Trust Board Meeting

Date and Time: Thursday 5 October 2017, 10:00 – 12:45
Venue: Hyde Park Room, 1st Floor, Lanesborough Wing

Time	Item	Subject and Lead	Action	Format
		FEEDBACK FROM BOARD WALKABOUT		
10:00		**Visits to Various Parts of the Tooting Site** Board Members	-	Verbal
		OPENING ADMINISTRATION		
10:30	**1.1**	**Welcome and Apologies** Chairman, Gillian Norton	-	Verbal
	1.2	**Declarations of Interest** All	-	Verbal
	1.3	**Minutes of Meeting held on 07.09.17** Chairman, Gillian Norton	Approve	Paper
	1.4	**Action Log and Matters Arising** All	Review	Paper
	1.5	**CEO's Update – including an Update on Elective Care Recovery Programme** Chief Executive, Jacqueline Totterdell	Inform	Paper
		STRATEGY		
10:45	**2.1**	**Trust Response to *Providing High Quality Healthcare Services 2020 to 2030*** Chief Executive, Jacqueline Totterdell	Inform	Paper
		QUALITY		
10:50	**3.1**	**Quality Committee Report** Chair of Committee, Sir Norman Williams	Assure	Oral
	3.2	**Quality Improvement Plan** Chief Nurse and Director of Infection Prevention & Control, Avey Bhatia	Assure	Paper
		PERFORMANCE		
11:15	**4.1**	**Integrated Quality & Performance Report** Executive Team	Review	Paper
	4.2	**Emergency Prevention Preparedness & Response – Assurance and Compliance Report** Chief Operating Officer, Ellis Pullinger	Assure	Paper
		FINANCE		
11:45	**5.1**	**Finance & Performance Committee Report** Chair of Committee, Ann Beasley	Assure	Oral
	5.2	**Month 5 Finance Report** Chief Financial Officer, Andrew Grimshaw	Assure	Paper
		WORKFORCE		
12:00	**6.1**	**Workforce & Education Committee Report (including Update from Guardian for Safe Working)** Chair of Committee, Stephen Collier	Assure	Oral
		GOVERNANCE		
12:10	**7.1**	**Audit Committee Report** Chair of Committee, Sarah Wilton	Assure	Paper
	7.2	**Corporate Risk Register**	Assure	Paper

		Chief Nurse and Director of Infection Prevention & Control, Avey Bhatia & Elizabeth Palmer, Director of Quality Governance		
CLOSING ADMINISTRATION				
12:30	**8.1**	**Questions from the Public**	-	Oral
	8.2	**Any New Risks or Issues** All		-
	8.3	**Any Other Business** Chair	-	-
	8.4	**Reflection on Meeting** All	-	Oral
12:45	**Close**			
Resolution to move to closed session In accordance with Section 1 (2) Public Bodies (Admissions to Meeting) Act 1960, the Board is invited to approve the following resolution: "That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest".				

Date and Time of Next Meeting: Thursday 9 November 2017

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.

Trust Board Dates 2017-18 (Thursdays)		
09.11.17 10:00 – 13:00	07.12.17 10:00 – 13:00	11.01.18 10:00 – 13:00
08.02.18 10:00 – 13:00	08.03.18 10:00 – 13:00	

Membership and Those in Attendance		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Sir Norman Williams	Non-Executive Director/Senior Independent Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
In Attendance	**Designation**	**Abbreviation**
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Efficiency, Delivery & Transformation	DEDT
Richard Hancock	Interim Director of Estates & Facilities	DE&F
Ellis Pullinger	Chief Operating Officer	COO
Mike Murphy	Quality Improvement Director – NHS Improvement	QID
Secretariat		
Fiona Barr	Corporate Secretary and Head of Corporate Governance	Trust Sec
Richard Coxon	Membership & Engagement Manager	MEM

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting
7 September 2017 – From 10:00, Hyde Park Room, 1st Floor, Lanesborough Wing

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Andrew Rhodes	Acting Medical Director	MD
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Avey Bhatia	Chief Nurse	CN
Andrew Grimshaw	Chief Finance Officer	CFO
IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
Karen Daly	Associate Medical Director/Responsible Officer (item 3.5)	AMD-RO
James Friend	Director of Delivery, Efficiency & Transformation	DEDT
Richard Hancock	Director of Estates & Facilities	DE&F
Nigel Kennea	Associate Medical Director (item 3.4)	AMD
Ellis Pullinger	Chief Operating Officer	COO
APOLOGIES		
Jenny Higham	Non-Executive Director	NED
SECRETARIAT		
Fiona Barr	Trust Secretary & Head of Corporate Governance	Trust Sec
Richard Coxon	Membership & Engagement Manager	MEM

Feedback from Board Walkabout

The Board members began by giving feedback from their visit to Queen Mary's Hospital (QMH) on the 10.08.17. The departments visited included: Outpatients, Diagnostics, Gwynne Holford Ward, Wolfson Rehabilitation Unit, Amputee Rehabilitation Unit and Wheelchair Service. General themes included positive, courteous and enthusiastic staff with all areas feeling airy, light and providing a calm atmosphere for both patients and staff. It was agreed that the Roehampton campus was underutilised and the additional capacity could be used to alleviate pressure on the Tooting campus. It was noted that the high level skills of the amputee and wheelchair service needed to be developed for a new generation through apprenticeships. There had been an opportunity to try the patient food at lunchtime and Board Members were impressed with the choice available. The MD stated that he had been to the staff canteen there the week after and was disappointed at what was on offer.

At today's walkabout Board members visited: the Spiritual Centre, Brodie Ward, Porters' Lodge, Pharmacy, Mortuary, Dragon Centre and Dialysis Unit. The feedback was very positive about the Spiritual Centre which provided a calm multi-faith area in the centre of the hospital for everyone and the Henry Marsh Garden, by the Brodie Ward, for providing a quiet area for patients. The porters were welcoming and positive despite the very poor condition of the Porters' Lodge. The majority of staff who met Board members were very committed and had good ideas on how to improve efficiency. Succession planning was also found to be an issue with long serving staff moving to other trusts due to lack of progression opportunities. The pharmacy was very impressive though the estate could benefit from a refresh.

1. OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and gave apologies from Jenny Higham. She reported that John Murray & Tom West from Deloitte were in attendance.
1.2	The Chairman mentioned that a new Non-Executive Director had been selected for appointment following a rigorous day of assessment. The candidate would be presented for formal approval at the Council of Governor meeting on 14.09.17 and would commence with the Trust following completion of the appropriate checks. There were also interviews scheduled for the posts of Director of Strategy and Director of Estates for later in the month.
1.3	The Annual Members' Meeting would take place later in the day which will be celebration of staff achievements. The Chairman explained that during the day, visitors and staff at both the Roehampton and Tooting campuses were being invited to write down on post it notes what they love about the Trust or working here.
Declarations of Interest	
1.4	There were no declarations of interest.
Minutes of Meeting held on 06.07.17	
1.5	These were accepted as a true and accurate record of the meeting held on 06.07.17.
Action Log and Matters Arising	
1.6	The Board noted that most actions on the Action Log were proposed for closure as they were either on the agenda for discussion or because appropriate action had been taken outside the meeting.
CEO's Report	
1.7	The CEO gave a brief report, advising that: i. Following the inspection by the Care Quality Commission (CQC) in May, the Trust had now received the official report which noted a number of considerable improvements though indicated there was still much work to do. ii. The Elective Care Recovery (ECR) Programme had become a main priority with a major restructure of the team which would now report to the Chief Operating Officer. A formal update report would be brought to the Board meeting setting out actions for both the Roehampton and Tooting campuses. Diana Lacey, outgoing ECR Programme Director, was thanked for all her hard work. iii. The Integrated Sexual Health Services would be moving to a new provider (CLCH) from the 01.10.17 after the Trust opted not to bid for the service. Staff were being supported in their transfer to CLCH which was actively considering what model it needed going forward. The HIV service currently provided would be unaffected. iv. The CEO also met with 100 OP staff last week to discuss the Trust and way forward. v. Good progress was being made with the external review of governance and a number of internal processes were being updated and improved as a result.
STRATEGY	

South West London Sustainability & Transformation Partnerships (STP) and Acute Provider Collaborative	
2.1	The Board was advised that transformation of both planned care and emergency care pathways was under development through the work of the South West London (SWL) STP and the SWL Acute Provider Collaborative. This may pave the way for an Accountable Care System (ACS) or an Accountable Care Organisation (ACO) though discussions were still at an early stage.
2.2	The Executive was keen to apprise the Trust Board of these developments and to keep it fully briefed so that the Trust could take an active role in the development of any changes.
2.3	The Board agreed to receive further updates at the Board meeting in September, covering the SWL Procurement Hub and the hosting arrangements for South West London Pathology (SWLP) and South West London Elective Orthopaedic Centre (SWLEOC). The Board noted progress with other collaborative arrangements in SWL including the Staff Bank which had harmonised pay amongst key groups of staff. Once the impact of this had been assessed, there would be expansion into other staff groups and this represented a key strand of the strategy to reduce agency spending.
2.4	The Chairman welcomed the update and agreed that this was an important area of development which would pick up pace once the new Director of Strategy was appointed.
TB.07.09.17/40	**Receive a paper on the SWL Collaborative Governance Arrangements for approval at the 05.10.17 Board meeting.** **LEAD: Chief Operating Officer, Ellis Pullinger**
TB.07.09.17/41	**Receive a report on the proposed arrangements for the SWL Procurement Hub.** **LEAD: Chief Financial Officer, Andrew Grimshaw**
QUALITY	
Quality Committee Report	
3.1	The Chair of the Quality Committee gave an update report from the meeting held on the 26.07.17. He noted the intention which was welcomed to return the Committee to meeting monthly.
3.2	There had been two Never Events in operating theatres and measures to address this had included training all the teams concerned using human factors training and this approach was welcomed.
3.3	A comprehensive nursing review into the nursing establishment had been conducted by the Chief Nurse. The staffing levels were reviewed and matched against national and speciality guidance. This process identified the equivalent of 54wte that could safely be removed from the ward budgets, saving £3.9m; the process was supported by NHS Improvement (NHSI).
3.4	Whilst there had been a greater incidence of MRSA in recent months, a deep dive review considered by the Committee indicated that there had no lapses in care. There were concerns that compliance against hand hygiene and basic infection control procedures had reduced though this was being addressed through a Period of Increased Surveillance Audit (PISA) process.
3.5	The Committee had been informed that the Trust had received an alert from NICOR (National Institute for Cardiovascular Outcomes Research) and an external independent review was being commissioned to investigate if there was a problem and, if so, recommend measures to be taken.
3.6	The Committee also considered the Annual Safeguarding Report for Children which was incorrectly described in the Committee report to the Board as the Annual Safeguarding Report for Adults. This error was noted
3.7	The Committee received the report.

Care Quality Commission Report and Action Plan	
3.7	The CN introduced the Report and Action Plan. The CQC had found significant progress had been made against the section 29a warning notice but also identified areas that required continued focus and improvement. The warning notice had been lifted but improvement notices remained for regulations 5, 12, 15 and 17 which were being addressed.
3.8	A detailed response had been produced and returned to the CQC by the 29.08.17 deadline; the CQC would continue to monitor progress.
3.9	The Chair of the Audit Committee welcomed the report and recent improvements on the follow up and closure of Internal Audit recommendations which had been identified by the CQC as an area of weakness.
3.10	The report was received.
Outstanding Care Every Time – Our Quality Improvement Plan	
3.11	The CN was pleased and proud to be presenting the Quality Improvement Plan (QIP) in its new format which set out the Trust's statement of intent in relation to its quality priorities and how these would be measured. She reported that there had been a high level of clinical involvement in the production of the new QIP though advised that it remained under review. Whilst it would remain very much a "live" and dynamic document, she was keen to finalise and publish it following input from the Board.
3.12	Non-Executive Directors welcomed the plan but agreed it would benefit from further discussion particularly in relation to indicating as it had not been previously considered by any Board Committee. It was agreed that a separate Board Workshop would be arranged to finalise the QIP prior to submission in final form to the Quality Committee and Board.
TB.07.09.17/42	**Arrange QIP Board Workshop before the next Quality Committee on 27.09.17. LEAD: Trust Secretary & Head of Corporate Governance, Fiona Barr**
Mortality Monitoring – Learning from Patient Deaths Update	
3.13	Nigel Kennea, AMD and Neonatologist, joined the meeting to present the paper. He explained that the Trust had to have a policy on Learning from Patient Deaths which was compliant with the National Framework on Learning from Patient Deaths and this was scheduled for approval at PSQB later in September.
3.14	It was noted that between 80-90% of deaths in the Trust were reviewed in the Trust and whilst St George's was a leader in the area of learning from patient deaths, and mortality statistics remained positive, the Board questioned if it had the right information to detect any emerging problems. In this regard it considered the National Hip Fracture Database report (September 2017) which showed the Trust as a mortality outlier for 2016. Nigel Kennea explained that even before the report was received, all cases had already been subject to review and validation which indicated that the majority of the patients were elderly and had co-morbidities which reduced their chances of survival. However what was the subject of on-going monitoring and review was the for prioritising of younger complex patients over older patients with co-morbidities at times of high stress, for example in winter when theatre time is limited.
3.15	In this regard, Nigel Kennea raised the importance of having clarity on the consultant in charge of a patient's care and noted that this could be difficult if the patient had multiple needs. Following a brief discussion, it was agreed that the Medical Director look into consultant attribution and report back to the Quality Committee on how this would be achieved and by when.
TB.07.09.17/43	**Advise how consultant attribution is agreed and report this to the Quality Committee. LEAD: Acting Medical Director, Andy Rhodes, and Associate Medical Director and Neonatologist, Nigel Kennea**

3.16	The Board received the report.
A Framework of Quality Assurance for Responsible Officers and Revalidation	
3.16	Karen Daly, the AMD-RO, presented the report explaining that as a designated body the Trust and its Responsible Officer (RO) had statutory responsibilities that were monitored by NHS England. These responsibilities included the oversight of annual appraisal of the medical employees of the Trust and the monitoring of their fitness to practice.
3.17	Karen Daly explained that in response to the completed return sent into NHS England (NHSE) in June 2017, NHSE identified two areas of concern in the national comparator report: i. The Trust had only a basic administrative process for recording the appraisal of doctors and only one validation support officer who sent out manual reminders and recorded information on a spreadsheet. This was an area which could be improved. ii. Whilst there was a process in place to manage areas of concern for medical practice it was not felt to be robust and could be strengthened – particularly through the triangulation of information.
3.18	The Chair of the Audit Committee expressed concern that there was no electronic system to support revalidation and identify concerns with fitness to practice. The AMD-RO explained that the Trust uses NHS MAG form but data was collected manually. However the Trust was in the process of purchasing a multisource 360 assessment tool.
3.19	It was agreed that a better electronic system was required to support and that this should be prioritised in the Capital Programme.
3.21	The Board thanked the AMD-RO for her report and looked forward to receiving another annual report next September though asked that she provide interim reports to the Workforce & Education Committee in the meantime.
TB.07.09.17/44	**Provide interim reports on Medical Revalidation to the Workforce & Education Committee.** **LEAD: Acting Medical Director, Andy Rhodes, and Associate Medical Director and Responsible Officer Karen Daley**
PERFORMANCE	
Integrated Performance Report	
4.1	The DEDT reported that there had been a Never Event in July 2017 which meant there had been two cases to date in 2017-18. There were 11 Serious Incidents (SIs) declared in July 2017 including one in Pharmacy. On the safety thermometer, performance had dropped since December to slightly below 95% and the CN was looking into the causes of this.
4.2	The DHROD reported that the workforce benchmark data against other trusts will be built into future reports. Staff sickness had increased to 3.6% compared to 3.4% the previous month. Human Resources had been trialling a new initiative to manage staff sickness and the Workforce & Education Committee will look at the impact of this.
4.3	The report was received.
Winter Preparedness 2017-18	
4.4	The COO presented the report which outlined the Trust's preparedness for Winter 2017-18 as well as sector wide planning. It was noted that this item would return regularly as the Board would want to monitor progress and performance throughout the winter months.
4.5	The report was received.

FINANCE	
Finance & Performance Committee Report	
5.1	The Chair of the Finance & Performance Committee (FPC) reported the financial performance had been discussed in detail at the last meeting and noted significant improvements in the level and type of financial reporting. The Financial Recovery Programme (FRP) workshops had played a key role in supporting refinements to the FRP.
5.2	In closing the item, she explained that the Committee had reviewed the Capital Programme which was the first time it had been received at the Committee. She welcomed its consideration later on the Board agenda. She also noted continued nervousness around financial planning for 2018-19 though advised that a paper outlining the process was scheduled for FPC.27.09.17.
Month 4 Finance Report	
5.3	The CFO presented the Month 4 Finance Report which showed a cumulative deficit of £28.5m in July, a favourable variance of £0.03m and in line with what has been agreed with NHSI. The delivery of £45m yearend deficit remained still at risk though mitigations included identifying more cost improvement programmes (CIPs) and maintaining a strong grip on financial performance. Income was £8.9m adverse to plan though expenditure was £8.9m favourable to plan.
5.4	The CFO noted that the Trust was ahead of plan on CIPs though a number remained "amber" as the actions required to achieve them had not yet been set out. He advised that the Trust continued to rely on working capital support from the Department of Health. .
5.5	In closing he noted that action was still required to validate income recovery and improve the depth of coding and reporting. This was a very complex multi-factoral issue with implications throughout the organisation to address it successfully.
5.6	The report was received.
Capital Plan Allocations 2017-18	
5.7	The CFO reported that the Capital Plan for 2017-18 was £43.9m and that discussions were ongoing with NHSI regarding emergency capital. Whilst this had not yet been secured, NHSI were described as being "sympathetic" to the request for additional funding.
5.8	The Board was asked to note that the FPC had agreed: i. The proposed approach to manage the overall Capital Programme given the forecast overspend. ii. To support the continued Information Management & Technology (IMT) expenditure above allocation, noting that this is at risk unless further capital funding could be secured. iii. To mitigate the forecast expenditure two parallel actions would be progressed: 1. Seek additional capital funds, primarily in relation to IMT. 2. Identify options to reduce the forecast outturn to within available expenditure. This would require other programmes and projects to be reduced/delayed. iv. The prioritisation of IMT and medical equipment due to their relationship to both quality improvement and RTT.
5.9	The report was received.
Evaluation of Overseas Visitors and Migrant Cost Recovery Project	
5.10	The CFO introduced the report which set out the findings from the Overseas Visitors study in Obstetrics. The aim was to establish the eligibility of patients for free NHS treatment

	and the pilot was part of a Department of Health and NHSI strategy to recover income from patients who were not eligible for free NHS care. As at 31.12.16 the overall outstanding Trust debt from overseas visitors was circa £5m with £1.75m attributable to Obstetrics.
5.11	During the pilot, new processes were introduced which required all new patients to provide two forms of identification and proof of residency at their first appointment. This helped identify whether the patient was legally resident in the UK in the previous 12 months and entitled to free NHS care. Following the introduction of the new processes 99% of the total patients seen were able to confirm eligibility. The remaining 1% (18 patients) were not eligible and were invoiced accordingly.
5.12	The Board received the report.
Children Safeguarding Annual Report 2016-17	
6.1	The CN introduced the report which had previously been considered at the Quality Committee. Staff training at all levels was now seen as very good and the focus had now turned to targeting areas which were outliers; staff who had not been trained were not able to practise. The CN noted that one of the main areas of risk was the Trust's IT systems – as records were fragmented, it was difficult to get a whole view of a patient's care (whether adult or paediatric).
6.2	The CN reported high levels of confidence that staff would follow the safeguarding policy for children and flag a child for whom they had safeguarding concerns. However she noted that not all of the necessary documentation was completed in all cases. She added that there was a growing awareness and sensitivity amongst staff to look for child safeguarding signals when seeing vulnerable adult patients – "treat the adult, treat the child" – and getting the timing right on when and how to involve external stakeholders, though this should be applauded.
6.3	The Chairman thanked the CN for the excellent report which highlighted all the right concerns. The Chairman asked how the Trust's children's safeguarding arrangements are viewed externally. The CN responded that she believed that the Chair of the local Safeguarding Board would respond positively. The report was received.
Fit and Proper Persons Update Report	
6.4	The DHROD introduced the report which sought to give the Board full assurance that the Trust was now fully compliant with Regulation 5: Fit & Proper Persons: Directors.
6.5	Following the CQC's unannounced visit in May 2017 where they found that the Trust did not have "suitable arrangements in place for ensuring Directors were fit and proper" and found files were incomplete, the Trust had asked Internal Audit to conduct a deep dive into the Trust's Fit & Proper Person process. Internal Audit gave reasonable assurance on the process but identified a number of small improvements that could be made, such as keeping a checklist of progress against the checks..
6.6	Some small errors were noted in the report's appendix though these would be corrected and an updated appendix uploaded to the website. This would be an area that the CQC would reinspect on their return to be fully satisfied that the Trust's procedures and record keeping was in order.
TB.07.09.17/45	**Correct the appendix to the Fit and Proper Persons Update Report and upload to the website.** **LEAD: Director of HR & OD, Harbhajan Brar**
6.7	The Board thanked the DHROD for taking the grip required on this process. It was noted that the new NED would not start without all the necessary paperwork and checks being completed which the Trust's recruitment team would process.
6.8	The report was received.

6. CLOSING ADMINISTRATION	
Questions from Public	
7.1	Khaled Simmons, Public Governor for Merton explained that he had recently visited the Roehampton site and noted that some areas appeared to be under-utilised. In response, the CEO advised that a strategy for QMH was under development and there may be scope to re-locate overcrowded services from Tooting to Roehampton. He asked a second question about the human factors training mentioned earlier in the meeting and the MD explained that the Trust had an advanced patient simulation and skills centre which provided a very effective environment for multi-disciplinary learning.
7.2	Hazel Ingram, Patient Experience Representative, commented that the patient experience at the Roehampton site was better than at Tooting but noted that at Roehampton waiting times were sometimes longer, for example at Christmas. In response, the CEO explained that there was a lot of operational detail behind the Trust's winter plans to try to minimise disruption to patients during the bank holidays.
7.3	There was a final question relating to what was being done to support staff, for example those affected by the loss of the Sexual Health Services contract. The Board recognised that this was a difficult time for those particular staff. A number of mechanisms were in place to listen to staff concerns, such as Team Talk, Listening into Action and the soon to be launched "Big Conversations". Whilst the Executive closely monitored sickness absence, levels at the Trust were in line with comparable trusts.
Any New Risks or Issues	
7.2	There were no new risks or issues.
Any Other Business	
7.3	There were no items of any other business.
Staff Story	
Kelly Kohut, Lead Genetic Counsellor, and her team were nominated for a Trust Values Award in August 2017 for their great work in providing personalised, sensitive care to patients who had a significant risk of breast and ovarian cancer due to a BRCA1 or BRCA2 gene mutation. These patients were faced with difficult decisions about risk reducing surgery and the challenge of sharing information with their families. The team was also involved in the 100,000 Genomes project in which St George's had an excellent reputation and this was a likely area of expansion. In closing she described a close team dynamic with team members supporting each other and to celebrating each other's success.	

