

St. George's – update on trust developments

Presentation to Merton Health Scrutiny Panel
13 November 2013

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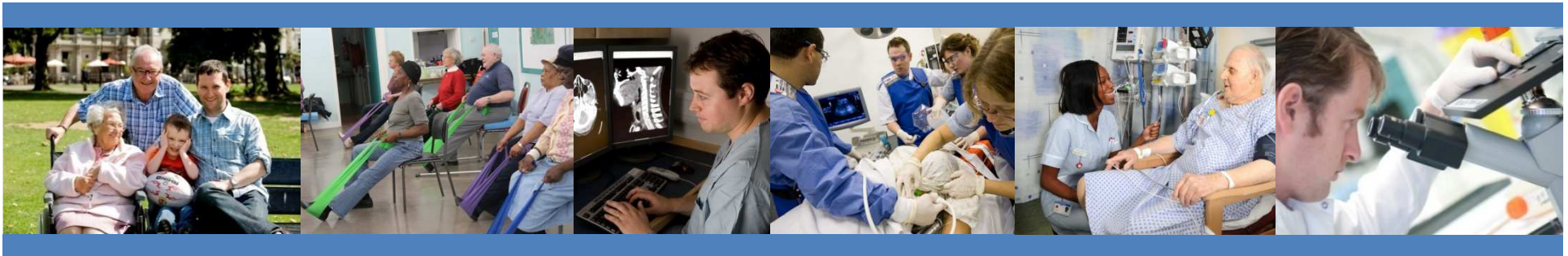
Miles Scott, Chief Executive
Alison Robertson, Chief Nurse
Peter Jenkinson, Director of Corporate Affairs

Contents

- Quality improvement strategy
- Care Quality Commission inspections
- Planning for Winter/emergency care
- Future developments – plans for major service and capital developments
- Foundation Trust application

Quality Improvement Strategy 2012 – 2017

Approved by the Trust board November 2012



Why do we need a quality Improvement Strategy ?

- Refreshed trust strategy: 10 year vision, underpinned by a series of principles, one of which is to focus on quality and drive continuous improvement.
- Increasing focus on NHS to deliver quality (rather than quantity)
- Increasingly demanding targets for quality of care.
- Poor quality costs.
- Feedback from patients, service users and stakeholders.
- Local drivers for change – CCG, health and Well Being Boards, London Quality and Safety programme, BSBV.
- Post Francis – Keogh Review, Berwick Report, Cavendish Review, Hart/Clwyd review (not yet published).

So what does this mean ?

- St George's has much to be proud of, we deliver a range of services that are comparable against national or international best practice standards.
- We have a developing patient safety programme but there is more work to do to become a learning organisation that is prepared to challenge poor practice in order to increase our reliability and reduce inconsistency.
- We are building a strong foundation to improve our patient and service users experience and can demonstrate that a relentless focus on this can deliver results, such as in our maternity services. However, again it is too inconsistent and we want to continue to demonstrate continual improvement in this domain of quality. Caring for patients is our core business and we need to make sure that staff strongly focus on every aspect of the experience of the care and services they provide to ensure that our patients report a high patient experience.
- This means that we need to overlay our quality improvement strategy on a strong organisational culture with all our staff taking responsibility, not only for what they do but for what others do.

What is our approach?



Our quality improvement strategy will be underpinned by three supporting domains:-

Patient safety

- Will I feel safe?
- Will I be protected from avoidable harm?

Patient experience

- Will I feel cared for?
- Will I be treated with compassion, dignity and respect in a clean, safe and well managed environment?

Patient outcomes

- How will my clinical procedure be carried out?
- What will its results be?
- What about my quality of life after treatment?

Our strategy has been converted into an implementation plan and is monitored by the Quality and Risk Committee (sub committee of trust board).

Improving Patient Experience – our commitment to patients



How ?

- Programme of cleaning and environmental inspections.
- Continue to promote and champion the 'Protected Mealtime' initiative. Ensure that those who require help at mealtimes are clearly identified and properly supported.
- Raise awareness and understanding to improve the care of patients with Dementia ('Butterfly Scheme')
- Increased our resource to support the care of people with learning difficulties (one part time to two full time posts)
- Focus on gathering and using feedback to make improvements.

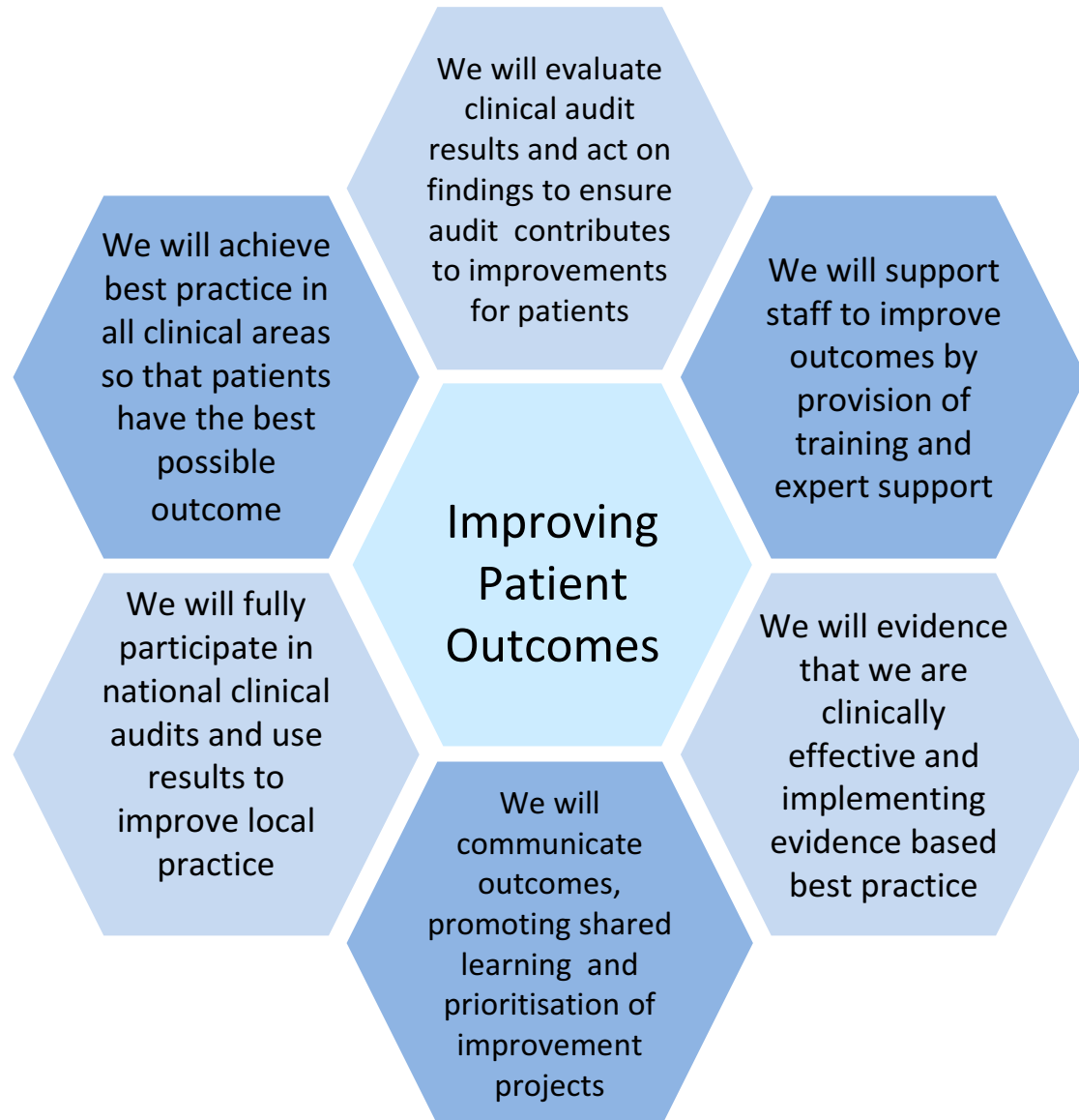
Improving Patient Safety – our commitment to patients



How ?

