs analysis is completed to inform MAST requirements and identify areas for bespoke internal training or to inform priority areas for external commissioning				B4	
Reputational Importance-Increased levels of staff turnover - higher numbers of staff leaving due to lack of training opportunities and impact on ability to recruit replacement staff	PS			NCO	3	3	9	M1	all staff to have annual Personal Development Plan with clear process to assess and prioritise education and development needs	2	2	4	B1	Improved staff retention
								M2	model of CPD across staff groups reviewed to enable the offer to be provided in the most efficient way i.e. not just class room courses				B2	Improved staff recruitment
								M3	development of the central education training hub to enable full oversight of opportunities available, promotion Trust wide				B3	Improved staff satisfaction
Financially Viability -the investment needed in the education environment and digital platform is not aligned to strategy needs, wider funding streams can't meet the deliverables detailed	PS	PE		NCO	3	3	9	M1	aligned education strategy vision with the emerging Trust digital and estates strategy,	3	2	6	B1	priority areas for funding to support strategy ambitions
								M2	1-5 year implementation plans aligned to funding flows and speed of wider enabling strategy implementation				B2	Improved flexibility of work force through better utilisation of clinical skills across all Trust sites
								M3	Priorities aligned with the workforce strategy and emerging new roles, back fill funding				B3	
								M4	maximise opportunities to access funding- income generation with course provision , partnership working with the charity , Health Innovation Network and Health Education England grant applications				B4	
								M5	strategy support prioritisation of funding allocation				B5	

Meeting Title:	Trust Board		
Date:	27 February 2020	**Agenda No**	**5.2**
Report Title:	**Digital strategy**		
Lead Director/ Manager:	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Elizabeth White, Chief Information Officer Matt Laundy, Chief Clinical Information Officer Jenny Muir, Chief Nurse Information Officer Ralph Michell, Head of Strategy		
Presented for:	Approval		

Executive Summary:

Board is asked to approve the Trust's proposed digital strategy for 2020-24.

Ensuring our staff and patients have access to the digital technology and information they need is a key part of our strategy for 2019 – 2024. Easier access to information, including through digital technology, is reshaping the way we live our lives, and the way we access and interact with services. The Trust's digital strategy sets out the organisation's ambitions for building on that opportunity over the coming years. Delivering 'digitally-enabled care' is also a national priority, as set out in the national NHS Long Term Plan.

The proposed strategy builds on a range of staff and public engagement, as described in the document.

The strategy was the subject of discussion at a Board seminar in January, intended to test a set of proposals and options with the board. The table below summarises the feedback from the Board seminar:

Feedback from Board seminar	How this has been incorporated
The board asked for a review of the proposed strategic priorities, to explore scope for reducing the number of them.	The strategic priorities have been cut down and some have been grouped together
The board agreed that the Trust should be aiming to spend 4% of turnover on ICT	This is reflected as a slide in the proposed strategy
The board gave a steer that whilst the Trust should seize on the opportunities of collaboration, it should not let a desire to collaborate slow it down in addressing the Trust's pressing ICT challenges	This is reflected as a slide in the proposed strategy
The board gave a steer that the Trust needed to have clear central controls in place on ICT, whilst providing individual services with flexibility for innovation (e.g. by setting clear standards, policies)	This is reflected as a slide in the proposed strategy

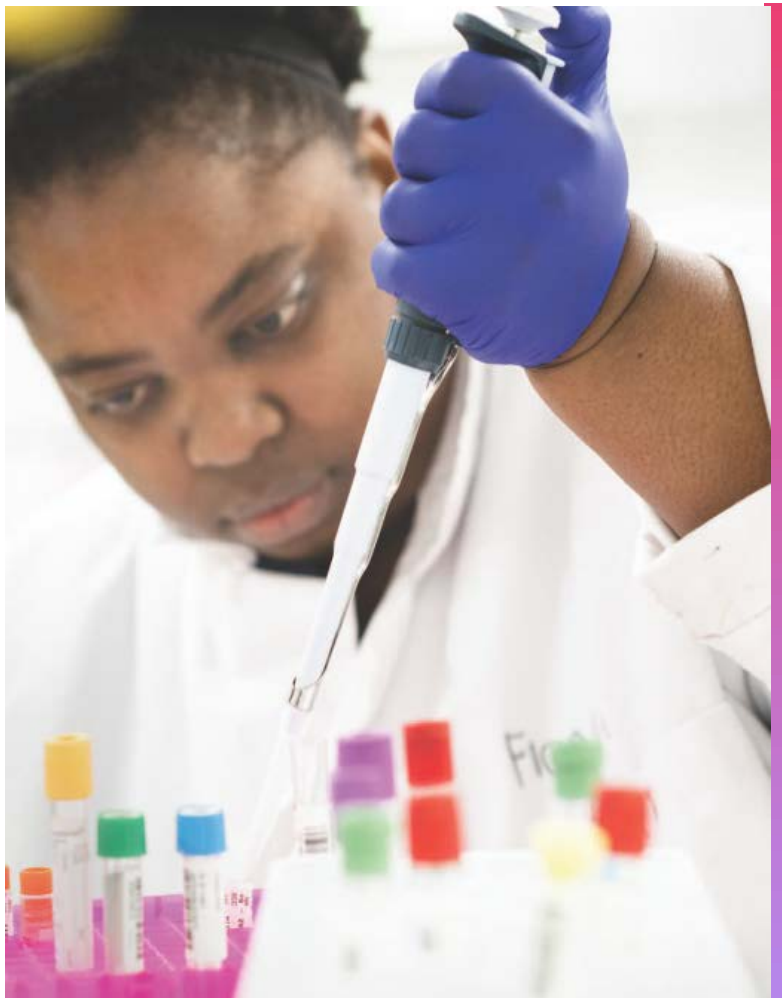
A draft of the strategy was reviewed by the Finance and Investment Committee (FIC) on 20 February 2020. FIC asked for the analysis set out in the strategy to more explicitly reflect the Trust's relatively low resilience due to its ageing infrastructure, and this has been reflected in the proposed strategy. **FIC's**

	recommendation is that the Board approve the strategy with this amendment. Both at FIC and at Council of Governors, there was discussion as to how the strategy would be implemented, and which deliverables would fall into 20/21 - 21/22 and which would need to come later. Given the uncertainty around the Trust's capital budget for 20/21, FIC agreed that a high-level 2 year implementation plan should not be included in the strategy but should be brought to FIC once budgets are agreed. Council of Governors was also keen to be kept updated on progress in implementing the strategy. Alignment between this digital strategy and the Trust's outpatient strategy (which envisages a major shift from face-to-face to virtual activity) is key. Both strategies are being put to Board for approval at the same time. The outpatient strategy reflects the importance of IT, and the digital strategy includes explicit commitments on outpatient transformation (under the section of the digital strategy on enabling new models of care). To support this alignment, an outpatient strategy implementation group will be convened to oversee progress of the strategy, which will include representation from IT and other corporate departments. An Equalities Impact Assessment and Quality Impact Assessment have been undertaken to help manage any equality- and quality-related risks. Once the strategy is approved, it will be translated into the Trust's 20/21 business plan (e.g. via corporate objectives and the capital programme currently being developed).		
Recommendation:	Board is asked to approve the proposed strategy.		
Supports			
Trust Strategic Objective:	Build a better St. George's		
CQC Theme:	**Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Strategic Change		
Implications			
Risk:			
Legal/Regulatory:	N/A		
Resources:	Resources allocated to implementation of the strategy will be agreed annually as part of the business planning process.		
Previously Considered by:	Board Seminar Informatics Governing Group Trust Executive Committee Council of Governors Finance and Investment Committee	**Date:**	29 January 2020 17 February 2020 19 February 2020 19 February 2020 20 February 2020
Appendices:	Proposed digital strategy		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Digital Strategy 2020 – 2024



February 2020

Contents

Outstanding care every time

Introduction

Ensuring our staff and patients have access to the digital technology and information they need is a key part of our strategy for 2019 – 2024.

Delivering outstanding care, every time

Our strategy for 2019-2024

Our vision is to provide outstanding care, every time for our patients, staff and the communities we serve.
We have agreed four priorities that will drive what we do and influence the decisions we will take over the next five years.

Strong foundations

To provide outstanding care, every time

- We will provide outstanding care, every time
- We will provide the right care, in the right place, at the right time
- We will invest in our staff
- We will manage our funding and spending, and invest in our future
- We will improve our buildings and hospital estate
- We will make sure our staff and patients have access to the digital technology and information they need, when and where they need it

Excellent local services

To provide excellent local hospital services for the people of Wandsworth and Merton

- We will provide planned care that fits around our patients' lives using the latest technology
- We will provide more same day emergency care

Closer collaboration

To work with others to provide health services for people across south west London

- We will work with our partners to provide care closer to patients' homes
- We will work with neighbouring hospitals to make sure patients get the care they need
- We will work with others to meet the changing needs of our ageing population

Leading specialist healthcare

To provide specialist healthcare for the people of south west London, Surrey, Sussex and beyond

- We will continue to be the main provider of specialist services for our region, including as the major trauma centre
- We will be a major centre for cancer, children's and neuroscience services
- We will take part in commercial opportunities that enable us to invest more in NHS care
- We will develop tomorrow's treatments, today, through innovation, research and training

Easier access to information, including through digital technology, is reshaping the way we live our lives, and the way we access and interact with services.

This strategy sets out our ambitions for building on that opportunity over the coming years.

Outstanding care every time

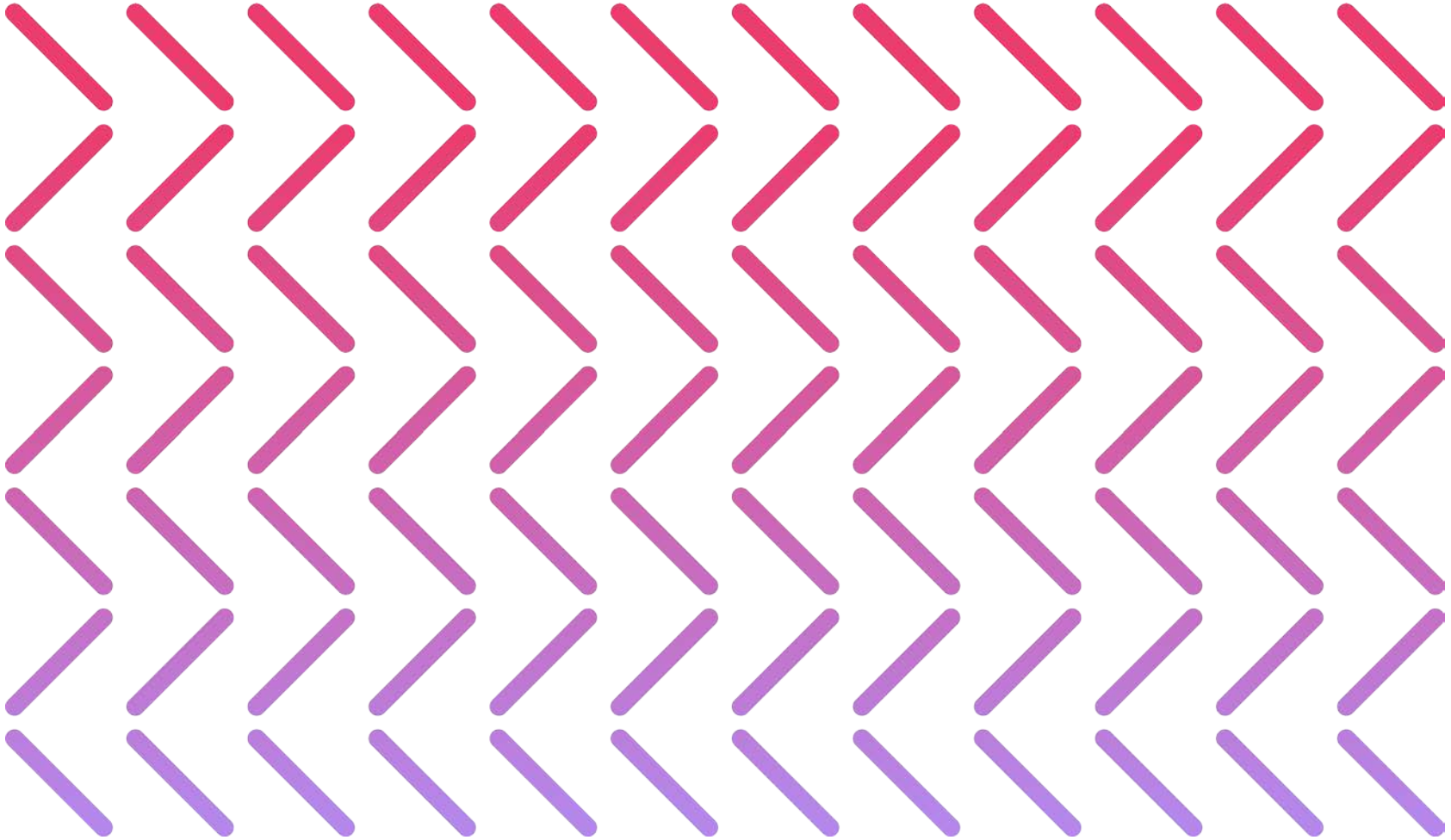
Engaging with our staff and patients

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.

Where we have come from, and where we are now



Outstanding care every time

Our staff and patients want us to improve our ICT

A range of public/staff engagement events were held to develop the Trust's clinical strategy, where feedback on ICT was a common theme. Public and staff engagement events have also been held specifically to help develop the digital strategy. Key priorities for our stakeholders 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)

The NHS Long Term Plan envisages ‘digitally-enabled care’

The NHS Long-Term Plan outlines the following key priorities on ‘digitally-enabled care’:

Priority	Detail	SGUH digital strategy therefore needs to…
Empowering people	For instance: the NHS App will create a standard online way for people to access the NHS; women will be able to access their maternity record digitally, support will be given to the development of a range of apps to support particular conditions, patients with long-term conditions will have access to their health record via the NHS app, patients will be able to incorporate information into their own personal health records	• Support patient empowerment: e.g. enabling patients to access / in some cases change their personal health records, or to manage their conditions through apps
Supporting health and care professionals	we will ensure that health and care professionals have the tools they need to efficiently deliver safe and effective patient care – e.g. supporting staff to capture health & care information digitally at the point of care.	• Continue the shift from paper to electronic systems
Supporting clinical care	for instance, the NHS app and its browser-based equivalent will enable people to follow a simple triage online to help them manage their own health needs or direct them to the appropriate service; patients will have more access to ‘virtual’ GP and outpatient appointments, helping to reduce face-to-face outpatient activity by 30%; and all providers will be expected to advance to a “core level of digitisation” by 2024, covering clinical operational processes across all settings, locations and departments, with robust modern IT infrastructure services for hosting, storage, networks and cyber security).	• Support the delivery of new models of care – particularly ‘virtual’ outpatient appointments • Support the modernisation of IT infrastructure
Improving population health	for instance, deploying population health management solutions to help Integrated Care Systems understand the areas of greatest health need	• Support steps taken by the SWL system towards use of population health management solutions
Improving clinical efficiency and safety	for instance: pathology networks, exploiting the potential of artificial intelligence, leading to quicker test turnaround times and improved access to more complex tests; diagnostic imaging networks enabling the rapid transfer of clinical images from care settings to the relevant specialist to interpret; protecting the NHS from cybercrime	• Ensure the Trust is well placed to benefit from the quality & efficiency opportunities resulting from new technologies such as AI • Ensure the Trust meets national cyber security standards

We have ambitious plans for the NHS in South West London

The draft SWL plan submitted to NHSE/I sets out a range of commitments on the use of technology, data and information:

Priority	Examples of actions in SWL plan
1. Creating straightforward **digital access to services**; helping patients/carers managing their health	• Piloting SWL personal health record, allowing people in SWL to access their own care record – to be rolled out by 2021 • Create a personal health and care application so that people can manage their hospital appointments by 2021
2. Ensuring **clinicians can access and interact with patient records**/ care plans wherever they are	• Use digital technology to transform outpatients, reducing face-to-face visits by a third over 5 years • Identify where digital process changes (e.g. machine learning) can improve pathways
3. Making **data interoperable and accessible**	• Deliver and make available whole systems intelligence so that the needs of our entire population can be predicted and met • Expand the SWL population health management proof of concept to primary care and our four acute trusts
4. Improving system-wide **infrastructure**, processes and roll-out of nationally required digital capabilities	• Secure investment to improve infrastructure • Plan/procure infrastructure as a system rather than individual organisations • Create a robust, common technical and application infrastructure, including core hospital electronic patient record systems, across SWL

The Trust's 5-year strategy relies on digital improvements

7 key implications for the digital strategy from the Trust's 5 year strategy:

Section of SGUH strategy	Digital strategy needs to…….
Strong foundations (outstanding quality; improved performance; right workforce model, skills & culture; financial improvement; estates improvement)	1. Support efforts to improve efficiency 2. Support our ambitions on quality / safety (e.g. via interoperable clinical systems) 3. Support estates improvement & make the Trust a more attractive place to work (e.g. by enabling flexible / home working)
Excellent local services (planned care that fits around patients' lives, using latest technology; more same day emergency care)	4. Enable the Trust to deliver new models of care, built around patients' lives (e.g. virtual consultations)
Closer collaboration (work with partners to deliver care closer to home; work with DGHs to rebalance specialist/DGH work across SWL; work with partners to meet needs of ageing population)	5. Enable closer collaboration with the wider health system (e.g. through appropriate sharing of patient information, work via the Acute Provider Collaborative joint IM&T projects)
Leading specialist healthcare (main provider of specialist services for our region, including as MTC; major centre for cancer, paediatrics and neurosciences; pursue commercial opportunities; innovation, research & training)	6. Support the appropriate sharing of information across our specialist networks (e.g. with Surrey and Sussex for tertiary services; with the RMP Cancer Alliance for cancer) 7. Support the Trust's research output (e.g. by enabling researchers to access appropriate patient data)

The Trust’s plans in a range of other areas also rely on digital improvement

The Trust is currently developing a range of corporate strategies which also need to be reflected in our digital strategy:

Strategy	Key implications for digital strategy
Research	• Commits to rebuilding the datawarehouse in a way that makes it a resource for researchers
Workforce	• Commits to building an environment more conducive to flexible working
Quality	• Commits to better use of data and electronic systems to improve quality of care
Education	• Commits to providing education in innovative ways, including through better use of technology
Outpatients	• Involves a ‘menu’ of changes to outpatient services (e.g. self-care, improved referrals, enhanced virtual triage, phone clinics) designed to deliver vs the national ambition to reduce face-to-face attendances by 33%. Each item of this menu could require different levels of ICT support.

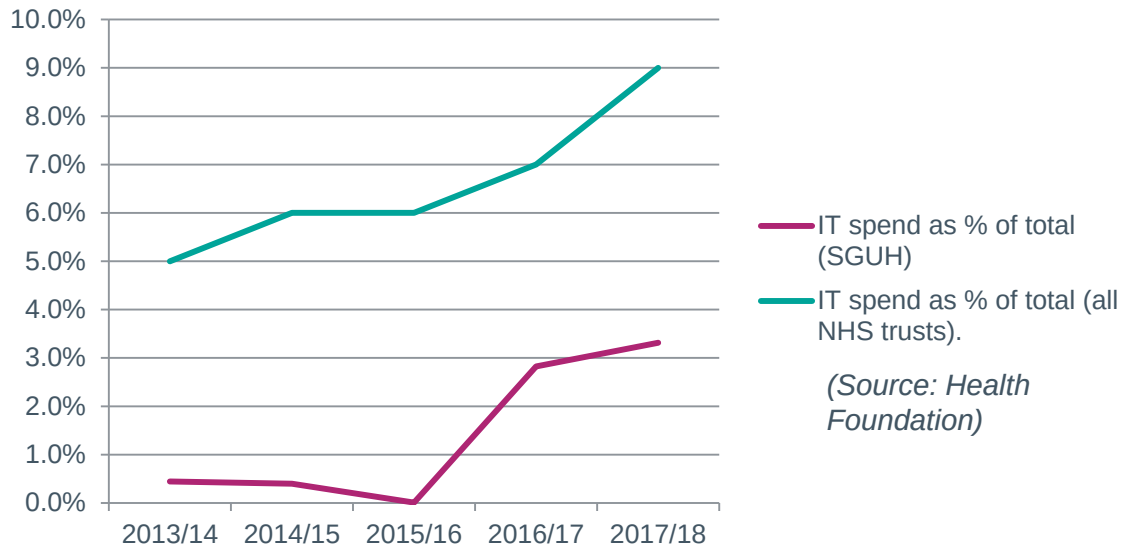
But historically, we have invested less in ICT than our peers

Information technology is playing an increasingly important role in healthcare worldwide.

In the UK, NHS trusts are reflecting this in their spending despite a challenging financial environment. In the last decade, UK capital spending in healthcare has been below the OECD average, falling as a percentage of GDP, and NHS trusts have seen significant fluctuation in capital budgets. Despite those relatively low levels of funding and significant fluctuation, capital spending on IT and intangible assets (mostly software licenses) has steadily grown.

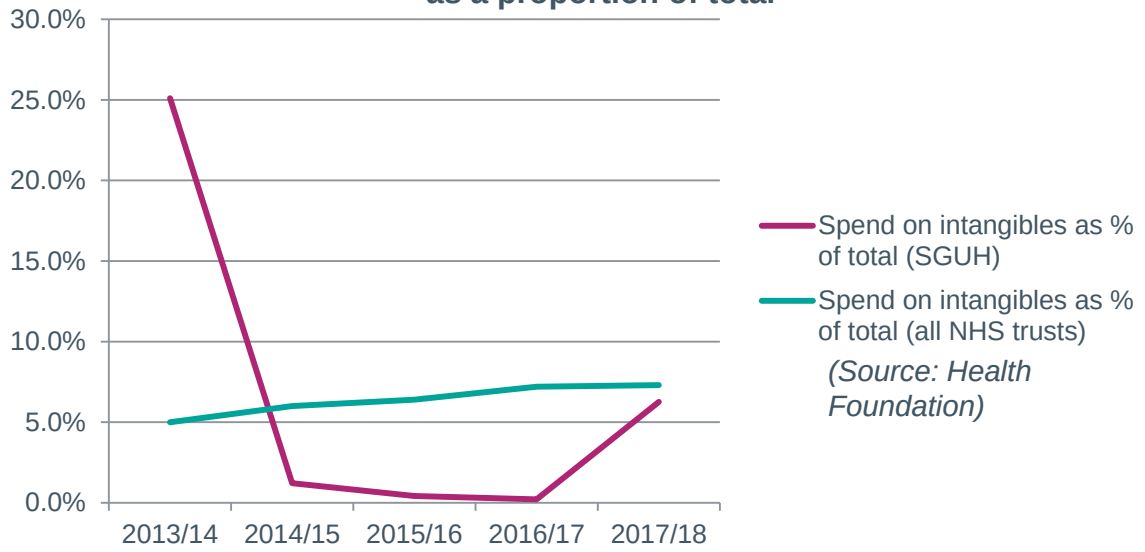
At St George's, in recent years spending on IT has been below average, and spend on intangible assets has been 'feast or famine', as the graphs below illustrate. In 18/19 the Trust reversed some of these trends and c. 17% of capital additions were on IT and 6% on intangibles.

Capital additions on IT as a proportion of total



(Source: Health Foundation)

Capital additions on intangibles as a proportion of total



(Source: Health Foundation)

Outstanding care every time

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.

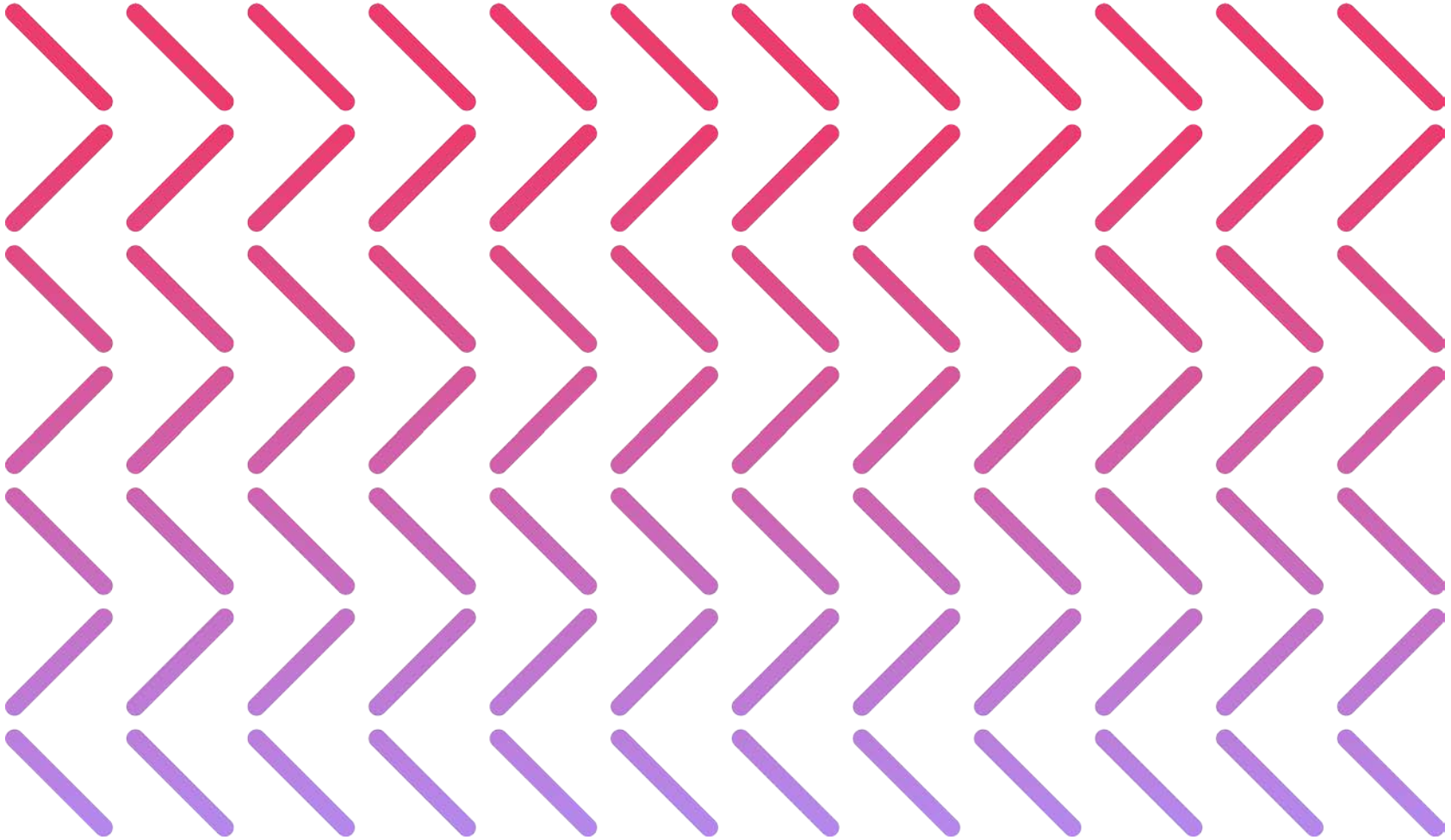
Weaknesses

- **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
- **Resilience**: related to ageing infrastructure and switchboard system.

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

Where we go next



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

We will make our infrastructure more robust

When we surveyed staff on their key priorities as part of developing this strategy, the top priority was seen as upgrading our IT infrastructure (e.g. network, VDI capacity, WiFi, Computers). Cyber crime is a national priority, and all NHS organisations will be required to undertake a range of measures to protect themselves against this growing threat.

Building a robust IT infrastructure is therefore one of our key strategic priorities, and one that will enable our other ambitions to deliver new models of care for our patients, and support new ways of working for our staff.

Objectives	Key deliverables
We will upgrade our IT infrastructure and telephony systems	• virtual desktop infrastructure (VDI) upgrade, • Replacing network to be fit for the future • data centre upgrade, • conversion of most telephony to voice over internet • new staff intranet. • Improved use of digital platforms in education/training
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	• New electronic systems in specialties such as maternity and theatres • Update/replacement of key non-clinical systems (e.g. Windows 10, Office 365).
We will strengthen our systems and processes for cyber-security	• Implementation of secure email • Implementation of ‘demilitarised zone’

Outstanding care every time

We will enable new models of care for our patients

Strong information management is an essential foundation to the Trust's desire to improve the care we offer our patients. Access to linked and searchable clinical, radiological and pathological datasets is also a key enabler to the Trust's desire to develop new treatments via research, as set out in the Trust's 2019-24 research strategy.

Better use of information technology will also underpin our ability to interact with our patients differently, particularly for outpatient consultations. This is a key priority nationally, for our local commissioners and for the Trust itself, and has been a consistent part of the feedback from our staff and public engagement.

Objectives	Key deliverables
Our approach to business intelligence will be proactive, outward-looking, and focused on enabling future improvement of our services	• Re-build of data warehouse, including to enable better use of data by researchers across the Trust • Build capability/capacity for more proactive approach to information management
We will use information technology to interact with our patients differently (phone, online, video), sparing them trips to hospital wherever possible	• Specialty-level development of iClip to enable more virtual outpatient clinics / fewer face-to-face attendances, starting with some prioritised specialties in 20/21 • Development of 'patient portal', enabling patients to access and amend their health records

We will enable new ways of working for our staff

ICT has a major impact on the working lives of our staff – causing frustration at its worst, and improving staff experience and productivity at its best.

Improving our infrastructure will have a significant impact here, with staff able to use faster, more responsive and more integrated ICT. But above and beyond that, we also want to make it easier for our clinicians to work across sites and organisational boundaries, and to make use of the latest technology.

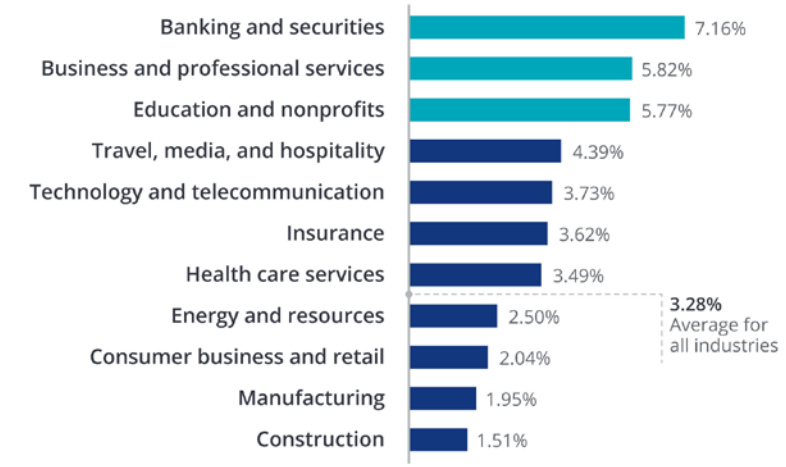
Objectives	Key deliverables
We will enable our clinicians to access the information they need from other NHS providers at the point of contact with a patient	• Optimise use of Health Information Exchange • Interoperable clinical systems with key partners across South West London / specialist networks
We will enable our staff to do more work remotely	• Embed tools that enable virtual/cross-site/home working (e.g. document sharing, videoconferencing), to support the Trust's workforce strategy
We will use the latest technology and systems to help staff work efficiently and effectively – including making use of big data and AI	• iClip optimisation to support Trust quality priorities (e.g. deteriorating patients) • Support assessment and introduction of diagnostic AI where appropriate • Develop & deliver effective training via multiple platforms
We will complete the shift from paper-based to efficient and effective electronic clinical systems	• Roll-out of iClip across outpatient services • Optimising inpatient systems to reduce use of paper

To deliver this strategy, we will aspire to invest 4% of turnover in ICT each year

Historically, St George's has tended to invest between 2% and 3% of its turnover on ICT. This has often been below average for NHS trusts, and below average for the health care industry. It has also followed a pattern of 'feast or famine', with high spending one year followed by low spend the next, making it hard to plan. We now face the challenge of gaining lost ground as a result of historic underinvestment, as well as investing to deliver our ambitions for the future.