Date and Time of Next Meeting: Thursday 5 October 2017, from 10:00

Action Ref	Theme	Action	Due	Revised Date	Lead	Commentary	Status
TB.06.07.17/35	**Fit & Proper Persons Regulations**	Provide a quarterly and annual report on compliance with the Fit & Proper Persons Regulation to the Board.	TB.09.11.17		DHROD	On forward plan.	Ongoing
TB.06.07.17/36	**St George's Charity**	Schedule a meeting with between the Board and the Trustees of the St George's Charity every six months.	TB. 11.01.18		Trust Sec	On forward plan.	Ongoing
TB.06.07.17/38	**Staff Engagement and E&D Statistics**	Regularly report on staff engagement and metrics on equality, diversity and inclusion in the workforce element of the IPR.	Q3 2017-18		DHROD	Under consideration.	Open
TB.07.09.17/40	**Collaborative Governance Arrangements**	Receive a paper on the SWL Collaborative Governance Arrangements for approval at the 05.10.17 Board meeting.	CB.05.10.17		COO	On the CB.05.10.17 agenda.	Proposed for Closure
TB.07.09.17/41	**SWL Procurement Hub**	Receive a report on the proposed arrangements for the SWL Procurement Hub.	CB.05.10.17		CFO	A paper setting out the future procurement arrangements was considered and approved at FPC.27.09.17.	Proposed for Closure
TB.07.09.17/42	**QIP Board Workshop**	Arrange QIP Board Workshop before the next Quality Committee on 27.09.17.	15.09.17		Trust Sec	Arranged for 15.09.17.	Closed
TB.07.09.17/43	**Consultant Attribution**	Advise how consultant attribution is agreed and report this to the Quality Committee.	QC.29.11.17		Acting MD & Nigel Kennea	Scheduled for QC.29.11.17.	Open
TB.07.09.17/44	**Medical Revalidation**	Provide interim reports Medical Revalidation to the Workforce & Education Committee.	Q3 2017-18		Acting MD & Karen Daly	Under consideration.	Open
TB.07.09.17/45	**Fit & Proper Persons Regulations**	Correct the appendix to the Fit and Proper Persons Update Report and upload to the website.	Sep-17		DHROD/Trust Sec	Appendix received and uploaded to website 27.09.17.	Proposed for Closure

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 October 2017	**Agenda No.**	1.5
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Jacqueline Totterdell, CEO		
Report Author:	Chris Rolfe, Associate Director of Communications		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	Overview of the Trust activity since the last Board Meeting.		
Recommendation:	The Board to receive this report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led, Safe, Caring, Effective and Responsive		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	

Chief Executive Officer's Update
Trust Board, 5 October 2017

1. PURPOSE

1.1 To provide an update of activities of the Trusts activities since the last Board Meeting.

1.2 It has been a busy few weeks since the last Trust Board meeting in September, although I am pleased to say that we have made progress in a number of areas since then.

1.3 The key updates I want to provide this month are as follows:

2. Non-Executive and Executive Director Appointments

2.1 Earlier this month, we announced the appointment of Suzanne Marsello as our new Director of Strategy.

2.2 Suzanne's start date has yet to be agreed, but I expect her to join the Trust in the next three months.

2.3 Suzanne is no stranger to the Trust, and has previously held a number of senior operational and strategic roles within the organisation.

2.4 She is currently Director of Strategy and Commercial Development at South West London and St George's Mental Health NHS Trust.

2.5 Since starting in May, the need for an organisational strategy has come across loud and clear to me when speaking to staff. Of course, this won't be resolved overnight, but Suzanne's appointment is a significant and positive step forward.

2.6 We are also recruiting to the Director of Estates and Director of Corporate Affairs roles, and hope to be in a position to make substantive appointments to both positions shortly.

2.7 Finally, I would also like to welcome Tim Wright to the Trust, who is our new Non-Executive Director. Tim's background in IT is going to be particularly useful for us, and I look forward to working with him as a new member of the Board.

2.8 Mike Murphy has also joined as our new Improvement Director for Quality, and is a welcome addition to the Trust.

3. Referral to treatment/data quality challenges

3.1 As I've said previously, referral to treatment/data quality challenges are our number one safety issue at the Trust and, whilst I am confident we are taking it seriously, it is clear there is still a huge amount to do.

3.2 At the last Trust Board meeting in September, we talked about the patient tracking problems identified at Queen Mary's Hospital.

3.3 The patient tracking systems used at the hospital have clearly not been fit for purpose, and an external review has shown that patient safety has been potentially compromised as a result.

3.4 We have taken some immediate remedial actions to improve the situation at Queen Mary's – for example, we have 'switched off' the auto-discharge function being used incorrectly on the hospital's Patient Administration System.

3.5 We are also creating effective patient tracking systems, and now know how many patients are on our waiting lists at Queen Mary's, and how long they have been waiting.

3.6 That said, major referral to treatment/data quality challenges remain at St George's and Queen Mary's; both in terms of validating existing records, but also ensuring all new patients are tracked correctly, and treatment pathways accurately recorded.

3.7 Ellis Pullinger, our Chief Operating Officer, is leading the recovery work, whilst also working with our managers and clinicians to ensure patients are treated as quickly as possible, and waiting lists reduced in a timely fashion.

4. Sustainability and Transformation Plan

4.1 We remain heavily engaged with the south west London Sustainability and Transformation Plan (STP).

4.2 Ensuring St George's has a strong and active voice in these discussions is important to Gillian, as Chairman, and myself, as Chief Executive; and of course Suzanne Marsello when she joins as Director of Strategy.

4.3 For the time being, our focus at St George's is on ensuring we provide high quality services for local people; securing our clinical tertiary pathways; and supporting district general hospital services in south west London.

4.4 The STP discussions are evolving, and everyone's focus is on looking at what this is eventually going to mean for services on the ground; but I am confident there is a greater impetus and momentum behind discussions.

4.5 The Trust Board will be aware of Epsom and St Helier's engagement exercise, which we have responded to formally together with Croydon and Kingston; and the work Epsom and St Helier has undertaken will also play into the STP discussions as well.

5. Celebrating St George's

5.1 Our Annual Members' Meeting directly after September's Trust Board meeting was a success, and I would like to thank a number of our Governors, who stopped patients and staff during the course of the day to collect their positives experiences of the Trust.

5.2 Last month, Gillian and I also attended a meeting of the Wandsworth Health Overview and Scrutiny Committee, which is attended by elected officials and members of the public.

5.3 The committee members asked for an update on progress, but said in unison that they were pleased with the progress we are making, as well as our openness about the challenges we face.

5.4 We were also pleased to welcome a visit from health minister Jackie Doyle-Price MP earlier this month. The Minister met with members of our organ donation team, and was rightly impressed with the people she met – including Kathryn Harrison, our lead governor, who as some of you will know donated a kidney here at St George's.

5.5 Collectively, these highlights from the last month remind me that we are an organisation people want to be associated with – and rightly so, because we can be brilliant, as shown by our staff on a regular basis.

6. St George's Hospital Charity

6.1 Finally, I want to praise the work of our hospital charity.

6.2 Last week, I was also delighted to attend a very special event at St George's, as the hospital's charity opened a new room on the Ruth Myles Unit for teenagers and young people with cancer.

6.3 The event was organised by St George's Hospital Charity, who funded the room together with £20,000 from Furzedown FACE, a local community group, and other contributors.

6.4 The charity does tremendous things for the services we run, and it was a real honour to attend.

6.5 I also know the Trust Board has made a commitment to work much more closely with the charity, which I think is a really positive step.

7. RECOMMENDATION

7.1 To receive the report for information.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 October 2017	**Agenda No**	2.1
Report Title:	Trust Response to Providing High Quality Healthcare Services 2020 to 2030		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive Officer		
Report Author:	Jacqueline Totterdell, Chief Executive Officer		
Presented for:	Approval Decision Ratification Assurance Discussion Inform Steer Review Other (specify)		
Executive Summary:	Epsom & St Helier University Hospitals NHS Trust has published an involvement document *Providing high quality healthcare services 2020 to 2030* which relates to providing healthcare services in South West London: https://www.epsom-sthelier.nhs.uk/ A joint response to the document has been agreed with Kingston Hospital and Croydon University Hospital and sent to the CEO of Epsom & St Helier University Hospitals NHS Trust. This is attached at Appendix 1.		
Recommendation:	Receive for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	
Appendices:	Letter sent to Daniel Elkeles, CEO, Epsom & St Helier University Hospitals NHS Trust		

Joint Response to *Providing High Quality Healthcare Services 2020 – 2030* published by Epsom & St Helier University Hospitals NHS Trust
Trust Board 5 October 2017

1.0 PURPOSE

1.1 To present the joint response to Epsom & St Helier University Hospitals NHS Trust's engagement document: *Providing High Quality Healthcare Services 2020 – 2030*.

2.0 BACKGROUND

2.1 Over the summer, Epsom & St Helier University Hospitals NHS Trust produced a document entitled *Providing High Quality Healthcare Services 2020 – 2030* which set out how it planned to develop its local hospitals and provide high-quality buildings to meet changing health needs and continue to deliver local services; this required an investment of £300 and £400 million. Responses were required by the end of September 2017.

3.0 JOINT RESPONSE

3.1 The three South West London trusts, St George's, Kingston Hospital and Croydon University Hospital produced a joint response which has been sent to the CEO of Epsom & St Helier University Hospitals NHS Trust. This is attached at Appendix 1.

4.0 RECOMMENDATION

4.1 To note for information.

Author: Jacqueline Totterdell
Date: 28.09.17

APPENDIX 1

Text of Joint Statement sent in response
Providing High Quality Healthcare Services 2020 to 2030

To: CEO of Epsom & St Helier University Hospitals NHS Trust
From: CEOs of St George's University Hospitals NHS Foundation Trust, Kingston Hospital and Croydon University Hospital

Response

Thank you for the opportunity to comment on your involvement document *Providing high quality healthcare services 2012 to 2030.*

We have reviewed this document and would like to offer the following joint response.

We fully support the need to improve the infrastructure and environment for acute services across South West London and note the particular challenges at St Helier. Given the need for major capital investment across the South West London acute sites, it is important that within the option appraisal for acute services across Epsom & St Helier, there is careful consideration to the services that should be provided alongside the six core acute services, so that we have vibrant, sustainable acute hospitals at Kingston and Croydon and a regional centre of excellence at St George's to go alongside the acute solution for Epsom and St Helier. This will require a review of both the total service disposition and the scale of the six core services within the Epsom & St Helier option appraisal. This needs to take place together with the three other acute providers but most notably with St George's.

The work currently being undertaken with NHSI on clinical and financial sustainability at acute trusts in south west London should go some way in helping us to understand this position further and feed into the next round of discussions.

This review needs also to include clinical support services such as Pathology and back office services as these should be aligned to the South West London Acute Provider Collaborative' s agreed strategy for clinical support services and non-clinical services. We also understand that the process of full consultation will be led by the local commissioner and Sustainability & Transformation Partnership which we wish to be fully engaged with.

We hope you find these comments helpful.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 October 2017	**Agenda No**	3.2
Report Title:	Outstanding Care Every Time - Our Quality Improvement Plan		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse & Director of Infection Prevention and Control Andrew Rhodes, Medical Director		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	Our Quality Improvement Plan describes the programmes and projects through which the Trust will meet our objective to provide outstanding care every time.		
Recommendation:	The Board is asked to approve the Quality Improvement Plan.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led, Safe, Caring, Effective and Responsive		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:			
Legal/Regulatory:	CQC Regulatory Framework - (Health & Social Care Act 2015)		
Resources:			
Previously Considered by:	Quality Committee Trust Board Clinical Quality Review Group	**Date**	27 Sep 17 07 Sep 17 16 Aug 17
Equality Impact Assessment:	N/A		
Appendices:			

Outstanding Care Every Time – Our Quality Improvement Plan
Trust Board 5th October 2017

1.0 PURPOSE

1.1 Over recent months we have reconfigured our improvement programme to ensure that we embed a culture of continuous improvement in the organisation. The areas of improvement identified during the 2016 and May 2017 inspections are incorporated into the programme which has pulled together our wider quality and financial recovery objectives.

1.2 Outstanding Care Every Time - Our Quality Improvement Plan (QIP) summarises the objectives for the next 18 months of the programme and sets out the workstreams and projects that sit within it. It also describes how the programme is governed and how we are monitoring the effectiveness of the projects as they are delivered.

2.0 CONTEXT

2.1 Since the Board saw the QIP at its meeting in September it has been shared widely with our stakeholders, asking for their comments on the plan. In addition to feedback from the Board we have had comments from our commissioners, governors, Healthwatch and patient representatives.

2.2 The QIP has been strengthened to include more detail on the workstreams in the Flow and Transformation programme and to describe how the Elective Care Recovery Programme links into the QIP.

2.3 Changes have also been made to clarify that the document is a summary of an 18 month programme. It has been agreed that the detailed project plans for individual workstreams will be made available on the Quality Hub of the Trust website.

2.4 Some further outcome measures have been identified and incorporated into the complaints workstream and the learning from incidents workstream plans.

3.0 NEXT STEPS

3.1 When the QIP is approved there is a communication plan to launch it across the Trust and with our wider stakeholders.

4.0 RECOMMENDATION

4.1 The Board is asked to approve the Quality Improvement Plan

Author: Elizabeth Palmer
Date: 28 September 2017

St George's University Hospitals NHS
NHS Foundation Trust

OUTSTANDING CARE, EVERY TIME

OUR QUALITY IMPROVEMENT PLAN

SEPTEMBER 2017

Contents

Executive Summary

Over one million patients in south west London and beyond rely on the hospital and community services we provide each year. With over 9,000 dedicated staff, we are the largest healthcare provider, major teaching hospital and tertiary care centre for south west London, Surrey and beyond.

We want to provide the best possible care for our patients. Our most recent full-scale Care Quality Commission (CQC) inspection in June 2016 showed we weren't doing this consistently, and their report (published in November 2016) marked the start of an improvement journey for all of us.

Since then, we have made a number of improvements – from modernising some of our operating theatres to stabilising our senior leadership team. However, we are now looking at our longer term ambitions as part of our quality improvement journey to become an outstanding Trust, recognised for the care we provide and the staff we develop.

Outstanding Care, Every Time

Our Quality Improvement Plan (QIP) reflects this renewed focus and puts the patient at the centre of everything we do. Our ambition is to provide Outstanding Care, Every Time for every single one of our patients, wherever they are treated.

Outstanding Care, Every Time means;

- Every patient receives safe and outstanding care
- The right patient is seen in the right place at the right time, every time
- Staff say "I'm proud to work at St George's"
- All staff – wherever they work – can shine and contribute to our future

Our Quality Improvement Plan is the start of an 18 month journey towards outstanding care. By delivering it, we will equip our staff with a long-term framework, methodology and passion for improving patient safety and quality. We will ensure that we embed a culture of excellence and always continue to look at how we can improve. The plan demonstrates a deep rooted desire running throughout the organisation to always find ways to make things better for our patients. We will ensure that as a Trust we make the best of use of this commitment and that we remain enthusiastic and passionate about quality improvement throughout the delivery of the plan and in to the future.

We want to demonstrate that we offer highest standards of clinical services to our local community and beyond and that we remain true to our values to provide excellence across clinical care, education and research. Our staff know the services they run best, and they will drive our Quality Improvement Plan forward. The improvements we want to make – set out in this document - will be embedded into the culture of the organisation, and help us build the capacity and capability to improve as we go forward.

Our Quality Improvement Plan covers everything from end of life care, dementia care, outpatients, and emergency care as well as being more responsive to the findings of the NHS Friends and Family test – all with the aim of providing Outstanding Care, Every Time. The following pages provide an overview of the Quality Improvement Plan. They describe the background to the plan and how it has evolved over the past year.

The document includes the interventions we have taken in response to our most recent full CQC inspection in June 2016. It details how by bringing together people from all areas of the Trust who had different perspectives on what is needed to improve our services, we developed a long term plan and approach to quality improvement. A significant proportion of the document describes each of the improvement areas we are focussing on. The various elements of each project are summarised with their key metrics for success to monitor and track progress.

We are determined to deliver this plan, but we recognise and know we can't do this alone. We are already receiving welcome support to help us to make these improvements. We value the support of our stakeholders, our partner organisations and, critically, our staff and patients as we work together to deliver the necessary change.

This plan demonstrates our commitment and ambition to provide Outstanding Care, Every Time.

A message from Jacqueline Totterdell, Chief Executive

As Chief Executive, I see every day the positive impact we have on patients, and the communities we serve. This is down to the 9,000 staff who work across our hospital and many community services.

I joined the Trust in May 2017 and, whilst the challenges we face are immense, I am confident we have the skills and desire to make St George's great again – and ultimately put us in a position to deliver Outstanding Care, Every Time.

I have been struck by how much good-will there is locally, and amongst the communities we serve, for St George's to succeed. This includes our patients, but also the many partner organisations we work with – this inspires me, and re-emphasises the importance of delivering the improvements we want to make.

Of course, our ambition to provide Outstanding Care, Every Time will be difficult, and challenging – and I believe strongly that, however much progress we make, there will always be additional improvements we want to make.

Great organisations never think they have reached their goals – they always want to be better. This is the type of organisation I want us to be here at St George's.

This document represents our Quality Improvement Plan, but the real work to deliver Outstanding Care, Every Time must happen on the ground, in our hospitals and community services – and I am confident we are already making progress in this regard.

Thank you

Jacqueline Totterdell,

Chief Executive

Introduction & Background

Who is responsible for delivering our Quality Improvement Plan?

The Trust Board acknowledge the findings of the fullscale CQC inspection and are clear about the challenges the Trust faces to achieve significant improvement. The immediate challenges following the CQC's inspection in June 2016 fell into the following areas.

- Financial challenges
- Unstable leadership
- Weak governance and assurance processes
- Variable adherence to infection control procedures
- Low levels of mandatory training completion by staff
- Lack of formal mental capacity assessments
- Poor staff engagement
- Significant estates and IT challenges due to historical under-investment
- Failure to deliver access targets
- Lack of stakeholder confidence, and strategic direction
- Data quality

Since April 2017, key substantive appointments have been made to the Trust Board which has included the appointment of individuals with significant experience in leading a Trust through a substantial quality improvement journey. This includes the appointment of a new Chair and Chief Executive, with other substantive appointments made including a Chief Financial Officer, Chief Operational Officer, Director of Delivery, Efficiency and Transformation, and Director of Human Resources and Organisational Development.

The Chief Executive is ultimately responsible for implementing the actions in this document. The Medical Director and the Chief Nurse and Director of Infection Prevention and Control provide the leadership for the Quality Improvement Plan. Individual improvement programmes have been developed and led by our staff - clinical, operational, and corporate services will work together to ensure we provide high quality care and improved patient experience.

The Trust is also working closely with NHS Improvement, through an Improvement Director who is supporting the Trust with the delivery of the Quality Improvement Plan.

Chair/Chief Executive Approval (on behalf of the Board)

Jacqueline Totterdell,
Chief Executive

Gillian Norton,
Chairman

Background to the Quality Improvement Plan

On 1 November 2016, the Care Quality Commission (CQC) published its inspection report for St George's following a visit to the Trust in June 2016. The CQC is the independent regulator of health and social care in England. The CQC's role is to ensure healthcare organisations like St George's provide people with safe, effective, compassionate, high quality care.

- The CQC disappointingly found a number of significant issues that resulted in an overall rating of "Inadequate" for the services we provide

- Both St George's Hospital and Queen Mary's Hospital, Roehampton (and the community services we provide) were rated as **Requires Improvement**. The Trust was rated as **Inadequate** for being safe and well-led, and **Requires Improvement** for being effective and responsive. The Trust was given a rating of **Good** for being caring

- The CQC also recommended St George's be placed in quality special measures, which meant the Trust was able to access support to help deliver the required improvements

- In addition, the CQC issued the Trust with a Section 29a Warning Notice. A Section 29a Warning Notice required the Trust to take immediate actions specifically to: provide safe and fit premises at St George's Hospital; obtain consent under the Mental Capacity Act; ensure good governance and ensure we meet the fit and proper person test regulation.

- We immediately began addressing the requirements within the Section 29a Warning Notice to improve the quality of our services. You can read how we responded and the changes we made on **page 11**.

In May 2017 a focused inspection by the CQC has shown some improvements at St George's. You can read a description of these on **page 14**.

Our Quality Improvement Plan is not just a response to the Care Quality Commission's (CQC) Inspection report of November 2016. It also includes the actions that we feel are necessary to provide the communities we serve with safe, effective, compassionate and high quality care.

Having managed the immediate issues, since May 2017 we have further developed and revised the Quality Improvement Plan. In order to safeguard the provision of safe and effective care for our patients as a matter of course, we needed to think beyond the day-to-day issues to ensure that we can deliver long term strategic improvements that will benefit our patients for years to come.

We have put safety at the heart of everything we do. We are strengthening our response to risk, reducing harm, building reliable systems and addressing the issues with our estate to support our staff to provide safe and effective care. We will involve patients in the design and delivery of our services so that we better understand what matters to them.

To give confidence to our stakeholders, staff and patients that we are making continued improvements, the Quality Improvement Plan is underpinned by improvement milestones and metrics to ensure that we can effectively track our progress.

Our plan involves fundamental improvements to services, structures and systems to ensure we deliver the immediate changes required and position the organisation to be able to respond to the demands of the future. The delivery of our Quality Improvement Plan will maintain and build on our recent progress to ensure our actions will lead to measurable improvements in the quality and safety of care for our patients.

CQC 2016 Rating

Below are the 2016 ratings for St George's Hospital, the Community Services and the overall rating for the Trust.