- Established a network of clinical governance leads across all care groups, with clear leadership across all disciplines.
- Supporting awareness, understanding and compliance with our new handover policy.
- Regular staff safety forum – led by Chief Nurse and Medical Director, use of a serious incident as a case study to highlight key safety messages and promote Executive visibility.
- Safe Staffing tool to monitor safety on a daily basis.
- Trustwide taskforce to support pressure ulcer prevention and reduce the incidence of healthcare acquired pressure ulcers.

Improving Patient Outcomes – our commitment to patients



How ?

- Continue to maintain lower than expected mortality rates and investigate any areas that prompt an alert.
- Better evidence our support/compliance with NICE Guidance.
- Increase uptake of training to improve the audit skills of our staff.
- Ensure our clinical audit strategy is aligned to the national requirement for clinical audit as well as supporting trust objectives.

Who is responsible ?



- **Sarah Wilton: Non Executive Director chairs the Quality and Risk Committee**



- **Prof. Alison Robertson: Chief Nurse/Director of Operations leads the patient experience and patient safety domains. Also Director of Infection Prevention and Control.**



- **Dr Ros Given Wilson: Medical Director leads the patient outcomes domain**



- **Peter Jenkinson: Director of Corporate Affairs leads on Quality governance**

Care Quality Commission Inspections

- 2-day inspection in January 2013
- Identified 6 areas of non-compliance in which action was required. Of these 6 areas, 3 were considered by the CQC to have a minor impact on patients and services and 3 were considered to have a moderate impact.
- Improvement programme followed, including full implementation of the agreed action plan arising from the CQC's inspection
- Follow-up inspection of the St George's Hospital site, 15-17 August.
- Total of 15 inspectors, mix of CQC inspectors and clinical specialists, and experts by experience.
- Included evening and weekend visits.
- Revisited the areas and outcomes covered in the January inspection plus some others – total of 21 wards or departments.
- The inspection was carried out using the same inspection methodology as used in January. 8 outcomes were tested.

Care Quality Commission Inspections

- Final report issued to the trust 23 October (not yet published by the CQC)
- Compliance with five standards and non-compliance in three, all of which judged to have 'minor' impact on patients.
- An action plan to address the remaining areas of non-compliance will be returned to the CQC by their deadline of 6th November.

Key points

Four outcomes judged to be non-compliant in January were compliant in the August inspection:

- Respecting & involving people who use services
- Care & welfare of people who use services
- Meeting nutritional needs
- Cleanliness & infection control

Two outcomes were not re-assessed by the CQC:

- Safeguarding people who use services
- Supporting workers

Two new outcomes were included in the August inspection













- Management of medicines
- Assessing & monitoring the quality of service provision

Two outcomes were judged as non-compliant in both the January and August inspections (the issues giving rise to non-compliance in August were different in nature and the area of the trust in which they were identified:

- Staffing
- Records

Care Quality Commission Inspections

Table 1

CQC Outcome	Topic	January 2013		August 2013		
		Compliance	Impact	Compliance	Impact	Issue identified
1	Respecting & involving people who use services		moderate		n/a	
4	Care & welfare of people who use services		moderate		n/a	
5	Meeting nutritional needs		minor		n/a	
7	Safeguarding people who use services from abuse		n/a			
8	Cleanliness and infection control		moderate		n/a	
9	Management of medicines				minor	Lack of monitoring of min/max temperatures of drugs fridges
13	Staffing		minor		minor	Staffing levels on Trevor Howell ward & day unit
14	Supporting workers		n/a			
16	Assessing & monitoring the quality of service provision				n/a	
21	Records		minor		minor	Incomplete record keeping on Brodie & Caroline wards

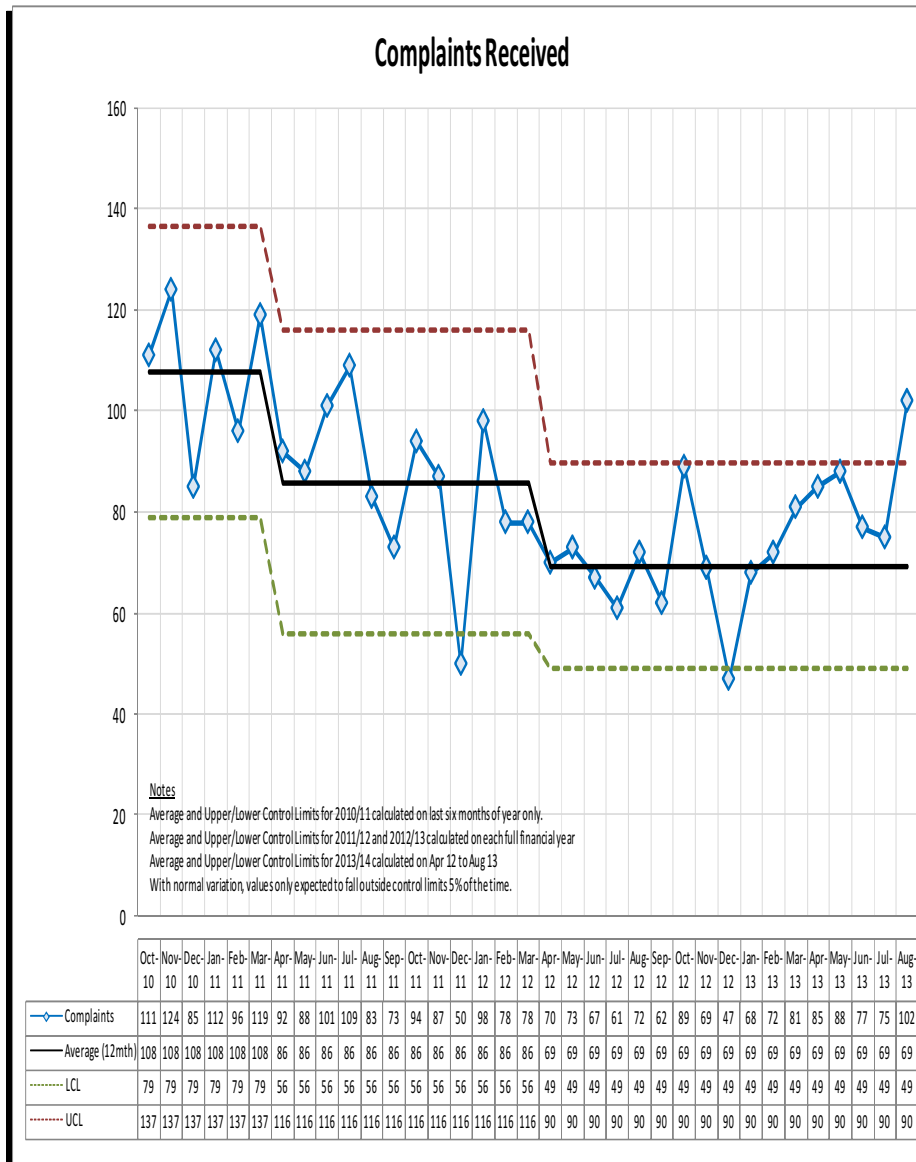
Care Quality Commission Inspections

- New 'Chief Inspector' Inspection to follow in Q4 of 13/14 (wave 2) – due to being an aspirant foundation trust.
- New inspection regime will mirror Ofsted approach in rating the quality of care in Hospitals as:
 - Outstanding
 - Good
 - Requires Improvement
 - Inadequate
- Need to achieve a rating of 'good' or 'outstanding' to progress into the Monitor phase of the FT pipeline.
- Publication of CQC's new intelligent monitoring data in October showed the trust to be in band 6 (lowest risk).

