Trust Board Meeting

Date and Time: Thursday 7 September 2017, 10:00 – 13:30
Venue: Hyde Park Room, 1st Floor, Lanesborough Wing

Time	Item	Subject and Lead	Action	Format
10:00 – FEEDBACK FROM BOARD WALKABOUT INCLUDING VISIT TO QMH ON 10.08.17				
		OPENING ADMINISTRATION		
10:30	**1.1**	**Welcome and Apologies** Chairman	-	Verbal
	1.2	**Declarations of Interest** All	-	Verbal
	1.3	**Minutes of Meeting held on 06.07.17** Chairman	Approve	Paper
	1.4	**Action Log and Matters Arising** All	Review	Paper
	1.5	**CEO's Update** Chief Executive	Inform	Paper
		STRATEGY		
10:40	**2.1**	**South West London STP and Acute Provider Collaborative** Chief Executive	Update	Paper
		QUALITY		
10:50	**3.1**	**Quality Committee Report** Chair of Committee	Assure	Paper
	3.2	**Care Quality Commission Report and Action Plan** Chief Nurse, Avey Bhatia	Assure	Paper
	3.3	**Outstanding Care Every Time – Our Quality Improvement Plan** Chief Nurse, Avey Bhatia	Approve	Paper
	3.4	**Mortality Monitoring - Learning from Patient Deaths Update** Acting Medical Director, Andy Rhodes	Update	Paper
	3.5	**A Framework of Quality Assurance for Responsible Officers and Revalidation** Acting Medical Director, Andy Rhodes	Assure	Paper
		PERFORMANCE		
11:50	**4.1**	**Integrated Quality & Performance Report** Executive Team	Review	Paper
	4.2	**Winter Preparedness 2017-18** Chief Operating Officer, Ellis Pullinger	Assure	Paper
		FINANCE		
12:20	**5.1**	**Finance & Performance Committee Report** Chair of Committee, Ann Beasley	Assure	Verbal
	5.2	**Month 4 Finance Report** Chief Financial Officer, Andrew Grimshaw	Assure	Paper
	5.3	**Capital Plan Allocations 2017-18** Chief Financial Officer, Andrew Grimshaw	Inform	Paper
	5.4	**Evaluation of Overseas Visitors and Migrant Cost Recovery Pilot** Chief Financial Officer, Andrew Grimshaw	Update	Paper
		GOVERNANCE		
12:50	**6.1**	**Children Safeguarding Annual Report 2016-17** Chief Nurse, Avey Bhatia	Assure	Paper
	6.2	**Fit and Proper Persons Update Report** Harbhajan Brar, Director of Human Resources	Assure	Paper
		CLOSING ADMINISTRATION		
13:00	**7.1**	**Questions from the Public**	-	Oral
	7.2	**Any New Risks or Issues**		-

		All		
	7.3	**Items for October 2017 Meeting** i. Board Assurance Framework ii. External Governance Review		-
	7.4	**Any Other Business** Chair	-	-
	7.5	**Reflection on Meeting** All	-	Oral
13:15	**Close**			
	STAFF STORY			
	In line with the day's theme of celebrating staff achievements, there will be staff stories at this month's Board. There will be one or two members of staff who have recently won a Trust Values Award. Briefings on their roles and the nature of their achievements will be provided in advance.			
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 5 October 2017

Trust Board
Purpose and Meetings

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)		
05.10.17 10:00 – 13:00	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

Minutes of Trust Board Meeting
6 July 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
Jenny Higham	Non-Executive Director	NED
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
Sunil Dasan	Guardian for Safe Working (for Item 5.4)	GSW
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Nigel Kennea	Associate Medical Director (representing the Medical Director)	AMD
Diana Lacey	Elective Care Recovery Programme Director (Part)	ECRPD
Ellis Pullinger	Chief Operating Officer	COO
Chris Rolfe	Associate Director of Communications	ADC
IN ATTENDANCE FROM ST GEORGE'S CHARITY (PART)		
Martyn Willis	Chief Executive	
Dr Carol Varlaam	Vice Chair	
Anthony Marshal	Treasurer	
Dr Hazel Norman	Trustee	
Mike Rappolt	Trustee	
Zeynep Meric Smith	Trustee	
APOLOGIES		
Andrew Rhodes	Acting Medical Director	MD
SECRETARIAT		
Fiona Barr	Trust Secretary & Head of Corporate Governance	Trust Sec
Rebecca Randall	Board and Committee Secretary (Temporary)	Board Sec

Feedback from Board Walkabout

Board members visited a number of departments including: Security, Bereavement, PALS office, Heberden (Dementia) Ward, Therapy Outpatients, Jungle (Day and Planned Admission) Ward, Gwillam (Maternity) Ward, Gunning (Orthopaedic) Ward, Surgical Admissions, Kent Ward and Acute Surgery.