Summary and full CQC reports can be found on the CQC website: **https://www.cqc.org.uk/provider/RJ7**

Our ratings for St George's Hospital - Tooting

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	☆ Outstanding	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Community health inpatient services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Community End of Life Care services	Requires improvement	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Overall Community	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Our ratings for St George's University Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Section 29a Improvement Warning Notice

In response to the S29a Warning Notice received in June 2016 the Trust prioritised actions against the following issues:

CQC S29a Compliance Issues	What we did
■ Maintenance and refurbishment of Operating Theatres ■ Lack of capital investment in Lanesborough Wing, St James Wing and Paul Calvert Theatres ■ Thermoregulation Lanesborough Theatre 1 ■ Theatre air handling in units in St James Wing failing	■ Theatre Refurbishment Plan produced for schedule of work for 16 theatres. ■ Each set of theatres will take five months to complete. ■ St James Wing Theatre 3 and 4 completed ■ Two air handling units have been replaced. ■ Service and Maintenance Contract in place. ■ Paul Calvert Theatres (3) to commence September 2017 ■ St James Wing Theatre 7 to commence December 2017 ■ St James Wing Theatres 1 and 2 to commence April 2018 ■ Lanesborough Wing (Theatres 1, 2, and 3) to commence August 2018
■ Repair of maternity staff room roof in Lanesborough Wing	■ Repairs have been completed to the ceiling
■ Continued occupation of Wandle Unit after fire concerns identified	■ Building has been demolished
■ Conclude renal unit patient moves from Buckland Ward, Knightsbridge Wing	■ Knightsbridge Wing decant and relocation programme completed. ■ Renal unit no longer provided on Buckland ward
■ Assure fixed wire installation compliance across the St George's site	■ Fixed Wiring Testing Schedule in place
■ Water safety Management – Legionella contamination ■ Water safety Management – Pseudomonas	■ Flushing compliance record in place and have achieved 100% compliance
■ Mental Capacity Act (MCA) Policy requires updating ■ Recording of MCA and Best Interest Decisions ■ Awareness amongst staff of care interventions that might constitute restraint – bed rails and use of mittens to prevent removal of Nasogastric tubes	■ Updated the Mental Capacity Act Policy ■ MCA/ Deprivation of Liberty Safeguards training in place ■ Further MCA Audit completed in January 2017 ■ Project group established to focus on wards identified as a concern
■ Fragmentation of Hospital and Community End of Life Care (EoLC) Teams	■ EoLC Strategy in patnership with key stakeholders ■ Joint working group and case discussion between services
■ Risk Management process insufficient process	■ Risk Management Policy updated ■ Good Governance Master Class training provided ■ Risk Management Committee forward plan and Terms of Reference (ToR) in place
■ Timeliness of reporting and investigating Serious Incidents (SI), particularly in Surgery	■ Active Serious Incidents (SI) performance monitoring and update of policy
■ Referral To Treatment (RTT) waiting list management	■ Clinical Harm Group established ■ Recovery Programme established including RTT
■ Monitoring serial numbers for FP10 prescription pads, particularly in OPD	■ Provision and monitoring processes amended ■ Audit results of the provision of FP10 prescription monitoring
■ Radiographers administering contrast media without authorised Patient Group Directions (PGD) in place	■ Copies of all 16 applicable PGDs signed off
■ Inadequate compliance with Fit & Proper Person Checks amongst Board members	■ "Fit and Proper Person" resolved for all Executive and Non–Executive Directors
■ Workforce Race Equality Standards (WRES) 2015 published without presentation to the Board	■ WRES action plan presented to the Trust Board December 2016

CQC Inspection May 2017

In May 2017 the CQC undertook a focused inspection which showed improvements at the Trust. During the inspection the Trust was assessed as meeting the requirements of the Section 29a Warning Notice. The CQC findings include:

- The Trust had made significant progress with regards to addressing legionella risks in the water system
- There had been improvements in monitoring prescriptions and the risk of these going missing had been reduced
- Renal services had been relocated, so patients were no longer in an unsafe environment
- Operating theatres 5 and 6 had been refurbished since the previous inspection
- The water leaks to the maternity staff room had been resolved
- Governance around estates management had improved and annual reports were pubished for all services
- Serious Incidents were now being reported within internal and external Key Performance Indicator deadlines
- Mental Capacity Act and Deprivation of Liberty Safeguards training, understanding and application had improved
- There were mechanisms in place to ensure that staff delivering End of Life Care services in the acute hospitals and community services worked closely together
- The Trust was continuing to fail to meet the Fit and Proper Person Requirement regulation
- Systems and processes that operate effectively in accordance with good governance remain weak

Key CQC recommendations were that the Trust

- Must ensure the Trust has systems and processes that operate effectively in accordance with good governance
- Must strengthen governance and reporting arrangements, so as to provide the Board with increased oversight of Elective Care Recovery programme / RTT delivery
- Must continue to address the gaps in assurance with regards to estates maintenance
- Must ensure it meets the Fit and Proper Person Requirement regulation

What we have done to support the Quality Improvement Plan?

In May 2017, we revised our Quality Improvement Plan and how we supported it. Since then, we have undertaken the following activities to support the revised Quality Improvement Plan:

- Refreshed our internal inspection model in July 2017 to include Infection Control, Estates and Facilities and patient representatives. Two wards are inspected each week and an action report is produced with follow-up supportive action planning meetings
- Launched a real-time Quality Reporting system across the Trust. This system brings together quality and performance data for all wards and services in one place, to provide a more simplified and standardised overview of our clinical data
- Refreshed our unannounced Quality Audits in line with the new Quality Reporting system. Staff from Corporate Nursing, Infection Control, Estates and Facilities, Patient representatives, Medical staff and Therapies attended
- Introduced external Quality and Safety inspections led by staff from NHSI in collaboration with Trust staff. The first external inspection took place in June 2017 with a second scheduled for September 2017
- Engaged with the Institute of Health Improvement (IHI) to provide an independent assessment of the Trust's quality improvement culture, strategies, policies, and priorities. Based on the results IHI will support the Trust using an agreed quality improvement methodology to adopt a comprehensive and effective framework for building capacity, capability and the cultural foundation to promote and sustain value-based healthcare and quality
- In addition to internal reviews and data, external data and quality sources will be used for benchmarking and quality improvement, for example Getting It Right First Time (GIRFT).

Our **Quality Improvement Plan**

May 2017 onwards


Butterfly
Are you a person living with Dementia?
Do you support someone living with Dementia?

Developing the Quality Improvement Plan

Our Quality Improvement Plan is a key driver for change, as are our Financial and Elective Care Recovery Programmes. Our Financial Recovery Programme focuses on cost improvement programmes, reducing our spend and becoming more efficient as a Trust, whilst the Elective Care Recovery Plan focuses on the important issues with our data quality, and the operational processes and technology we use to support this. These three programmes have been developed in parallel to ensure we address our quality, financial and performance challenges at the same time, rather than in isolation.

In addition to these major programmes, other key change programmes are in place which will have an impact on the quality of care we provide. One example is the Staff Engagement Programme which aims to improve the way we work with each other. This programme focuses on staff engagement, equality and inclusion and ensuring that we are exceeding the Workforce Race Equality Standard (WRES) requirements. It aims to ensure that we are able to respond appropriately and sensitively to diversity, including gender, race and ethnicity, disability, religion, sexuality, class and age – to recognise the factors that can influence staff, their behaviours and the quality of care they provide.

As described on **page 9** the design of our Quality Improvement Plan has evolved from an initial response to the Care Quality Commission's (CQC) Inspection report of November 2016, to now describe our long term vision to provide Outstanding, Care, Every Time.

Key to the development of the plan has been the involvement of our staff to identify the project areas for improvement. The projects they have identified will be delivered through a framework of three areas of major change, together with two enabling workstreams.

To ensure we can effectively monitor and track our performance, we have developed a governance structure (on **page 22**) for the Quality Improvement Plan, which flows from the Terms of Reference reporting for each workstream through to Trust Board reporting. The framework and governance plan were developed by the Programme Management Office (PMO), with staff in conjunction with the Medical Director and Chief Nurse as the Executive leads for the Quality Improvement Programme, along with input from the workstream leads.

Each workstream within our Quality Improvement Plan has a Terms of Reference which details how work will be coordinated, prioritised, with outcomes, milestones and key performance indicators (KPI's). Milestones vary between short term, within the current year, and longer term, up to 4 years.

The Terms of Reference provide for communication of where the project is, where the project is heading, the timescales involved and the activities that need to be undertaken to allow the project to deliver. Each Terms of Reference details the concerns raised by the CQC during their 2016 inspection. For example, the Deteriorating Patient's Terms of Reference details that following the CQC findings in June 2016 it was recognised that improvements were required in respect to recognising and escalating deteriorating patients. The CQC found that there was an inconsistent approach on the wards to requesting advice and support for the deteriorating patient and that there was no critical care outreach team to review deteriorating patients at short notice. In response, the Terms of Reference detail and articulate the actions we have taken so far to mitigate this, what we want to achieve and what are our key change objectives for this project are in the future.

The Terms of Reference provide the project management method and control of projects. They include a detailed workstream governance plan, a programme organisation and structure, reporting arrangements, a workstream implementation plan and the required capital investment.

Each workstream has a clear set of activities and milestones for the lifecycle of the project. For example, an activity in the End of Life Care project is to staff provide more training on how to discuss the last hours and days of life with a patient and their family. In both the Complaints Management and Theatres workstream, activities included holding workshops with staff to understand their views on how we improve the quality of service and care we provide.

The outcomes of the activities from each workstream are reviewed monthly at the Quality Delivery Board.

Each workstream has senior clinical leadership and is supported by a team structure who are described in the Terms of Reference. The workstream lead provides oversight on the linkages and dependencies between activities to ensure that the workstreams are not working independently of each other. They are the means of identifying the critical paths for linked activities such as the End of Life Care and Deteriorating Patients workstreams which both aim to ensure that our staff feel confident and have the skills, training and support to recognise when patients are deteriorating.

The latest developments for each project are overseen by the PMO and publicised on the quality area of the Trust intranet and website. The PMO has been resourced to support the QIP and regularly meets with the workstream and project leads to monitor achievements, milestones and KPIs.

The PMO support ensures that anything that might prevent a workstream from achieving its objectives is dealt with promptly and additional support is provided to the programme.

Ensuring that we work closely with and support our stakeholders and staff is critical to the delivery of the plan. With this is mind we will continue to develop our programme management and governance approach throughout our improvement journey.

Quality Improvement Plan Delivery Framework

PROGRAMMES	WORKSTREAMS	PROJECTS				
SAFE & EFFECTIVE CARE	FUNDAMENTALS OF CARE	Risk Assessments	Infection Control	Consent	Patient Experience	
	END OF LIFE CARE	Strategy Implementation				
	DEMENTIA, MCA & DOLS	MCA Compliance	Use of Restraints	Carer Access		
	DETERIORATING PATIENT	Deteriorating Adult	Sepsis			
	MEDICINES OPTIMISATION	Handling of Medication	Expedite Discharges			
FLOW & CLINICAL TRANSFORMATION	UNPLANNED/ ADMITTED CARE	Front Door Streaming	ED processes	Ambulatory Care	Inpatients Processes	Discharge Processes
	THEATRES	Theatre Environment	NATSSIPS	Efficiency		
	OUTPATIENTS	Environment	Efficiency			
	RTT	RTT programme				
QUALITY & RISK	FLOOR TO BOARD GOVERNANCE	Corporate Governance	Clinical Governance			
	COMPLAINTS MANAGEMENT	Improvements to Process and Quality	Thematic Reviews			
	LEARNING FROM INCIDENTS	Learning from staff groups	Thematic learning	Mapping and establish best practice		
	CLINICAL RECORDS	Access to records	Ward Records Storage			
ENABLERS: ESTATES & IT	ESTATES RECOVERY PLAN	Recovery Plan Delivery				
	IT STRATEGY	10 Year Plan Delivery	Infrastructure Innovations and Solutions			
ENABLERS: ENGAGEMENT & LEADERSHIP	LEADERSHIP & CULTURE	Institute for Health Improvement (IHI) programme				
	ENGAGEMENT	Staff Engagement				

How we will implement the Quality Improvement Plan

Our Quality Improvement Plan describes our vision to provide Outstanding Care, Every Time for each of our patients wherever they are treated. Outstanding Care, Every Time means:

- Every patient receives safe and outstanding care
- The right patient is seen in the right place at the right time, every time
- Staff say "I'm proud to work at St George's"
- All staff - wherever they work - can shine and contribute to our future

The Quality Improvement Plan will be delivered through a framework of three areas of major change together with two quality improvement enabling workstreams.

1) Safe and Effective Care - to consistently deliver the fundamentals of patient care and ensure that improvements we make are sustained in the long term.

The projects within the Safe and Effective Care workstream are designed to ensure that we get the basics right for all of our patients and we further develop our patient care to be outstanding, every time. All Quality Improvement Plan workstreams impact the Safe and Care Effective Care programme and the quality of care we provide. The Estates workstream, for example, has a short-term strategy to stabilise and improve our estate and that equipment used must be clean, secure, suitable, maintained and used properly – which has a direct impact on the quality care we provide.

Ensuring we provide the fundamental standards of care make up a significant portion of the day-to-day activities at the Trust. There is an existing quality governance structure in place to ensure we provide safe and effective care. As part of the quality improvement journey, we are aligning this to our Quality Improvement Plan and dedicating a workstream to reviewing the effectiveness of this and further improving our quality governance. We have also aligned the Quality Delivery Board and the Financial Recovery Board which is described in more detail on **page 22**.

Alongside the Quality Improvement Plan we measure how safe and effective our care is in a number of ways. These include audit programmes, ward safety huddles, multidisciplinary audits, ward conversations, inspections, safety walkabouts, back to the floor meetings and Board visits. We have developed a quality dashboard for each clinical area so we can identify where we need to improve to our performance. In October 2017 we will begin a ward accreditation programme to recognise the achievements of our staff and wards.

Although we gather feedback from our individual patients through the Friend and Family Test and localised patient surveys, we will be improving the way we engage with our patients and use their feedback to drive improvement.

On **page 26** you can see the workstreams and projects that make up the Safe and Effective Care programme.

2) Flow and Clinical Transformation - we will make the process and operational changes to improve the flow of patients along their care pathway, from arrival through to discharge.

Many of our staff are involved in the Trust-wide Flow & Clinical Transformation programme as part of their day-to-day work, in particular with

initiatives such as pre-11am discharge, and the outpatients and theatres programmes.

The Flow and Clinical Transformation programme is addressing how effectively a patient moves along their care pathway from arrival to discharge. How a patient flows though the hospital affects all of our staff. The effective flow of patients means that patients who are coming for planned care as well as those who come to us for emergency care will have a better quality experience through being able to access their treatment in a timely way. Through the programme we aim to reduce waiting times, cancellations and clear the patient backlogs. To drive our ambition for quality we aim to improve the patient experience from the moment they come into our services until they leave. We will ensure they recieve the right information, are booked efficiently in advance, have safe and effective care and are discharged as soon as safely possible.

Ensuring that we make the operational changes to improve patient flow and make the most efficient use our resources also helps to improve the Trust's financial position. For this reason the Flow & Clinical Transformation workstream is governed by and reports in to both the Quality Delivery Board and the Financial Recovery Board.

On **page 33** you can see the workstreams and projects that make up the Flow & Clinical Transformation programme.

3) **Quality and Risk - handle risk effectively throughout the organisation through effective systems and processes that are used and understood by our staff.**

A significant part of this work stream is designed to improve how we learn as an organisation when things don't go how we expected them too.

For our patients, our aim is to avoid preventable harm. Should patients be harmed, we want to make sure that we are open and honest and that as an organisation we learn from these events to stop them from happening again. We also want to ensure that our patients receive high quality feedback and a timely response to their complaints.

For our staff our aim is to provide a safe environment and promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events, and feel empowered to make the changes necessary to avoid them happening in the future. We aim to ensure a consistent feedback loop to staff to learn from the incidents and complaints reported and this will be addressed so there is visibility at service to Board level.

We aim to ensure we have good quality governance processes such as at ward handover times, ward rounds, National Early Warnings System (NEWS) recognition, record keeping and storage, infection control procedures, identifying and recording end-of-life care needs, and recording do not attempt resuscitate (DNAR) decisions. A key part of this programme is to ensure we work within all clinical guidelines and the use of national clinical guidelines is evident throughout our services.

On **page 41** you can see the workstreams and projects that make up the Quality and Risk programme.

These are supported by two quality improvement enabling programmes:

4) Estates & IT - improve our systems and environment so that we are making what's right for patients the easiest thing for staff to do.

5) Leadership and Engagement - ensure our current and future leaders are supported and developed to deliver high quality, compassionate care, and that we engage with our staff who know our services best.

How we will implement the Quality Improvement Plan - Governance arrangements

We have developed a governance structure for our Quality Improvement Programme which is aligned to the Trust's Financial Recovery Programme. This had oversight and external scrutiny at Trust level by NHS Improvement. Each workstream has developed a Terms of Reference and is held accountable through the Quality Delivery Board which ultimately reports to the Board via the Finance and Quality Delivery Board as detailed in the diagram on page 23.

Responsibilities of programme Lead

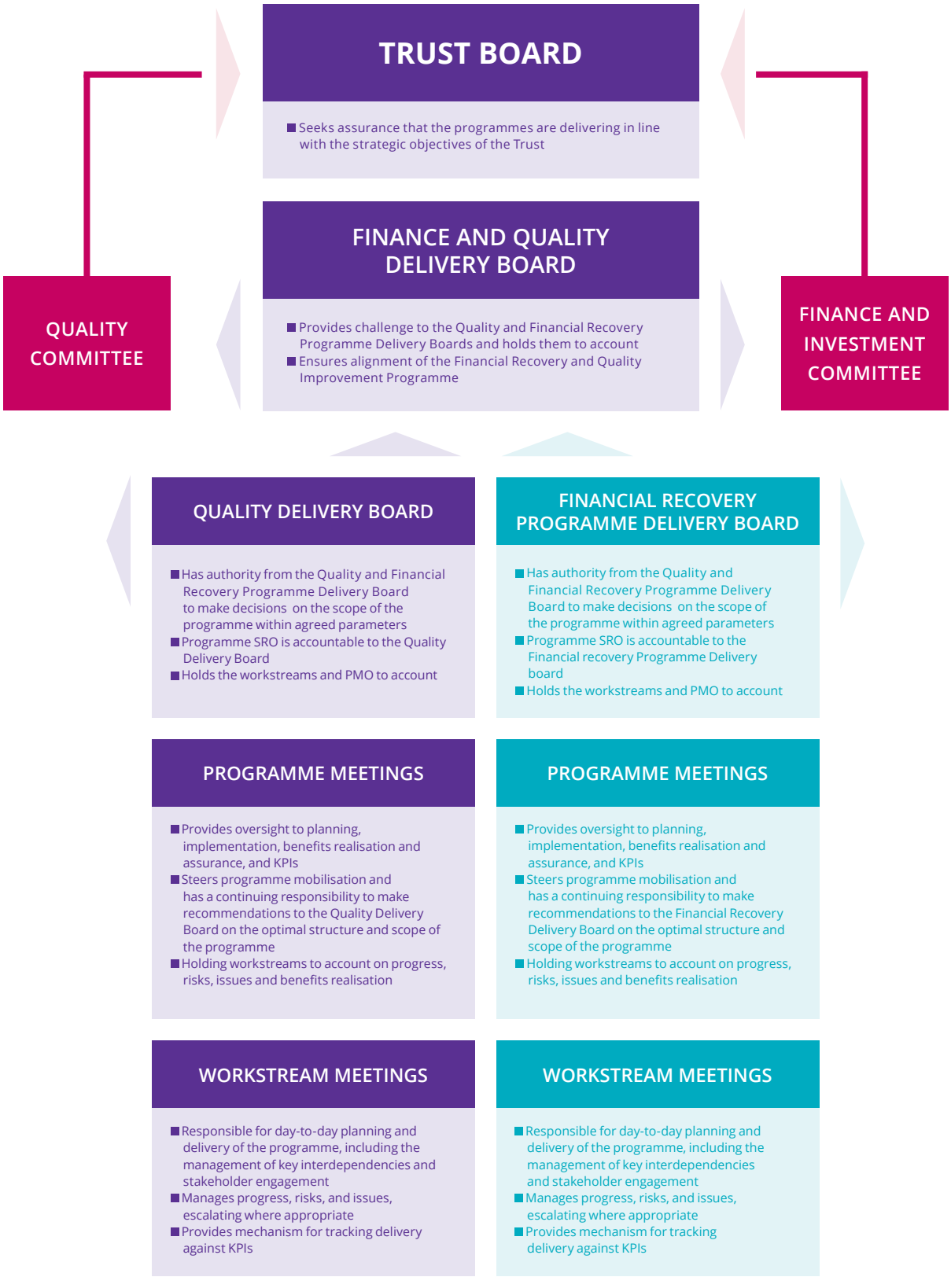
- The programme lead for each programme is responsible for ensuring that the identified outcomes, Key Performance Indicators (KPI's) and actions identified by the programme / workstream are agreed and delivered
- The programme lead will be allocated responsibility for overseeing the implementation and impact of each of the workstreams associated to their programme
- The programme lead will provide both support and challenge to the workstream Senior Responsible Officers (SROs) at the relevant governance meeting if concerns are identified, or the delivery of actions are delayed to meet the stated outcomes. Programme SROs will be requested to identify mitigating actions to bring the delivery back on track.

Responsibilities of Divisional Leads/ Trust Leads/ Staff with actions

- The QIP must be monitored on a regular basis by Divisional Leads and programme Leads to ensure it remains on track, pro-actively identifying slippage and mitigating actions to rectify as soon as possible.

Responsibilities of the central programme management office (PMO) team

- The central PMO team will provide support to the Divisions / programme Leads to ensure that the quality improvement plan is co-ordinated appropriately.


TRUST BOARD
Seeks assurance that the programmes are delivering in line with the strategic objectives of the Trust
FINANCE AND QUALITY DELIVERY BOARD
Provides challenge to the Quality and Financial Recovery Programme Delivery Boards and holds them to account
Ensures alignment of the Financial Recovery and Quality Improvement Programme
QUALITY COMMITTEE
FINANCE AND INVESTMENT COMMITTEE
QUALITY DELIVERY BOARD
Has authority from the Quality and Financial Recovery Programme Delivery Board to make decisions on the scope of the programme within agreed parameters
Programme SRO is accountable to the Quality Delivery Board
Holds the workstreams and PMO to account
FINANCIAL RECOVERY PROGRAMME DELIVERY BOARD
Has authority from the Quality and Financial Recovery Programme Delivery Board to make decisions on the scope of the programme within agreed parameters
Programme SRO is accountable to the Financial recovery Programme Delivery board
Holds the workstreams and PMO to account
PROGRAMME MEETINGS
Provides oversight to planning, implementation, benefits realisation and assurance, and KPIs
Steers programme mobilisation and has a continuing responsibility to make recommendations to the Quality Delivery Board on the optimal structure and scope of the programme
Holding workstreams to account on progress, risks, issues and benefits realisation
PROGRAMME MEETINGS
Provides oversight to planning, implementation, benefits realisation and assurance, and KPIs
Steers programme mobilisation and has a continuing responsibility to make recommendations to the Financial Recovery Delivery Board on the optimal structure and scope of the programme
Holding workstreams to account on progress, risks, issues and benefits realisation
WORKSTREAM MEETINGS
Responsible for day-to-day planning and delivery of the programme, including the management of key interdependencies and stakeholder engagement
Manages progress, risks, and issues, escalating where appropriate
Provides mechanism for tracking delivery against KPIs
WORKSTREAM MEETINGS
Responsible for day-to-day planning and delivery of the programme, including the management of key interdependencies and stakeholder engagement
Manages progress, risks, and issues, escalating where appropriate
Provides mechanism for tracking delivery against KPIs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Safe & Effective Care

The Safe and Effective Care Improvement programme has five workstreams predominantly focusing on delivering the fundamentals of patient care and ensuring that improvements we make are sustained in the long term.