TDA Clinical Quality review visit

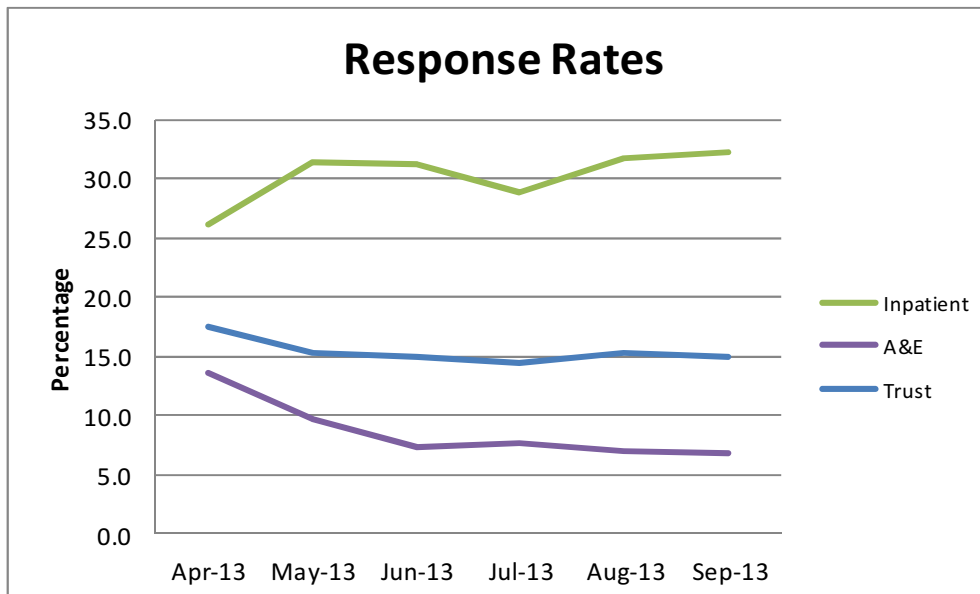
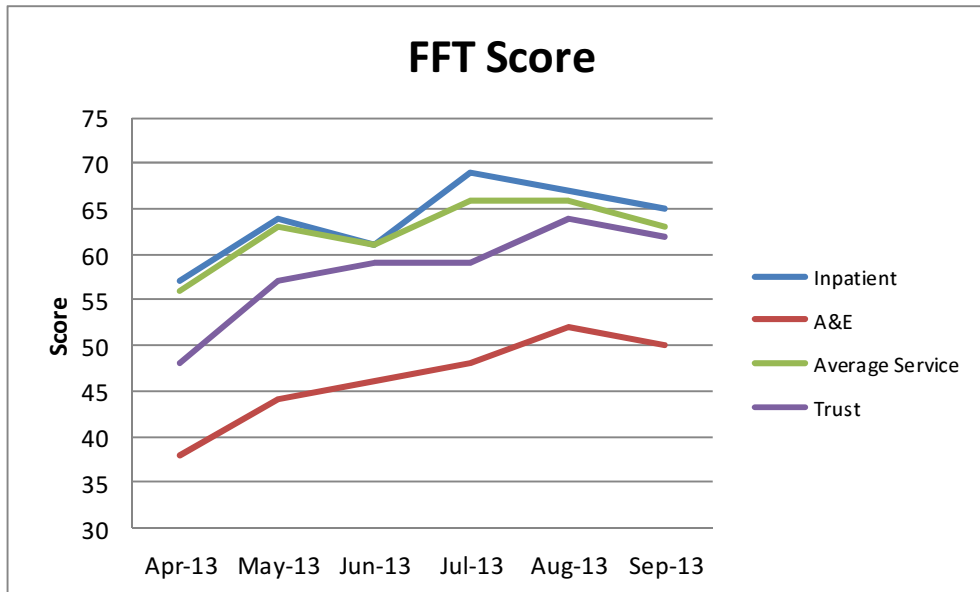
- Visit 7-Aug-13
- Part of its quality assurance in the FT application process
- Five teams from the NTDA (2 people per team)
- Staff focus groups, visits to clinical areas, meetings with key senior staff,
- St. George's and Queen Mary's Hospital sites visited and focus groups with community staff which were held at the St. John's Centre in Battersea.
- Purpose was for the NTDA to fill in information gaps regarding the Trust (e.g. in relation to mortality monitoring), and to provide feedback to the Trust that may be helpful in preparation for the CQC visit.
- Feedback was positive overall - confirmed that they would have been able to recommend to the NTDA Board that the Trust was ready to be referred to Monitor on the basis of the visit.

Complaints



- 20% reduction overall from previous year
- PALS saw contacts increased but concerns decreased
- Biggest increase was in “care” = medical care, from 10 in Q1 to 46 in Q4
- This year Q1 increase – August considerable but back on track
- Now using SPC’s
- Performance re: response times struggling
- but 3 day acknowledgement better
- Themes – communication, waiting/delays, attitude, multiple moves
- Outcomes good, experience less so - similar to NIPS and Cancer survey
- Actions match themes
- Some hotpots – aware & monitoring
- Increase in good news/thank you letters
- New processes more streamlined
- Plans – RAG rating report, satisfaction survey, benchmark when Clewyd/Hart published

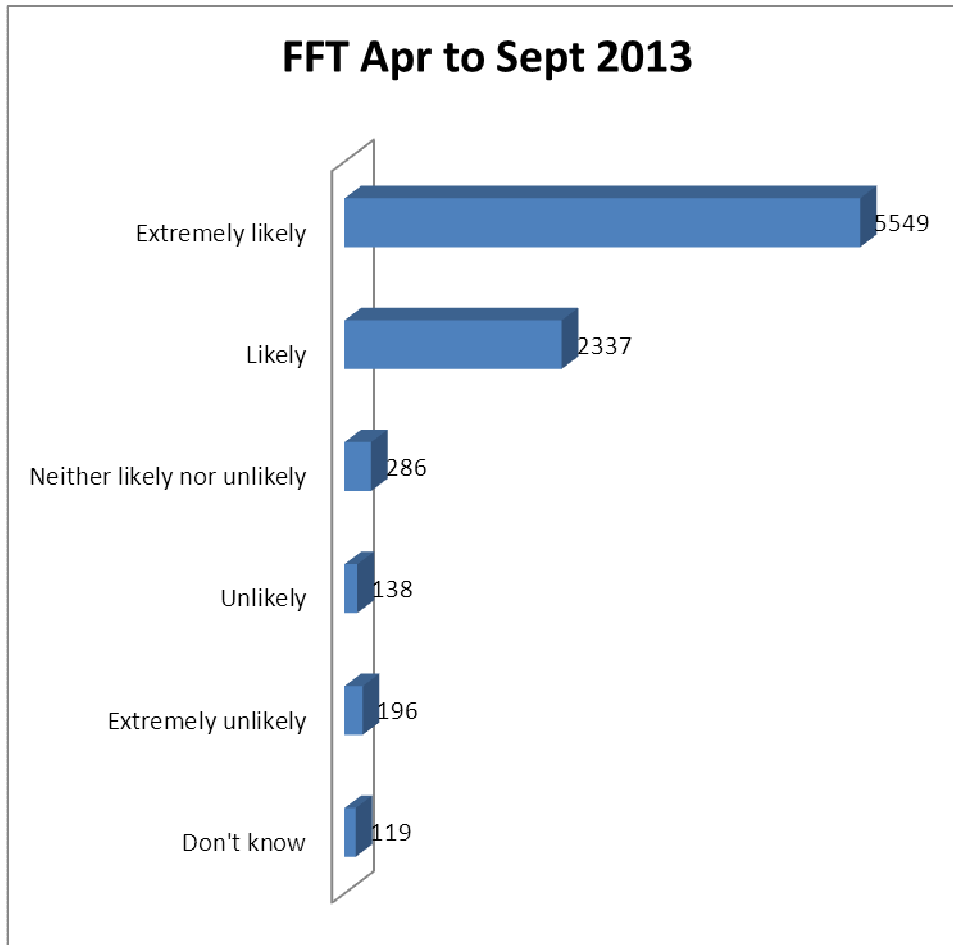
Friends and Family Test



- Well embedded
- Apr to Sept 8,625 surveys
- Overall very positive
- Improving Net Promoter scores
- Average service score good
- Response rates good generally but A&E a significant challenge
- A variety of methods used, mostly tablets
- Volunteers and patient reps
- Qualitative text feedback
- Some confusion re: question as other answers don't always match "extremely unlikely" rating