The amount we spend on ICT is not entirely within our control, as capital spending is partly dependent on national decision-making. That said, over 2020-24 our planning assumption is that we need to invest 4% of turnover on ICT, and we will work with our system partners to seek to deliver that.

Figure 1. IT budget as a percentage of revenue



Source: Deloitte 2016–2017 Global CIO Survey, N=747.

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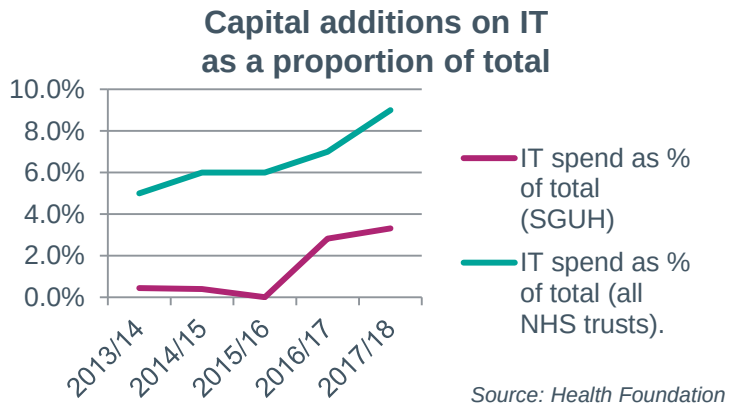
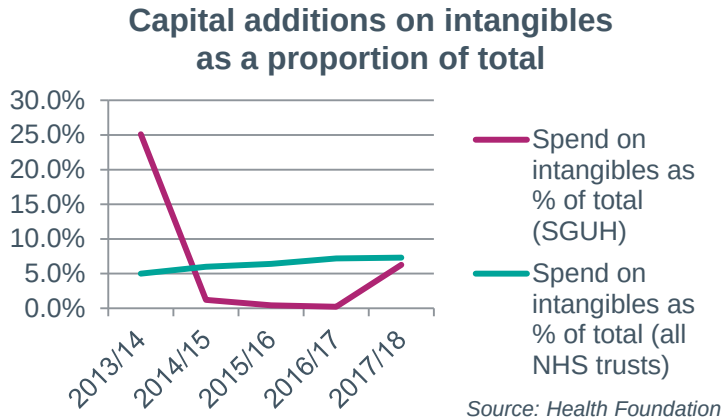


Source: Health Foundation



Source: Health Foundation

Outstanding care every time

We will pursue a collaborative approach where it delivers demonstrable value

St George's faces a range of significant ICT-related challenges and risks, many of them particular to us as a Trust, and requiring us to seek solutions at maximum possible speed. In these instances we are likely to need to pursue individual solutions, rather than seeking to collaborate with other NHS organisations whose priorities and need to act at pace may be different.

However, elsewhere we will seek to deliver elements of this strategy in collaboration with our partners, particularly via the South West London Acute Provider Collaborative (APC). Our collaborative effort will particularly focus on our strategic objective to enable our clinicians to access the information they need from other NHS providers at the point of contact with a patient.

For instance:

- We will continue collaborating with other Trusts on the Health Information Exchange, enabling clinicians in one provider to access relevant patient data from another
- As we continue the shift from paper-based to electronic, and upgrade our existing systems, we will work with other providers to maximise interoperability between our clinical systems
- We will jointly procure new technology/systems where appropriate (e.g. building the Acute Provider Collaborative's joint procurement of a picture archiving and communication system or PACS in radiology)

We will ensure appropriate central oversight of ICT

The Trust's 9,000 staff use hundreds of clinical and non-clinical systems, and hundreds of PCs and other devices.

We want our staff to be able to adopt new systems and equipment, but we also need to ensure that any new systems are interoperable, and that any new systems or equipment can be appropriately maintained, developed and protected in terms of cyber security.

We will therefore adopt clear corporate standards, policies, supportive pathways for innovation and governance structures that give individual services the flexibility to be innovative and adopt new technology, whilst ensuring interoperability and capacity for maintenance across the Trust.

Management of any such new assets will therefore sit with corporate ICT, and there will be a centrally-driven programme of gradually ensuring all existing systems are interoperable (which may include some services being required to move to a new system).

We will drive forward implementation of this strategy through the annual planning process

Work is already underway to deliver some of the objectives set out in this strategy.

Each year, an implementation plan will be produced to set out actions to deliver on the ambitions set out in this strategy, and reflected in the Trust's annual business plan – for instance via corporate objectives, and the annual capital plan.

The Information Governance Group, Trust Executive Committee, and Finance and Investment Committee will track progress against the strategy on a quarterly basis. Finance and Investment Committee will regularly provide assurance to Trust Board that appropriate progress is being made.

Whilst the action set out here will reduce a range of risks that the Trust currently faces (e.g. in relation to running multiple clinical systems that are not interoperable), the scale and complexity of those risks mean that they will not be eliminated overnight. The Trust will need to continue managing IT-related risks via its established risk management processes and governance.

Delivering our ambitions will also require different ways of working and culture change within the organisation, and we will build provision for that into our approach to project implementation.

After two years, given the rapidly changing external environment, we will review this strategy and consider whether it requires a refresh.

Meeting Title:	Trust Board		
Date:	27 February 2020	**Agenda No**	**5.3**
Report Title:	**Draft Outpatient Strategy**		
Lead Director/ Manager:	Avey Bhatia, Chief Operating Officer Emilie Perry, Divisional Director of Children, Women, Diagnostics and Therapies		
Report Author:	Ralph Michell, Head of Strategy		
Presented for:	Approval		
Executive Summary:	**Outpatient transformation is a priority** in the Trust's five-year strategy. It is one of the South West London Health and Care Partnership's 6 clinical priority areas. It is also a national priority, with the NHS Long Term Plan committing to a 33% reduction in face-to-face outpatient activity over five years. **In July 2019, the Board agreed a vision for the future of outpatient services**. It was agreed that a strategy for delivering that vision would be brought to Board at the same time as the Trust's digital strategy. Both are now being brought to Board for sign-off. **The strategy for outpatient transformation was discussed at a Board seminar in January, and at TEC and Council of Governors in February – with much of the discussion focused on level of pace and ambition. The draft strategy is based on this discussion** (summarised in the body of the paper). **Work has been undertaken to ensure the outpatient strategy and digital strategy are aligned**. Board is being asked to sign off both strategies at the same time. The outpatient strategy reflects the importance of IT, and the digital strategy includes explicit commitments on outpatient transformation (under the section of the digital strategy on enabling new models of care). To support this alignment, an outpatient strategy implementation group will be convened to oversee progress of the strategy, which will include representation from IT and other corporate departments. A key priority will be ensuring that the roll-out of iClip across the Trust's outpatient services, and efforts to grow virtual activity/reduce face-to-face appointments, are closely coordinated. **At this stage, Board is being asked to sign off a 4-year strategy. More detailed implementation plans will follow** as part of the annual business planning cycle, building on continuing discussion with commissioners. The emergent plan for 20/21 is outlined in the body of this paper. This however will be confirmed as part of 20/21 business planning, rather than being set out in the 4-year strategy. **Delivery of the strategy will be dependent on the availability of funds for double running.** The draft strategy currently commits in principle to making available a 'transformation fund' for specialties to bid into, to cover such transitional costs. A robust process would be put in place to vet bids and ensure value for money. The Board is not at this stage being asked to agree the size of this fund. The proposition being discussed as part of business planning for 20/21 is for the Trust to set aside £500k, and invite local commissioners to make a similar contribution as part of a 'whole system fund' – but this will be confirmed as part of ongoing discussion with local commissioners and the Trust's internal process of prioritising service developments for 20/21. **At this stage Board is being asked to confirm in principle that it is content to set aside funds to cover double**		

	running costs, and to state this in the strategy. **The draft strategy also commits in principle to providing specialties changing their outpatient model with dedicated change management resource, and ring-fenced support from a range of corporate functions** (such as ICT and the corporate outpatient department). The Trust is in discussion with the CCG about establishing a joint transformation team, and corporate departments have agreed an expected level of input per specialty supported. On the basis of the trajectory described in the strategy (with the pace of change accelerating over time, and 5-10 specialties supported per year), it is anticipated that this programme management and input from corporate teams can be provided in 20/21 via prioritisation, rather than incurring a new cost pressure. **Next steps will include development of a more detailed implementation plan** via discussions with commissioners and via the Trust's internal process of business planning for 20/21.		
Recommendation:	Board is asked to: a) Note the interdependence between implementation of this strategy in 20/21 and the Board's ongoing discussions on service developments for 20/21, and agree that the strategy should commit in principle to establishing a 'transformation fund' for specialties to bid into. b) Note the risks and next steps set out in this paper, including the development of a more detailed implementation plan as part of 20/21 business planning. c) Approve the draft outpatient strategy.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person; Right care, right place, right time; Balance the books, invest in our future.		
CQC Theme:	**Responsive**: services are organised so that they meet your needs. **Well Led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	As detailed in the body of the paper		
Legal/Regulatory:	N/A		
Resources:	As detailed in the body of the paper		
Previously Considered by:	Board Seminar Trust Executive Committee Council of Governors	**Date:**	29 January 2020 19 February 2020 19 February 2020
Appendices:	Draft Outpatient Strategy		

OUTPATIENT STRATEGY

February 2020

1.0 Introduction

1.1 In July 2019, the Board agreed a vision for the future of outpatient services.

1.2 It was agreed that a strategy for delivering that vision would be brought to Board at the same time as the Trust's digital strategy. Both are now scheduled for Board sign-off on 27 February 2020.

1.3 This paper summarises the process for developing the outpatient strategy, and delivery implications (including resource requirements, risks and next steps). The draft outpatient strategy is attached as an annex.

2.0 Process and Timescales

2.1 The strategy has been based on extensive feedback from staff and patients:

- To help develop the Trust's five-year strategy, over 30 care groups undertook a 'strengths, weaknesses, opportunities and threats' (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.

2.2 The specialty-based approach set out in the draft strategy has also been developed in collaboration with local commissioners via discussions at the Planned Care Operational Group and Planned Care Delivery Board.

2.3 A board seminar was held in January 2020, where a range of options were discussed with the Board. The attached draft strategy is based on the steer from the Board on a number of issues, including those summarised in the following table:

Feedback from Board seminar	Resulting action
Board asked for the strategy to be more explicit about cross-system working, including allowing for the possibility that this agenda could in future be driven more strongly at SWL level	This is reflected in the final draft strategy (slide titled "we will work closely with system partners to deliver change").
The Board agreed that the Trust should not seek to take cost out via this agenda in 20/21	This steer is reflected in the draft strategy (slide titled "we will prioritise delivering improvements in quality and waiting times, with cost savings following later")
The Board asked to see more detail on implementation	This detail is not set out in the five-year strategy, but will be as part of the annual plan for 20/21.

3.0 Ambition, pace and scale

3.1 A key area of debate at both the Board seminar, Council of Governors and at Trust Executive Committee was on the pace at which the Trust is able to move on this agenda.

3.2 The Trust sees the transformation of outpatient services as a strategic priority, as do the Trust's commissioners and the wider South West London Health and Care Partnership. This is also a national priority, with NHS England committed to a 33% reduction in face to face activity over the coming years. There is therefore a strong appetite amongst executives, non-executives, Trust staff and the Trust's stakeholders to deliver a significant acceleration in progress from the start of the next financial year.

3.3 In considering the trajectory of change over the coming years, however, the Trust has to take into account:

a) The culture change needed to deliver on this agenda, which is likely to accelerate over time as more specialties prove concepts / successfully implement new models of care
b) The roll-out of iClip to outpatient services across the Trust, planned for 20/21 – a major programme of change for the year ahead but also a significant enabler of acceleration thereafter
c) The restructure of the corporate outpatient department, currently paused but due to be completed by the end of 20/21 – again, a major and potentially disruptive organisational change in the coming year but one that should enable acceleration in future years
d) The Trust's constrained financial position. Implementing new models of care in outpatient services will incur double running costs, and require dedicated project management support. The pace and scale at which the Trust is able to move each year is therefore partly dependent on the level of resource it can allocate to this agenda – but the Trust's financial room for manoeuvre on service developments is limited.
e) Competing priorities which will require consume significant leadership time in 20/21 (such as achieving financial balance, and delivering improvements in quality of care).

3.4 For these reasons, the draft strategy describes the Trust's expectation that the pace of change will accelerate over time, with 20/21 seeing a degree of change that is significant but smaller than what follows in future years.

4.0 Alignment with the Trust's digital strategy

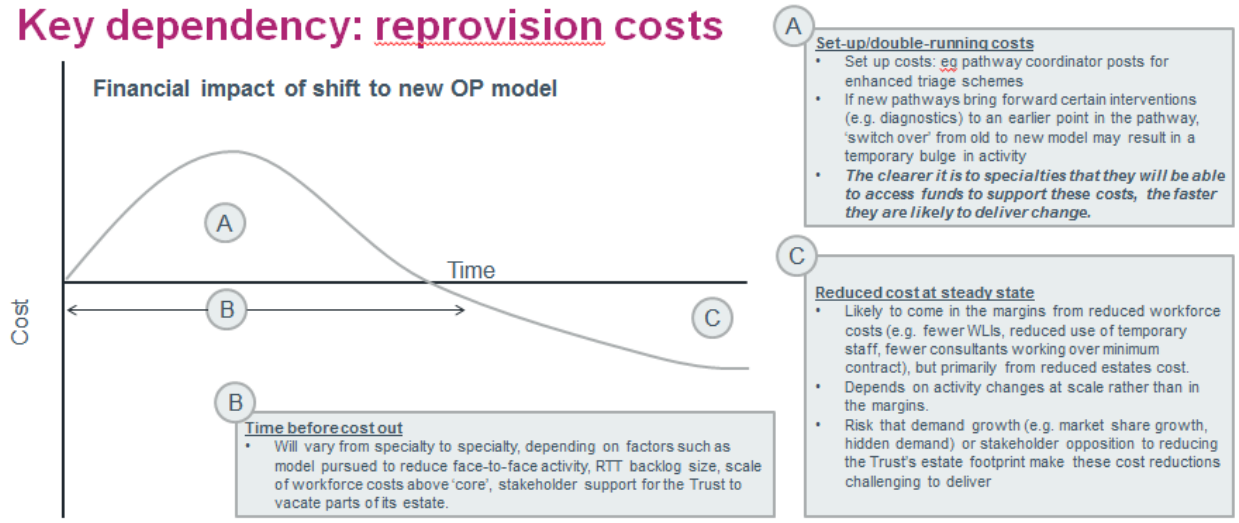
4.1 Work has been undertaken to ensure the outpatient strategy and digital strategy are aligned.

4.2 Board is being asked to sign off both strategies at the same time. The outpatient strategy reflects the importance of IT, and the digital strategy includes explicit commitments on outpatient transformation (under the section of the digital strategy on enabling new models of care).

4.3 To support this alignment, an outpatient strategy implementation group will be convened to oversee progress of the strategy, which will include representation from IT and other corporate departments. A key priority will be ensuring that the roll-out of iClip across the Trust's outpatient services, and efforts to grow virtual activity/reduce face-to-face appointments, are closely coordinated.

5.0 Resource implications

5.1 As the Board noted at its January seminar, the transformation of outpatient services should ultimately lead to a more efficient model of care, but there will be a period in which the Trust incurs transitional costs.



5.2 The draft strategy currently commits in principle to making available a 'transformation fund' for specialties to bid into, to cover such transitional costs. A robust process would be put in place to vet bids and ensure value for money.

5.3 The Board is not at this stage being asked to agree the size of this fund. The proposition being discussed as part of business planning for 20/21 is for the Trust to set aside £500k, and invite local commissioners to make a similar contribution as part of a 'whole system fund' – but this will be confirmed as part of ongoing discussion with local commissioners and the Trust's internal process of prioritising service developments for 20/21. At this stage Board is being asked to confirm in principle that it is content to set aside funds to cover double running costs, and to state this in the strategy.