The following pages provide a summary of the detailed workstream plans that underpin the Safe and Effective Care programme.

SAFE & EFFECTIVE CARE

WORKSTREAMS

FUNDAMENTALS OF CARE	END OF LIFE CARE	DEMENTIA, MCA & DOLS	DETERIORATING PATIENT	MEDICINES OPTIMISATION

PROJECTS

Risk Assessments	Strategy Implementation	MCA Compliance	Deteriorating Adult	Handling of Medication
Infection Control		Use of Restraints	Sepsis	Expedite Discharges
Consent		Carer Access		
Patient Experience				

Fundamentals of Care

Aim: To consistently deliver the fundamentals of patient care to ensure our patients are kept safe and free of avoidable harm.

We will:

- Ensure patients receive safe care and are not put at risk of avoidable harm
- Ensure all premises and equipment used is clean, secure, suitable, maintained and used properly
- Deliver quality improvements with a focus on Harm Free Care to prevent patients across our services from harm, including pressure ulcers, falls, hospital-acquired infections and Venous Thromboembolism (VTE).

How we will achieve this:

Infection control

- Provide accurate information and reporting on identified infections and hand hygiene variants
- Undertake focused audits on four wards per month to achieve perfect hand hygiene outcomes of 95% compliance
- Improve the accuracy of the hand hygiene audit through quarterly cross-divisional audits
- Ensure that Aseptic Non-Touch Technique (ANTT) competences are being met
- Ensure prompt identification and isolation of patients with an infection to reduce risk of transmitting infection to other people.

Harm Free Care

- Increase the number of VTE, pressure ulcers, falls, environment, nutrition and risk assessments
- Ensure robust governance and processes are in place to proactively manage risk assessments

Further work will be completed as part of this workstream to identify MSSA, E Coli cases, consent and patient experience. Once a baseline can be identified a threshold/target will become an indicator for this workstream.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Hand Hygiene Audit compliance	95%
Fall resulting in moderate or above harm	0
VTE risk assessment completed	85%
Grade 3 & 4 pressure ulcers	0
Avoidable VTE events	0
Infection Control Mandatory and Statutory training (MAST) compliance	85%
Staff completed ANTT competences	95%
Clostridium difficile cases reported (yearly target)	31
MRSA bacteraemia reported	0
Harm Free Care to patients	95%

End of Life Care

Aim: Continue to improve the experience for patients and their loved ones at the end of their life.

We will:

- Improve End of Life Care (EoLC) for patients and their families across the Trust by focusing on the 'six ambitions of End of Life Care' and engaging and working with staff across all wards and departments to roll out the new EoLC strategy 'Getting end of life care right'
- Enhance quality of life for people with long term conditions
- Ensure that people have a positive experience of (health) care
- Ensure the care people receive, reaching the end of their life, is aligned to their needs and preferences
- Reduce unscheduled care hospital admissions leading to death in hospital (where death in hospital is against the patient's stated preference)
- Improve the co-ordination of EoLC between providers such as care homes and the community.

How we will achieve this:

- Patients who are nearing the end of their life will receive holistic, comprehensive assessments in response to their changing needs and preferences with the opportunity to discuss, develop and review a personalised care plan for current and future treatment
- Promote the use of Advance Care Planning to enable patients to state their EoLC wishes and ensure they are adhered to
- Improve the care for patients in their last year of life and ensure they have the opportunity to plan their care along with those close to them
- Develop transparent processes for access to rapid response 24/7 EoLC
- Change the perception of "Death is failure" to "A good death is a successful care outcome"
- Ensure health and social care professionals have access to a framework of appropriate and high quality training and education.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Relatives/carers who responded to the bereavement survey who rated overall care as good or excellent	100%
Complaints relating to EoLC themes for patients in our care	0
Serious incidents relating to EoLC themes for patients in our care	0

Dementia, Mental Capacity Act & Deprivation of Liberty Safeguards

Aim: Ensure there is no decision without the patient's or carer's involvement and the patient's wishes and values are at the centre of their care and treatment.

We will:

- Improve our compliance with Mental Capacity Act Assessment (MCAA)
- Improve the safe, effective and appropriate use of restraints (e.g. bed rails) throughout the Trust
- Improve carer access for patients with dementia
- Be recognised as a dementia friendly hospital

How we will achieve this:

- Avoid inappropriate use of restraints though training and education
- Improve compliance with dementia carers' survey to obtain better feedback from this important group of service users
- Work with wards to roll out dementia carers passports and facilitate overnight stays by carers
- Ensure staff have access to and complete dementia awareness training
- Increase use of the Butterfly Scheme
- Develop a dementia and delirium scorecard to monitor performance at Divisional level to drive continuous improvement
- Further work will be completed as part of this workstream to identify the number of patients that could potentially be on the Butterfly Scheme. Once a baseline can be identified a threshold/target for participation will become an indicator for this workstream.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
MCA audit compliance (St George's Hospital)	100%
MCA audit compliance (Queen Mary's Hospital)	100%
Staff completed dementia awareness training	85%
Carers who would like to stay overnight with patient, who actually stayed beside the patient	100%
Carers passports issued per month	15 per month
Dementia carers survey completed	20 per month

Deteriorating Patient

Aim: Recognise and manage the deteriorating patient and ensure staff support patients and carers to make a choice regarding their treatment

We will:

- Put in robust processes to effectively identify patients who are at risk of and/or are deteriorating
- Ensure staff are confident and competent in knowing how and when to escalate deteriorating patients in a timely manner
- Support staff working with patients and carers to make a choice regarding their treatment in line with DNACPR (Do not attempt CPR resuscitation) and end of life guidance as appropriate

How we will achieve this:

- Increase awareness and local ownership of the associated risks with a deteriorating patient in every ward
- Embed inpatient care and deteriorating adult care into the governance of every speciality care group
- Improve EWS (Early Warning Score, which supports the recognition of deteriorating patients) monitoring and escalation compliance
- Monitor mortality and incidents and feedback locally
- Achieve 100% SAFER (a standardised way of managing patient flow through hospital) compliance on the wards
- Set individual escalation and End of Life Care plans for every patient admitted to the hospital
- Patients who are nearing the end of their life will receive holistic, comprehensive assessments in response to their changing needs and preferences with the opportunity to discuss, develop and review a personalised care plan for current and future treatment

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
In hospital (All) Cardiac Arrest Rate/1000 admissions	50% reduction by April '18 from baseline of 14 (April 17)
Increase in compliance with appropriate response to EWS	85%
Blue light sepsis assessment and antibiotics in ED within one hour	85%

Medicines Optimisation

Aim: To ensure the safe and efficient storage and use of medicine and to continue to reduce the time a patient waits for their medicines.

We will:

- Ensure safe and secure handling of medicines focusing on room and fridge temperature monitoring solutions for medicines.
- Continue to improve discharge medication turnaround times for patients to improve the patient experience and patient flow through the Trust.

How we will achieve this:

- Ensure 80% of pharmacy staff resource is utilised for clinically focused patient-facing medicines optimisation and increase the number of prescribing and transcribing pharmacists
- Increase satellite dispensing pharmacies from three to four at St George's Hospital to ensure that patients receive their medication quicker than by dispensing from the central pharmacy
- Continue to reduce the turnaround time for patents receiving their discharge medications to support patient flow
- Increase the use of an external partner to provide monitored dosage systems to prevent delayed discharge

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Pharmacists actively prescribing	80%
Medication to take out (TTOs) dispensed in satellite dispensing units	90%
TTOs completed in less than 60 minutes in satellite dispensing units	90%
Monitored Dosage System dispensed by external partners	90%
Time taken to resolve Frequent High Temperatures in Clinical Areas (FHTCA)	6 weeks

Flow & Clinical Transformation

The Flow and Clinical Transformation programme has four workstreams predominantly focusing on ensuring we make the process and operational changes to improve the flow of patients along their care pathway, from arrival through to discharge.

The following pages provide a summary of the detailed workstream plans that underpin the Flow and Clinical Transformation programme.

FLOW & CLINICAL TRANSFORMATION

WORKSTREAMS

UNPLANNED/ ADMITTED CARE	THEATRES	OUTPATIENTS	REFERRAL TO TREATMENT (RTT)

PROJECTS

Front Door Streaming	Theatre Environment	Environment	RTT programme
ED processes	NATSSIPS	Efficiency	
Ambulatory Care	Efficiency		
Inpatients Processes			
Discharge Processes			

Unplanned and Admitted care

Aim: Improve the timeliness of emergency care for patients and consistently meet the A&E four-hour operating standard. Ensure that we admit patients to the right ward or place of care first time and ensure a positive patient experience. Align our people and clinical capacity to pathway demand and ensure our patients go to the most appropriate environment for their assessment, treatment, and care.

We will:

- Revise processes whereby patients on arrival receive the most appropriate environment for their assessment – in the hospital or out of hospital.
- Create a paper-free Emergency Department to enable our clinicians to focus their time on patient needs.
- Develop a systematic approach and physical space whereby adult and paediatric patient treatment needs can be on an ambulatory basis whenever possible as an alternative to admission.
- Enable direct and timely access to diagnostic tests and scans.
- Admit patients to the most appropriate environment for the patient's expected length of stay, with an early assessment and treatment plan toward discharge.
- Improve patient tracking systems electronically so that any task delays are rapidly identified and resolved and that every day every patient moves towards going home.
- Enable and institute consistent daily ward rounds and effective communication for every patient.
- Actively identify and resolve any internal or external constraints to discharge from the first day of stay.
- Develop boundary-less flow to minimise length of stay for patients requiring ongoing treatment or care, and create the flexibility within hospital to maintain a steady state during periods of increased demand.

How we will achieve this:

- More engagement and involvement of patients, front line staff, and partner organisations.
- Improve how we transfer of care from the acute setting into community settings.
- Establish underlying principles to reduce variation, improve reliability, increase consistency and increase responsiveness to problems in patient flow.
- Comprehensive analytic assessment of bed capacity, Length of Stay (LoS) performance versus peer Trusts, attainment and ward discharge metrics.
- Review of bed capacity and demand model.
- Implement the SAFER care bundle across all wards with consistent monitoring, as well as hospital at night and seven-day hospital initiatives.
- New processes within A&E to enable decisions for streaming patients to the appropriate care environment.
- New discharge processes, including discharge to assess and trusted assessor to ensure discharge focuses on individual patient needs.
- Integration of the discharge system with improved coordination of the expertise, skills, and capacity of colleagues internal and external to the Trust.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
A&E 4 hour operating standard	95%
Ambulance handover time 15min	100%
% of patients assessed within 15 min of arrival at A&E	100%
% of Daily discharges by 11am	40%
Bed Occupancy	92.5%
% of wards using SAFER	90% (staged)
Patient Experience (FFT)	95%

Theatres

Aim: To reduce cancellation of operations and make efficient use of our operating theatres.

We will:

- Co-ordinate operational, quality and financial improvement initiatives into one programme of work
- Increase theatre productivity
- Reduce cancellations on the day of surgery.

How we will achieve this:

We will improve our theatres efficiency, environment and outcomes through improvements in:

- Booking, admissions and staff/patient scheduling
- Pre-operative assessment
- Handling admissions via the Surgical Assessment Lounge (SAL)
- Preparing theatres to ensure they are ready to go without late starts
- Other areas of focus will be identified and indicators developed as part of the workstream activities.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Number of Serious Incidents / Never events	0
WHO checklist compliance	100%
Hand hygiene audit	95%
Increasing elective and day case activity	15% in target specialities
Increase pre-admission appointment attendees	20%
Local anaesthetics only lists	6 per week
Waiting list initiative reduction per year	300

Outpatients

Aim: To offer patients greater choice in how they access our services and ensure we match our capacity to patient demand.

We will:

- Ensure patients can have access to high quality outpatient care when they require it and have full access to virtual or other types of extended outpatient care
- Ensure waiting times are reduced to deliver constitutional standards and improve experience and outcomes for patients
- Review and improve the appointment booking system, putting an effective system in place where patients are booked into the right clinics and have the right information for their appointment
- Offer patients greater choice in how they access acute specialists with alternatives to face-to-face appointments
- Ensure that patients have easy access to the hospital to check appointment enquiries through phone and email systems and that DNA (did not attend) rates for appointments are reduced to acceptable levels

How we will achieve this:

- Work with patients, services, Clinical Commissioning Groups and other providers to create sustainability in key services
- Migrate to electronic referral in line with NHS standards in parallel with extended advice and guidance access so that referring clinicians are alerted to potentially more appropriate assessment and treatment environments for their patients
- Standardise outpatient pathways across the Trust by utilising technology appropriately to reduce administrative inefficiency and ensure all activity is recorded and reported to commissioners

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Outpatient Friends & Family Test	95%
First attendances per month	17196
Follow up attendances per month	29937
Advice and guidance activity per month (CQUIN)	100%
E-referral usage per month (CQUIN)	100%
Clinic appointment with eDM record	73%
Did Not Attend Rates	5%

Referral to Treatment

In January 2016, we became concerned about the quality and robustness of our data reporting, particularly for referral to treatment (RTT) metrics.

An external review of our RTT data and patient tracking systems last year identified a number of serious issues with our operational processes and technology that posed significant risks to the quality of care and patient safety, and flaws with our reporting processes at St George's Hospital (Tooting).

A subsequent review carried out in April 2017 identified similar problems at Queen Mary's Hospital in Roehampton.

In real terms, this means that many patients are waiting longer than they should for treatment. We are also unable to confirm, at this stage, how long some patients have been waiting for treatment.

It is clear that our systems and processes have fallen far below the high standards we judge acceptable. However, we have a new leadership team in place, and our priority is to deliver a robust and long-standing solution for our patients, and the communities we serve.

Patient safety is our number one priority

Due to the problems highlighted above, we suspended national reporting of our RTT data in June 2016. We won't recommence reporting until we have full confidence that the information we are providing is reliable.

We have established an Elective Care Recovery Programme, which reports to the Trust Board on a monthly basis.

The programme is designed to review and validate existing electronic patient records, so as to ensure patients aren't waiting longer than they should for treatment.

It is also establishing an effective patient tracking system for the future, meaning the treatment plans for new patients referred to both St George's and Queen Mary's are tracked and monitored effectively.

A key part of our improvement journey

Due to the size and scale of the challenge we face in this area, the Elective Care Recovery Programme is being run as a separate project separate to the immediate scope of our Quality Improvement Plan, Outstanding Care, Every Time.

However, delivering safe and effective patient tracking systems for the Trust – and addressing the historical problems we have identified – is a key part of our improvement journey.

As a result, the Elective Care Recovery Programme and our Quality Improvement Plan, Outstanding Care, Every Time, will remain closely linked, and both are key to our wider recovery as an organisation.


NHS
Nurse in Charge
St George's Healthcare NHS

Quality & Risk

The Quality and Risk Improvement programme has four workstreams predominantly focusing on how we handle risk effectively throughout the organisation through effective systems and processes that are used and understood by our staff.

The following pages provide a summary of the detailed workstream plans that underpin the Quality and Risk programme.

QUALITY & RISK

WORKSTREAMS

FLOOR TO BOARD GOVERNANCE	COMPLAINTS MANAGEMENT	LEARNING FROM INCIDENTS	CLINICAL RECORDS

PROJECTS

Corporate Governance	Improvements to process and quality	Learning from staff groups	Access to records
Clinical Governance	Thematic reviews	Thematic learning	Ward records storage
		Mapping and establish best practice	

Floor to Board Governance

Aim: To handle risk throughout the organisation through effective systems and processes that are used and understood by our staff. To ensure that information is provided to our Board to assure them we are operating effectively and our patients and staff are being well cared for.

We will:

- Ensure that our organisation maintains focus on strong integrated governance and leadership across quality, finance and operations, and stays in line with the changing environment
- Ensure we are able to identify and mitigate against risks in the organisation and that the organisation has line of sight of risks which may be barriers to achieving its key objectives.

How we will achieve this:

- Use the CQC Well-Led framework to ensure we are meeting our regulatory requirements
- Undertake an independent review of our corporate governance function
- Develop action plans to improve control RAG ratings and ensure the appropriate governance measures are in place to learn from incidents and complaints
- Continue to monitor compliance with the risk management policy
- Review all risk register controls and RAG ratings
- Update the training on how to RAG rate controls within our risk and issues process system DATIX.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Risks without green controls	0
Risks with no controls	0
Moderate/high/extreme risks	< 6% per month
Moderate/high/extreme risks with overdue actions	0
Moderate/high/extreme risks with no actions	0

Complaints Management

Aim: To ensure complaints are responded to in a timely manner, investigated thoroughly and that we learn from complaints so that the same type of incident doesn't happen again.

We will:

- Ensure there is a focus on the quality of engagement with the complainant to support resolution of issues or concerns as soon as possible
- Identify a way to process complaints that improves quality and effectively responds within agreed timeframes
- Be a learning organisation – responsive to our patients concerns and understanding how successful we are by asking our complainants about their experience of making a complaint through a new Complaints Satisfaction Survey
- Reduce future complaints by improving how we act on lessons learnt.

How we will achieve this:

- Review our current processes and use learning from other organisations to understand what 'good' looks like to ensure we develop the best approach to handling complaints
- Identify other forums for complaint resolutions such as informal face-to-face meeting and telephone contacts to ensure that we are responding to the patient needs
- Develop a robust communication and development campaign to ensure that customer service is embedded into our day-to-day activities with staff willing and confident to support individual complainants
- Develop divisional action plan trackers to ensure that all actions are followed through and for more complex or serious complaints actively engage and involve our patients to demonstrate we are improving services.
- Design a Complaints Satisfaction Survey to be in place by December 2017.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Compliance within 25 working days complaint response for green complaints	95%
Compliance with 40 working day complaint response for all amber complaints	95%
Compliance with 60 working day complaint response for all red complaints	95%
Complaints that require a second response	<8%
Complaints upheld by the Parliamentary and Health Service Ombudsmen (PHSO)	0

Learning from Incidents

Aim: To ensure that learning from incidents is implemented properly throughout the Trust, so as to reduce the risk of repeat occurrences of any issues identified.

We will:

- For our patients, our aim is to avoid preventable harm. Should patients be harmed, we want to make sure that we are open and honest and that as an organisation we learn from these events to stop them from happening again
- For our staff, our aim is to provide a safe environment and promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events and feel empowered to make changes necessary to avoid them happening in the future.
- Ensure that we address the human factors – environmental, organisational and the individual charateristics – which influence behaviour at work and the care our staff provide.

How we will achieve this:

- Review current practice and establish minimum standards for low and high level incident reporting and distribution, with improved communication to staff
- Ensure learning is embedded from actions resulting from incident investigations. We will evidence how effective this is through, ward safety huddles, inspections, safety walkabouts, back to the floor meetings and Board visits
- Survey staff to assess to what extent learning from incidents has been embedded
- Improve analysis of incident to allow for thematic analysis and identification of recurrent themes
- Improve learning from low level incident reporting
- Enhance incident reporting usage and feed-back
- Identify learning needs for specific staff groups and develop tailored approach.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Duty of Candour completed for all incidents (as graded on Datix) at moderate harm and above	100%
Duty of Candour completed within 10 working	100%
Incidents reported – non clinical	2200/year
Incidents reported – clinical	12,300/year
Serious Incidents declared	90/year
Serious Incidents investigations >60 days	0
Never Events declared	0
Staff who provide an informed response to the learning from incidents survey	95%

Clinical Records

Aim: To ensure patient care is not impacted by storage, completion or accessibility of clinical records. To ensure that staff meet the quality standards so we are able to support safe and effective care.

We will:

- Protect our patients by ensuring that records relating to the care and treatment for each patient are kept securely and are an accurate and complete record
- Ensure records are accessible to authorised staff in order that they may deliver, to people, care and treatment in a way that meets their needs and keeps them safe.

How we will achieve this:

- Identify areas of non-compliance for clinical record storage and barriers to compliance
- Review capacity of corporate secure record storage facilities
- Review the audit process for clinical records to improve the quality of clinical records
- Hold workshops with junior doctors and matrons to identify barriers to creating accurate notes
- Identify training needs for clinical groups and identify feedback forums to support learning
- Agree national and local quality standards so we can track our performance
- Develop action plan for remedial action at area level to enable compliance

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Number of outpatient appointments where clinical notes are not available	5%
Notes not securely stored on wards	0%
Clinical records quality of meeting national standards	98%


Trust Capital Projects Team
Human Resources
Estates

Enablers: Estates & IT and Engagement & Leadership

The Estates and IT programme has two workstreams predominantly focusing on how to improve our systems and environment so that we are making what's right for patients the easiest thing for staff to do.

The leadership and Engagement programmes has two workstreams designed to ensure that our current and future leaders are developed to deliver high quality, compassionate care, and we ensure our staff are at the centre of the changes we are making.

The following pages provide a summary of the detailed workstream plans that underpin the Estates and IT programme programme.

ENABLERS

ESTATES & IT

WORKSTREAMS

- ESTATES RECOVERY PLAN
- IT STRATEGY

PROJECTS

- Recovery Plan Delivery
- 10 Year Plan Delivery
- Infrastructure Innovations and Solutions

ENGAGEMENT & LEADERSHIP

WORKSTREAMS

- LEADERSHIP & CULTURE
- ENGAGEMENT

PROJECTS

- Institute for Health Improvement HI programme
- Staff Engagement

Enablers Programme: Estates

Aim: Our short-term strategy is one of stabilisation and improving our estate to get the basics right so that our environment makes outstanding care possible. In the longer term, we will transform our estate through the delivery of new estates infrastructure that has improved capacity, reliability and compliance to underpin the Trust's clinical vision and strategy.