FFT breakdown

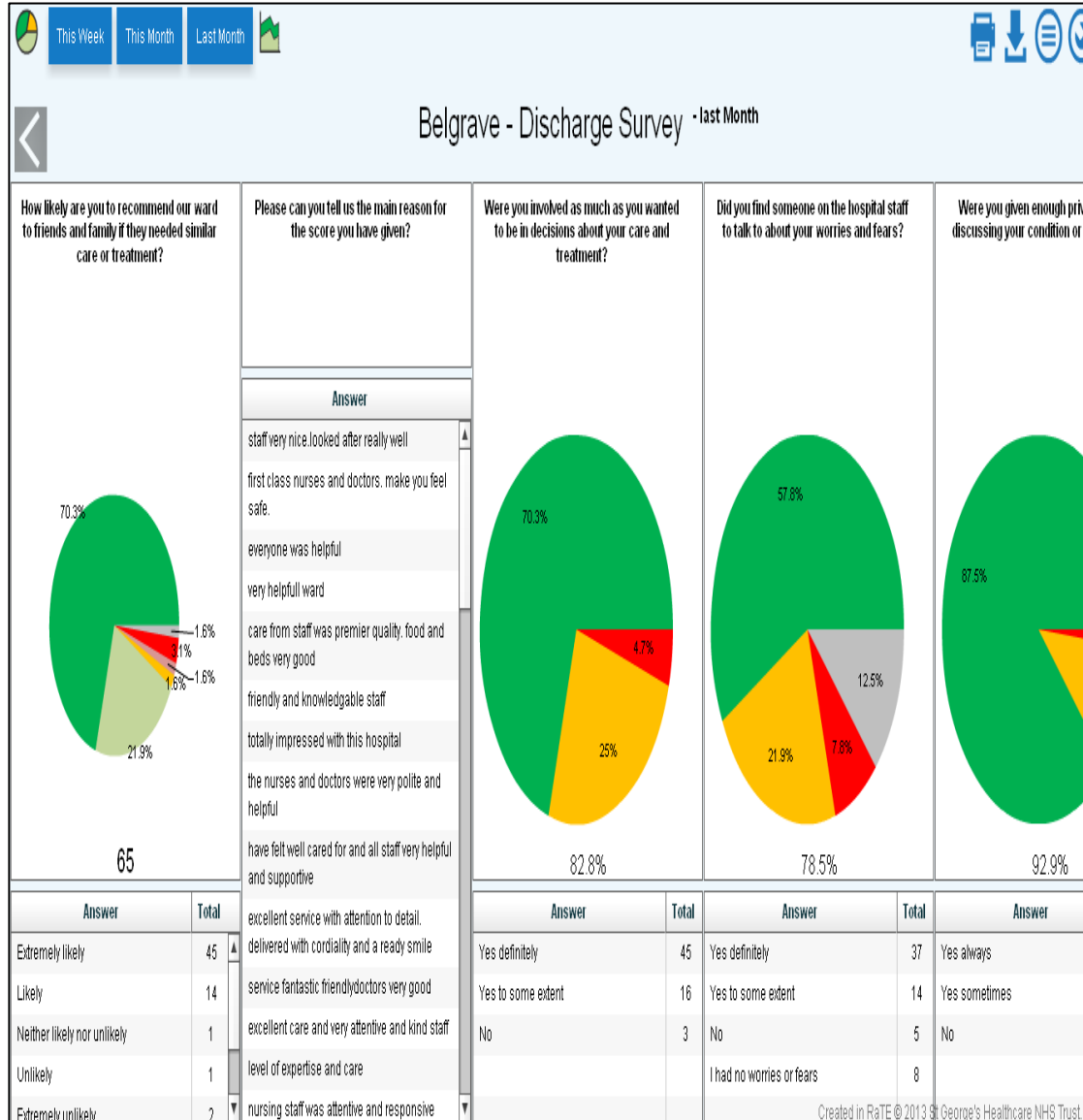
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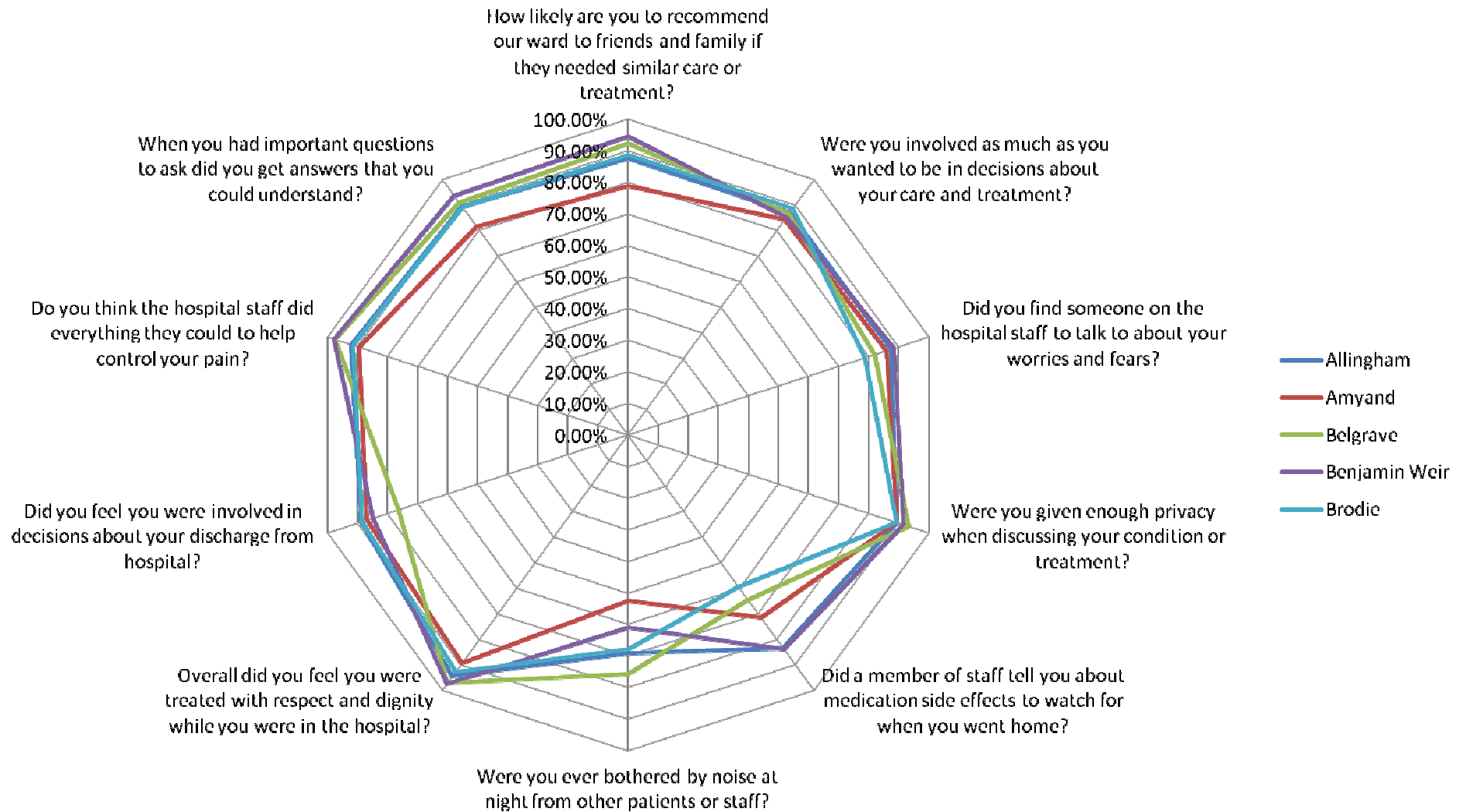
- The whole picture
- Overall generally very positive
- Some extremely unlikely ratings – majority A&E (waiting) and small numbers elsewhere (attitude, information and noise)
- Important to look at other patient feedback to triangulate
- Displayed in clinical areas
- Local ownership
- Board reporting and other committees

Other Patient Feedback

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- Bespoke Real Time Experience (RaTE) system
- 9 other questions & demographics
- Important to review with FFT
- Reasons given
- Intranet page & public facing
- Part of divisional performance review
- Thematic review
- Actions & learning at local level to drive quality improvements



Cancer Patient Experience

The results of the 2012/13 National Cancer Patient experience Survey which focussed on patients receiving treatment at St. George's from September to November 2012 were published in August.