5.4 The draft strategy also commits in principle to providing specialties changing their outpatient model with dedicated change management resource, and ring-fenced support from a range of corporate functions (such as ICT and the corporate outpatient department). The Trust is in discussion with the CCG about establishing a joint programme team, and corporate departments have agreed an expected level of input per specialty supported. On the basis of the trajectory described in the strategy (with the pace of change accelerating over time, and 5-10 specialties supported per year), it is anticipated that this programme management and input from corporate teams can be provided in 20/21 via prioritisation, rather than incurring a new cost pressure.

6.0 Next steps: implementation plan for 20/21

6.1 Once the strategy is agreed, it will be translated into an implementation plan for 20/21.

6.2 The emerging proposition (dependent on resource, and subject to confirmation via the business planning round and further discussion with commissioners) is to prioritise support for 7 specialties to transform their outpatient model in 20/21, as set out below. This prioritisation was based on an assessment of the scale of opportunity in each case, and readiness of specialties to realise those opportunities, as put to the Trust Board seminar in January 2020:

- urology,
- trauma and orthopaedics
- gastroenterology
- cardiology
- dermatology
- gynaecology,
- muscular-skeletal conditions

6.3 It is expected that this would enable the Trust to deliver a 1-2% reduction in face to face activity by March 2021 (equating to 5% full year effect) via a 33% increase in virtual activity (rising from c. 5% to 8% of total activity).

6.4 This activity would be closely coordinated with the specialty-by-specialty roll-out of iClip across outpatient services, and the completion of the restructure of the corporate outpatient department.

6.5 Once the strategy is approved, the Trust will conclude discussions with local commissioners on resource and pace/scale in 20/21, conclude internal prioritisation of service developments, and then reflect the outcome of these discussions in the annual plan for 20/21.

7.0 Risks

7.1 The approach set out above results in one key risk for the Trust/system as a whole in 20/21:

Risk	Detail	Impact	Likelihood	Risk score	Mitigation
Cost pressure	Risk that setting aside funds on the 20/21 service development list for a 'transformation fund' means the Trust's financial position vs target deteriorates	3	5	15	Seek SWL / national transformation funds to 'backfill' the funds set aside; make the bar for bids into the fund high in terms of proposal costs and ROI; seek further efficiencies elsewhere to balance cost pressure.

7.2 There are also a number of risks which the Outpatient Transformation Programme will have to manage in order to deliver the strategy successfully:

Risk	Detail	Impact	Likeli-hood	RAG	Mitigation
CCG contribution to 'transformation fund'	Risk that the CCG is not able to make a contribution to the proposed 'transformation fund', meaning less resource available to cover double running costs.	4	4		Reduce number of specialties supported with transformation funding; reduce level of funding each specialty receives; divert programme capacity to supporting other specialties with low-cost changes to balance impact.
Central programme team resource	Risk that the level of programme team resource envisaged cannot be provided from within existing resources	4	4		Revise programme team structure; seek greater input from specialties as opposed to central support
Reducing estates cost	Risk that cost reduction opportunity cannot be delivered because of stakeholder opposition (e.g. CCG, public) to the Trust reducing its estate footprint	4	3		Engage with system partners on estates strategy for SWL. Do not seek cost reduction via this programme for 20/21 as those discussions continue.
Increased demand	Risk that as capacity is freed up, demand for services may increase (either through market share shifts or uncovering latent demand), making it difficult to achieve further RTT improvement or take cost out	4	3		Explore collaborative SWL approach for some specialties, to reduce risk of different parts of system moving at different pace & seeing market share shifts.
Capacity & capability	Risk that competing pressures mean teams across the Trust (within specialty, across corporate teams) are unable to devote time envisaged for this agenda, slowing pace of change.	4	3		Ring fence time for this agenda at specialty level
IT	Risk that major IT projects (roll-out of iClip to outpatient services, introduction of patient portal, VDI upgrade) are delayed, delaying the acceleration envisaged for 21/22 onwards.	4	3		Prioritise service changes that are not reliant on major IT projects in first instance (e.g. enhanced triage, open access, phone clinics).
Corporate OP restructure	Risk that corporate outpatient restructure is delayed / diverts staff time from service transformation, delaying acceleration envisaged for 21/22 onwards	4	3		Ring fence time for this agenda within corporate outpatient department.
Opportunity in 20/21 lower than expected	Trajectory for 20/21 based on high-level assumptions for the priority specialties identified – risk that as these are scrutinised in more detail the opportunity is smaller than assumed.	3	3		Seek to bring forward delivery of other opportunities (e.g. virtual clinics / open access in specialties outside proposed priority list).
National guidance changes	Risk that national guidance specifies 33% reduction using different parameters to those used here (e.g. 33% reduction from 18/19 baseline + growth)	1	4		Revise trajectory annually, taking account of learning to date + any changes in national direction

8.0 Recommendations

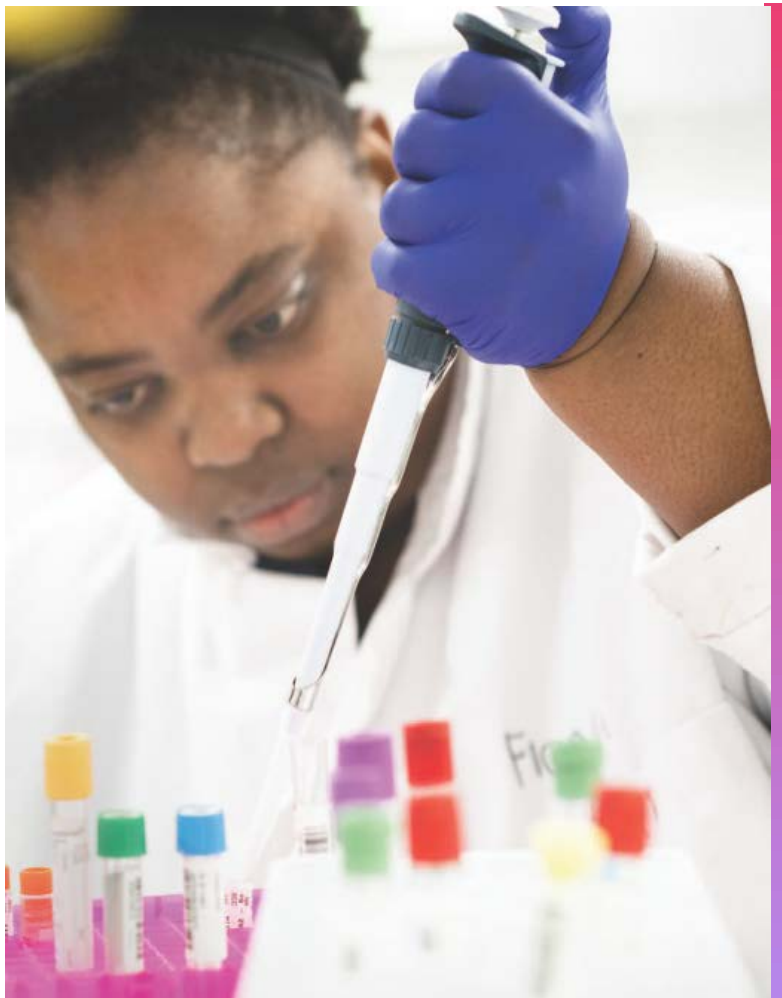
8.1 Board is asked to:

a) Note the interdependence between implementation of this strategy in 20/21 and the Board's ongoing discussions on service developments for 20/21, and agree that the strategy should commit in principle to establishing a 'transformation fund' for specialties to bid into
b) Note the risks and next steps set out in this paper, including the development of a more detailed implementation plan as part of 20/21 business planning
c) Approve the draft outpatient strategy

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Outpatient strategy



Avey Bhatia, COO
Emilie Perry, DDO CWDT
Ralph Michell, Head of Strategy
February 2020

Contents

Outstanding care every time

Introduction

Transforming our outpatient offering is a key part of our strategy for 2019 – 2024.

Delivering outstanding care, every time

Our strategy for 2019-2024

Our vision is to provide outstanding care, every time for our patients, staff and the communities we serve.
We have agreed four priorities that will drive what we do and influence the decisions we will take over the next five years.

Strong foundations

To provide outstanding care, every time

- We will provide outstanding care, every time
- We will provide the right care, in the right place, at the right time
- We will invest in our staff
- We will manage our funding and spending, and invest in our future
- We will improve our buildings and hospital estate
- We will make sure our staff and patients have access to the digital technology and information they need, when and where they need it

Excellent local services

To provide excellent local hospital services for the people of Wandsworth and Merton

- We will provide planned care that fits around our patients' lives using the latest technology
- We will provide more same day emergency care

Closer collaboration

To work with others to provide health services for people across south west London

- We will work with our partners to provide care closer to patients' homes
- We will work with neighbouring hospitals to make sure patients get the care they need
- We will work with others to meet the changing needs of our ageing population

Leading specialist healthcare

To provide specialist healthcare for the people of south west London, Surrey, Sussex and beyond

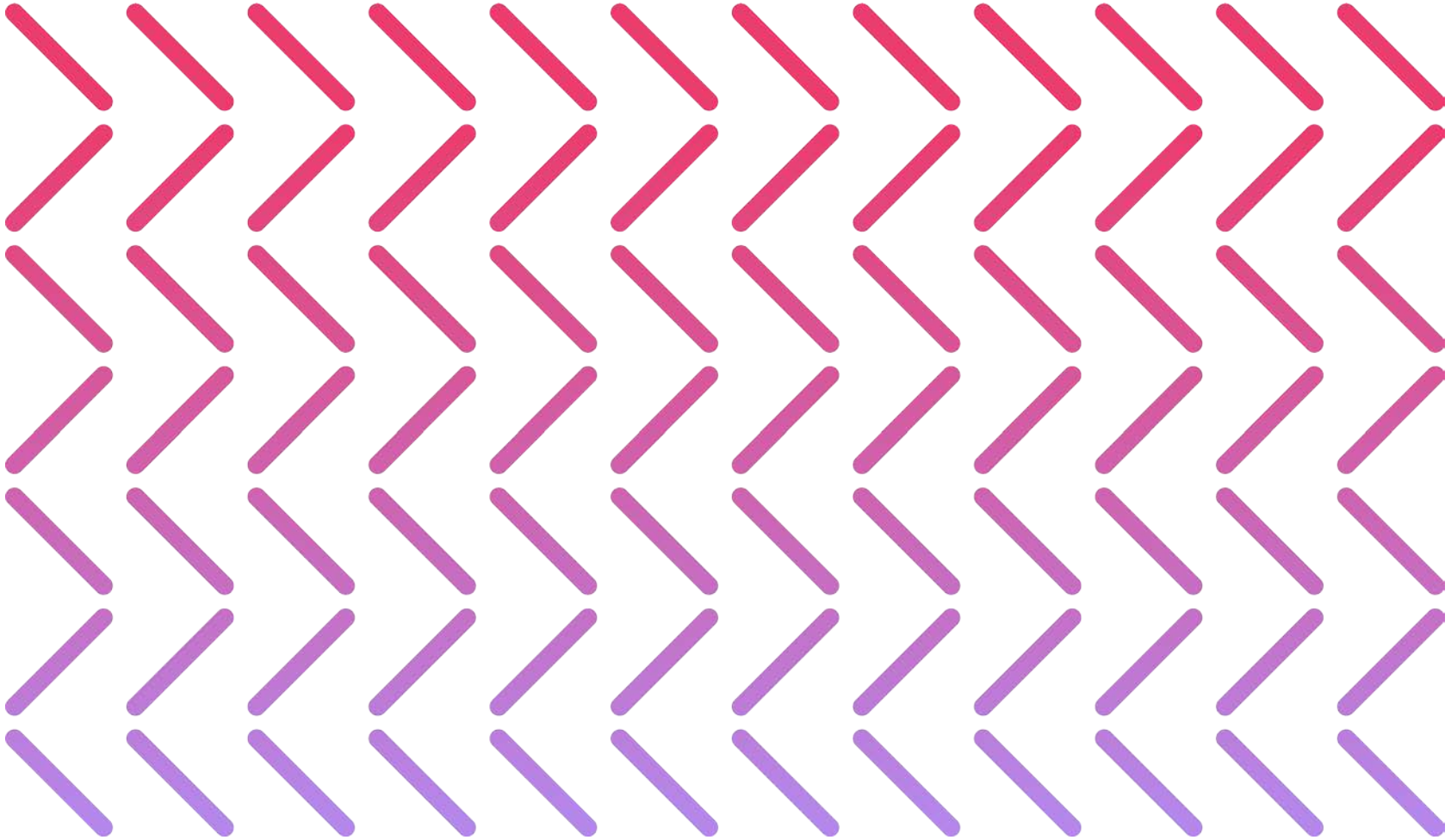
- We will continue to be the main provider of specialist services for our region, including as the major trauma centre
- We will be a major centre for cancer, children's and neuroscience services
- We will take part in commercial opportunities that enable us to invest more in NHS care
- We will develop tomorrow's treatments, today, through innovation, research and training

We are committed to providing planned care that fits around our patients' lives, using the latest technology.

Our strategy was clear that this meant a priority for the coming years would be to transform our outpatient offering.

Outstanding care every time

Where we are now



Outstanding care every time

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 'strengths, weaknesses, opportunities and threats' (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:

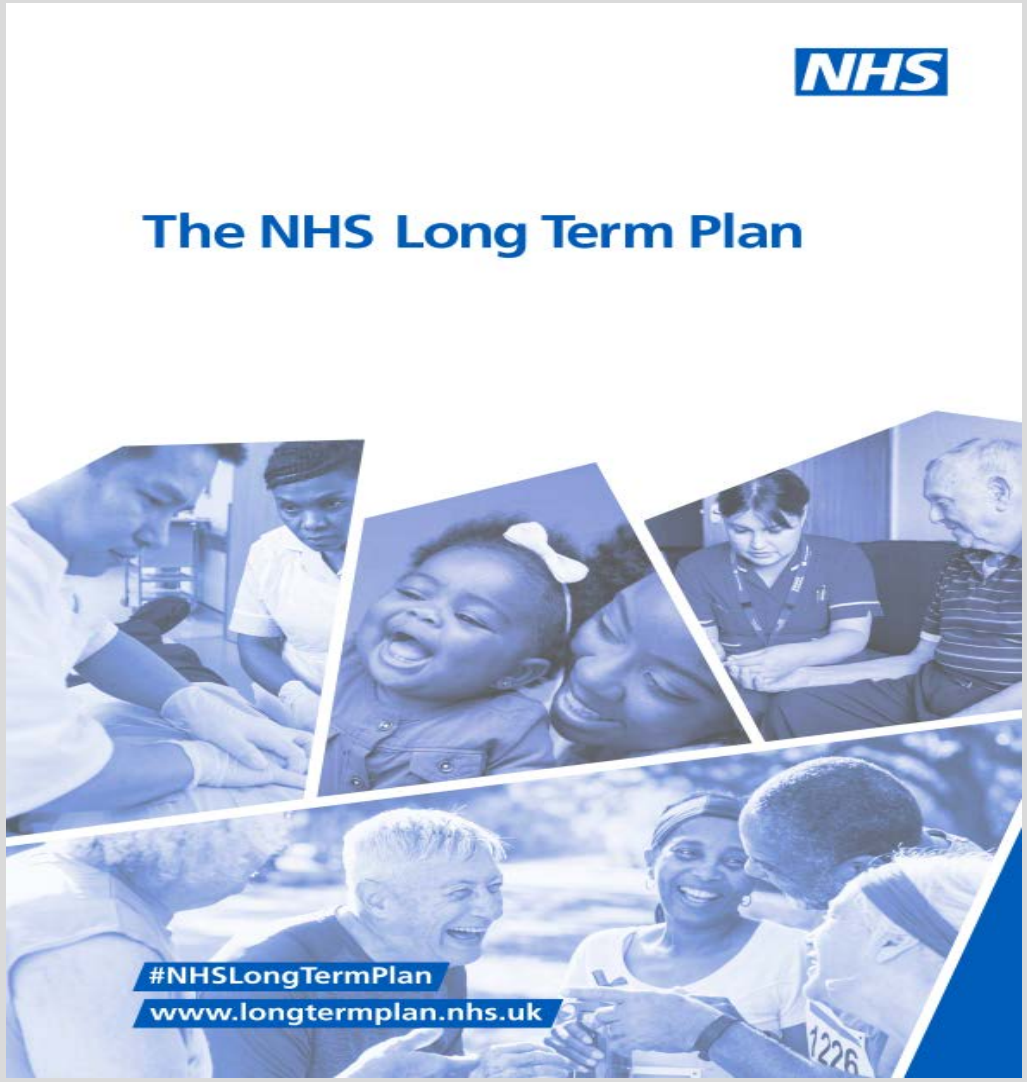
- Taking a menu-based approach to transformation rather than a 'one-size-fits-all' approach – with some services more suited to virtual working than others, greater scope for a different workforce mix in some than others, etc.;
- Anxiety about the Trust's ability to dedicate management capacity to implementing 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:

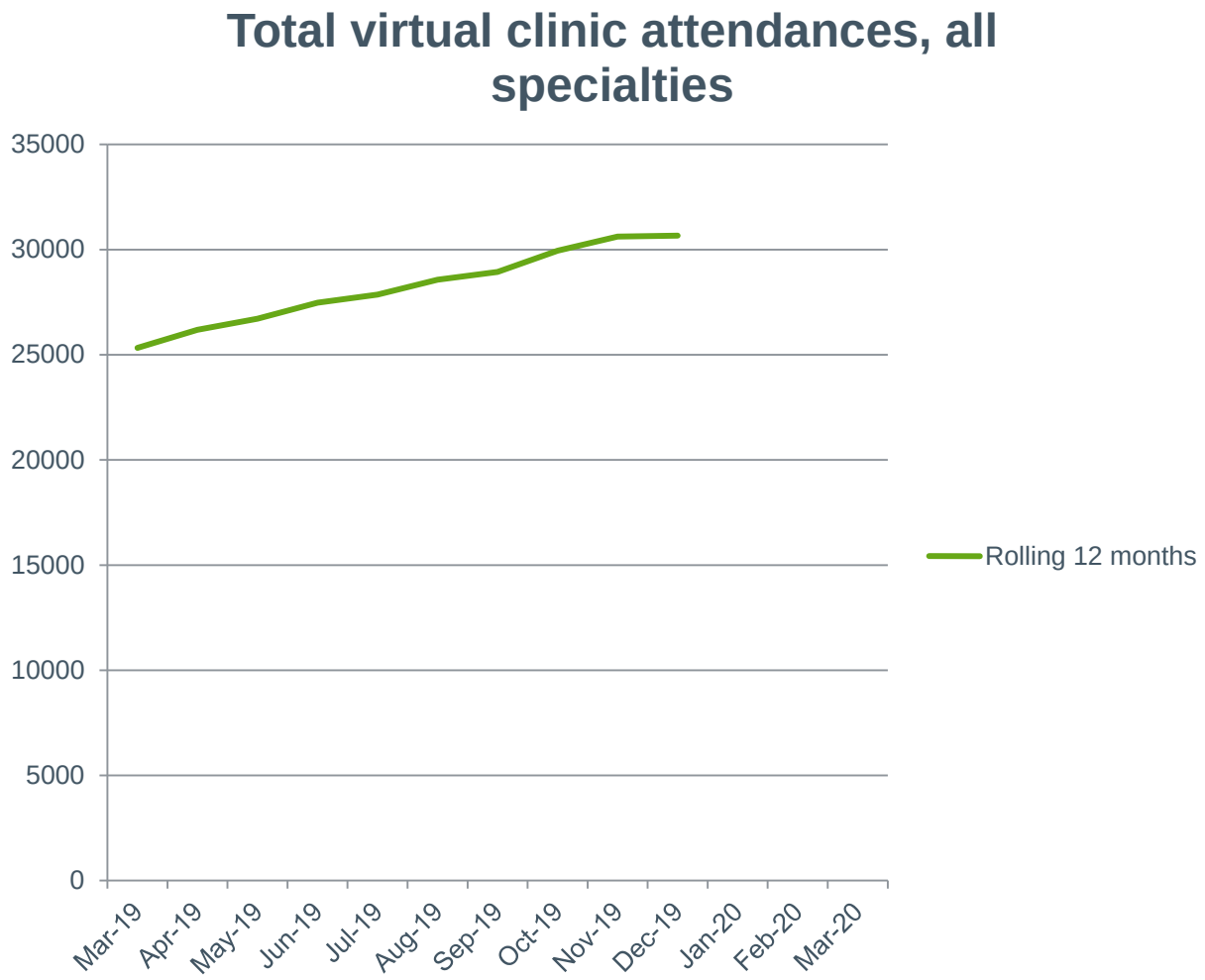
Freeing up space and workforce	• *Provision of more virtual clinics, better use of the non-consultant workforce (allied health professionals, specialist nurses, associate physicians), and supporting more patients to be cared for at home/in primary care, freeing up space and workforce to develop and grow 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).*

This vision means making a range of changes to services

To deliver this vision, different specialties might choose to change their service in different ways. The following ‘menu’ is based on work already undertaken at the Trust and 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 (model being rolled out at St George’s)
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 (model being rolled out for St George’s)
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

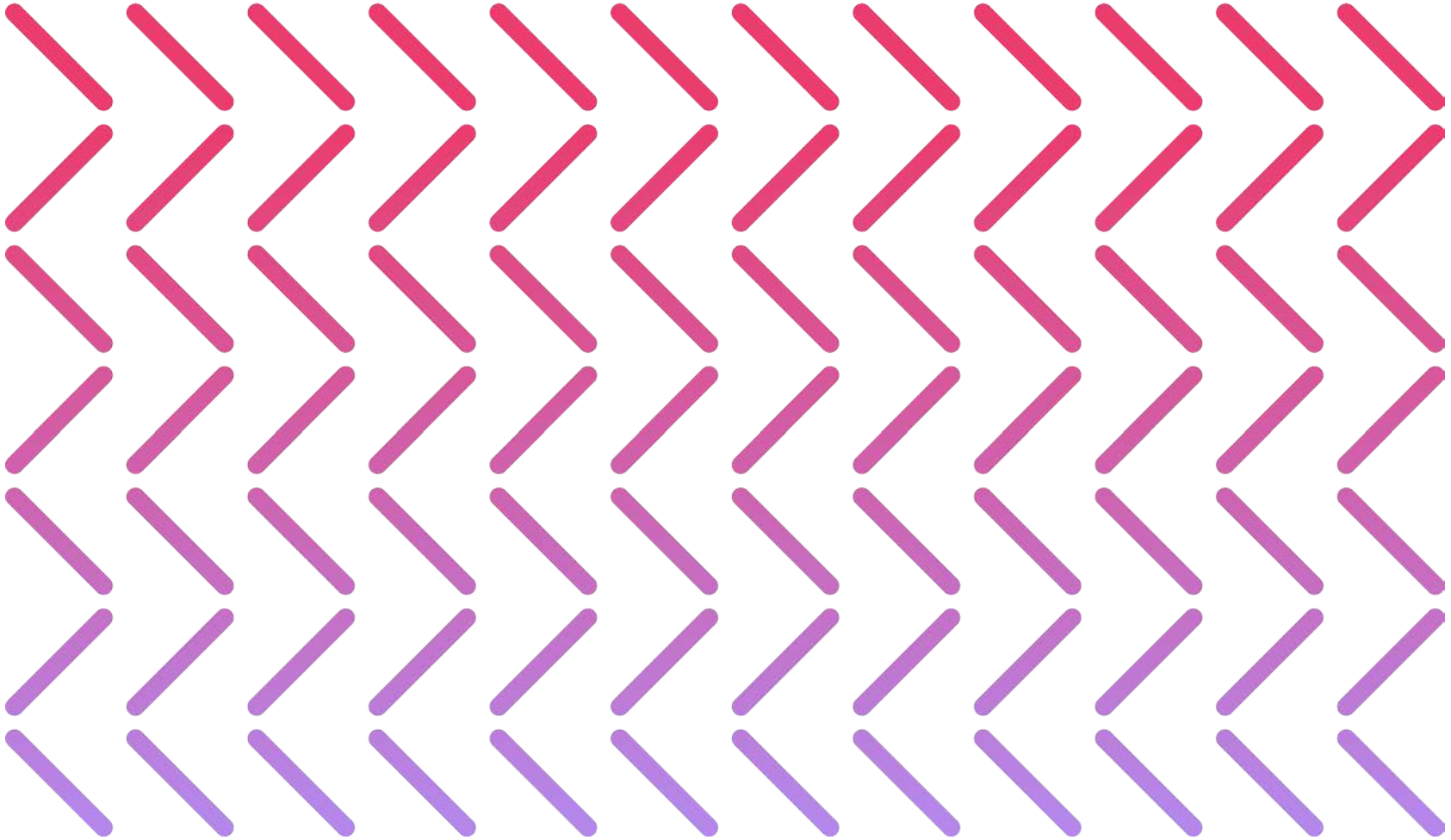
We have started making those changes, but need to accelerate



- 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.

Outstanding care every time

Where we go next



Outstanding care every time

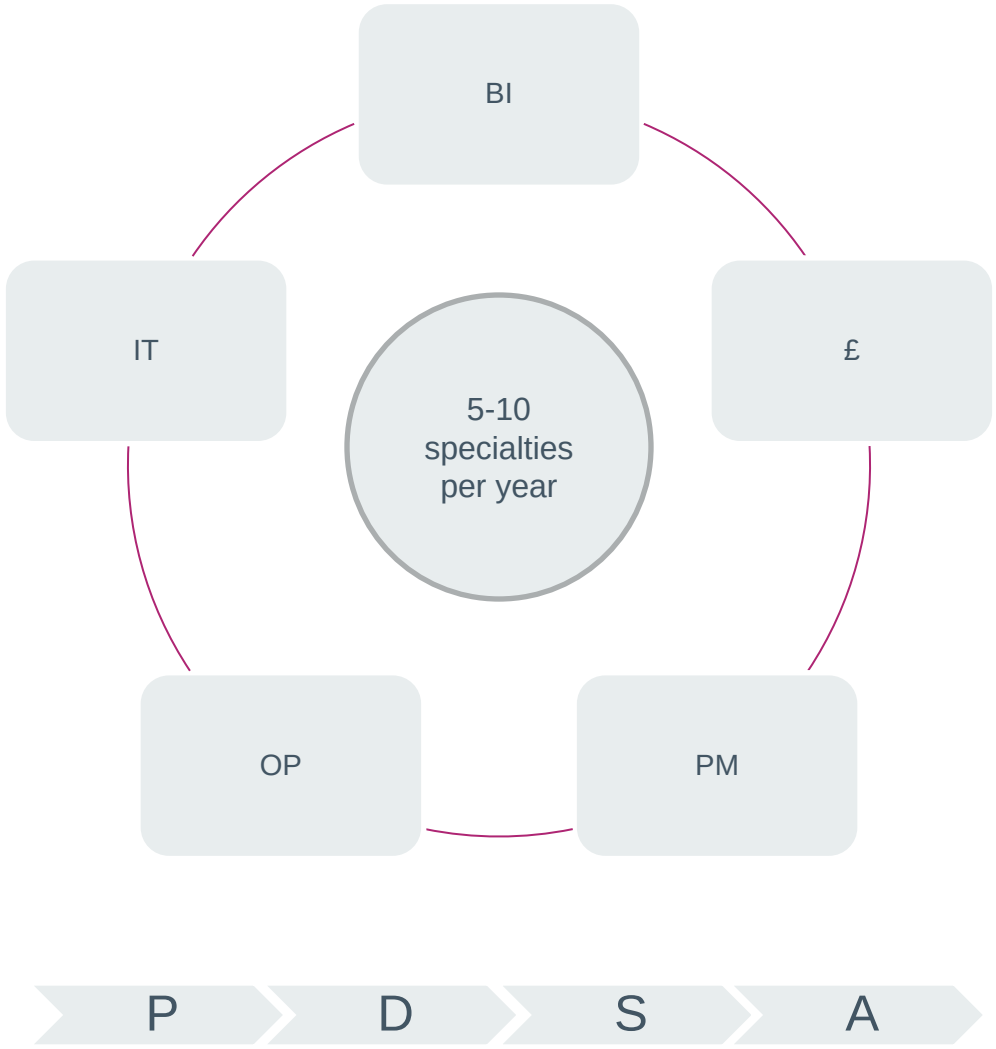
We will put in place the key enablers for change

Enabler	Detail	Proposed trajectory set out later in this pack assumes that…
Leadership	• Accelerating change will require **leadership at all levels (corporate, clinical, managerial)** to be able to prioritise this agenda in the context of a large number of competing priorities	• Each year we will support 5-10 specialties to deliver on this agenda at scale. For each of these specialties, we will ring-fence clinical and managerial time to work on outpatient transformation • Outpatient transformation will be driven forward as a priority by Trust leadership from Board level down
Culture	• Changes envisaged in national plan will require **culture/expectations to change** amongst both clinicians and patients	• We will support gradual changes in attitudes/expectations over time, with early adopters playing a key role in supporting culture change for services supported in later years
IT	• **Roll-out of iClip** to outpatient services across the Trust, and embedding the new ways of working it requires of clinicians, would be a significant enabler of acceleration. • Some of the changes to services envisaged will require small-scale IT support (e.g. service-level configuration of iClip to enable more efficient virtual 'enhanced triage'). • Other changes (e.g. to enable video consultations, patient portal) are likely to be longer-term solutions, dependent on capital availability.	• We will roll out iClip across outpatient services over the course of 20/21, enabling an acceleration of pace from 21/22 onwards • Depending on the availability of capital, we will develop a patient portal and invest in enabling more video clinics in later years • IT department time will be ring-fenced to work with each specialty supported

We will put in place the key enablers for change (2)

Enabler	Detail	Proposed trajectory set out later in this pack assumes that…
Corporate outpatient support	• The (currently paused) **restructure into 'hubs'** would support the faster adoption of new models. • Some of the options for changes to service may require corporate outpatient department to operate differently. • Some of the options for changes to service may enable a specialty to be more productive, delivering more activity per unit of resource – but this is likely to increase administrative activity for the corporate outpatient department. The Trust will need to be assured that the reduction in human administrative work assumed to result from iClip roll-out off-sets any such increase.	• We will complete the restructure of the corporate outpatient department by the end of 20/21, enabling further acceleration from 21/22 onwards. • We will ensure that corporate outpatient staff are involved from the start in co-design service changes
Reprovision costs	• Services may need to **'double run' old and new models of care for a period**, and uncertainty about whether/how they will be able to access associated funds is likely to slow the pace of change.	• We will make available a 'transformation fund' for the specialties being supported through change.
Change management resource	• To deliver acceleration, services are likely to require **dedicated change management resource**.	• As per the proposed approach set out later in this strategy, dedicated change management resource will be made available to those specialties supported to deliver change each year

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.

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.
- This menu will allow for a clear common currency, with corporate teams (e.g. IT, corporate outpatients, finance) understanding the implications / support required to deliver each element of the menu
- Via this process we will also explore the potential for innovative technology (e.g. apps, AI) to support transformation in each specialty, and we will align this work with efforts specialties are making on other agendas (e.g. risk-stratified follow-up and early diagnosis for cancer patients)
- Over time, the organisation will develop ‘off the shelf’ solutions to help each specialty adopt elements of the menu.