We will:

- Continue to stabilise our estate, to restore the Trust's performance and reputation as a university hospital providing excellence in both local healthcare and specialised services. This is our short-term strategy to improve our estates to get the basics right
- Improve the environment for staff and patients
- Ensure the Estates team provide a responsive service and addresses concerns by clinical staff

How we will achieve this:

- Vacate and demolish buildings that are no longer suitable for purpose, to create space for service improvement
- Modernise our theatres and wards in line with the clinical service needs
- Work through our backlog maintenance, fire, water, heating and ventilation safety; resolving our highest risks first
- Address our electrical compliance through the replacement and upgrade of our electrical infrastructure
- Improve capacity of our Emergency Department, ITU and Critical Care Unit
- Relaunch a more efficient and responsive Helpdesk.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
In line with the Carter Recommendations to ensure that 62.5% of the trust estate is used for clinical purposes	62.5%
All inpatient wards including ED at morning handover to report estates issues and log to the estates helpdesk for example; dishwasher blockage, medicines cabinets secure	95%
Acknowledgment by estates of all logged issues via estates helpdesk	100%
Initial assessment of logged issue by estates department	24hrs
Low use outlets are tracked and all are flushed routinely	100%
Valid training sessions available to ensure trained fire warden on each shift in every area	2 per week

Enablers Programme: IT

Aim: To provide the right infrastructure to support clinical and management systems for our staff to provide modern services to our patients and to accurate record activity.

We will:

- Improve patient experience and reduce harm by enabling and supporting the Financial Recovery Programme
- Reducing cost by supporting the Trust's Cost Improvement Programme (CIP)
- Improve Trust staff experience of using IT
- Improve the timeliness and availability of data to support clinical and administrative decision making.

How we will achieve this:

- Invest in technology including infrastructure, clinical and corporate systems, and training of staff
- Define and publish a range of IT metrics that demonstrate stability, responsiveness and consistency
- Invest in the informatics service
- Further work will be progressed as part of this workstream on the service desk function. Once a baseline can be identified a threshold/target will become an indicator for this workstream.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
A reduction in the number of clinical & organisational incidents recorded where IT infrastructure is a contributory factor	**50% reduction on 16/17 data**
A reduction in the number of medication administration errors accountable to IT failure	**50% reduction on 16/17 data**
A reduction in the number incidents related to failure to identify deteriorating patients accountable to IT failure	**50% reduction on 16/17 data**
Carry out an annual ICT staff satisfaction survey	**October 2017**
Create an IT Service desk dashboard of IT Key Performance Indicators (KPIs)	**November 2017**

Enablers Programme: Leadership

Aim: To ensure our current and future leaders are supported and developed to deliver high quality, compassionate care aligned to the needs of the populations we serve, in a cost-effective manner.

We will:

- Create the right conditions and environment in which staff will enable the Trust to deliver a continuously improving culture
- Develop the critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills
- Embed cultural and leadership behaviours that lead to higher quality care cultures amongst all staff in the organisation.

How we will achieve this:

- Use the NHS Healthcare Leadership Model as our leadership framework for the Trust
- Develop our existing leaders with a key focus on developing the four critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills
- Give our leaders time and space to lead service transformation/quality improvement, and find ways to bring their staff along with them
- Evaluate and measure the return on investment in leadership development skills to ensure we use the resources available in the most cost effective way.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Set up and commence delivery of a leadership / management development centre	Oct 2017
Number of identified staff participating in formal leadership development programmes	200 staff participants per year
Delivery of effective people management programme	200 staff participants per year
Members of the Trust participating in Board development programme	100%

Enablers Programme: Engagement

Aim: Ensure our staff are at the centre of the changes we are making and incorporate their views in to everything we do.

We will:

- Create the right conditions and environment in which staff will enable the Trust to deliver a continuously improving culture
- Engage staff with the overarching QIP objectives and run localised engagement events to support the delivery of each workstream

How we will achieve this:

- Run a Quality Improvement Week in November 2017
- Support programme managers to run localised engagement activities within their services
- Deliver the staff engagement plan, so we can improve these three key areas:
  - Improve staff engagement
  - Address bullying harassment
  - Improve equality and diversity
- Local QIP awareness and understanding events/meetings with toolkit produced by communications team.

We will use a range of indicators to measure this including:

Indicator	Successful when we achieve
Improved NHS National Staff Survey scores	**10% improvement on previous years scores**
Friends and Family Test (FFT) scores	**95% recommend**
Staff turnover	**≤15%**
Executive "Big Conversations"	**4 by Nov 2017**
Staff survey participation	**60%**


Are you a
person living
with Dementia?
Do you support someone
living with Dementia?

How we will communicate our **Quality Improvement Plan** achievements

Communications

The programme will require us to utilise existing communications channels and open new bespoke communications and engagement channels, including workshops, seminars, and drop in sessions.

Internal core channels

- eG St George's
- Intranet
- Medical Director's Bulletin
- Core Brief
- Senior Leaders Briefing
- CEO weekly message
- Consultants evening briefing sessions
- My George staff app
- CEO bi-monthly staff briefing sessions

New channels

- 1-2-1 face-to-face briefings
- In depth briefing notes to key stakeholders on significant issues
- Providing key lines for Executive Management Team (EMT) to discuss with stakeholders such as Healthwatch and MPs
- Attending GP locality/Trust events, or providing key messages to support
- Website section with key updates for the public with overview of improvements
- Social media, Facebook, LinkedIn, Twitter (also used by Trust staff)

Bespoke development

- Quality Improvement Week in October
- Monthly updates and heat map infographics(s) showing the progress across each workstream or a consolidated view across all programmes
- Success and good news stories shared
- Real-time quality improvement - watch/read as one project/team update as project progresses
- Series of workshops to involve staff in shaping how we get there and to generate understanding
- Senior leaders drop-in sessions for staff
- Visits by executives and Board members to projects and teams

Progress as of April 2017

- Local QIP awareness and understanding events/meetings with toolkit produced by communications team
- Quality improvement ambassadors/champions
- Quality improvement toolkit (ward based)
- In Touch – GP and primary care update
- Media positive proactive news stories and reactive media management
- FT members newsletter and annual meetings

If you have any questions about this plan or would like to comment or make a suggestion regarding its implementation, please contact: Avey Bhatia, Chief Nurse and Director of Infection Prevention & Control: avey.bhatia@stgeorges.nhs.uk, Elizabeth Palmer, Director of Quality Governance: elizabeth.palmer@stgeorges.nhs.uk, or contact the Communications Department: communications@stgeorges.nhs.uk


St George's Hospital Charity
St George's Healthcare
NHS

Contact us

Giving to George's

As well as making a donation there are lots of ways you can get involved with the St George's Hospital Charity. To find out more speak to the Giving to George's team.

Telephone: **0208725 4917**
Email: giving@stgeorges.nhs.uk
Web: www.stgeorgeshospitalcharity.org.uk

Volunteer

Our volunteers perform a number of varied roles, from manning information desks, general housekeeping, administration and helping patients find their way around. If you would like to volunteer at any St George's, University Hospitals NHS Foundation Trust sites, contact the voluntary services team.

Telephone: **020 8725 1452**
Email: zoe.holmes@stgeorges.nhs.uk

Request a printed copy

Contact the communications team if you would like a printed copy of the Quality Improvement Plan.

Telephone: **020 8725 5151**
Email: communications@stgeorges.nhs.uk

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StGeorgesTrust
@StGeorgesTrust
StGeorgesTrust

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Trust Board - 5th October 2017
Reporting period - August 2017

Excellence in specialist and community healthcare

Activity Summary

St George's University Hospitals NHS
NHS Foundation Trust

The table below compares activity to previous months and quarters and against plan for the reporting period

		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Aug-16	Aug-17	Variance	Plan Aug-17	Variance	YTD 16/17	YTD 17/18	Variance	Plan YTD	Variance
ED	ED Attendances	13,301	13,286	-0.11%	14,715	-9.71%	69,091	69,621	0.77%	72,624	-4.13%
Inpatient	Elective & Daycase	4,303	4,437	3.11%	4,647	-4.52%	21,229	22,697	6.92%	22,581	0.51%
	Non Elective	3,922	3,759	-4.16%	4,369	-13.96%	20,450	19,513	-4.58%	21,562	-9.50%
Outpatient	OP Attendances	54,028	51,748	-4.22%	53,122	-2.59%	269,337	264,841	-1.67%	258,229	2.56%

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

Source: SLAM

Executive Summary – August 2017

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- No patient Never Events reported in August. The Trust has reported two events year to date. There were 9 Serious Incidents (SI's) declared in August.
- Patient safety thermometer- % of patients with harm free care (all harm) remained at 93.8%
- In August the Trust reported four patients with hospital attributable Clostridium Difficile infection, which brings the trust year to date total to nine cases.
- Zero patients acquired an MRSA Bacteraemia in month, the trust total year to date is 4 against a ceiling of 0

Clinical Effectiveness

- Mortality is lower than expected for our patient group when benchmarked against national comparators
- Maternity indicators continue to show expected performance and a consistent trend

Access and Responsiveness

- The Four Hour Operating Standard was not achieved in August reporting a performance of 89.9% of patients admitted, discharged or transferred within four hours of arrival, this was also below the improvement trajectory agreed with NHS Improvement.
- Three out of eight cancer standards were met in July. This is a significant deterioration.
- Diagnostic performance remains below the 99% standard at Trust level, however in line with agreed local trajectory. Recovery actions have been agreed for those modalities not meeting the standard

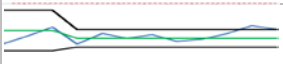
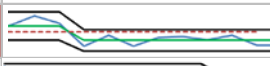
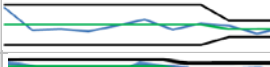
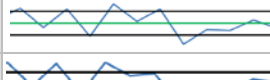
Patient Experience

- The Friends and Family Test (FFT) recommendation rate for inpatients was 96.7% in August and remains above threshold, providing a level of assurance for patient experience

Workforce

- Staff sickness remains above the trust target of 3%
- Non Medical Appraisal Rates have remained consistent with previous months.

Patient Safety

Indicator Description	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend
Number of Never Events in Month	0	0	0	0	0	0	1	0	0	0	1	1	0	
Number of SIs where Medication is a significant factor	0	0	0	2	0	1	0	0	0	0	0	1	1	
Number of Serious Incidents	N/A	4	7	10	4	8	6	8	5	6	8	10	9	
Serious Incidents - per 1000 bed days	N/A	0.30	0.52	0.76	0.30	0.58	0.46	0.56	0.37	0.43	0.58	0.73	0.70	
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.6%	96.5%	95.8%	93.7%	94.7%	93.7%	94.5%	94.6%	94.3%	94.7%	93.8%	93.8%	
Safety Thermometer - % of patients with harm free care (new harm)			98.8%	97.7%	97.7%	97.6%	97.9%	98.2%	97.7%	98.0%	97.9%	97.5%	97.8%	
Percentage of patients who have a VTE risk assessment	95%	96.3%	96.2%	95.9%	95.9%	96.8%	96.5%	96.3%	95.3%	96.2%	96.3%	95.8%	TBC	
Number of Patient Falls	N/A	155	128	154	116	161	137	154	111	137	132	143	127	
Number of patient falls- per 1000 bed days		11.76	9.46	11.69	8.79	11.76	10.48	10.70	8.32	9.88	9.52	10.41	9.88	
Attributable Grade 2 Pressure Ulcers per 1000 bed days	N/A	1.90	2.51	0.76	1.44	0.95	2.14	1.39	1.27	0.50	2.02	1.67	1.17	
Number of Grade 3 & 4 Pressure Ulcers		0	0	0	1	3	2	3	2	1	0	1	1	
Attributable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00	0.00	0.00	0.00	0.08	0.22	0.15	0.21	0.15	0.07	0.00	0.07	0.08	
Number of overdue CAS Alerts	0	1	1	1	1	1	1	1	1	1	0	0	0	

Briefing

- No Never Events reported in August, the Trust total remains two, year to date.
- The Trust declared 9 serious incidents in August 2017
- We continue to protect our patients from 'new harms' as evidenced when benchmarking our position nationally, however 'all harms' are below the threshold of 95%

Actions: The Safety Thermometer data for all harms is below the target of 95%. This was due to 82 harms being reported across 1,269 patients. These harms cover pressure ulcers, falls, catheter infections and VTE's. However, these are harms reported prior to the patients admission to the ward area. If patients present with pressure ulcers these are reported and reviewed by the Tissue Viability team. A programme of safety training has been initiated following the never events reported. The falls practitioner has started in the trust and has completed a review of the falls profile and validation of datix.

Infection Control

Indicator Description	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend (12 months)
MRSA (Incidences in month)	0	0	1	0	0	0	1	0	2	0	2	0	0	
Cdiff Incidences (in month)	31	3	6	4	4	3	4	3	1	1	1	2	4	
MSSA	N/A	4	6	5	0	7	2	2	3	2	4	5	4	
E-Coli	N/A	6	5	3	2	6	3	11	4	2	1	9	6	

Briefing

- There were four patients reported who suffered with a hospital acquired Clostridium Difficile Infection in August.
- C Diff threshold for 2017/18 remains the same as the previous year at 31 cases. There have been nine cases year to date.
- Root cause analysis is undertaken for each case to ensure that any opportunities for learning are captured and appropriate actions taken to prevent similar avoidable infections in the future
- There were zero patients who acquired an MRSA Bacteraemia in August, the Trust year to date total remains at four.

Actions:

Root cause analysis is under way for the four C diff incidences detected in August. These areas have been placed on a period of increased surveillance and an audit with the support of the infection control team to ensure infection control practice is being completed.

Mortality and Readmissions

Indicator Description	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	84.3	88.9	84.1	84.1	84.1	83.3	82.5	83.5	81.3	81.3	79.7	TBC	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	83.2	86.6	84.2	82.4	82.4	81.1	79.2	80.1	78.2	78.2	81.3	TBC	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	0.87	0.94	0.92	0.87	0.87	0.87	0.84	0.86	0.83	0.83	0.76	TBC	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.86	0.84	0.84	0.84	0.84	
Emergency Readmissions within 30 days following non elective spell	TBC	9.3%	9.1%	9.3%	9.8%	8.9%	10.2%	9.3%	9.5%	9.7%	9.7%	8.8%	7.0%	

Briefing

- Latest SHMI data for the Trust shows mortality remains lower than expected for our patient group when benchmarked against national comparators.
- Hospital Standardised Mortality Ratio information for August 2017 is not yet available

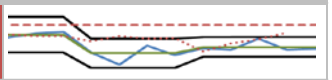
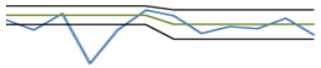
Maternity

- Maternity indicators continue to be monitored and reviewed by the Divisional Governance process

Indicator Description	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend
C Section Rate - Emergency and Non Elective	28%	24.4%	26.8%	26.1%	28.4%	28.8%	29.6%	34.1%	29.9%	29.1%	24.6%	29.5%	24.9%	
Admission of full term babies to neo-natal care		4	13	1	2	2	7	2	11	2	16	21	20	

Actions: All term admissions to the Neo-natal Unit are reviewed to identify any avoidable causes by the Trust's governance midwife and consultant and discussed at monthly risk and morbidity meeting. Improved reporting on datix through the addition of subcategories to be in place to assist in thematic reviews. Review of local and national data to be completed

Emergency Flow

Indicator Description	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend
4 Hour Operating Standard	95%	92.24%	93.21%	93.50%	89.14%	86.63%	90.59%	89.09%	90.50%	89.68%	92.12%	89.76%	89.99%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	0	1	0	1	0	0	1	0	0	0	
Ambulance Turnaround - % under 15 minutes	100%	56.1%	52.1%	53.8%	49.9%	46.9%	52.4%	50.2%	46.0%	48.4%	51.9%	48.9%	50.5%	
Ambulance Turnaround - % under 30 minutes	100%	97.2%	98.2%	97.8%	96.6%	96.4%	98.1%	97.6%	96.1%	96.7%	96.5%	97.4%	96.0%	
Ambulance Turnaround - number over 60 minutes	0	0	0	0	0	0	0	0	0	1	0	0	1	

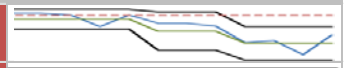
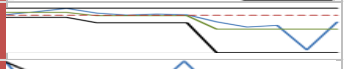
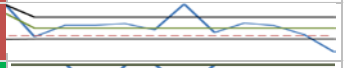
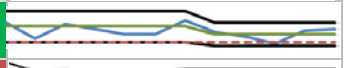
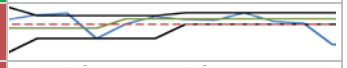
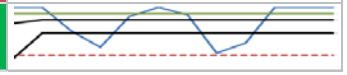
Briefing

- The Four Hour Operating Standard was not achieved in August reporting a performance of 89.99%, this was also below the improvement trajectory agreed with NHSI.
- Ambulance turnaround performance has recently been stable however performance decreased in the month of August relating to capacity within the Trust. The trusts 30 minute performance fell slightly in August.
- Much work is underway to further improve patient flow (expanding space for ambulatory care) and thus improve patient safety and experience and improve our ability to deliver performance

Actions

- Weekly “Communications Cell” in place to review the previous week’s performance and share lessons learned and agree actions.
- Daily forward look of staffing levels to ensure clinical staffing best matches time of attendances.
- A key action is to review ambulance handover processes to reduce delays in handover.
- The unplanned and admitted patient care programme led by divisional chair for Medicine and Cardiothoracic Division supported by clinicians throughout the Trust has been launched with the aim of providing patients with alternatives to emergency admission and of accelerating discharge to reduce overall bed occupancy.
- SAFER bundle is being rolled out to improve patient safety and remove non added value delays in the inpatient journey.

Cancer

Indicator Description	Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Trend (12 months)
Cancer 14 Day Standard	93%	95.1%	94.2%	93.2%	85.7%	93.3%	87.9%	87.9%	86.0%	75.4%	76.6%	67.4%	80.3%	
Cancer 14 Day Standard Breast Symptomatic	93%	94.2%	96.0%	98.9%	94.8%	93.2%	94.0%	93.4%	87.2%	82.7%	84.1%	62.9%	86.9%	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	100%	93.8%	98.8%	96.0%	96.0%	95.1%	100.0%	94.6%	96.4%	95.9%	94.2%	90.9%	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	98.4%	100.0%	100%	99%	100%	100%	100%	100%	100%	
Cancer 31 Day Diagnosis to Treatment	96%	97.4%	96.2%	97.2%	96.9%	96.6%	96.4%	97.5%	96.7%	96.4%	96.4%	96.8%	96.9%	
Cancer 62 Day Referral to Treatment Standard	85%	86.6%	88.3%	88.8%	80.0%	85.2%	87.7%	86.6%	86.3%	89.0%	87.3%	85.4%	77.8%	
Cancer 62 Day Referral to Treatment Screening	90%	95.8%	92.0%	96.2%	92.7%	92.7%	93.0%	96.2%	92.6%	92.7%	92.4%	92.5%	86.1%	
Cancer 62 Day Consultant Upgrade	85%	100.0%	100.0%	92.6%	87.5%	97.1%	100.0%	97.7%	85.7%	88.9%	100.0%	100.0%	100.0%	

Briefing

- The national standard to see all suspected cancer patients within 14 days of referral was not achieved at Trust in the month of July, however in line with recovery trajectories improvement has been observed reporting 80.3% with a total of 5 tumour sites remaining below target compared to nine in June.
- There has been significant capacity shortfall in Urology and Lower Gastrointestinal, the later seeing a 31% increase in referrals within the last 3 months, additional capacity was provided and backlog cleared within the first 2 weeks of August.
- Head and neck – ultrasound fine-needle aspiration biopsy (FNA) capacity is the biggest risk to head & neck tumour group, predominantly due to a significant increase in referrals through our partnership with Croydon Hospital.

Actions

- Increased leadership and management support given to TWR office. Additional staff from central booking office provided to help clear backlog.
- FNA capacity issue raised with commissioners to identify a system wide solution to identify local health system solution to support Croydon.
- To increase number of patients treated in September to help achieve recovery within 62 day performance

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Brain	93%	100.0%	100.0%	100.0%	85.7%	100.0%	66.7%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%
Breast	93%	95.6%	98.6%	96.1%	95.1%	93.0%	96.1%	89.9%	92.3%	88.7%	84.7%	69.5%	76.4%
Childrens	93%	100.0%	100.0%	100.0%	55.6%	100.0%	100.0%	100.0%	90.0%	66.7%	80.0%	66.7%	80.0%
Gynaecology	93%	90.1%	93.3%	89.8%	93.0%	95.7%	76.0%	75.4%	87.1%	64.6%	66.7%	75.6%	93.4%
Haematology	93%	93.8%	96.3%	95.2%	90.9%	100.0%	100.0%	100.0%	95.8%	76.2%	96.9%	76.9%	95.7%
Head & Neck	93%	97.4%	94.5%	95.4%	96.3%	95.9%	98.4%	97.4%	97.9%	90.9%	84.9%	82.4%	88.0%
Lower Gastrointestinal	93%	98.4%	95.3%	94.4%	93.6%	98.3%	95.7%	95.7%	90.5%	75.1%	90.7%	44.4%	60.0%
Lung	93%	88.1%	100.0%	97.9%	94.9%	100.0%	98.2%	100.0%	100.0%	96.2%	91.1%	91.2%	95.6%
Skin	93%	92.3%	92.1%	86.3%	59.8%	79.4%	67.1%	67.7%	57.4%	29.4%	48.1%	26.9%	74.3%
Upper Gastrointestinal	93%	88.3%	87.9%	100.0%	98.6%	96.6%	87.8%	95.3%	94.2%	88.8%	96.1%	93.8%	97.6%
Urology	93%	97.5%	90.5%	95.8%	96.3%	96.9%	98.1%	95.0%	98.4%	96.1%	90.1%	82.3%	93.8%

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Brain	85%	-	-	100.0%	100.0%	-	-	-	100.0%	50.0%	-	0.0%	100.0%
Breast	85%	100.0%	100.0%	100.0%	100.0%	86.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%
Childrens	85%	-	-	-	-	-	-	100.0%	-	-	-	-	-
Gynaecology	85%	66.7%	60.0%	100.0%	80.0%	92.3%	100.0%	100.0%	50.0%	100.0%	90.9%	100.0%	61.5%
Haematology	85%	100.0%	87.5%	100.0%	100.0%	70.0%	80.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%
Head & Neck	85%	66.7%	80.0%	85.7%	50.0%	100.0%	63.6%	72.7%	75.0%	58.3%	85.7%	46.2%	66.7%
Lower Gastrointestinal	85%	100.0%	83.3%	83.3%	66.7%	93.3%	76.5%	66.7%	71.4%	-	62.5%	100.0%	60.0%
Lung	85%	84.6%	100.0%	69.6%	68.8%	66.7%	80.0%	78.6%	73.7%	85.7%	85.7%	64.3%	41.7%
Skin	85%	95.7%	96.8%	92.3%	80.0%	100.0%	100.0%	95.5%	100.0%	93.3%	96.4%	95.7%	100.0%
Upper Gastrointestinal	85%	37.5%	100.0%	66.7%	85.7%	100.0%	50.0%	11.1%	100.0%	100.0%	100.0%	100.0%	100.0%
Urology	85%	87.0%	81.3%	93.5%	72.7%	70.4%	85.2%	87.9%	83.9%	90.0%	67.9%	81.8%	63.0%

Diagnostics

Indicator Description	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend
6 Week Diagnostic Performance	1%	0.9%	0.8%	0.7%	2.2%	5.1%	2.8%	2.9%	4.1%	3.3%	2.6%	2.7%	2.0%	
6 Week Diagnostic Breaches		56	57	50	151	372	219	222	313	248	197	190	158	
6 Week Diagnostic Waiting List Size		6,258	6,834	6,878	6,906	7,358	7,871	7,678	7,559	7,443	7,584	6,989	7,766	

Indicator Description	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend
MRI	1%	1.9%	1.0%	1.1%	1.7%	9.6%	4.3%	3.3%	2.6%	1.1%	0.6%	0.8%	0.2%	
CT	1%	0.3%	0.0%	0.0%	0.1%	0.6%	0.0%	0.7%	1.5%	0.5%	0.2%	0.2%	0.3%	
Non Obstetric Ultrasound	1%	0.0%	0.0%	0.1%	1.0%	3.0%	1.9%	3.0%	4.0%	2.5%	0.3%	1.1%	0.9%	
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%	
Dexa Scan	1%	0.6%	0.0%	0.0%	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%	4.5%	2.5%	6.5%	10.1%	11.3%	4.6%	5.7%	
Echocardiography	1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%	1.2%	9.4%	2.0%	3.0%	0.3%	
Electrophysiology	1%	100.0%	25.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	75.0%	75.0%	100.0%	
Peripheral Neorophys	1%	3.4%	1.2%	2.6%	0.4%	0.5%	0.0%	0.5%	0.0%	0.0%	0.0%	0.8%	0.0%	
Sleep Studies	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%	
Urodynamics	1%	50.0%	47.1%	80.0%	15.4%	0.0%	52.6%	55.0%	65.5%	75.6%	64.4%	64.2%	50.6%	
Colonoscopy	1%	0.0%	2.3%	1.4%	3.6%	20.2%	5.7%	8.7%	5.7%	4.7%	0.5%	1.8%	0.0%	
Flexi Sigmoidoscopy	1%	1.4%	5.3%	0.0%	10.5%	20.8%	12.0%	8.4%	6.7%	0.0%	1.1%	4.9%	0.7%	
Cystoscopy	1%	11.3%	2.8%	10.6%	28.3%	14.4%	9.9%	2.6%	15.0%	11.5%	24.4%	14.0%	12.3%	
Gastroscopy	1%	0.0%	4.0%	0.9%	7.2%	10.1%	3.2%	4.5%	12.7%	10.0%	9.2%	11.2%	6.7%	

Briefing: In August 2.0% of our patients were waiting greater than 6 weeks for a diagnostic procedure against a standard of 1%

Long waiters are within Audiology, Urodynamics and Endoscopy predominantly at the Queen Mary's site with the driver in Endoscopy linked to vacancies.