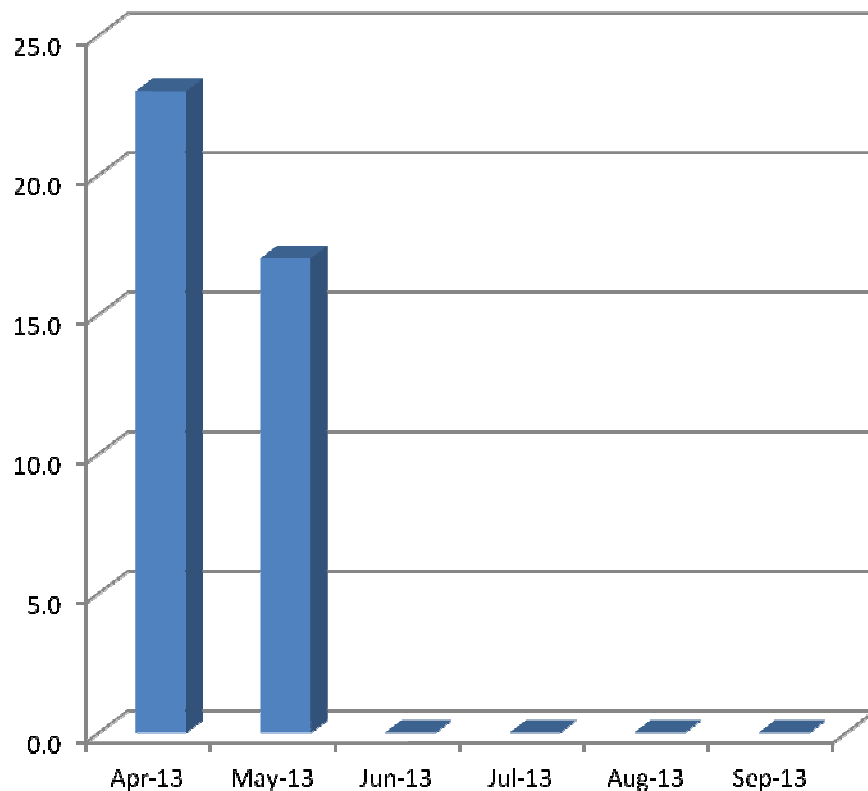
Overall the ratings for Cancer patients in England, including St George's, are high. Having said that 9 London Hospitals (including StGH) are in the bottom 10 for patient experience nationally, although it should be acknowledged that the range of results are very narrow.

We all agree we can do better

- Refurbishing outpatient clinic (opened October).
- Reviewing all written information given to patients for all cancer types.
- Reviewing how we inform patients about support available to them and their carers.
- Promoting the McMillian information and Support Centre and Increasing the availability of information in wards and clinics.
- Establishing a dedicated 'cancer patient helpline' telephone service.
- Implementing a new training programme to improve communication skills.
- Establishing a patient volunteer programme to help in busy clinics.
- Establishing patient workshops to help highlight communication issues and how they can be improved.

Minimising Mixed Sex Accommodation

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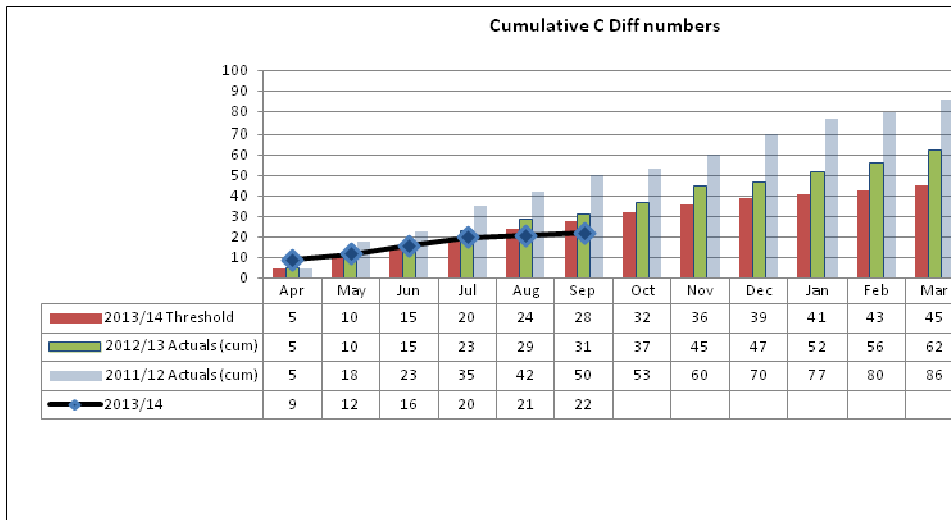


- 3 adult ITUs
- HASU
- Clinically appropriate
- Other ICNARC data positive
- Nationally differences in data collection
- Supported by CCG
- NTDA plans to change reporting nationally
- Other feedback positive re P&D

C Difficile Infections

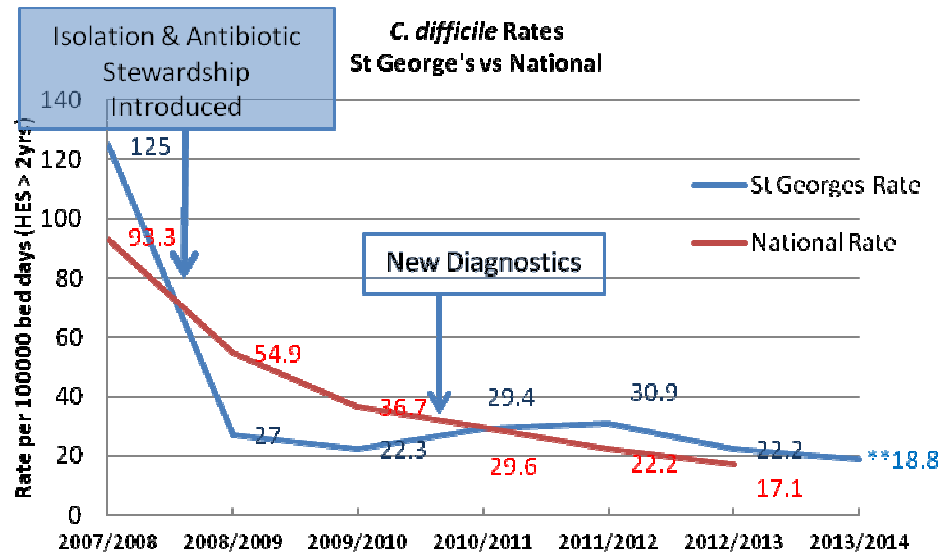
Performance : 1 C Diff cases in September 2013
Year to date total of 22 vs trajectory of 28