General themes included infection control and "bare below the elbow"; team work; communication between patients, relatives and staff; and rostering. Amongst the areas of concerns were the effect of Brexit on recruitment and retention; outpatient appointments; theatre times on Jungle ward and the challenge of fixed appointment slots when dealing with younger patients. IT, including concerns with iClip and delays in users logging in and out, were also raised as issues.

Some Board members had used the 15 Step Challenge to look at wards from the patients' perspective and

Gunning Ward was particularly commended for being tidy and welcoming whereas the Acute Surgery area was found to be cluttered with equipment. The Chairman thanked the Board members for their observations and encouraged the Executive both to take action on the areas of concern as well as encouraging all areas to perform to the level of the best.	
Patient Story	
Lauren Daly, a patient and also a member of the Trust's staff, told her story of experiencing a complication following her tonsillectomy. Lauren's initial surgery went well though a few days after discharge, her condition changed and she was re-admitted for further treatment and monitoring and had a further short stay in hospital. Her particular observations were of kind and caring staff who treated everyone with compassion and made them feel at ease. Overall she had a very positive experience.	
1. OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed Ellis Pullinger, the new Chief Operational Officer (COO), and Andrew Grimshaw, the new Chief Financial Officer (CFO). She also extended congratulations to Simon Mackenzie, former CEO, who had had taken up a new role at NHS Improvement (NHSI).
Declarations of Interest	
1.2	There were no declarations of interest.
Minutes of Meeting held on 08.06.17	
1.3	These were accepted as a true and accurate record of the meeting held on 08.06.17.
Action Log and Matters Arising	
1.4	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.
1.5	Under Matters Arising, the Chairman referred to the discussions at the last Board meeting on the Fit & Proper Person Policy and Procedure (FPPPP). She explained that at that point, the Board should have been more explicit about its judgement of the balance of risk so this could have been reflected in the minutes. That is, in exceptional circumstances when members of the Board were appointed and started in post before the FPPP had been completed, this was done following a risk assessment: the risk of the Board member starting without the FPPP checks being completed was weighed against the absence of a key post on the Board. She reiterated that this option should be used very sparingly, if at all, going forwards. The Board agreed that they had been very clear on the balance of risk and hoped not to be in such a position again. However if the Trust were to find itself in that exceptional position in the future, then there would be a full written risk analysis undertaken, which would be reported to the next Board meeting.
1.6	The Trust had received notification from the Care Quality Commission (CQC) that it had found some Board member files to be non-compliant with FPPP. The Chairman took this matter very seriously, particularly as the Board had previously received confirmation from the Executive that the files were in order. The DHROD confirmed that Internal Audit would independently audit the files during week commencing 17.07.17 to check compliance and this would be reported back to the Board. Going forwards, the Board would receive a