Actions

- Head and neck – ultrasound FNAs capacity and demand analysis completed and core sessions increased. Reviewing system wide capacity to share out demand.
- Urodynamics – additional clinics to clear backlog and provide additional ongoing capacity
- Endoscopy –additional capacity provided through waiting list initiatives. Recruitment ongoing to staff 2 additional rooms. Recentralisation of management at the QMH site and offering STG capacity to help recover position.
- Expected timescale for recovery of target is September 17

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend
Number of on the Day Cancellations		59	52	103	60	104	91	63	65	47	56	47	35	
Number of on the Day cancellations re-booked within 28 Days		56	49	88	45	92	89	56	61	45	52	43	30	
% of Patients re-booked within 28 Days	100%	94.9%	94.2%	85.4%	75.0%	88.5%	97.8%	88.9%	93.8%	95.7%	92.9%	91.5%	85.7%	

Briefing

- The number of patient procedures cancelled on the day has decreased in the month of August reporting 35 cancellations. Of the patients cancelled 85.7% (30) were rebooked within 28 days.
- When compared with our peers, St Georges has a high number of reportable on the day cancelled operations and services are working to improve this across all areas. The top three reasons for last minute cancelled operations are: 1. lack of theatre time, 2. an emergency case taking priority, 3. bed unavailability. These three reasons account for approximately 67% of last minute cancellations.

Actions

- Daily theatre briefing to confirm all theatres started on time.
- Daily monitoring and forward planning of HDU bed requirements to prevent cancellations due to lack of HDU beds.
- A theatre transformation programme has commenced, aiming to increase the number of patients treated in each theatre session. Focus will be on three key areas: 1. Locking down of fully booked lists 2 weeks in advance. 2. Increasing Pre-operative attendance to reduce cancellations. 3. First patient to the anaesthetic room by 8.30 to start on time.
- Improvement will be measured via a series of metrics with agreed targets.

Patient Experience

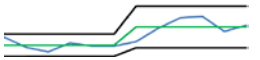
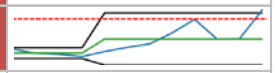
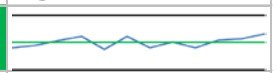
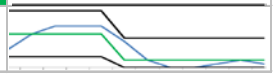
St George's University Hospitals NHS
NHS Foundation Trust

Indicator Description	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend
Emergency Department FFT - % positive responses	90%	83.1%	86.6%	84.4%	82.3%	85.0%	86.3%	82.8%	85.2%	83.0%	85.2%	83.9%	85.9%	
Inpatient FFT - % positive responses	95%	94.4%	95.4%	97.5%	95.9%	96.2%	96.9%	96.7%	95.8%	97.3%	96.0%	96.6%	96.8%	
Maternity FFT - Antenatal - % positive responses	90%	No Responses						100%		85.7%	100.0%	100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	95.0%	93.0%	100%	87.0%	89.0%	93.0%	97.0%	88.2%	100.0%	100.0%	95.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	96.0%	92.0%	95.0%	95.0%	95.0%	93.0%	90.0%	94.1%	97.9%	95.4%	87.1%	96.4%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	100%	93.0%	100%	100%	100%	100.0%	100%	100%	100%	100%	100%	98%	
Community FFT - % positive responses	90%	93.2%	88.2%	96.5%	94.7%	96.6%	96.2%	93.0%	93.0%	97.6%	96.3%	94.5%	98.3%	
Outpatient FFT - % positive responses	90%	86.9%	87.6%	94.9%	92.3%	94.8%	91.7%	88.1%	92.6%	95.6%	96.6%	94.2%	96.2%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints		91	67	92	56	85	73	79	63	76	75	61	99	

- ED Friends and Family Test (FFT) – The score has increased slightly in August reporting 85.9% , meaning that the percentage of patients recommending the service increased. However the percentage has remained stable and compared to our London peers our response rate is one of the best in London.
- Maternity FFT – The score for maternity care are above local threshold and work to increase the number of patients responding continues, Significant improvements have been made with the percentage of patients responding increasing by 22.41% in July and again in August.
- The number of complaints received by the Trust has shown a marked increase in August, this is not yet a trend. Similar peaks were seen in Aug and Sep 2016, the number of complaints received over the past 6 months is consistent with numbers for 2016/17 and a sustained reduction on the number received in 2015/16.

Actions: The ED management team are reviewing the results from the FFT survey for the last quarter to determine any further themes for improvement, an example being to review of staffing model to ensure response nurse available to support high volume periods and minimise delays for patients. A pilot of the new complaint handling process is underway, this has introduced direct contact by the service with the complainant at the earliest possible point to ensure the outcome the complainant is looking for is understood and to resolve the complaint at an early stage if possible.

Workforce

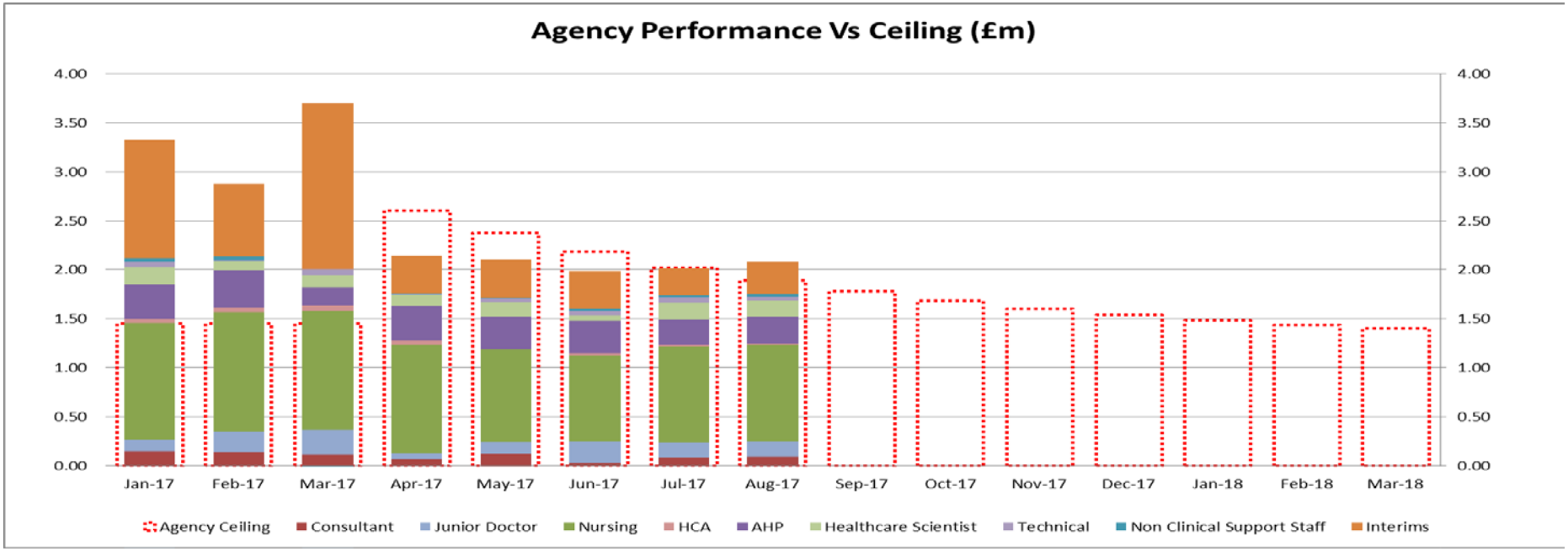
Indicator Description	Target	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Trend
Trust Level Sickness Rate	3%	3.5%	3.6%	3.8%	3.7%	4.2%	3.8%	3.3%	3.2%	3.4%	3.4%	3.6%	3.7%	
Trust Vacancy Rate	10%	15.7%	15.0%	14.7%	15.3%	15.1%	15.1%	15.4%	16.3%	17.0%	17.1%	16.1%	16.5%	
Trust Turnover Rate* Excludes Junior Doctors	10%	18.5%	18.5%	18.0%	18.1%	18.4%	18.5%	19.1%	19.1%	19.1%	18.8%	18.4%	19.6%	
Total Funded Establishment		9,748.11	9,782.73	9,788.42	9,804.22	9,856.56	9,834.97	9,798.10	9,784.10	9,924.93	9,947.77	9,878.79	9,855.40	
IPR Appraisal Rate - Medical Staff	90%	81.5%	82.2%	80.5%	76.0%	79.2%	81.3%	77.3%	82.4%	82.0%	74.2%	84.8%	79.0%	
IPR Appraisal Rate - Non Medical Staff	90%	69.0%	66.2%	65.6%	64.1%	67.5%	70.4%	72.8%	80.3%	78.2%	76.1%	76.1%	75.1%	
% of Staff who have completed MAST training (in the last 12 months)		80.0%	78.3%	80.0%	79.7%	81.9%	85.0%	85.0%	85.9%	87.0%	87.0%	86.0%	86.0%	
Ward Staffing Unfilled Duty Hours	10%	4.8%	5.1%	5.7%	6.2%	4.6%	6.2%	4.8%	5.5%	4.8%	5.8%	5.9%	6.5%	
Safe Staffing Alerts	0	5	9	11	11	11	7	2	0	0	1	2	1	

Briefing

- Funded Establishment decreased by 23.19 WTE to 9,855.40 WTE in August
- Vacancy Rate increased from 16.1% to 16.5%
- Turnover has increase to 19.6% in August compared to 18.4% for all staff groups.(excludes Junior doctors on rotation).
- Sickness has increased to 3.7% compared to 3.6% in the month previous
- Mandatory and Statutory Training figures for August were recorded at 86%
- Appraisal rates remain below target, with non medical remaining at a steady rate over the last 12 months. Non medical appraisal decreased slightly in August, however performance shows an on-going improvement on last year.

Actions To be updated at Finance and Performance Committee

Agency Use



Briefing

- The Trust's annual agency spend target set by NHSI is £24.5m. There is an internal annual agency target of £22.0m
- For August, the monthly target set was £1.89m.Total agency cost in August was £2.08m or 5.1% of the total pay costs
- From M1-4 2017/18, the average agency cost was 5.1% of total pay costs.
- Agency cost increased by £0.07m compared to July. In 2017/18 YTD, the Trust has performed better than the planned target by £0.78m.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 October 2017	**Agenda No**	4.2
Report Title:	2017 NHS England EPRR Assurance Return		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Kristel McDevitt (Emergency Preparedness Manager / EPLO)		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The following report covers the 2017 NHS England EPRR Assurance return and makes reference to the recent Emergency preparedness, Resilience and Response status report.		
Recommendation:	To note the information and current position of EPRR Assurance.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led)		
Implications			
Risk:	If the work is not maintained, there is a risk that the trust will not be prepared in the event of a Major Incident or Significant Business Continuity event.		
Legal/Regulatory:			
Resources:	There are no specific resource implications associated with this proposal.		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	This is in line with the principles of the Accessible Information Standard and Freedom of Information Act.		
Appendices:	A		

APPENDIX A

2017 NHS England EPRR Assurance Return

The NHS England EPRR Assurance process for 2017 has begun, with an initial self-assurance return submitted on 13th September, with the formal meeting to review the return and make any recommendations on 10th October (to be conducted by the Trust Emergency Accountable Officer, Head of Operations and EPLO with NHS England, NHS Improvement and a peer reviewer from a Major Trauma Centre). This will include a review as a Strategic Asset, which will involve a discussion on our role as a Major Trauma Centre within a trauma network (as part of the South West London and Surrey Trauma Network).

This initial assurance return is taken forward by the Emergency Preparedness Manager, on behalf of the AEO and the Trust. There is an assessment of compliance against a number of Core Standards (51) and Deep Dive analysis (on Governance this year). The Core standards take into consideration the key requirements of the Civil Contingencies Act (2004), the UK Government Legislation for Category 1 & 2 emergency responders.

Scoring is based on the Self-assessment RAG criteria 2017;
Red = Not compliant with core standard and no evidence of progress.
Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.
Green = fully compliant with core standard.

To summarise the initial Trust self-assurance return for 2017 is as follows:

The trust has **no REDs**, and scored **GREEN** in most areas, with evidence under the headers of Governance, Duty to Maintain Plans, Command and Control, Duty to communicate with the Public, Information Sharing, Co-operation, and Training and Exercising.

Five Core standards marked **AMBER** in the self-assurance return related to the following areas;

- Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response **(core standard 2)**

- Effective arrangements are in place to respond to the risks the organisation is exposed to, - corporate and service level Business Continuity (aligned to current nationally recognised BC standards) **(core standard 9)**

- Lockdown planning **(core standard 19)**

- Utilities, IT and Telecommunications Failure **(core standard 20)**

- Arrangements include how to continue your organisation's prioritised activities in the event of an emergency or business continuity incident insofar as is practical **(core standard 26)**

These have been deemed Amber as further work is needed to fully embed emergency preparedness (highlighting additional resources that may be required) and in planning arrangements, particularly around Business Continuity, IT and Utilities Infrastructure.

Under the CBRN return, all but one have been marked GREEN, the one marked AMBER is due to maintaining 23 protective suits not the required 24 (awaiting NHS England delivery of new suits)

Finally for the deep dive under Governance, four out of six areas have been marked AMBER (the other two areas marked GREEN). These will not be included in the overall core standards marking, but have been flagged as areas that need further exploration and specific arrangements put in place.

The EPRR status report produced in August to the Risk Committee (Annex B) does flag some of the concerns above and has been included in this report for your reference.

This can be found in the Reading Room on BoardPad

APPENDIX B

Meeting Title:	Risk Management Committee		
Date:	09/08/2017	**Agenda No**	
Report Title:	EPRR Status report – Update		
Lead Director/ Manager:	Ellis Pullinger		
Report Author:	Kristel McDevitt (Emergency Preparedness Manager / EPLO)		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted (select using highlight)		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	The following report covers the current work underway in support of the Emergency Preparedness, Resilience and Response arrangements of the Trust.		
Recommendation:	To note the work that is underway and confirmation of the next reporting period as February 2018.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led)		
Implications			
Risk:	If the work is not maintained, there is a risk that the trust will not be prepared in the event of a Major Incident or Significant Business Continuity event.		
Legal/Regulatory:	N/A		
Resources:	There are no specific resource implications associated with this proposal.		
Previously Considered by:		**Date**	
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard and Freedom of Information Act.		
Appendices:	**A) <u>Emergency Preparedness Status report</u>**		

APPENDIX A

Emergency Preparedness Status report

Emergency Preparedness Status Report

Following on from the EPRR Status report submitted to the Committee in February, please see below updated work progress report;

It is worth highlighting that the profile of Emergency Planning, Resilience and Response (EPRR) has greatly increased over the past year with terrorist incidents in London and Manchester and Worldwide Cyber-attack (filtered through the EPRR route for reporting and lessons identified, infrastructure and even clinical debriefs). This increased interest has been welcomed by the EPRR community, however additional burden on the trust to respond and recover (and resource) additional requests, both internal and external, at speed is challenging. It is worth noting we have managed to maintain an appropriate response so far.

Risk register- There has been no change to the EPRR risks or categorisation. It has been agreed that some of the EPRR risks are already covered in the departmental risk registers, such as loss of IT, electricity, built infrastructure, - so the EPRR risks are being updated (crossed referenced with the relevant departmental risks). For the high risk, high impact (20) Pandemic Influenza risk, plans are established to deal with infection control and staff shortages (business continuity planning and HR guidelines), with an acknowledgement that if the planning assumption of up to 50% shortages of staff across the Healthcare sector occurs, health care could be delivered very differently across England and therefore our close engagement with NHS England, and the professionals bodies will ensure appropriate guidance produced will be received and distributed. All other EPRR risks are being rechecked and validated during August 2017.

NHS England EPRR assurance - This will commence autumn 2017. The letter and core standards expect a self-assurance return in September, followed by a meeting in October between NHS England, the trust Accountable Emergency Officer (Board level representative) and the trust Emergency Preparedness Manager/ EPLO. The Deep Dive for this year's assurance will be on Governance. We will also receive a CBRN assurance visit, likely to be mid-September.

As a Major Trauma Centre, we have also been flagged as a NHS Strategic Asset, therefore additional evidence of our preparedness will be required (Major Incident Plan, Corporate Business Continuity Plan, EPRR Policy, Pandemic Influenza Plan, PTS assurance)

Last year EPRR assurance was GREEN in all areas apart from Business Continuity (AMBER). This was due to the trust 'suppliers' not aligned to the international standard ISO22301. This will not change for this year's assurance. Resourcing of a role to do this alignment will need to be considered to achieve this moving forward.

London Health Resilience Partnership (South) – NHS England and Director of Public Heath Co-chaired. Terms of reference are that the 'LHRP provides a strategic forum for local organisations to facilitate health sector preparedness and planning for emergencies. Members of the LHRP will be Executive Representatives who are able to authorise plans and commit resources on behalf of their organisations'. The Accountable Emergency Officer (AEO) is the preferred attendee at this meeting.

The meeting is held quarterly, with the last meeting attended by an Executive (Chief Information Officer) on 20 February and the EPLO. Moving forward, we will need to ensure appropriate

representation continues to attend these meetings. This is highlighted in the NHS England EPRR Assurance process – and is explicitly stated in the 'Governance' deep dive this year.

The new Hospital Incident Coordination centre (G2.099) was stood up during the Cyber Attack response and prepared in readiness for more London attacks during the UK Government 'Move to Critical' level (23 May -27th May). It continues to be well utilised for meetings on Business Continuity incidents across the trust and for training and exercising purposes.

Major Incident Steering group, chaired by the Clinical Director of ED. These meetings have been moved from quarterly to monthly, last held on 19th July. Following the activation of the Trusts Major Incident protocols for the Croydon Tram Derailment in November last year (trust report published in April 2017) the Major incident plan has been updated and was republished in May 2017. Given the terrorist events that occurred in London and Manchester this year, MISG are considering lessons identified from those trusts that were declared (St Georges was not declared but did accept trauma diverts). This includes a review of our trauma pathway and command 'huddle' model, lockdown principles of the trust and communications during a major incident. This work will continue over the next few months at pace.

On call Directors and Managers training continues to run monthly from January 2017, facilitated by the EPLO with support from HoN, Clinical Site Management team. It continues to be well attended by new General Managers joining the on call rota and experienced Director level Oncall staff who helpfully contributed to the discussion. There has also been a session with Executive Directors and one to one sessions with new executives with Head of Operations and EPLO.

Training - The trust supports the training of staff in Major Incident awareness, specific training at local level to prepare for a major incident and CBRN training. All new staff induction (not including doctors) have a brief presentation on a Major Incident / Business continuity event (every monday) and Line Managers induction (monthly) includes a presentation and discussion on their role and responsibilities. The Emergency Department also run a Major Incident session for new staff to their department.

Specific training for CBRN is also delivered by ED staff. This includes establishing the decontamination tent and the donning and doffing of Personal Respiratory Protective Suits (PRPS). The trust has a good supply of the Suits and appropriate inventory to support a CBRN event. To date a third of the ED Nurses have received training, with a programme underway to ensure on each shift adequate numbers have been trained for a CBRN event. There is also familiarisation with the principles of 'Initial Operational Reponses' (IOR) with wider staff groups planned for August and September.

The EPLO is working with the Clinical Director for Major Trauma (Heather Jarman) and the Trust Education centre for MAST module to be developed for Major Incidents.

Exercising - In terms of the NHS England Assurance process, the Major Incident in November counts as our 'live ' exercise for 2016/17, with the Command Post exercise conducted in December in 2016 (Train Derailment) and a communications test in January and May. We are also exploring running a Hospital Major Incident Medical Management & Support (HMIMMS) course with the Advance Life Support Group later this year.

The trust has also been approached and agreed to support the development of an NHS England / Public Health England off the shelf lockdown exercise being developed. We are assisting in the design of the product and as a test site for the final product, with proposed publication autumn 2017.