Actions

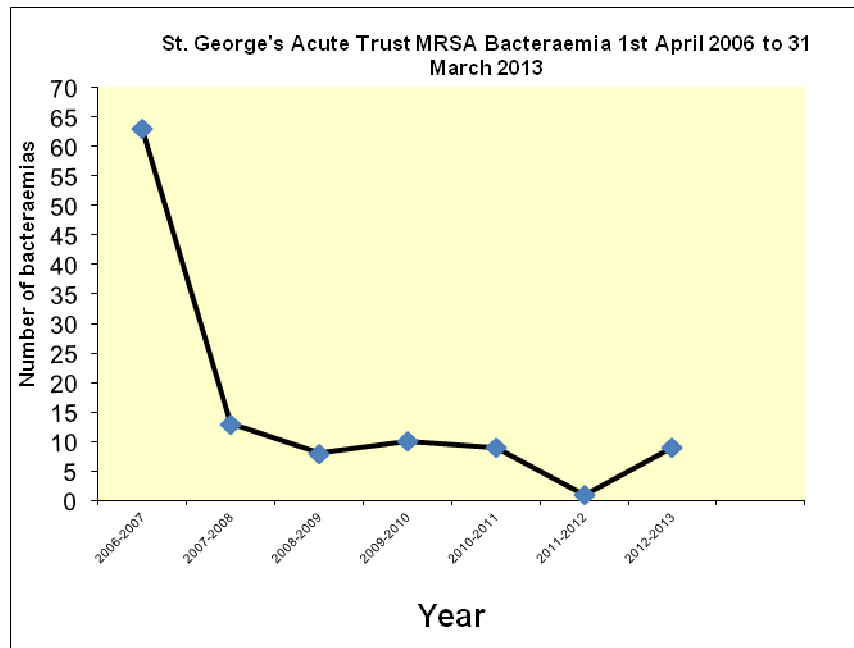
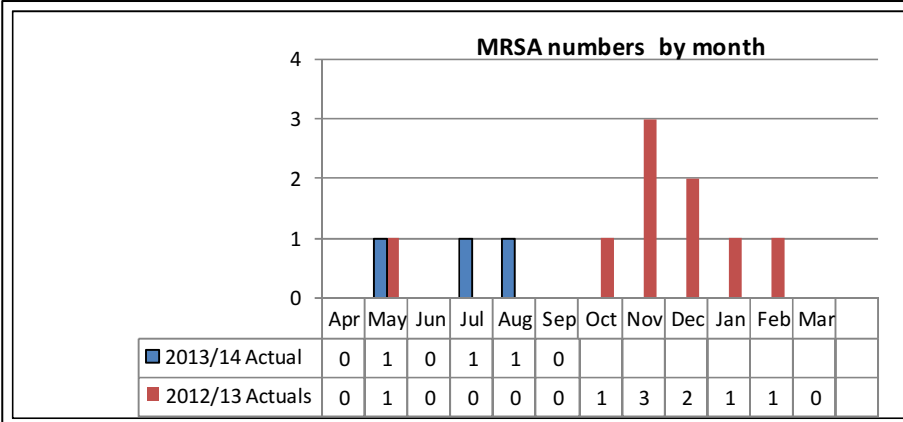


- Lowest level of *C. difficile* ever in this trust.
- Estimated annualised rate of 18.8 per 100 000 bed days.
- How did we get here?
 - Antimicrobial Stewardship Program.
 - Diarrhoea Protocol with assurance of clinical review.
 - Prompt isolation of diarrhoea cases
 - *C. difficile* ward rounds.
 - Improved diagnostics.
 - Introduction of fidaxomicin for treatment of disease.
 - Use of molecular diagnostic techniques to identify and isolate carriers.
 - Routine ribotyping of all *C. diff*s in hospital - no evidence of ongoing transmission.
 - Root Cause analyses to identify and address modifiable causes.
 - Learning from other trusts.

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Performance



Actions

Since 2006 there has been a dramatic decrease in MRSA but numbers have remained relatively static for past 5 years.

Core Strategies to reduce MRSA BSI

- Screening
- Decolonisation
- Isolation
- Hand Hygiene
- IV line Care
- Wound Care
- Antimicrobial Stewardship

Recent initiatives to maintain and improve practice of core strategies

- Improving line care: education, training, promotion, policy, documentation, surveillance. E.g. FRED campaign. IV line care rounds, cannulation packs, trust wide audits.
- Improve Blood Culture Competencies – medical and nursing staff.
- Improve Root Cause Analysis Tool

Our performance: SHMI + HSMR

Oversight of both measures by the trust Mortality Monitoring Group (MMG)

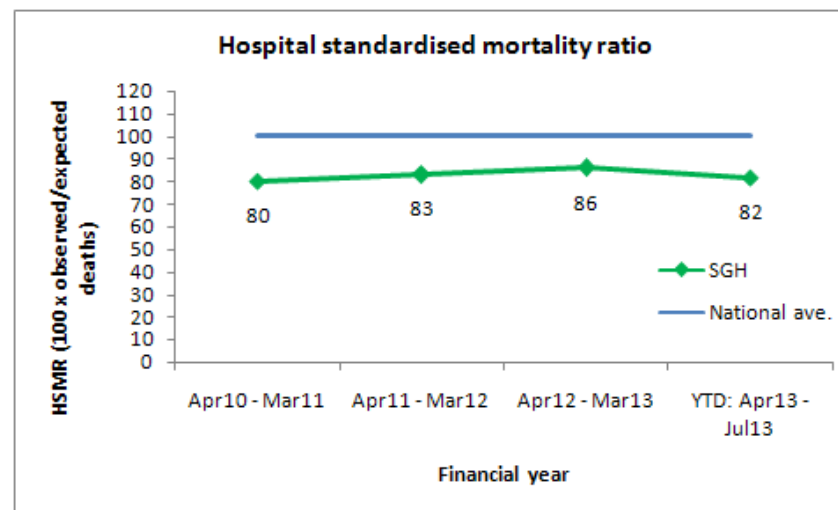
SHMI

- Latest score (Jan12-Dec12): 0.81, categorised as 'lower than expected'
- SGH identified as (positive) repeat outlier as our mortality has been lower than expected over 2 consecutive years

HSMR

- HSMR for most recent 12 months (Aug12 – Jul13): 85.2
- Significantly better than expected
- Monthly analysis by procedure, diagnosis and demographics
- 'Signals' investigated + reported to MMG
- Divisional mortality ratios included in quarterly performance monitoring

Period	SHMI	Banding
Jan11 – Dec11	0.79	Lower than expected
Apr11 – Mar12	0.79	Lower than expected
Jul11 – Jun12	0.80	Lower than expected
Oct11 – Sep12	0.82	Lower than expected
Jan12 – Dec12	0.81	Lower than expected



Hospital standardised mortality ratio (HSMR)

- Measure of whether mortality is in line with expected, based on national data
- Considers only in-hospital deaths and a basket of 56 diagnoses which accounts for around 85% of deaths
- Greater risk adjustment than the SHMI (palliative care, clinical classification system subgroups, social deprivation, past history of admissions, month of admission, source of admission)
- SGH subscribes to Dr Foster Intelligence which provides access to data, refreshed on a monthly basis
- Routinely analyse HSMR data by diagnosis group, procedure group and demographics with all 'signals' investigated and reported to Mortality Monitoring Group.
- Expressed as a ratio of observed to expected deaths x 100
- HSMR = 100 suggests observed deaths are in line with the expected number
- HSMR > 100 suggests higher than expected mortality (not necessarily statistically significant)
- HSMR < 100 suggests lower than expected mortality (not necessarily statistically significant)
- Data published annually in The Hospital Guide, with statistically significant outliers identified

Summary hospital-level mortality indicator (SHMI)

- Ratio between the expected number of patients who die following a treatment at the Trust and the number that would be expected to die on the basis of the average England figures, given the characteristics of the patients treated there.
- Introduced in October 2011 following recommendations from the Francis Inquiry that there should be a single and consistent mortality indicator for the NHS
- Includes all English acute non-specialist providers and considers all deaths in hospital and any within 30 days of discharge
- Shows whether the number of deaths linked to a particular hospital is more or less than expected, and whether that difference is statistically significant
- The expected number of deaths is calculated from a risk adjustment model developed for each diagnosis group that accounts for age, gender, admission method + co-morbidity
- SHMI = 1 suggests observed deaths are exactly in line with the expected number
- SHMI > 1 suggests higher than expected mortality (not necessarily statistically significant)
- SHMI < 1 suggests lower than expected mortality (not necessarily statistically significant)
- Published quarterly at organisation level by the Health + Social Care Information Centre, with statistically significant outliers identified.