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

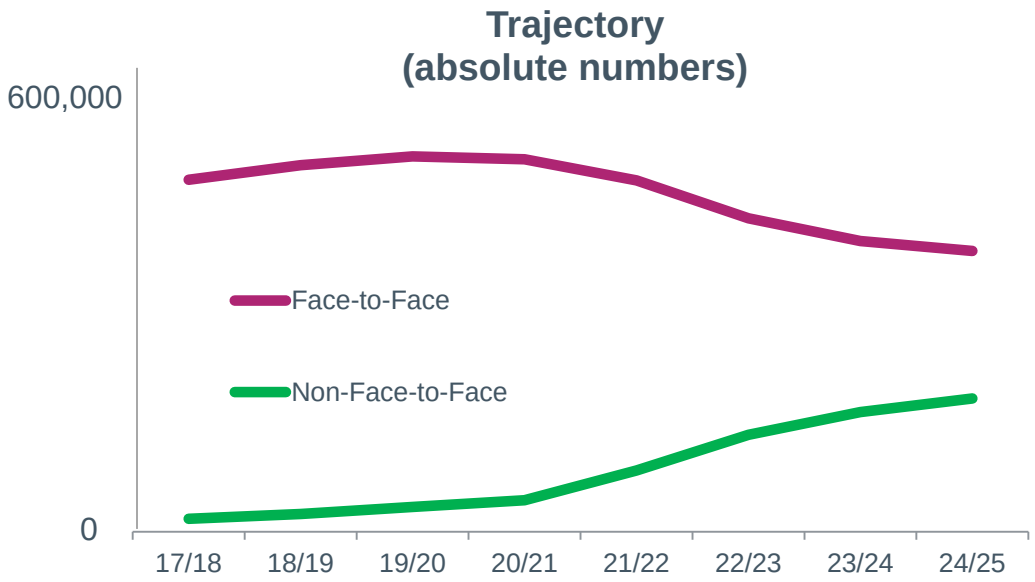
We will work closely with system partners to deliver change

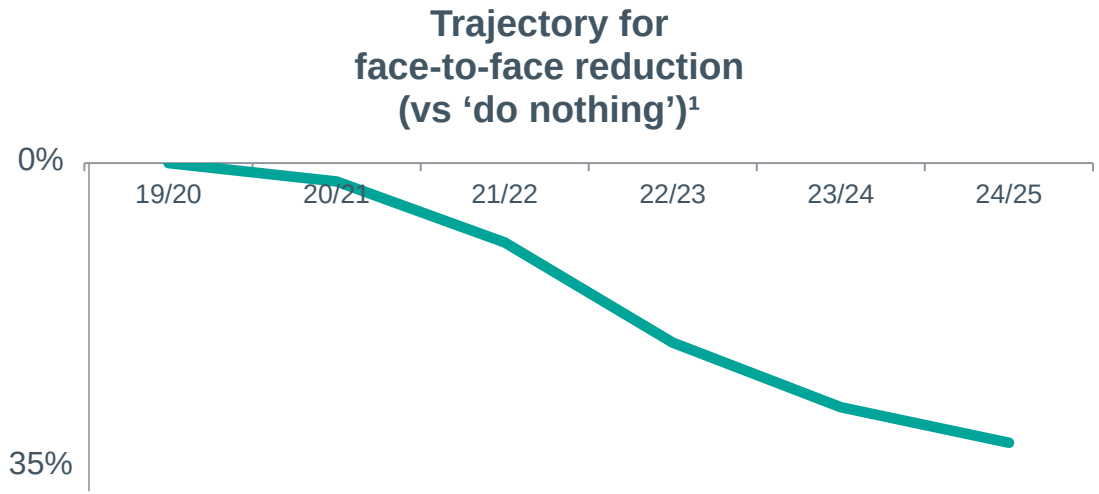
The successful transformation of outpatient services will rely not just on the Trust, but on our partners in primary care (e.g. making changes in referral practice) and commissioners.

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 ambitions set out in the national NHS Long Term Plan.

1. Baseline for the 33% reduction described in national long term plan is assumed to be 18/19. 33% reduction is assumed to be vs a 'do nothing' scenario of year-on-year growth of 2% per year for new activity and 1% per year for follow-ups.

Outstanding care every time

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.

Meeting Title:	Trust Board		
Date:	27 February 2020	**Agenda No**	5.4.1
Report Title:	Horizon Scanning Report, November 2019 – February 2020: Emerging policy, political, legislative and regulatory issues		
Lead:	Stephen Jones, Chief Corporate Affairs Officer		
Report Author:	Stephen Jones, Chief Corporate Affairs Officer		
Presented for:	Information		
Executive Summary:	This report provides a quarterly update to the Trust Board on emerging political, legislative, policy and regulatory issues that have relevance to the Trust. This report focuses on key developments between November 2019 and February 2020, highlighting in particular developments in relation to: • The political and legislative environment • The NHS policy and institutional landscape • System and professional regulation • Current inquiries The report is intended to support the Board in providing a regular and systematic review of national political, policy and regulatory developments. It is distinct from the strategy horizon-scanning work which is reported in a separate slide deck under this agenda item. Previous reports on emerging political, legislative, policy and regulatory issues covering the periods April to July 2019 and August to October 2019 were presented to the Board at its meetings in July 2019 and October 2019 respectively.		
Recommendation:	The Board is asked to note the update on emerging policy, legislative and regulatory issues between November 2019 and February 2020.		
Supports			
Trust Strategic Objective:	All		
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:	As set out in the paper.		
Previously Considered by:	Trust Executive Committee	**Date**	19/02/2020
Appendices:	Horizon Scanning Report, November 2019 – February 2020: Emerging policy, political, legislative and regulatory issues		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Horizon Scanning report: November 2019 – February 2020

Emerging policy, political, legislative and regulatory issues

Stephen Jones
Chief Corporate Affairs Officer

27 February 2020

1. Purpose

The NHS Leadership Academy identifies three essential 'building blocks' in helping NHS boards to exercise their roles of formulating strategy, ensuring accountability and shaping a healthy culture effectively. Effective boards are informed by the external context within which they operate. They are informed by and shape the intelligence on understanding local needs, trends and comparative information on organisational performance, and give priority to engagement with stakeholders and opinion formers. This report provides the Board with a regular update on key developments in the Trust's external environment at the national level, particularly in relation to:

- **Political and legislative developments**: Current and emerging political and parliamentary developments at a national level with direct or indirect implications, or potential implications, for the Trust; key changes, or potential future changes, to primary legislation and regulations.
- **NHS policy and institutional landscape**: Changes and developments in relation to significant new national policy as determined by the central NHS organisations, and changes to the national architecture and structures of the NHS and those organisations with which the Trust interacts.
- **System and professional regulation**: Changes and prospective changes to the regulatory landscape, of both system regulators and relevant professional regulators with potential relevance to the Trust.
- **Reports and updates from key stakeholders**: Topical reports from key national bodies and other stakeholders of relevance to the Trust, and highlights of recent Board meetings of key system partners.
- **Current inquiries**: Summary of key inquiries that are underway.
- **Appointments**: Key appointments to national bodies and other key stakeholders.

This is the third such report to the Board and the format and issues will be kept under review to ensure the Board receives, through this report, a comprehensive quarterly update on key issues relating to these areas. It is distinct from the strategy horizon scanning report which focuses on regional and local issues.

2. Political and legislative developments

General Election and Queen's Speech, December 2019

- The General Election held on 12 December 2019 resulted in an 80-seat majority for the Conservative Party. The composition of the House of Commons following the election is: 365 seats for the Conservative Party (+47); 203 seats to the Labour Party (-59); 48 seats to the Scottish National Party (+13); 11 seats to the Liberal Democrats (-1); 8 to the DUP (-2); and a further 15 seats across the other political parties (+2).

- Following the general election, a Queen's Speech was held on 19 December 2019. As expected, the Speech listed a number of specific legislative commitments in relation to the NHS:

    - **NHS Funding Bill:** The Bill seeks to enshrine in legislation the Government's commitment to invest an additional £33.9bn every year into the NHS to 2024 . The Bill would place a legal duty on the Government to guarantee a minimum level of spending every year, rising to £148.5bn by 2024. The Secretary of State for Health and Social Care introduced the Bill into the House of Commons on 15 January 2020. The Bill completed its stages in the House of Commons on 4 February and is scheduled to have its Second Reading in the House of Lords on 26 February 2020.

    - **NHS Long Term Plan Bill:** The Government stated that would bring forward legislation to help implement the NHS Long Term Plan. The Bill has not yet been published or introduced to Parliament. However, the Government stated that it was considering the recommendations from NHS England and NHS Improvement as to the requirements of new legislation to remove the barriers to delivery of the Plan and to better integration of services. The Board's Horizon Scanning Report of October 2019 set out the recommendations put forward by NHSE&I.

    - **Medicines and Medical Devices Bill:** The stated aim of the legislation is to ensure the NHS and patients have access to the best innovative medicines, including by making it easier for hospitals to manufacture and trial innovative personalised and short-lived medicines, streamlining the licencing and regulation of such medicines, and updating safety requirements. The Bill was introduced to Parliament on 13 February and is scheduled to have its Second Reading on 2 March 2020.

2. Political and legislative developments

Queen's Speech (continued):

- **Health Service Safety Investigations Bill:** Reflecting the commitment in the October 2019 Queen's Speech, the December Speech reiterated the commitment to establish the HSSIB as a new Executive Non-Departmental Public Body. HSSIB investigations will be independent and professionally led and investigations will be undertaken for the purpose of learning and not for attributing blame or finding fault. The purpose of investigations will be to ensure the root causes for mistakes can be identified and the lessons are widely shared.

- Alongside the specific legislative commitments in the Speech was a re-iteration of the Government's commitment to long term reform of the social care system. The plans set out a commitment to reach a cross-party consensus and put social care on a sustainable footing.

- The Speech also set out plans to review the Mental Health Act. The Government commissioned a review of the Act in 2017 which reported in December 2018. The Queen's Speech set out plans to publish a White Paper setting out the Government's proposals for reform of the Act in early 2020, paving the way for a new Bill to implement the reforms. The Government's stated objectives are to give people greater control over their treatment and ensure that people have the dignity and respect they deserve.

UK withdrawal from the EU

- Following December 2019 general election, the Government passed the EU (Withdrawal) Act and the United Kingdom left the European Union on 31 January 2020. The UK is now in a transition period until 31 December 2020 during which it will remain subject to the EU's rules and a member of the single market. The transition period can be extended if both sides agree by one or two years, thought an agreement to do so would need to be reached by 1 July 2020.

- During the transition period, the health sector is not expected to experience significant change. Freedom of movement will remain in place until the end of the transition period and Trusts can recruit EU nationals as they do now. Beyond the transition, the Government will need to pass an Immigration Bill. The Government is expected to introduce an NHS Visa which would reduce visa costs for those coming to work in the NHS, via a fast tracked route. EU citizens currently in the UK can apply for pre-settled or settled status and must do so by 30 June 2021.

3. NHS policy and institutional landscape

A Greener NHS

- On 25 January 2020, the NHS Chief Executive, Sir Simon Stevens, launched the “greener NHS campaign” through which the NHS and its staff will step up action to tackle the climate “health emergency” this year, helping prevent illness, reducing pressure on A&Es, and, it is intended, saving tens of thousands of lives.

- NHS England is establishing an expert panel to chart a practical route map this year to enable the NHS to get to ‘net zero’, becoming the world’s first major health service to do so. The Expert Panel will look at changes the NHS can make in its own activities; in its supply chain; and through wider partnerships – thereby also contributing to the government’s overall target for the UK. These include the Long Term Plan commitment to better use technology to make up to 30 million outpatient appointments redundant, sparing patients thousands of unnecessary trips to and from hospital. It will also look at changes that can be made in the NHS’s medical devices, consumables and pharmaceutical supply, and areas the NHS can influence such as the energy sector as the health service moves to using more renewable energy.

- The Panel will submit an interim report to NHS England in the summer with the final report expected in the Autumn, ahead of the COP26 International Meeting in Glasgow. The NHS Chief Executive will also act as an adviser to Climate Assembly UK.

Flexible training for healthcare professionals

- On 9 February 2020, the Government announced that it was exploring how to better recognise the skills and experience of existing healthcare professionals who want to train in a different area of healthcare. Newly designed courses could take into account existing qualifications, training and experience, making it easier and quicker for existing healthcare professionals such as physiotherapists or pharmacists to train as doctors.The current training standards are set by the EU. They mean that healthcare professionals wishing to move into another area have to complete a set training course, regardless of any existing health background or qualifications. This includes 5,500 hours of training and a minimum of 5 years to become a doctor. Under the potential new system, a physiotherapist who has been in the job for 10 years could complete training based on their experience and qualifications, rather than fixed time-frames. It could also allow people from a wider range of backgrounds to train, by offering training that can fit around caring or parenting responsibilities.

3. NHS policy and institutional landscape

Free hospital car parking

- On 27 December 2019, the Secretary of State for Health and Social Care announced changes to hospital car parking charging. Under the changes, from April 2020, all 206 hospital trusts in England will be expected to provide free car parking to groups that may be frequent hospital visitors, or those disproportionately impacted by daily or hourly charges for parking, including:
    - blue badge holders
    - frequent outpatients who have to attend regular appointments to manage long-term conditions

Free parking will also be offered at specific times of day to certain groups, including:

- parents of sick children staying in hospital overnight
- staff working night shifts

The government says it will work with NHS organisations to ensure that it spreads existing good practice from NHS organisations applying current exemptions effectively to others. It will also use the NHS standard contract if needed to ensure compliance. In addition, it will assesses where capital investment could help to improve the experience of patients and visitors. Technological options will also be explored including Automatic Number Plate Recognition (ANPR) systems or token systems where eligible people can them redeem free parking, or receive a refund

Funding for nursing students

- In December 2019, the Government announced that nursing students would benefit from guaranteed, additional support of at least £5,000 a year to help with living costs. The funding will be given to all new and continuing degree-level nursing, midwifery and many allied health students from September 2020. It is expected to benefit more than 35,000 students every year In addition, there will be up to £3,000 further funding available for eligible students, including for: specialist disciplines that struggle to recruit, including mental health; an additional childcare allowance, on top of the £1,000 already on offer; areas of the country which have seen a decrease in people accepted on some nursing, midwifery and allied health courses over the past year. The funding will not need to be repaid. It is linked to the Government's stated commitment of increasing nurse numbers over the next five years.

3. NHS policy and institutional landscape

NHS Non-Emergency Patient Transport Services (NEPTS) Review

- In autumn 2019 NHS England and NHS Improvement announced it would review non-emergency patient transport services (NEPTS). NEPTS take patients to and from their homes, to their care provider, for planned appointments and treatment. NEPTS are for those patients who: have a condition such that they need additional medical support during their journey; find it difficult to walk; are the parents, guardians, or children, of patients who need transport. A 2019 report by Healthwatch, Age UK, and Kidney Care UK, set out the challenges people face, when travelling to and from NHS providers.

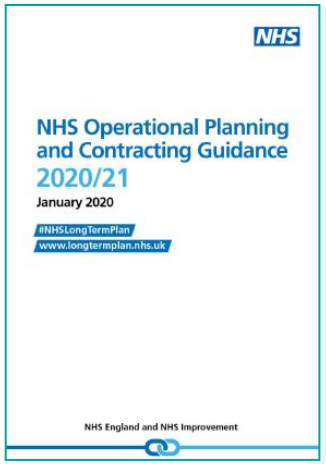
The review is analysing how the current NEPTS system works and determine how best to improve patient transport services in England, within existing and planned NHS resources. The review will consider: Service access and activity; Service quality; User experience; Providers' economic resilience; and service sustainability and affordability. The review will also consider the environmental impacts of patient transport services, and how future changes in provision might reduce air pollutant emissions.

Implementing the Medical Examiner system: Good practice guidance

- In February 2020, good practice guidance was published to support medical examiners and to ensure that medical examiner offices are implemented consistently. The guidelines provide learning from pilots and early adopters and will help trusts to follow the national model. The guidance covers arrangements for establishing ME offices, principles for MEs, operational requirements and ways of working, and how MEs should engage with coroners.

- Alongside the good practice guidance, NHS England and NHS Improvement have published guidance regarding the reimbursement for Medical Examiner systems in England during the non-statutory period. This also includes deadlines for data collection and format.