Mass Casualty planning – NHS England Regional Mass Casualty and Major Trauma planning workshops to inform London wide framework for response have taken place across the Spring and Summer 2017, with St Georges requested as a key stakeholder (represented by the Clinical Directors for ED and Major Trauma, Trauma Network lead, ITU Consultant, Head of Operations and EPLO). Once this work is complete, the Mass Casualty Framework for London will be rolled out and we will ensure it complements our local arrangements.

Counter terrorism Police Briefing – Staff awareness briefings have been conducted by the Police since December 2016, to different staffing group from Consultants, Registrars, Nursing staff and Security and Portering. This will continue throughout 2017. We will also conduct a hospital 'lockdown' table top exercise with the police (Project Griffin) on 24th August 2017. This is aimed at senior managers and designed to help them think about what you do if we have a marauding terrorist near our site or in our hospital.

Business Continuity Plan progress report

The Business Continuity steering group continues to meet on a monthly basis (last meeting 24th July) to discuss any new incidents that test BC plans and to flag any upcoming planning requirements that affect service delivery (including Summer and Winter weather planning, estates or IT system shutdowns) with monthly meetings scheduled for the rest of 2017.

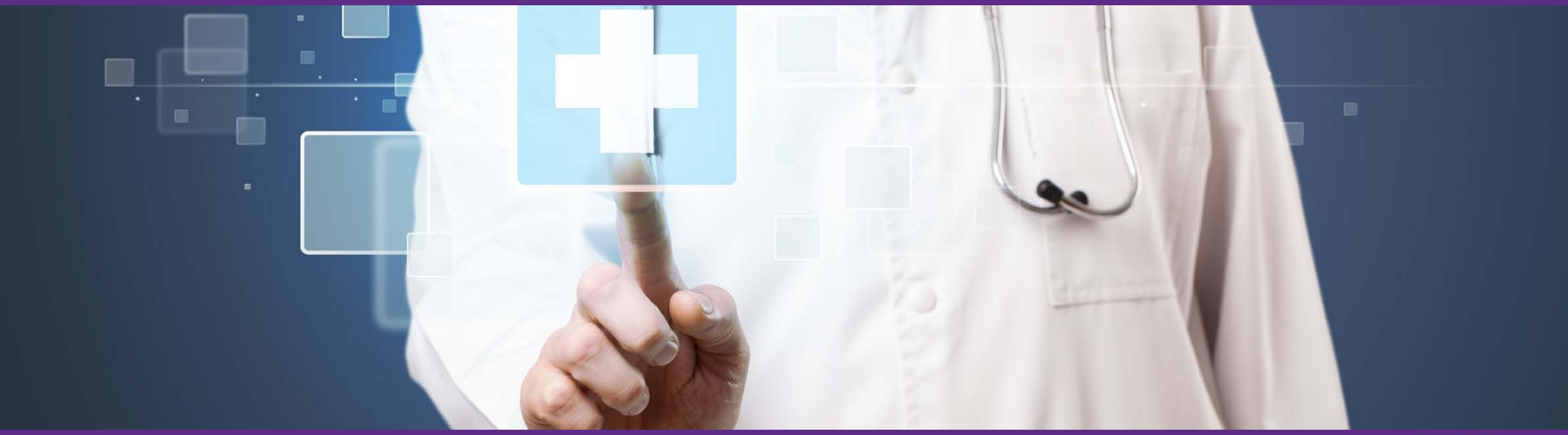
The Corporate Business Continuity plan remains extant as the framework to support an activation of a significant business continuity event. This wasn't designed as a detailed planning document but instead is the overarching support, with the work being undertaken at a local level.

All service areas are working to update their business continuity plans. It continues to be challenging to recognise and imbed learning from incidents but we will continue to build on this during 2017/18.

A Business Continuity exercise on the failure of IT systems was undertaken in February and further evacuation exercising at local level continues, with a table top exercise (a round table discussion with scenarios) planned for 10th August - to test multiple wards for horizontal and vertical evacuation (Lanesborough, first floor Neo Natal, Theatres and Delivery Suite).

As per the agreed six monthly reporting period, the next report from the EPLO will be February 2018, unless exceptional issues that need to be brought to the attention of the Risk Management Committee.

ENDS.



St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 5 (August 2017)

Chief Finance Officer
5th October 2017.

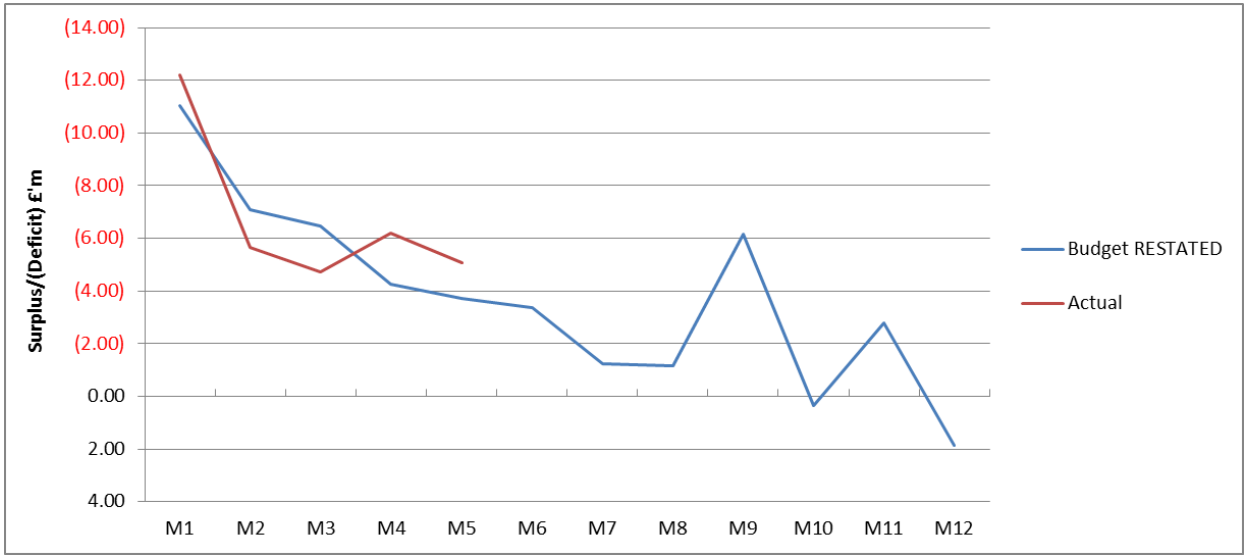
Executive Summary – Month 05 (August)

St George's University Hospitals NHS
NHS Foundation Trust

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £33.9m at the end of the August, an adverse variance to plan of £1.3m. However, the over delivery of CIPs totalling £2.3m is supporting this position. If these CIPs were excluded, the underlying position would be £3.6m adverse to plan. Within the position income is adverse to plan, with this being partly offset by expenditure underspends.	£1.3m Adv to plan	£0.3m Fav to plan
Income	Income is being reported at £7.2m adverse to plan year to date, with a favourable movement in month of £1.7m. Included within the month 5 results are £2.1m of income relating to prior periods. There is a lower than planned income of £3.0m in Elective and Non Elective of £1.0m. Non-SLA income is also under plan by £2.2m, as well Exclusions income by £2.8m, but this will be offset by reduced expenditure.	£7.2m Adv to plan	£8.9m Adv to plan
Expenditure	Expenditure is £5.6m favourable to plan at month 5, £3.0m adverse in month. The majority of the favourable position is in pay, £6.0m YTD with underspends seen in Nursing, Non Clinical and ST&T categories. Non-pay is £0.4m overspent, with the main drivers being IT MSA costs and RTA bad debt provisions.	£5.6m Fav to plan	£8.9m Fav to plan
CIP	The Trust planned to deliver £6.2m of CIPs by the end of August. To date, £8.5m of CIPs have been reported; £2.9m of income actions and £5.6m of expenditure reductions. As noted above, the over delivery of CIPs is supporting the trust's bottom line. If these were excluded then the overall favourable variance from the planned deficit would move to a £3.6m adverse position.	£2.3m Fav to plan	£3.7m Fav to plan
Capital	Capital expenditure of £19.1m has been incurred year to date. This is £0.4m below plan YTD. The capital budget has been formulated on the expectation that the Trust will secure further DH capital funding of approx £8.4m to finance extensive investment in the IT infrastructure. Despite an independent audit recommending approval of £8.4m of tis bid, the Trust has not received approval from NHSI. Therefore the Trust is in the process of undertaking a re-forecasting and re-prioritisation exercise to ensure the minimum level of IT capital investment required this year may be accommodated within the original capital budget of £43.9m in the event the bid is not approved.	£0.4m Fav to plan	£0.2m Fav to plan
Cash	At the end of Month 5, the Trust's cash balance was £7.3m, which is better than plan by £4.3m. The Trust borrowed approx.£8m from working capital facilities in M05 and has borrowed £19m YTD – in line with plan. The Trust has secured £11m borrowing in September and has requested a further approx. £4.5m for October to finance the on-going deficit. These working capital borrowings are subject to an interest rate of 6% because the Trust is in financial subject measures.	£3.3m Fav to plan	£2.0m Fav to plan
Financial Risk Rating-Use of Resources (UOR)	At the end of August, the Trust's UOR score was: Capital service cover rating: Plan – 4; Actual – 4 Liquidity rating: Plan – 4; Actual – 4 I&E margin rating: Plan – 4; Actual – 4 Distance from financial plan: Plan – n/a; Actual – 2 Agency rating: Plan – 1; Actual – 1	Overall score 4	Overall score 4

1. Month 5 Financial Performance

L2	L3 Cat	M5 Budget (£m)	M5 Actual (£m)	M5 Variance (£m)	M5 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Income	SLA Healthcare Income	57.6	57.5	(0.1)	(0.2%)	277.7	272.7	(5.0)	(1.8%)
	Other Income	8.6	10.5	1.8	21.0%	48.2	45.9	(2.2)	(4.6%)
Income Total		66.3	68.0	1.7	2.6%	325.9	318.7	(7.2)	(2.2%)
Expenditure	Pay	(40.7)	(41.0)	(0.3)	(0.7%)	(208.9)	(202.9)	6.0	2.9%
	Non Pay	(26.4)	(29.2)	(2.8)	(10.4%)	(135.4)	(135.8)	(0.4)	(0.3%)
Expenditure Total		(67.2)	(70.2)	(3.0)	(4.5%)	(344.3)	(338.7)	5.6	1.6%
Post Ebitda		(2.8)	(2.8)	(0.0)	(0.3%)	(14.2)	(13.9)	0.3	1.9%
Grand Total		(3.7)	(5.1)	(1.4)	(36.4%)	(32.6)	(33.9)	(1.3)	(4.1%)



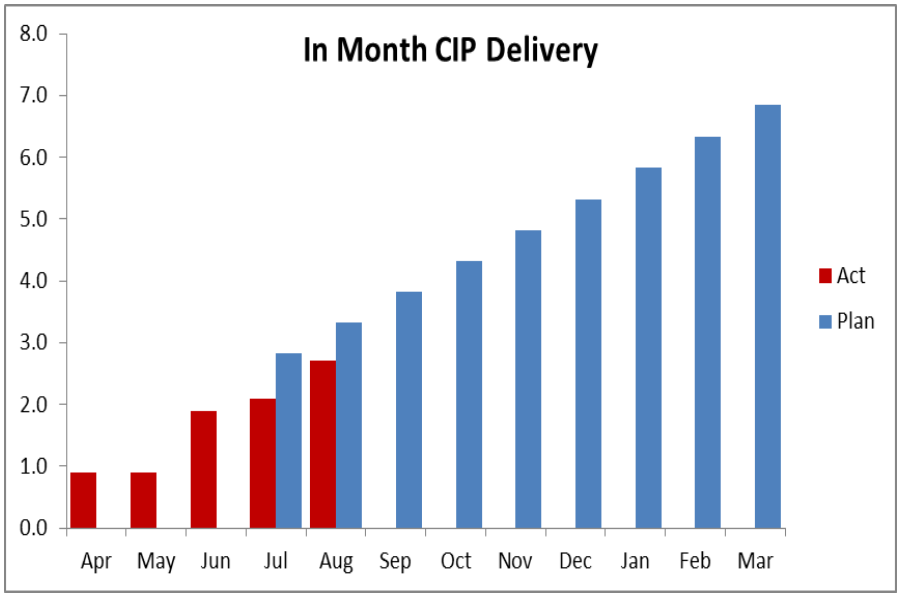
Trust Overview

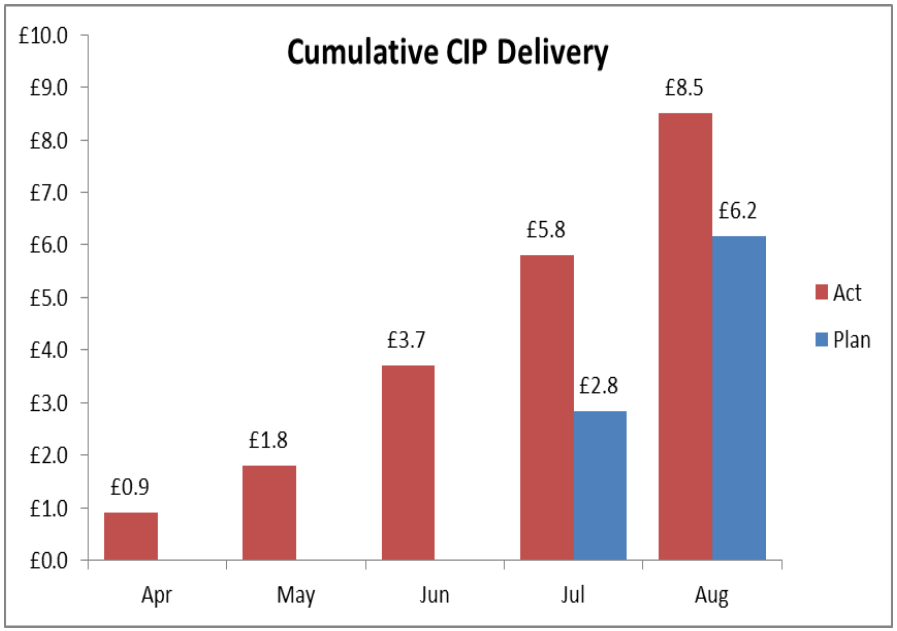
- Overall the Trust is reporting a deficit of £33.9m at the end of Month 05, an adverse variance to plan of £1.3m.
- **Income** is £7.2m adverse to plan. £3.6m of the under recovery of income is directly offset with underspends in expenditure (SLA Pass-through £2.9m, South West London Pathology £0.7m).
- **SLA Income** is £5m under plan, owing to shortfalls of £2.9m on pass-through, £3m in Elective and £1m in Non Elective offset by £1.9m over performance in Outpatients, Beddays and A&E. A £2.1m prior period SLA income catch-up is driven by both price of £0.9m and volume of £1.2m.
- **Other income** under plan by £2.2m; with the key drivers being Diagnostics (£0.9m) which is directly offset in SLA income and non-pay, lower than planned private patients income (£0.7m), and an under-performance on direct access pathology income.
- **Pay** is £6m favourable, with all major staff groups underspending with the exception of medical pay.
- **Non-pay** is £0.4m overspent, due to IT MSA consultancy services costs (£0.9m) and RTA bad debt (£0.5m), offset by pass drugs and devices underspends.
- **CIP delivery** of £8.5m is £2.3m ahead of plan. If this were excluded from the reported position then the overall position would show an adverse variance to plan of £3.7m. This indicates there is overall pressure in the Trusts baseline financial position at month 05, with the primary driver being lower than planned income recovery

ACTION REQUIRED

- Validate income recovery; depth of coding and reporting.
- Review and validate pathology income underperformance

2. Month 5 CIP Performance





CIP Overview

- At the end of Month 5, the Trust is reporting the delivery of £8.5m of savings from Cost Improvement Programmes (CIPs)
- The majority of CIPs delivered to date are non pay - £3.8m (44%), pay savings account for a further £1.8m (21%) with income contributing the balance of £2.9m (34%)

NB - In the revised financial plan CIPs are not planned to deliver during Q1 meaning the value of the CIPs 'ahead of plan' is favourably supporting the Trust's reported bottom line. This is the reason the two graphs on the left do not show any planned delivery (blue bars) in the first three months. It is also important to note that in the revised financial plan the full year CIP target is shown as £43.5m in the graphs and variances as CIP Contingency of £3.5m is used to offset the total value.

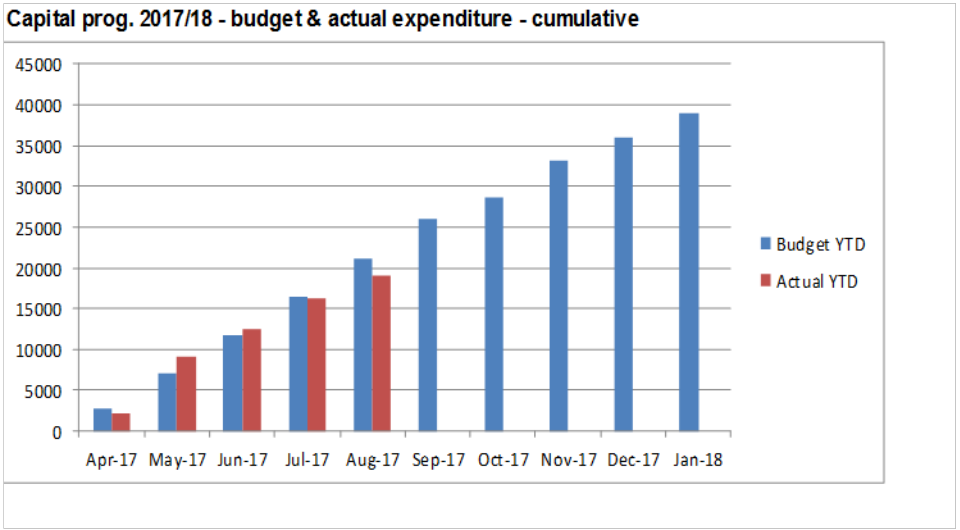
Actions

- The Trust requires CIP plans which deliver £47.0m of savings in 2017/18 and an on going 'Pipeline' of schemes in development for 2018/19
- As reported at September's FSM meeting £39.4m of the Trust's schemes have been rated 'Green'. To provide assurance that the CIP plans will deliver the required level of savings the Trust needs to progress all plans to 'Green' as a matter of urgency . It is now critical to increase this to £47m by the next FSM meeting (scheduled for early October)
- The Trust needs to identify and implement the recovery actions necessary so that it can deliver its agreed year end deficit of £45m. Additional CIP plans or controls may be required to mitigate any shortfall or pressures

3. Month 5 Capital Programme

Capital expenditure summary M05 2017/18

Spend category	2017/18 Budget	M05 YTD Budget £000	M05 YTD actual £000	*M05 YTD Variance*
Energy Perform Contract	5,555	5,355	5,327	*28*
Infra Renewal	10,492	3,040	1,875	*1,165*
Med Eqpt	3,194	2,126	2,478	*-352*
Major Projs	19,684	6,156	4,842	*1,314*
IMT	2,567	2,568	3,930	*-1,362*
Other	601	119	542	*-423*
SWL PATH	684	93	99	*-6*
Contingency	1,096	45	0	*45*
Total	43,873	19,502	19,093	*409*



- The capital budget for 2017/18 is £43.9m. This includes secured DH capital loan financing of £16.2m.
- Capital expenditure in August was £2.8m and M05 YTD expenditure is £19.1m i.e. an under spend of £0.4m YTD.
- The capital budget has been formulated on the expectation that the Trust will secure further DH capital funding of approx £8.4m to finance extensive investment in the IT infrastructure.
- The Trust is in the process of undertaking a re-forecasting and re-prioritisation exercise to ensure the minimum level of IT capital investment required this year may be accommodated within the original capital budget of £43.9m in the event the bid is not approved. Spend on IM&T above the original plan has been approved by the Trust Board. This exercise involves identifying expenditure in other spend categories which may be rescheduled to next year. The M05 forecast is for £48.7m (M04: £50.9m) capital expenditure this year and the Trust is actively exploring measures to reduce the forecast by £4.7m in order to balance the budget.
- It is proposed that the results of the re-forecasting/re-prioritisation exercise will be submitted to the Finance and Performance Committee for approval next month.

4. Month 5 YTD Analysis of Cash Movement

Source and application of funds - cash movement analysis: 2017/18 outturn vs Plan

		Actual M05 vs Plan M05	
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*
Opening cash 01.04.17	5.0	6.0	*1.0*
Income and expenditure deficit	-33.1	-34.4	*-1.3*
Depreciation	11.3	10.0	*-1.3*
Interest payable	3.1	3.1	*0.0*
PDC dividend	1.5	1.4	*-0.1*
Other non-cash items	-0.1	-0.1	*0.0*
Operating deficit	**-17.4**	**-20.0**	*-2.7*
Change in stock	-0.2	-0.3	*-0.1*
Change in debtors	-7.2	-12.4	*-5.2*
Change in creditors	14.2	20.9	*6.7*
Net change in working capital	6.9	8.2	1.3
Capital spend (excl leases)	-21.5	-17.6	*3.9*
Interest paid	-1.6	-1.6	*0.0*
PDC dividend paid	0.0	0.0	*0.0*
Other	-0.2	-0.1	*0.1*
Investing activities	-23.2	-19.3	3.9
WCF borrowing	19.0	19.0	*0.0*
Capital loans	16.2	16.2	*0.0*
Loan/finance lease repayments	-3.5	-2.8	*0.7*
Closing cash 31.07.17 / 31.03.18	**3.0**	**7.3**	*4.3*

M05 YTD cash movement

- The cumulative M05 I&E deficit was £34.4m –£1.3m worse than plan.
- Within the I&E deficit of £34.4m, depreciation (£10m) does not impact cash. The charges for interest payable (£3.1m) and PDC dividend (£1.4m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £20m.
- The operating variance from plan of £2.7m in cash is in part attributable to the lower depreciation charge.
- Working capital performed overall £1.3m better than plan.
- The Trust borrowed approx.£8m from working capital facilities in M05 and has borrowed £19m YTD – in line with plan. The Trust has secured £11m borrowing in September and has requested a further approx. £4.5m for October to finance the on-going deficit. These working capital borrowings are subject to an interest rate of 6% because the Trust is in financial subject measures.
- The Trust has drawn down its £16.2m capital loan in full to finance expenditure on the NHSI-financed capital projects per the successful bid made last year.