A&E performance and Winter planning

Context



- St George's annual plan for 2013/14 includes additional investment for winter 2013.
- This investment was guided by detailed demand and capacity modelling.
- When the plan is fully implemented in Spring 2014 we will have additional bed capacity of 40 acute and cardiology beds, (a combination of additional bed spaces and beds freed up by other developments).
- The trust is investing £3m of its capital on this plan
- For these investments to secure sustainable performance at St. George's this winter they need to be additional to all of the capacity put in place last winter and the additional initiatives, posts and schemes put in place with the support of winter funding we had in 2012/13
- **However** this briefing highlights key risks to sustaining this performance even with the extra capacity outlined above
- The key risk factors are:
 - increased activity at St George's year to date in 2013/14
 - lack of winter funding for St George's in 2013/14

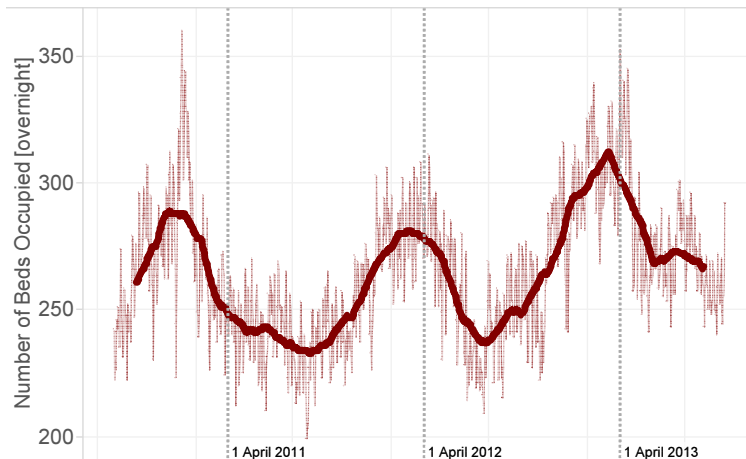
CAPACITY ACTION PLAN FOR 2013/14

Plan	Milestone	Which division?	When by
Beds	Open 23 acute medicine beds on Caesar Hawkins ward for winter	Medicine& Cardiovasc	Oct 13
	Focus on Length of Stay (LoS) in acute medicine (RCP4), senior health, surgery & neurosurgery (RCP3)	Divisional Chairs	Mar 14
	Relocate and expand Surgical Admissions Lounge (SAL) to release 6 surgical beds	Surgery & Neuro	Dec 13
	Complete business case for Surgical Assessment Unit	Surgery & Neuro	Mar 14
	Plan for medium to long term capacity expansion in neuroscience	Surgery & Neuro	Sep 13
	Redevelopment of the existing SAL(on Gray/Vernon wards) into new bed capacity - 15 beds with en suite facilities: Medicine in winter, surgery in summer	Surgery & Neuro /Medicine& Cardiovasc	Nov 13
Critical Care	Plan for 5 additional beds for winter 2013	CWDTCC*	Dec 13
	Complete business case for definitive expansion of General Intensive Care Unit (GICU) in 14/15	CWDTCC*	Jun13

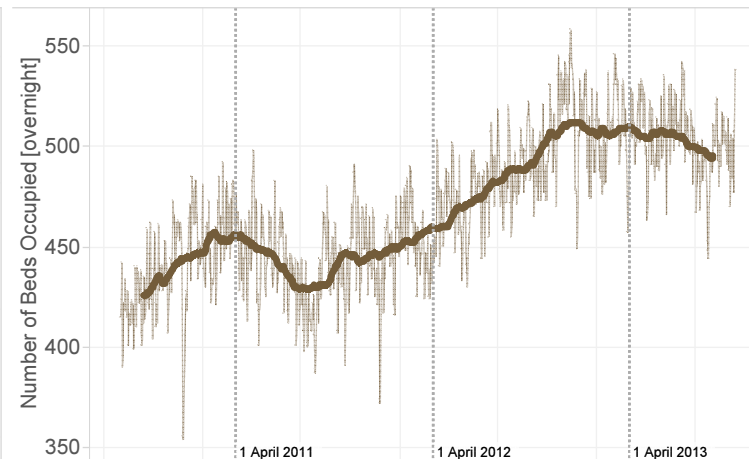
*CWDTCC = Children's, Women's, Diagnostics, Therapies & Critical Care Division

INCREASING PRESSURE ON BEDS

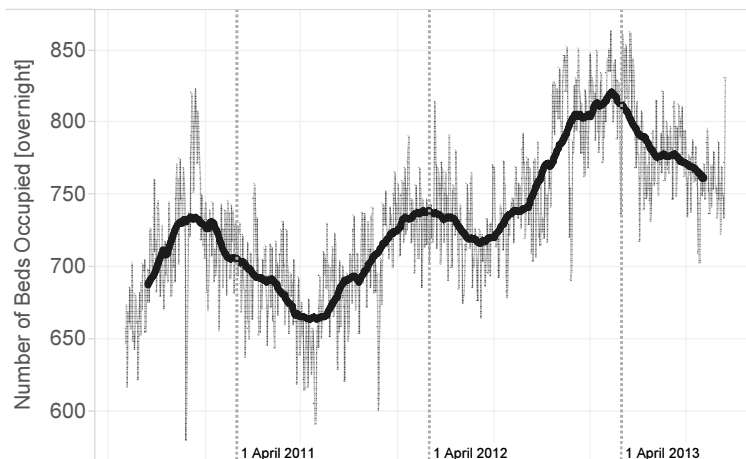
Geriatric & General Medicine Non-Elective Patients
(Actual vs. 12 week Moving Average)



Non-Elective Patients exc. Geriatrics & General Medicine
(Actual vs. 12 week Moving Average, excludes Obstetrics)



All Non-Elective Patients
(Actual vs. 12 week Moving Average, excludes Obstetrics)



- During 2013/14 to date we have seen a significant further rise in demand for acute inpatient capacity at St George's beyond what was modelled in our capacity plan and agreed with commissioners
- These graphs show the increase in occupied beds by non elective activity over the past three years

ACTIVITY TO DATE IN 2013/14

- Activity has been higher than forecast for the first four months of 13/14, for example General Medical Emergency activity was 5% greater than plan at Month 4.
- Length of stay (LoS) has reduced since April 13, but only back to where it was last summer (see next slide).
- Bed pressures have been at higher than winter levels until August 13 - June and July had higher activity than the preceding winter months.
- We have done a crude trust level analysis using the first four months of 13/14 by extrapolating activity to year end, using average Length of stay as it has been for months 1-4, assuming an average of 90% occupancy, and factoring in the planned winter beds
 - Trust wide, this indicates a **25 bed shortfall** on plan.
- This will be an underestimate because it does not take into account the big seasonal changes in medicine, also research evidences that average LoS considerably underestimates bed need.
- So we have also done further simulation analyses on the major pressure areas using Month 1-4 activity increases, and actual LoS distributions
- The simulation shows that if these patterns persist, we will be approximately
 - 15 beds** short on plan in medicine -**15 beds** short on plan in surgery
 - 10 beds** short on plan in neurosurgery
- This does not include smaller pressures in some specialties and there will be some small offsets from lower bed need in other specialties
- **In summary, modelling suggests a shortfall in capacity of between 25 to 40 beds for the upcoming winter**

WINTER FUNDING IN 2013/14

- £500m of winter funding has been identified nationally for the next two winters. However none of this has been allocated to St George's.
- St George's has consistently emphasised that the local share of these funds needs to be at least at the level of 2012/13 to support the need for additional winter capacity in the trust and in and the wider health system to ensure that we can deliver operational performance and quality & safety for our patients.
- In 2012/13 the trust and local CCGs received winter pressures funding to the sum of £2.5m (£1.8m from the national fund and £0.7m through Wandsworth PCT). Although this was not confirmed in the 2012/13 financial year until December 2012, this funding was deployed in full and made a significant contribution to performance across the system. Indeed the trust continued a number of these schemes into the first quarter of 2013/14 to address continuing emergency pressures.
- St George's will also be adversely affected as the result of neighbouring health communities not benefiting from winter funding on the basis of past good performance.
- The next slide demonstrates that non elective threshold adjustment monies (NETA) pertaining to St George's emergency activity are distributed widely amongst CCGs in SW London and beyond and also in NHS England; it is vital this reinvestment comes to the trust to support winter planning.