4. System and professional regulation



NHS Operational Planning and Contracting Guidance 2020/21

- On 30 January 2020, NHS England and NHS Improvement published its planning guidance for 2020/21. The new guidance sets out what the NHS is expected to deliver in 2020/21 in the context of the vision for 2023/24 established in the NHS Long Term Plan.

- **System working:** The new guidance places significant emphasis on system working. It highlights that all parts of the system are working to be part of an Integrated Care System by April 2021 and emphasises that 202/21 will be a critical year in this process, with many parts of the system starting to work as ICSs by default during the year. Working through system wide governance arrangements will be a key part of this in 2020. In addition, this year, narrative plans are now expected to provide a wider system perspective. System control total will continue to be operated. Some capital funding and revenue transformation funding will be allocated at system level.

- **Operational requirements:** The Clinically-led review of operating standards is currently being tested in 70 Trusts across the country and final recommendations are expected in Spring 2020. Until then, current operational standards remain in place.
    - In terms of Urgent and Emergency Care, the guidance emphasises that emergency care performance must improve against the 2019/20 benchmark. To this end, organisations will be expected to reduce general and acute bed occupancy to maximum 92% capacity and it states that the long term reduction across the NHS in the number of beds should not continue. By September 2020, all providers are expected to meet the standard of Same Day Emergency Care for 12 hours per day as well as acute frailty services for 70 hours a week.
    - On RTT, waits of 52 weeks are expected to be eradicated and waiting lists across the NHS are expected to be lower by January 2021, with every provider having made a contribution to this. Financial sanctions will remain in place for any providers who breach the 52 week limit for any patient.

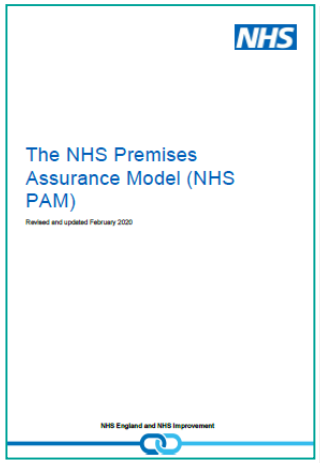
- **Finance:** Five financial tests require each system and each provider within it to: meet its trajectory for 2020/21 and the following three years; achieve cash-releasing productivity growth of at least 1.1% each year; reduce the growth in demand for care via integration and prevention; reduce unwarranted variation in performance; and make better use of capital investment and existing assets. Cost improvement plans need to be fully developed before the start of the financial year and agreed between commissioners and providers . For 2020/21, the Financial Recovery Fund (FRF) will be the sole source of financial support for NHS providers and CCGs that are otherwise unable to live within their means.

4. System and professional regulation

NHS Workforce Race Equality Standard data report, 2019

- On 13 February 2020, NHS England and NHS Improvement published the latest Workforce Race Equality report for the NHS in England. The WRES report measures the experience and opportunities of white and BAME staff across the NHS using nine key indicators, including access to promotion and exposure to discrimination. The key findings from the report are:
    - In 2019, 19.7% of staff working for NHS trusts and clinical commissioning groups (CCGs) in England were from a black and minority ethnic (BME) background; this has been increasing over time.
    - Across all NHS trusts and CCGs, there were 16,112 more BME staff in 2019 compared with 2018.
    - The total number of BME staff at very senior manager (VSM) pay band has increased by 21, from 122 in 2018 to 143 in 2019, and is up by 30% since 2016.
    - White applicants were 1.46 times more likely to be appointed from shortlisting compared to BME applicants; a similar figure to that reported in 2018, and an improvement on the 1.60 times gap in 2017 and 2016.
    - The relative likelihood of BME staff entering the formal disciplinary process compared with white staff has reduced year-on-year, from 1.56 in 2016 to 1.22 in 2019.
    - WRES indicators relating to staff perceptions of discrimination, bullying, harassment and abuse, and on beliefs regarding equal opportunities in the workplace, have not changed for both BME and white staff.
    - The relative likelihood of white staff accessing non–mandatory training and continuous professional development (CPD) compared with BME staff was 1.15. This remained the same as last year.
    - 8.4% of board members in NHS trusts were from a BME background; an improvement from 7.4% in 2018 and 7.0% in 2017.
    - The number of BME board members in trusts increased by 35 in 2019 compared with 2018 – an additional 18 executive and 17 non-executive board members.
    - In 2014, two-fifths of all NHS trusts in London had zero BME board members. As at 1 December 2019, all London trusts have at least one BME board member; a significant improvement. 14.7% of Very Senior Managers in London are now from a BME background.

4. System and professional regulation



NHS Premises Assurance Model

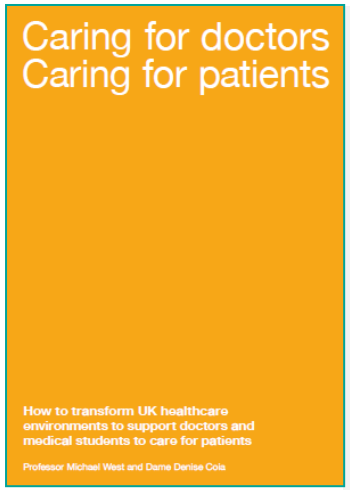
- In February 2020, an updated NHS Premises Assurance Model (PAM) was published which NHS provider organisations are now required to implement. The NHS PAM has been updated for 2020 to: reflect feedback from users; incorporate amendments identified by the NHS PAM working group; incorporate changes to the strategy for the NHS estate as set out in relevant guidance ie the NHS Long Term Plan; and to reflect the letter *NHS Estates and Facilities – Premises Assurance*, sent on 15 March 2018 to directors of estates.

- The NHS PAM was developed to provide a nationally consistent basis for assurance for Trust Boards on regulatory and statutory requirements related to estates and related services. It is intended to provide assurance in relation to the right set out in the NHS Constitution "to be cared for in a clean, safe, secure, and suitable environment". This assurance can then be used more widely and be provided to commissioners, regulators, the public and other interested stakeholders. In this way, the NHS PAM bridges the space between NHS boards and the operational detail of its day-to-day estates and facilities operations. The model can be used as a prompt for further investigation, and to stimulate better-informed dialogue as to how the premises can be more efficiently used, more effectively managed, and contribute to the overall strategic objectives of the organisation.

Updated Model Hospital data

- In February 2020, updated Model Hospital data was published which includes the 2018/19 costing and opportunities data annual update. Reference costs data has been replaced with national cost collection (patient-level costing, PLICS) data, providing a more accurate and detailed analysis of acute hospital activity. The update also includes:
  - new improvement opportunities spanning all areas, including clinical service lines and workforce
  - updated productivity metrics
  - a new sub-compartment in the operational productivity area: resource productivity splits
  - site-level breakdown for all metrics in the estates and facilities compartment.

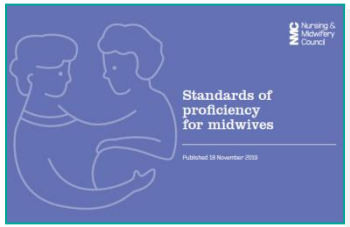
4. System and professional regulation



GMC Report: Caring for Doctors, Caring for Patients

- On 15 November 2019, the General Medical Council published the report of an independent review it had commissioned into the factors impacting on the mental health and wellbeing of medical students and doctors across the UK. The review was led by Professor Michael West and Dame Denise Coia. They were asked to examine root causes of poor wellbeing, and solutions applied in both primary and secondary care and heard evidence from clinicians working across a range of disciplines around the UK

- The report identifies a need to address the wellbeing of doctors faced with higher workloads, whose own health impacts on patient care. Recommendations include compassionate leadership models giving doctors more say over the culture of their workplaces, adopting minimum standards of food and rest facilities, and standardising rota designs which take account of workload and available staff. The review found many individual employers and clinical teams are already implementing local solutions to address issues affecting the health and wellbeing of doctors. Professor West and Dame Denise believe that health services could be a 'model for the world' in how to develop workplace cultures that support doctors' core work needs if these solutions were consistently applied. Other recommendations for health service leaders include improvements to team-working, culture and leadership, and workloads.



NMC's new Standards of Proficiency for Midwives

- On 18 November 2019, the Nursing and Midwifery Council published its new standards of proficiency for midwives. The Standards are intended to ensure the role of the midwife evolves to meet changing individual needs and the changing needs of the system. They place particular emphasis on perinatal mental health and also recognise the role of midwives in improving public health.

5. Current inquiries

Report of the Independent Inquiry into the issues raised by Paterson

- In December 2017, the Government commissioned an independent inquiry to investigate the malpractice of Dr Ian Paterson, a West Midlands-based breast surgeon convicted and imprisoned for wounding with intent and harming patients, and to make recommendations to improve patient safety. Paterson practised as a breast surgeon at Heart of England NHS Foundation Trust (HEFT) and in the independent sector. The inquiry was chaired by Right Reverend Graham James, then Bishop of Norwich. A total of 211 patients or their relatives gave evidence to the inquiry.

- The inquiry established that there had been concerns about Paterson's practise for many years. Clinical colleagues first raised serious concerns about his practise in 2003 and he was ultimately suspended by HEFT in 2011 and by Spire later that year. In 2017, Paterson was convicted of 17 counts of wounding with intent and three counts of unlawful wounding relating to nine women and one man who he had treated as private patients between 1997 and 2011. He was initially jailed for 15 years, but his sentence was increased to 20 years by the Court of Appeal in August 2017.

- The inquiry found that the hospitals in which Paterson worked did not look closely at the practices he was performing to make sure he was fit to practise them. The appraisal system did not pick up concerns about him, nor did the wider monitoring systems in place at the time. MDT meetings did not challenge Paterson's practise and the hospitals did not review his scope of practice or practising privileges. The inquiry also found there was a failure of the NHS and independent sector to communicate fully with each other. The review also identified shortcomings in the local processes for raising concerns and in local complaints processes. Evidence to the inquiry, particularly from the GMC, also raised the issue of the extent and effectiveness of the Trust Board's oversight of clinical governance. The effectiveness of the Board in overseeing the culture of the Trust was also criticised by the review, which was described as lacking curiosity about Paterson's practise.

- The inquiry highlighted that existing systems, process and regulatory mechanisms were in place but did not work effectively. Its 15 recommendations were framed in that context and related to: information provided to patients; consent; the operation of MDTs; complaints; patient recall and ongoing care; improving recall procedures; clinical indemnity; the regulatory system; investigating healthcare professionals' practice and behaviour; corporate accountability; and the adoption of the inquiry's recommendations in the independent sector.

5. Current inquiries

Independent Inquiry INTO Maternity Services at Shrewsbury and Telford NHS Trust

- An independent inquiry into maternity services at Shrewsbury and Telford NHS Trust was launched in 2017 at the request of the Secretary of State for Health and Social Care. The inquiry is looking into the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at the Trust. The review is being led by NHS Improvement and is being chaired by Donna Ockenden.

- Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be reviewed by the maternity review team to ensure rigour and application of good practice.

Independent Review of Maternity Services at East Kent NHS Foundation Trust

- NHS England and NHS Improvement announced on 13 February 2020 that they had asked Dr Bill Kirkup to carry out a review into the circumstances of maternity deaths at East Kent NHS Foundation Trust. The review will look at preventable and avoidable deaths of newborns to ensure the trust learns lessons from each case and is putting in place appropriate processes to safeguard families.

- The independent assessment to learn lessons for the future will be undertaken alongside work going on now in the trust to put in place immediate improvements, led by England's most senior midwife, Jacqueline Dunkley Bent, with support from Dr Aidan Fowler the NHS' National Patient Safety Director. The review, which is expected to begin shortly, will carry out an independent look-back review, in partnership with affected families, of potentially avoidable or preventable deaths of babies in East Kent. Dr Kirkup is also being asked to consider what wider regulatory or practice changes are needed to guarantee safe services at any other maternity units where concerns may arise.

5. Current inquiries

Infected Blood Inquiry

- The Inquiry is examining why men, women and children across the UK were given infected blood and / or infected blood products; the impact on their families; how the authorities responded; the nature of any support provided following infection; questions of consent; and whether there was a cover-up.

- Following hearings in the autumn of 2019, the total number of people who have given oral evidence to the Inquiry since April stands at 189. The Inquiry has also received nearly 4,000 written statements. To date, more than 11.5 million pages have been reviewed by the Inquiry team and around 2.5 million pages placed on the Inquiry's documents system, a figure which grows at an average of 40,000 pages per week.

- On 29 January 2020, the Inquiry published a report prepared by the Inquiry's intermediaries, a group of professionals trained to engage with those who did not feel able to provide oral or written testimony to the inquiry as a result of the stigma associated with their illnesses. The report covers a number of people's experiences, without revealing their identities. The intermediaries continue to be available for people who would like to contribute to the Inquiry by speaking to them rather than by giving a witness statement. It will inform the next phase of the Inquiry's work.

- In the week beginning 24 February 2020, the Inquiry will hear evidence from independent experts for the first time. Many important issues have already been raised by people who are infected and affected, related to the impact of the medical conditions they were diagnosed with, both for themselves, and their loved ones. The stated aim of these hearings is to establish the clinical context for those conditions, and consider their care and treatment from a modern perspective.

6. Recent appointments

Secretary of State for Health and Social Care and Junior DHSC Ministerial team

- Following the Government reshuffle on 13 February 2020, it has been confirmed that Rt Hon Matt Hancock MP will remain as Secretary of State for Health and Social Care. Mr Hancock has held the role since 9 July 2018.
- Helen Whatley, MP for Faversham and Mid-Kent, has been appointed as Minister of State for Care, replacing Caroline Dineage. Ms Whatley was previously Parliamentary Undersecretary of State at the Department of Culture, Media and Sport from September 2019 to February 2020.
- The rest of the junior ministerial team at DHSC remains unchanged following the reshuffle:
    - Edward Argar retains his role as Minister of State for Health, a post he has held since 10 September 2019.
    - Jo Churchill retains her role as Parliamentary Under-Secretary of State for Prevention, Public Health and Primary Care, having been appointed to the role on 26 July 2019.
    - Nadine Dorries retains her role as Parliamentary Under-Secretary of State for Mental Health, Suicide Prevention and Patient Safety, having been appointed to the role on 27 July 2019.

Health Select Committee Chair

- On 29 January 2020, Rt Hon Jeremy Hunt MP, former Secretary of State for Health and Social Care and former Foreign Secretary, was elected by the House of Commons as the new Chair of the Health and Social Care Select Committee. He replaces Dr Sarah Wollaston as Committee Chair, who lost her seat in the House of Commons in the December 2019 general election.
- The remaining members of the Health and Social Care Select Committee are expected to be appointed shortly. As with all Select Committees, membership of the Committee will reflect party size in the House of Commons.

Chair of the NHS Confederation

- Lord Adebowale has been appointed as Chair of the NHS Confederation and will take up the role in April 2020. Lord Adebowale is currently Chief Executive of Turning Point (since 2001) and served as a Non-Executive Director of NHS England from 2012 to 2018. He replaces Sir Andrew Cash, who has served as Chair since former Chair Stephen Dorrell stood down in November 2019. Lord Adebowale sits as a Crossbench Peer in the House of Lords.

Outstanding care every time

Meeting Title:	Trust Board		
Date:	27 February 2020	**Agenda No**	**5.4.2**
Report Title:	**Horizon Scanning Q3, 2019-20 Report**		
Lead Director/ Manager:	Suzanne Marsello, Chief Strategy Officer		
Report Author:	Ralph Michell, Head of Strategy Laura Carberry, Strategy and Partnership Manager		
Presented for:	Note		
Executive Summary:	This Horizon Scanning Report is intended to apprise Trust Board of the latest local developments in south west London, based on CCG Board and Health and Wellbeing Board papers, and on current and future Clinical Tender opportunities. It is a quarterly report. It should be considered alongside the Chief Corporate Affairs Officer's Horizon Scanning Q3, 2019-20 Report on National Policy.		
Recommendation:	Board is asked to note the update.		
Supports			
Trust Strategic Objective:	1. Treat the patient, treat the person 2. Right care, right place, right time 3. Balance the books, invest in our future 4. Build a better St. George's 5. Champion Team St. George's 6. Develop tomorrow's treatments today		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Responsive**: services are organised so that they meet your needs. 4. **Caring**: staff involve and treat you with compassion, kindness, dignity and respect. 5. **Well Led**: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	N/A		
Previously Considered by:	Trust Executive Committee	**Date**	19/2/20
Appendices:	N/A		

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NHS
St George's University Hospitals
NHS Foundation Trust

Horizon Scanning Report Q3, 2019-20

Regional and Local Updates

This Horizon Scanning Report is intended to apprise Trust Board of the latest Regional and Local Updates.