5. Balance Sheet as at Month 5 2017/18

St George's University Hospitals NHS
NHS Foundation Trust

Balance sheet AUGUST 2017

	Mar-17 Audited £000	Aug-17 Plan £000	Aug-17 Actual £000	*YTD Variance £000*	**Explanations of balance sheet variances**
Fixed assets	335,834	344,116	345,002	*-886*	Lower depreciation charge than plan
Stock	6,575	6,755	6,868	*-113*	Year end stock higher than 16/17 plan: movement since y/e in line with 17/18 plan.
Debtors	101,837	109,015	114,234	*-5,219*	Collection of 16/17 SLA debt delayed by CCGs pending finalisation of challenges
Cash	6,022	3,000	7,306	*-4,306*	Higher opening cash than plan.
Creditors	-118,305	-131,498	-139,198	*7,700*	Agreed deferral of CNST payments to later in the year.
Capital creditors	-5,284	-2,284	-6,698	*4,414*	Timing of capital payments has increased capital creditors at M04
PDC div creditor	0	-1,473	-1,375	*-98*	
Int payable creditor	-259	-1,679	-1,665	*-14*	
Provisions< 1 year	-335	-335	-252	*-83*	
Borrowings< 1 year	-55,206	-56,950	-56,786	*-164*	Lower drawdowns due to higher opening cash bal & lower capital spend than plan
Net current assets/-liabilities	**-64,955**	**-75,449**	**-77,566**	*2,116*	
Provisions> 1 year	-988	-838	-988	*150*	
Borrowings> 1 year	-164,524	-195,530	-195,476	*-54*	Lower drawdowns due to higher opening cash bal & lower capital spend than plan
Long-term liabilities	**-165,512**	**-196,368**	**-196,464**	*96*	
Net assets	**105,367**	**72,299**	**70,972**	*1,327*	
Taxpayer's equity					
Public Dividend Capital	129,956	129,956	129,956	*0*	
Retained Earnings	-114,843	-147,911	-149,201	*1,290*	Higher I&E deficit than plan
Revaluation Reserve	89,103	89,103	89,066	*37*	
Other reserves	1,150	1,150	1,150	*0*	
Total taxpayer's equity	**105,367**	**72,299**	**70,972**	*1,327*	

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M5 YTD)	Actual (M5 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	2
Agency rating	1	1

Basis of the scoring mechanism

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

- 1 represents the best score, with 4 being the worst.
- At the end of August, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. Furthermore, interim spend has reduced significantly this year due to the IT MSA, with costs now being reflected in non-pay.
- The distance from plan score of 2 is based on being on plan at M5.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board Meeting		
Date:	5 October 2017	**Agenda No.**	**6.1**
Report Title:	Workforce and Education Committee Report		
Lead Director/ Manager:	Harbhajan Brar, HR & OD Director		
Report Author:	Stephen Collier, Chair, Workforce & Education Committee		
Presented for:	Information		
Executive Summary:	This paper sets out the key issues reviewed and agreed by the Committee at its meeting on 4 October 2017, including the report received from the Trust's Guardian of Safe Working.		
Recommendation:	Receive this report		
Supports			
Trust Strategic Objective:			
CQC Theme:	Are services at this Trust well led		
Single Oversight Framework Theme:			
Implications			
Risk:			
Legal/Regulatory:			
Previously Considered by:	N/A	**Date:**	
Equality Impact Assessment:			

Workforce and Education Committee Report

Attendance

This paper reports on the Workforce and Education Committee held yesterday morning (4 October) with good attendance, although it was disappointing that - with one exception - the divisions were generally not represented there despite having been invited. This is particularly so given that a number of the issues discussed will affect them.

Key points:

We received a report from Sunil Dasan, our **Guardian of Safe Working**. He highlighted two instances that raised specific patient safety concerns and Harbhajan has agreed to review and report back on steps being taken to address recurrences in future. We were also concerned about the apparent lack of progress in General Surgery, noting that they are to receive another fine for the intractability of matters giving rise to exception reporting. Whilst we accepted that the number of level 1 trainees makes rostering of cover tight, the fact that this is still an issue does raise a systemic concern. We accept that it is not our role to design out a solution. We do however want assurance that one is being generated, and Harbhajan will take to EMT on Monday.

As part of his **HRD Report**, Harbhajan updated us on a number of matters, including:-

- On the latest F&F results, 79% would recommend the Trust as a place for treatment (up 2% from last quarter), and 51% would recommend the Trust as a place to work (up 7% from last quarter)
- We are hoping this also comes through in the NHS Staff Survey which formally launches at SGH on the 9 October 2017
- St George's charity has approved £80k funding to support 50 overseas qualified nurses currently working at SGH as HCAs to become UK registered nurses, and approved £50k part year funding to establish a bursary fund to support staff in their continued professional development, where no other funds are available.
- MAST compliance has ticked up though appraisal achievement has ticked down. Actions are being taken.

We agreed revised **Terms of Reference**, noting that this was on an interim basis and that the Trust Secretary would offer further suggestions for improvement as part of a wider governance review.

We began to think about **workforce planning** for next year, and the focus areas and stretch targets we need to set. Although it was not used at the meeting, Harbhajan had commissioned the preparation of a chart showing monthly progression on pay spend since August 2016. Some progress evident, but still much to do. As a Committee, we intend to focus more on supporting the Trust in achieving its workforce targets.

We approved:-

- A **Staff Engagement Plan** (led by Alison Benincasa)
- A **WRES Engagement Plan** (led by Donna Harding), in which we nominated Gillian as the lead NED in this area.
- A proposed approach to **Staff Values** (led by Liz Woods)
- A proposal for further work on and a particular approach to **pensions flexibility**. I now need to go and talk to the University about where this may land.

There were various other reports and matters, but they are not included here as this is a summary.

Stephen J Collier

5 October 2017

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 October 2017	**Agenda No.**	**7.1**
Report Title:	Report to the Board from Audit Committee: 13 September 2017		
Lead Director/ Manager:	Sarah Wilton, Chair, Audit Committee		
Report Author:	Sarah Wilton, Chair, Audit Committee		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	Enclosed are the key messages from the Audit Committee meeting held on 13 September 2017. The Board is asked to note the proceedings.		
Recommendation:	Receive the report.		
Supports			
Trust Strategic Objective:	All Corporate Objectives.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:			
Implications			
Risk:	Risks are identified within the report.		
Legal/Regulatory:	The Audit Committee is a statutory Committee.		
Previously Considered by:	N/A	**Date:**	
Equality Impact Assessment:	N/A		

Report from the Audit Committee Meeting on 13 September 2017
Trust Board 05.10.17

The key points which the Audit Committee wishes to bring to the Board's attention this month following its last meeting are listed below:

ACTION TRACKER

1. We had been assured that the Executive would address the action tracker robustly with at least quarterly oversight from EMT: reasonably good progress now seems to be being made to provide the necessary assurance that all significant Internal Audit recommendations are completed within the agreed timeframe and it has been agreed that deadlines for completing these recommendations can in future only be put back by agreement with the CEO. However the Committee was very concerned that seven Priority 1 recommendations still remain outstanding beyond the agreed deadlines, and that several outstanding matters are marked as the responsibility of executives who have left the Trust.

2. We ask the Board to continue to endorse the approach which requires the Executive to co-operate with TIAA, to take responsibility individually and severally as an Executive team for progressing and implementing agreed actions arising from Internal Audits and to report back progress to the Audit Committee in a timely manner. The Committee expects that all outstanding and overdue actions and recommendations will be complete by its next meeting in November. The Committee also notes that the Care Quality Commission (CQC) has also expressed concern at the delay in completing agreed actions from internal audits.

INTERNAL AUDIT

3. The Audit Committee received final reports for three 2016/17 Internal Audit Reports: Governance – Framework, Governance – Board Assurance and Estates and Facilities (Facilities Management), all of which received only limited assurance. The Committee stressed to the Executives responsible that all actions arising from these audits must be completed within the agreed timescales.

4. The Audit Committee received final reports for four 2017/18 Internal Audit Reports: Data Quality Cancer Pathway, Agency Spend, Fit and Proper Persons, Mortality – all of which received reasonable assurance. However two completed 2017/18 Internal Audit Reports were reported with limited assurance: Procurement and Interims and IR35.

5. The Audit Committee noted its concern that two of the current year audits, both focussing on key areas, had received only limited assurance, particularly since the clear objective as agreed with the Executive is for the Trust to move to a position, through its recovery plan, to ensure that the overall Head of Internal Audit Opinion for 2017/18 must be one of at least reasonable assurance.

6. For reasons including annual leave and timing clashes with other committees, only the Medical Director attended the full Audit Committee to respond for the Executive Management Team (EMT) to matters of concern raised by the Audit Committee, both in response to Internal Audit reports and other matters (Larry Murphy – interim Chief Information Officer - and Richard Hancock – interim Director of Estates & Facilities - attended to speak to their agenda items, and Robert Flanagan – Director of Financial Operations - attended for Andrew Grimshaw – Chief Financial Officer (CFO)). The CEO has agreed that this position is entirely unsatisfactory and has committed to ensure that such Committee clashes will be avoided in future.

7. The Committee discussed proposals to update the current year's Internal Audit Plan to reflect changing priorities and the need for assurance in a number of new areas. Particular areas requiring additional assurance are the RTT programme, consultant appraisal and revalidation (following Board discussion in September), dual prescribing, information security and preparedness for compliance by May 2018 with General Data Protection Regulations, and data quality. The Committee also needs to be assured, for itself at its November meeting and for NHSI, on the processes in place to ensure completeness and accuracy of coding of Trust income. Additional issues may come to light with the imminent completion and implementation of the BAF, so the Audit Committee agreed to review the revised Internal Audit Plan 2017/18 proposals, following detailed EMT review, at its November meeting.

8. The Committee agreed a proposal for the evaluation of Internal Audit Effectiveness, which will be led by the Trust Secretary and Head of Corporate Governance.

EXTERNAL AUDIT

9. The External Auditor's proposed engagement letter, and fee proposal, was discussed and is recommended for approval by the governing body.

10. The report from the auditors setting out matters identified in the course of their year end audit was again noted: not all agreed actions have yet been completed and the Executive committed to providing an updated report, showing completion of all matters, in November. Good progress was noted on completion of timely and regular bank account reconciliations.

11. Progress is being made on the agreed programme for selecting the Trust's external auditor for 2018/19 onwards. The Committee was assured by the DFO that the required timeline, enabling approval by the Council of Governors on 6 December 2017, will be met.

COUNTER FRAUD

12. The progress on several cases was discussed and noted: three are of particular concern and were discussed in detail. Counter Fraud are completing urgent reviews with Procurement and HR leads to ensure that gaps in controls are closed.

13. The Committee is still not adequately assured that the learning from completed cases is being appropriately disseminated so that the risk of similar frauds occurring can be reduced. It was agreed that Counter Fraud will liaise with the Communications team to agree how awareness across the Trust can be improved, and also that a regular quarterly report on Counter Fraud will be presented to EMT.

14. It was very clear to the Committee that this important area needs greater attention from EMT and the CFO, and a response to this requirement will be discussed with the Audit Committee at its November meeting.

WHISTLEBLOWING

15. The Director of HR and OD (DHROD) had attended the last Audit Committee meeting in May to update the Committee on whistleblowing. He had confirmed that an updated policy is being finalised along with better mechanisms to support staff who wished to whistle-blow or speak up. He had also provided assurance that five current cases were being appropriately dealt with – the detail of these cases will be discussed as necessary in the Workforce & Education Committee. Owing to annual leave, the DHROD was unable to report back to the Committee in September, as planned, with the updated policy and to provide assurance that the Trust has in place an effective system to deal with and support whistleblowers. This report will now be considered in November 2017.

PROCUREMENT, PROJECT COMPLIANCE, BREACHES AND WAIVERS, AGED DEBT

16. The Committee had not received the necessary report on breaches and waivers at the May meeting, owing to the ongoing staff shortages and changes in the Procurement team. The Committee considered this to be unacceptable and required full restitution of breaches and waivers reporting from September onwards. This report was still not available for the September meeting.

17. Robert Flanagan (DFO) and Ian White (Interim Head of Procurement) described the additional grip that they are taking on the Trust's procurement processes, including a root cause analysis on each breach and waiver and regular meetings with each Directorate to understand and improve the procurement pipeline and areas of non-compliance. Ian explained that the impact of these changes would take a few months to embed so he would return to the Audit Committee in January 2018 with a full update, including the breaches and waivers report.

COMMITTEE EFFECTIVENESS

18. The Audit Committee Chairman urged the Executive to improve on its production of papers for Committee meetings, noting that it was not acceptable for the Secretariat and the Committee to receive late papers or no papers at all. While she accepted that the Executive team is currently very stretched, the Committee considers it to be essential to have full, clear and concise papers circulated at least five working days in advance of each Committee meeting to support good governance and decision making.

Author: Sarah Wilton, Chair of Audit Committee
Date: September 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	5 October 2017	**Agenda No**	7.2
Report Title:	Corporate Risk Report		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The September 2017 meeting of the Risk Management Committee reviewed the corporate risk register. This paper provides a summary of the assurances received by the committee on the control of the significant risks and changes made to risk scores as a result; risks agreed for escalation to the CRR from a divisional risk register; and the mitigating actions and plans for two risks scored at 25.		
Recommendation:	The Trust Board is asked to note the: • mitigating actions being taken to increase control of the two highest scored risks • changes to the risk scores as set out in the paper; • addition of a risk to the CRR; and • actions being taken to review risks that cover broad areas, this to provide an understanding of the risk score of individual risks and their control.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe, Well-led		
Single Oversight Framework Theme:	Quality of Care Leadership and improvement capability		
Implications			
Risk:	Risk to meeting the Trust's strategic objectives.		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Previously Considered by:	Risk Management Committee	**Date**	13 Sep 17
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1 Summary Corporate Risk Register		

Corporate Risk Report
Trust Board 5th October 2017

1.0 PURPOSE

1.1 To provide the Board with assurance on the control of risks contributing to the Trust's strategic risks.

1.2 To provide the Board with a summary of the corporate risks, **appendix 1**.

2.0 BACKGROUND

2.1 The Corporate Risk Register (CRR) has been reviewed at the Risk Management Committee, this report provides a summary of the assurances received by the committee on the control of the significant risks and changes made to risk scores as a result; risks agreed for escalation to the CRR from a divisional risk register; and the mitigating actions and plans for two risks scored at 25.

3.0 CORPORATE RISK REGISTER

3.1 There are currently 24 risks on the corporate risk register scored at 15 or above, table 1 shows distribution of risk against the Trust's strategic objectives.

3.2 Two risks, one related to IM&T and one related to the management of information are scored at 25 and have been scored at this level for some months, **appendix 1**. The committee sought assurance on the actions being taken to reduce these risk scores to an acceptable level. Both of these risks are brought to the attention of the Board together with information on the action being taken to reduce the level of risk.

- CRR-0001 **Data quality, completeness or consistency***;*
- CRR-0009 **ICT infrastructure failure**;

These risks relate to the lack of investment in the IM&T environment over recent years, an issue discussed before at Trust Board. In order to address these risks urgent actions are being undertaken to reduce the headline risk, while medium term plans are agreed that will address the underlying causes. Immediate actions include;

- Additional capital investment of £16m is being sought to support further investment in IM&T. £9m of this has already been made available to the IM&T function, with bids for a further £7m having been made. This funding is above agreed capital funds, and further funding has been requested from NHSI to cover this. A schedule of urgent works has been agreed by the EMT to address priority issues which will help stabilise the IM&T environment. Spend against the £9m has already commenced.
- Steps have been taken to strengthen the Trust's Information Department, with a new Head of Information and other additional staff being engaged.
- The role out of the Cerner PAS system to Queen Mary Hospital is being prioritised.

While these actions will reduce the immediacy of risks identified further work will be required to address the underlying causes. An IM&T Strategy is being developed in order to ensure a comprehensive plan is in place. A seminar of the Board has been organised for October to review progress. The Trust expects to reduce the headline level of risk in both of these areas to 20 before the next Trust Board meeting, and to set out the actions necessary to reduce the final level of risk to acceptable levels.

Risk score / Strategic Objectives	Score 25	Score 20	Score 16	Score 15	Total
1.High Quality Care	1	2	3	2	8
2. Teaching and Research	0	0	0	0	0
3. Modernising our Buildings and Internal Systems	1	4	1	2	8
4. Valuing our Staff	0	1	2	0	3
5. Financial Sustainability	0	3	2	0	5
6. Partnership Working	0	0	0	0	0
Total	2	10	8	4	24

Table 1: Risks by Risk Score and Strategic Objective

3.3 Risks escalated to the Corporate Risk Register

A new risk identified in the ICT risk register was presented. The risk is related to the fragmentation of management information and the data warehouse. The risk has been evaluated and given a risk score of 20 (4x5=20), the Risk Management Committee agreed that this risk will be escalated to the CRR.

3.4 Reduction to risk scores

The committee considered the assurances presented on the controls put in place to manage corporate risk **CRR-1143.** This risk concerns recognising, escalating and responding to the signs of the deteriorating patient and had a risk score of 20 (5x4=20). The committee received assurances on the controls put in place to date and agreed to downgrade the likelihood from 4 to 3. The committee consider that the controls have helped to further mitigate the risk. New risk score (5x3=15).

3.5 Risks to be reviewed

The Risk Management Committee discussed the following corporate risks and further to the assurances provided in para 3.2 has asked the responsible lead to extract contributing risks to enable the risk profile of these large areas of risk to be understood.

- CRR-0001 Data Quality, completeness or consistency*;*
- CRR-0009 ICT infrastructure failure;

As part of the work for the new Board Assurance Framework the corporate risk register is being reviewed to ensure that corporate risks that contribute to the strategic risks of the Trust are sufficiently detailed.

4. RECOMMENDATIONS

4.1 The Trust Board is asked to note the:

- changes to the risk scores as set out in the paper;
- addition of a risk to the CRR;
- actions being taken to review risks that cover broad areas, this to provide an understanding of the risk score of individual risks and their control; and
- mitigating actions being taken to increase control of the two highest scored risks.

Author: Elizabeth Palmer **Date:** 26/09/17

St George's University Hospitals NHS
NHS Foundation Trust

APPENDIX 1

Summary Corporate Risk Register

AR	Andy Rhodes	Medical Director	RH	Richard Hancock	Advisor to the Board
EL	Ellis Pullinger	Chief Operating Officer	RF	Robert Flanagan	Director of Finance Operations
HB	Harbhajan Brar	Director of HR	ADA	Anna D'Alessandro	Director of Finance Performance
LM	Larry Murphy	Chief Information Officer	PL	Paul Linehan	Head of Governance
ABE	Alison Benincasa	Divisional Chair (CSD)	JF	James Friend	Director of Efficiency, Delivery & Transformation
AB	Avey Bhatia	Chief Nurse			

Strategic Objective	Lead	Start Date	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017	In month change	Change/progress
1.High Quality Care									↑↓↔	
CRR-0001 **Inadequate Data Quality, completeness or consistency**	AR	Jul 2016	**25** ●	**25** ●	**25** ●	**25** ●	**25** ●	**25** ●	↔	
CRR-0010 **Fragmented Electronic and manual patient records**	AR	Jun 2016	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	↔	
CRR-0011 **Below target ED four hour performance**	EP	Jun 2014	**20** ●	**20** ●	**20** ●	**15** ●	**15** ●	**15** ●	↔	
CRR-0012 **Risk of patient harm as result of waiting too long for treatment**	EP	May 2014	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	↔	
CRR-0019 **Failure to recognise, communicate and act on abnormal clinical findings**	AR	Jul 2016	**16** ●	**16** ●	**16** ●	**16** ●	**16** ●	**16** ●	↔	
CRR-0023 **Below target 2-week wait performance**	EP	Aug 2016	**16** ●	**16** ●	**16** ●	**16** ●	**16** ●	**16** ●	↔	
CRR-0029 **Failure to arrange follow-up appointments or treatments (where clinically required)**	AR	Sep 2016	**16** ●	**16** ●	**16** ●	**16** ●	**16** ●	**16** ●	↔	
CRR-1143 **Recognising, escalating and responding to the signs of deterioration**	AR	Dec 2016	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	**15** ●	↓	Reduction in score agreed at RMC Sep17 following review of assurances on the effectiveness of controls.

Strategic Objective	Lead	Start Date	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017	In month change	Change/progress
3. Modernising our Buildings and Internal Systems:									↑↓↔	
CRR-0007 **Potential unplanned closure of premises / non-compliance with estates or Fire legislation**	RH	Mar 2013	**20** ●	**20** ●	**20** ●	**20** ●	**15** ●	**15** ●	↔	
CRR-0008 **Inability to address backlog maintenance requirements**	RH	Jul 2016	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	↔	
CRR-0009 **ICT Infrastructure failure**	LM	Jul 2016	**25** ●	**25** ●	**25** ●	**25** ●	**25** ●	**25** ●	↔	
CRR-0013 **Exposure to Cyber or Malware attack**	LM	Apr 2016	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	↔	
CRR-0015 **Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressure**	RF	Jul 2015	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	↔	
CRR-0016 **Bacterial contamination of water supply (Legionella, Pseudomonas)**	AB / RH	May 2014	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	↔	
CRR-1310 **Electrical Infrastructure - Potential interruption to electrical supply**	RH	Aug 2017						**15** ●	**NEW**	
CRR-1311 **Electrical Infrastructure - No compliance with Electricity at Work Regulations and BS7671**	RH	Aug 2017						**16** ●	**NEW**	

Strategic Objective	Lead	Start Date	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017	In month change	Change/progress
4. Valuing our Staff:									↑↓↔	
CRR-0014 **Failure to secure colleague engagement**	HB	Apr 2016	20 ●	20 ●	20 ●	20 ●	**16** ●	**16** ●	↔	
CRR-0022 **Insufficient management capacity or capability to deliver turnaround programme**	JF	Oct 2015	20 ●	20 ●	20 ●	20 ●	20 ●	20 ●	↔	
CRR-0025 **Unsustainable levels of staff turnover**	HB	Oct 2015	15 ●	15 ●	15 ●	15 ●	**16** ●	**16** ●	↔	

Strategic Objective	Lead	Start Date	Mar 2017	Apr 2017	May 2017	June 2017	July 2017	Aug 2017	In month change	Change/progress
5. Financial Sustainability									↑↓↔	
CRR-0026 **Inability to control agency temporary staffing and associated staffing costs**	HB	Sep 2016	20 ●	20 ●	20 ●	20 ●	**16** ●	**16** ●	↔	
CRR-0027 **Risk of failure to deliver the financial control total**	ADA	Oct 2016	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	**20** ●	↔	
CRR-0028 **Inability to meet regulatory requirements due to financial system and process failure**	RF	Oct 2016	16 ●	16 ●	16 ●	16 ●	**16** ●	**16** ●	↔	
CRR-1228 **Insufficient Cost Improvement/ Transformation Programme in 2017/18**	JF	Apr 2017		20 ●	20 ●	20 ●	**20** ●	**20** ●	↔	
CRR-1235 **Insufficient cash to meet payment demands (2017/18)**	RF	Apr 2017		20 ●	20 ●	20 ●	**20** ●	**20** ●	↔	