NON-ELECTIVE THRESHOLD ADJUSTMENT (NETA) ANALYSIS



CCG Recipient / Commissioner	Location	Loss (£m)
NHSE Specialist	Specialist	2.68
Wandsworth CCG	Local - Our Urgent Care Board	1.35
Croydon CCG	Local - Different Urgent Care Board	0.99
Sutton CCG	Local - Different Urgent Care Board	0.96
Surrey Downs CCG	Non local	0.69
Lambeth CCG	Local - Our Urgent Care Board	0.68
Kingston CCG	Local - Different Urgent Care Board	0.63
Merton CCG	Local - Our Urgent Care Board	0.33
Richmond CCG	Local - Different Urgent Care Board	0.24
Other CCGs	Non local	0.67
TOTAL		9.22

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- Based on an activity forecast outturn at Month 3 13/14, due to the extra emergency activity that has arrived at St George's over and above plan, this total value is predicted to increase from £9.22m to **£13.56m**
- Of the £2.36m NETA money available to our local Urgent Care Board, £1.25m of the Wandsworth CCG NETA funding is being spent assisting local winter pressures, with £905k coming directly to St George's to help improve flows and 7 day working. £315k is going to WSS for additional step down capacity and weekend social care
- WCCG have recently made a further £1.256m available to St George's to support winter beds, elective surgery off site and operational site management.
- Merton have an integrated care project board of which St. George's is a member. Two key schemes launched, Community Prevention of Admissions Team and Proactive LTC Management, both aimed at admission prevention.

RISKS

- There are important consequences for patients and staff, and also organisational performance of not planning appropriate capacity for the rest of 2013/14 These include:
 - Compromising patient experience and risking patient safety by operating beyond recommended levels of bed occupancy and throughput:
 - Significant numbers of medical and surgical outliers throughout the winter
 - Patients with specialist needs not accessing the most appropriate beds
 - Delays in accepting inter-hospital transfers for acute tertiary services such as cardiac surgery and neurosurgery
 - Prolonged use of escalation areas only appropriate for inpatient care as a last resort eg endoscopy, neuro day unit
 - Reliance on temporary staffing to cover additional activity
 - Some evidence that acute services are operating at the limits of safe early discharge, eg readmission rates, compliance with heart failure pathway
 - Extended periods of red alert and use of business continuity measures taking senior clinical staff and managers away from other activities such as clinical governance, service improvement and productivity/Cost Improvement Programme (CIP) planning
 - Negative impact on staff morale and experience of operating at or beyond capacity
 - Significant cancellations of elective surgery which may impact upon delivery of the 18 week RTT standard. This then entails unplanned outsourcing of elective activity to the private sector to maintain RTT performance which is not ideal in quality terms and adds financial pressure to the organisation
 - Constant use of unfunded escalation areas having to be mitigated by opportunistic, non-recurring financial measures
 - The financial value of the NETA to St George's on current plan is £9.22m. The 30% marginal rate does not cover the financial cost of opening of escalation areas, utilising private sector capacity or the loss of elective income built into our budget

MITIGATING THE CURRENT LEVEL OF RISK

EMERGENCY CARE INTENSIVE SUPPORT TEAM (ECIST) VISIT

- St George's had a visit from the Emergency Care Intensive Support Team (ECIST) in September 13, at our invitation
- The final report is due on the 23rd September, but initial high level feedback is:
 - Emergency Department (ED) and Acute Medical Unit (AMU) are functioning well – there are some areas for improvement, but they are not the main problem with respect to patient flow
 - Real time information for bed management decisions is urgently required
 - There needs to be a focus on discharge and internal waits
 - Seven day working is needed, particularly in specialty wards
 - A surgical SAU is required – this is planned for 14/15 as requires capital build
 - St George's needs more robust pathways for the management of frailty
 - We need to review opportunities for further community integration
- The ECIST team will be returning to the trust to assist us with the implementation of change in the above areas

SUMMARY

- St George's planned capacity in 13/14 and put initiatives in place to accommodate capacity shortfalls, but activity to date is well above plan
- Revised analysis shows that we are between 25 and 40 beds short for winter over and above our current plan if winter patterns persist
- We must therefore collectively ensure that the healthcare system does not fail over the winter, and we are working with our local Urgent Care Board on this
- Following this analysis and the ECIST visit, to mitigate risks for winter 13/14 St George's has clear actions on:
 - Delivering the new beds
 - Deployment of the currently agreed NETA monies
 - Review of daily bed management
 - Discharge processes and internal waits
 - Seven day working where possible – through NETA and/or redesign
 - Opportunities for managing patients elsewhere – community division to lead
 - Management of frailty - review of pathways
 - Further admission prevention where possible through further ambulatory emergency care
- We cannot guarantee that despite these measures that we can fully mitigate the risks that this winter poses

Future developments

Our strategy



St. George's board signed off the new strategy in November 2012. In the strategy the trust outlines a vision for how it will develop over the next decade, which is to have or be:

- **Renowned integrated services enabling people to live at home**
- **Providing the highest quality local hospital care in the most effective and efficient way**
- **A comprehensive regional hospital with outstanding outcomes**
- **Thriving research, innovation and education driving improvement in clinical care**
- **A workforce proud to provide excellent care, teaching and research**
- **Transformed productivity, environment and systems**

Major service and capital developments



Children's & Women's Hospital

Establishing a Children's & Women's Hospital in Lanesborough Wing by 2017/18, as the leading centre for south west London. First phase (children's 5th floor) to start 2014.

Emergency care

building on its success as one of four major trauma centres in London by establishing a helipad, to be opened April 2014.

Renal services

Working with commissioners to develop a robust and sustainable solution for the future provision of renal services for south west London. Re-provision of service in better quality accommodation.

South west London pathology service

Working with partners to implement a single south west London pathology service, with hub at St. George's.

Integrated services

Continue to developed integration between health and social care, focusing on treatment in the community and in patients' homes.



Foundation Trust application

Foundation trust application



We are in the process of making submitting our application for foundation trust status, aiming for authorisation by summer 2014



KEY MILESTONE	TIMESCALES
Submission to NTDA	2 January 2014
B2B with NTDA	w/c 10 March 2014
NTDA Board approval	20 March 2014
Submission to Monitor	April 2014
Authorisation	Late summer 2014



Why is becoming a foundation trust so important to St. George's?

Becoming a foundation trust is a crucial step in achieving our ten-year vision to be recognised as an excellent integrated care provider and a comprehensive specialist health centre for South West London, Surrey and beyond with thriving programmes of education and research.

Becoming a Foundation Trust is harder than ever but this is a good thing for our patients. The quality of patient care provided by Foundation Trusts and the reliability of their accreditation has been under the spotlight like never before. We welcome the increased focus this has brought to the patient experience and all aspects of care, including feedback from patients and their carers and also the quality of our facilities and surroundings.

Achieving Foundation Trust status against a backdrop of increased scrutiny gives us, our patients and the public, assurance that we are living our values and providing high quality services.

We want to involve our community more closely in the decisions we make and becoming a Foundation Trust will strengthen our ability to achieve this by creating a membership and council of governors who will work together with us to make sure we continue to provide the best care we can.

Becoming a membership organisation will create a cultural environment that is characterised by involvement, responsiveness and openness with patients.

Foundation trust application



Becoming an FT means a fundamental change in the governance of the trust:

➤ **Membership**

- To date 20,000 members have joined
- Membership engagement strategy agreed to keep those members informed and involved

➤ **Council of Governors**

- Elections for public and staff governors currently ongoing – election results to be announced 19 November
- 4 public governors from Merton
- Stakeholder governor to represent Merton council
- Representing the views of members, patients and public, having an input into key decisions and holding the Board of Directors to account