Suzanne Marsello
Chief Strategy Officer

February 2020

CONTENTS

INTRODUCTION

This report is intended to keep Trust Board informed of:

a) local developments in South West London, based on summaries of CCG Board and Health and Wellbeing Board papers, and;

b) Clinical tender opportunities on the horizon.

It should be read alongside the horizon scanning report on national policy produced by the Corporate Office.

HIGHLIGHTS

Some key highlights / common themes of particular relevance to the Trust are set out below. NB this does not summarise all the items set out in the main body of the report.

Item	Notes	Likely to be of particular interest to…
Finance	CCG Boards financial focus on latest performance and position at M6. Activity in Acute Trusts, Continuing Healthcare expansion, Drug Prescriptions by GPs, Investment in MH and, Learning Disability placements identified as issues/ risks.	• Deputy Chief Executive / Chief Finance Officer
CCG Merger in south west London	CCG Boards all agreed to assume the constitution proposed and the application has been approved by NHSE/I. Consultation commenced in November 2019 on proposed single structure with outcome reported and response in 2020 and expected formalisation and implementation/ operation from 1 April 2020. Also discussed at some Health and Wellbeing Boards.	• Chief Strategy Officer • Deputy Chief Executive / Chief Finance Officer
2020/21 Business Planning	CCG Board discussions linked to Health and Care Plans and an approach of collaboration, an emphasis/ focus on acute admission avoidance with Community Services, Elective Repatriations, Mental Health, and Outpatient Transformation as well as improving the financial position for the system as a whole.	• Chief Strategy Officer • Deputy Chief Executive / Chief Finance Officer • Chief Operating Officer
Improving Healthcare Together Programme	Consultation on three potential options for the location of a brand-new specialist emergency care hospital- on the Epsom, St Helier or Sutton hospital sites- has been launched and runs until 1 April 2020.	• Trust Executive Team

WANDSWORTH CCG AND HWB: Q3, 2019-20

BOARD PAPERS SUMMARY

CCG Board (November 2019) *Bi-Monthly Meetings*

- Noted progress of the **merger of CCGs in South West London**. All six CCGs have now voted to adopt the proposed new constitution, and NHS England have approved the application to merge. Consultation with staff on proposed changes to structures began in November, and the CCGs will merge on 1 April 2020.
- Discussed a proposed **approach to planning for 2020/21**. This approach is intended to be framed around the Wandsworth Health and Care Plan, and more collaborative in nature with providers and other stakeholders – for instance based on the principle that savings should be genuine savings for the system and not at the risk of individual partners.

Board Papers can be found at: https://www.wandsworthccg.nhs.uk/aboutus/OurBoard/Pages/Board-Papers.aspx

Health and Wellbeing Board (November 2019) *Quarterly Meetings*

- This meeting was cancelled. The Health and Wellbeing Board is next due to meet in February 2020.

MERTON CCG AND HWB: Q3, 2019-20

BOARD PAPERS SUMMARY

CCG Board (November 2019)

Bi-Monthly Meetings

- Received **finance update**, ,at month 6 CCG is forecasting an unmitigated risk of around £0.65m . Predominant risks are in acute activity, learning disability placements and category M drug purchased through GGP prescribing .
- Merton **Annual Public Health Report on tackling diabetes** 2019 presented- focussed on tackling diabetes as the number of people in Merton affected are increasing year on year, and diabetes is a priority for the boroughs Health and Wellbeing Board to support the development of a system wider approach to prevention.
- **South West London Merger Application** – board noted approval from NHS England and NHS Improvement to proceed with the merger of the 6 CCG's on the 1 April 2020. Detailed programme plan to implement changes developed . Consultation with staff on proposed changes commenced November with response published in the New Year.
- **Systems Planning** – board asked to note the collaborative system planning approach with providers of health and care. Focus on partnership approach; move from commissioner<->provider bilateral relationship to multilateral discussion and agreement .

Board Papers can be found at: https://www.mertonccg.nhs.uk/about-us/Our-Governing-Body/Pages/Governing-Body-Papers.aspx

Health and Wellbeing Board (October 2019)

Quarterly Meetings

- Board approved plans for public communication of the final **Merton Health and Care Plan** 2019-2021.
- **Health and Wellbeing Strategy Priority actions** presented for consideration by the Board- new priority healthy workplace, and keeping momentum on tackling diabetes.
- **Better Care Fund plan update** for nothing by the Board, detailing areas where funding had been allocated . Priority areas for investment aligned to the Merton Health and Care Together Programme (Integrated Locality Teams, Integrated Intermediate Care , Enhanced Support to Care Homes).
- **South West London CCG Merger update**, for noting by the board, draft single CCG structure has been shared with staff for consultation , with merger effective from 1 April 2020.

Board Papers can be found at: https://democracy.merton.gov.uk/ieListDocuments.aspx?CId=184&MId=3479&Ver=4

CROYDON CCG AND HWB: Q3, 2019-20

BOARD PAPERS SUMMARY

CCG Board (November 2019)

Bi-Monthly Meetings

- Welcomed a **range of joint appointments** across the CCG and Trust, including a joint Trust CEO/Placed Based Leader for health; a joint chief financial officer, a joint chief operating officer, and a joint director of strategy and transformation.
- Received an update on the '**Mental Health Support Teams in Schools**' (MHST) project
- Noted progress of the **merger of CCGs in South West London**. All six CCGs have now voted to adopt the proposed new constitution, and NHS England have approved the application to merge. Consultation with staff on proposed changes to structures began in November, and the CCGs will merge on 1 April 2020.
- Received an update on **planning for 2020/21 and beyond**, based on a 'whole system approach' and prioritising improvements in mental health, reduction in unnecessary admissions via strengthening of community services, 'repatriating' more elective secondary care (including from St George's), and reducing unnecessary outpatient activity.

Board Papers can be found at: https://www.croydonccg.nhs.uk/about-us/Governing%20body/Pages/Governing-body-papers.aspx

Health and Wellbeing Board (October 2019)

Quarterly Meetings

- Received updates on work to improve **mental health and emotional wellbeing in children and young people**.
- Reviewed the Croydon response to the national **Prevention Green Paper** .
- Received an update on **commissioning intentions** for 2020/21 across the CCG and local council.
- Noted the **annual seasonal flu plan**.

Board Papers can be found at: https://democracy.croydon.gov.uk/ieListDocuments.aspx?CId=172&MId=1758&Ver=4 and https://democracy.croydon.gov.uk/ieListDocuments.aspx?CId=172&MId=1961&Ver=4

KINGSTON CCG AND HWB: Q3, 2019-20

BOARD PAPERS SUMMARY

CCG Board (November 2019)

Bi-Monthly Meetings

- Board received **finance update**- Kingston CCG is expected to meet all financial targets as at September 2019, including the planned break- event position. Underlying position at month 6 is £4.1M deficit (1.5%). Deterioration since month 5, due to high growth in the acute sector, continuing healthcare growth and high levels of mental health investment.
- **South West London CCG Merger update**, for noting by the board, with merger effective from 1 April 2020.
- **Special Education Needs and Disability (SEND)** update provided on actions taken following inspection in 2018 and written statement of actions received.

Board Papers can be found at: https://www.kingstonccg.nhs.uk/about-us/7-may-2019.htm , https://www.kingstonccg.nhs.uk/about-us/2-july-2019.htm and https://www.kingstonccg.nhs.uk/about-us/3-september-2019.htm

Health and Wellbeing Board (November 2019)

Quarterly Meetings

- The **2019/20 Better Care Fund Plan (BCF)** was presented; it builds on and continues to deliver Health and Social Care integration as a programme of work with a focus on admission and ambulance call avoidance; the development of a 7 day Community and Integrated Intermediate Care Services; discharges, Length of Stay and patients that are stranded supported by a MD; fewer Nursing and Residential Home placements and, the introduction of a Trusted Assessor Model. Board noted the changes to the planning requirements for 19/20 and the joint priorities and planning approach was endorsed.
- **Annual Report of the Child Death Overview Panel** for 2018/19- Board considered the report, learning from the report noted, supporting the dissemination of learning to partners and general public regarding child safety.
- **Public Health Annual update**– Board noted report.
- **Partners' Update and Work Programme**- Board noted report and the work programme.
- **SEND Partnership Board** – board noted progress on the SEND Transformation Plan and that an OFSTED would be re- inspecting gin 2020.

Board Papers can be found at: https://moderngov.kingston.gov.uk/ieListDocuments.aspx?CId=488&MId=8791

RICHMOND CCG AND HWB: Q3, 2019-20

BOARD PAPERS SUMMARY

CCG Board (November 2019) *Bi-Monthly Meetings*

- Noted the CCG's **financial position** at month 6, the CCG is reporting to achieve the planned surplus of £0.1m.
- The Five Year **Health and Care Plan** discussion document for people in South West London has been shared with partners and will be published following feedback.
- **SWL CCG's merger** – progress and next steps noted by board with the new CCG operating from the 1 April 2020.
- **Managing Directors report** noted updates on the following - **Special Educational Needs and Disability (SEND)**, designated clinical and medical officer appointed and local government association peer review completed ; **Crisis Café**- established managed by Richmond Borough Mind; **Planned care Transformation Programme** Briefing- programme covers a no of areas including gynaecology, respiratory, theatres and urology. Work streams established with aim to reduce activity, improve efficiency and create a more connected system.
- **Future ways of working- integrated health and care**, to note discussions continue across Richmond on the developing local 'place' structures for Richmond.
- **Richmond Carer Strategy** – Board noted the development of the Richmond Carer Strategy 2020-2025 . The strategy sets out the priorities to support, recognise and value carers over the next 5 years.
- **CQC Review of Health Services for Children Looked After and Safeguarding**- to note to review findings and an over view of the programme to address the recommendations.

Board Papers can be found at: http://www.richmondccg.nhs.uk/about-us/governing-body/governing-body-papers

RICHMOND CCG AND HWB: Q3, 2019-20

BOARD PAPERS SUMMARY continued…

Health and Wellbeing Board (November 2019) *Quarterly Meetings*

- The **Richmond Health and Wellbeing Board** is a partnership between Richmond Council, local GPs, Clinical Commissioning Group and Voluntary Sector. The focus of the board is to:
  - Improve population health and reduce health inequalities;
  - Reform the way the health and care system works, and;
  - Protect the health of residents.
- Board meet in November , no minutes available as yet . The agenda covered the following areas:
  - Richmond Better Care Fund 2019-20;
  - Refresh of the Children's and Young People's Plan;
  - Richmond SEND Future Plans 2019/20 to 2021/22;
  - Healthwatch Richmond Annual report 2018/19, and;
  - Health and Wellbeing Board communication update.

Board Papers can be found at: https://cabnet.richmond.gov.uk/ieListDocuments.aspx?CId=643&MId=4793&Ver=4

SUTTON CCG AND HWB: Q3, 2019-20

BOARD PAPERS SUMMARY

CCG Board (November 2019)

Bi-Monthly Meetings

- Board received updates on the below in the Directors update report:
  - **Election of chair for South West London CCG**- following NHS England's approval to merge the 6 CCG's, agreement has been reached to appoint 1 chair for SWL CCG, whiles maintaining a borough-based clinical lead. Dr Andrew Murray, Merton CCG's current Chair , has been elected to take on the new role effective from 1 April 2010
  - **Planned care transformation programme**- On the 30 October 2019, Primary Care clinicians, working with CCG colleagues came together to think creatively about the opportunities for Primary Care in Sutton to support local planned care transformation programmes. The output of the workshop will translated into an engagement schemes for Sutton Practices for 2020/21.
  - Suicide prevention project- the SWL mental health team is working in collaboration with the six local authorise, South West London and St George's Mental Health NHS Trust, the Metropolitan Police and Mind to deliver 2 prevention projects; suicide prevention trail blazer aims to prevent suicide amongst middle age men and the suicide bereavement liaison service. Schemes funded through NHS England .
  - SWL CCG merger – Board received update that the new CCG will come into operation on the 1 April 2020, with staff consultation under way mid November and outcomes published in the New Year
  - Financial position Month 6- Board notes; CCG reporting on plan year to date and full year forecast, net risk to meeting 19/20 (control total) is £5.9M, SWLHCP is working on an aggregated whole system control total basis.

Board Papers can be found at: https://www.suttonccg.nhs.uk/Aboutus/Our-board/Sutton%20board%20papers/FINAL%20SCCG%20GB%20071119.pdf

Health and Wellbeing Board

Quarterly Meetings

- No meeting planned in Q3, 2019/20. The Health and Wellbeing Board was next due to meet in January 2020 which has been cancelled with the next meeting planned in March 2020.

MERTON, SURREY DOWNS AND SUTTON CCGs

IMPROVING HEALTHCARE TOGETHER PROGRAMME

Health leaders from NHS Surrey Downs, Sutton and Merton CCGs have agreed to launch a public consultation on proposals to invest £500 million to improve hospital services.

The consultation considers three potential options for the location of a brand-new specialist emergency care hospital – on the Epsom, St Helier or Sutton hospital sites. Sutton was agreed by the CCGs as a preferred option for the consultation, but health leaders were clear that all three options could be delivered by the NHS.

The new 21st century hospital facility would bring together six services for the most unwell patients, as well as births in hospital. All three options would see the majority of services (85%) staying at Epsom Hospital and St Helier Hospital, with an investment of at least £80 million in the current buildings. Both hospitals would run round the clock, 365 days a year, with urgent treatment centres, inpatient and outpatient services.

The CCGs have set out their preferred option for the new state-of-the-art hospital facility to be Sutton Hospital, next to the Royal Marsden specialist cancer hospital. Services provided at the specialist emergency care hospital would include A&E, critical care, emergency surgery, births in hospital and inpatient children's beds. The consultation proposals explain that this option would have the greatest benefit for the most people, the least overall impact on travel for older people and those from deprived communities, while also having the smallest increase in average travel time for the most people. It would also be the easiest and fastest to build – taking around four years, rather than up to seven for the alternative options.

The consultation period is Wednesday 8 January and Wednesday 1 April 2020. A copy of the full consultation document and a consultation questionnaire can be accessed from www.improvinghealthcaretogether.org.uk

CURRENT OPPORTUNITIES FOR ST GEORGE'S

CLINICAL TENDERS

The following clinical tenders are have been open to tender or due to be open which may provide St Georges' to introduce new clinical services, expand current provision or retain existing services:

Abnormally Invasive Placenta Specialist Services

- Ahead of formal tender notification, a market engagement exercise has been carried out by NHS England on their intention to tender for services to provide specialised maternity services to women diagnosed with abnormally invasive placenta.
- Women's service (CWDT) have submitted a response to the market engagement exercise and await the formal tender notification.
- An options paper was presented to IDG in August outlining the services' intention to bid.
- We have not yet had notification when the tender will open.

Termination of Pregnancy Services (TOPS) for Patients with Complex Co-Morbidities

- Women's services (CWDT) contributed to a market engagement exercise in August.
- It is anticipated that between 30- 40 Centres will be commissioned in England; activity of 3,000 cases per annum nationally with costs covered by the National Tariff for Termination Services.
- NHS England expect to formally procure 'Termination of Pregnancy Services (TOPS) for Patients with Complex Co-Morbidities', with a contract commencement date in April 2020.
- We have not yet had confirmation of when the tender will open.

Intestinal Failure centres

- NHS England recently tendered for specialist Intestinal Failure centres, with "North West and South West London" being one lot.
- The deadline for bids was the 7th November 2019.
- The Trust was part of a bid submission in partnership with St Mark's (NWL) as the lead provider.
- The outcome of the tender is due to be communicated at the end of January.