	quarterly and annual report to demonstrate ongoing compliance. This was agreed.
TB.06.07.17/35	**Provide a quarterly and annual report on compliance with the Fit & Proper Persons Regulation to the Board.** **LEAD: Director of Human Resources & Organisational Development**
CEO's Report	
1.9	The CEO gave a brief report, advising that: i. Following the Grenfell fire, all Trust buildings had undergone fire safety checks and no concerns had been raised. ii. Infection Prevention and Control (IPC) was an increasing priority due to the four cases of MRSA in the last three months. The NEDs expressed concerns about consultants not being "bare below the elbow" and asked how the Executive would challenge this behaviour and improve compliance. The CN advised that she and the MD were working on a revised uniform policy to clarify what was expected and acceptable in clinical areas. This would be developed in August with a view to implementation in September 2017. This was welcomed. iii. The Trust underwent an externally facilitated quality and safety review in June involving representatives from NHSI, with support from staff, patient representatives Governors. There were some positives as well as some areas for improvement though overall it had been a very good learning opportunity and action had been taken as a result. iv. Staff continued to do excellent and important work around the Trust which should be highlighted and praised. To this end, she mentioned the Tree of Life event on 01.07.17 which paid tribute to, thanked and remembered the many people who had donated life-saving organs on the last year. It had been a very moving ceremony.
2. ST GEORGE'S HOSPITAL CHARITY	
Presentation from Trustees	
2.1	Dr Hazel Norman, one of the Trustees of St George's Hospital Charity, gave a presentation to the Board which: • Explained why the Trust and the Charity should work closely together. • Invited one of the NEDs to become a Charity Trustee. • Highlighted some of the important contributions made by the Charity over the last ten years. • Suggested joint collaboration on a major fundraising campaign. • Encouraged the relationship between the two organisations to be renewed for the benefit of staff and patients – particularly as the Charity felt that it was not being fully utilised.
2.2	The Chairman and CEO agreed that the Charity was very important for the Trust and explained that on appointment, the Director of Strategy would be the main Executive link though until then, the CFO would be the main contact for the Trustees. Further CFO and DHROD were keen to explore opportunities to use charitable funds for staff development and/or capital investment projects and it was agreed that this would be discussed more fully with the Trustees outside the meeting, including any restrictions on funds.
2.3	The Chairman confirmed her intention for the new NED to play a lead role with the Charity on appointment though until then Deputy Chairman, Ann Beasley, would be happy to work with the Charity.
2.4	To cement the new working relationship, it was decided that the Trust and Charity would meet every six months.
TB.06.07.17/36	**Schedule a meeting with between the Board and the Trustees of the St George's Charity every six months.**

	LEAD: Trust Secretary
3. PATIENT SAFETY, QUALITY AND PERFORMANCE	
Quality Improvement Plan	
3.1	The CN explained that a new approach was being taken with the Trust's Quality Improvement Programme (QIP). Finance and quality had equal priority and were indivisible and to this end the new QIP was fully aligned with the Financial Recovery Plan (FRP) to deliver a "One Team, One Plan" approach to get the Trust out of both Quality and Financial Special Measures.
3.2	As with the FRP, the programmes of work which underpinned the QIP had clear patient-focussed outcomes and targets; to support delivery, each of the 17 workstreams had been assigned a clinical lead and programme management support.
3.3	To enable the Board to track progress, a number of Patient Outcome Measures were being developed as the Key Performance Indicators (KPIs) which would be presented to the Board each month as a dashboard. These were still under development but those which were proposed were included in the paper for consideration.
3.4	The CEO reminded the Board that outstanding trusts always sought out greater improvement and this was the cultural shift that the QIP was trying to embed within the organisation.
3.5	The NEDs welcomed a more thorough and planned approach to the QIP and one which built on the best practice of the FRP though explained that to be assured of progress, they needed to see more evidence of positive change. In short, they needed to see that the work that was being done was actually making a difference. They encouraged the CN to identify two or three iconic items which would demonstrate that the Trust looked and felt different – and to focus on these items. The new Uniform Policy and improved compliance with "bare below the elbow" were suggested as possibilities. Also with the change in the QIP, the NEDs also sought reassurance that the actions originally identified to address Quality Special Measures and the S29A letters were still included within the agreed workstreams. This was confirmed.
3.6	The Board received the report and looked forward to the further development and refinement of the Quality Improvement Dashboard. It was also agreed that the QIP would be discussed more fully at the Quality Committee on 26.07.17 and in the future, key metrics from the QIP would be presented in the Integrated Performance Report (IPR).
Integrated Performance Report	
3.7	The CN introduced the quality elements of the IPR advising that two patients had developed an MRSA Bacteraemia in June, which brought the total for the year to four against a zero ceiling. A detailed review of the cases was underway and that the findings of the reviews would be presented at the next Quality Committee. NED Jenny Higham asked what lessons were being learned and if there needed to be a change in practice or behaviour. The CN advised that she and the IPC team were focusing on basic standards of IPC compliance, such as handwashing and ward/equipment cleanliness. The CN explained that standards needed to be raised across the hospital and then be sustained which included compliance with the dress code policy. Jenny Higham challenged when actions would be complete and the CN advised good progress was being made with particular focus on hand hygiene on cleaning equipment and part of the Quality Improvement Plan. A regular audit programme was in place for both hand hygiene and cleanliness which outlined areas for focus. The CN also explained that the initial findings from the investigations did not demonstrate lapses in care however there is good evidence that the patients were colonised and that the subsequent development of MRSA bacteraemia took place while patients received care at St George's and that they were

	cared for in the same bay on the same ward. Thus the importance of compliance with basic standards of IPC are essential at all times. Jenny asked for further clarification on what other actions are being taken. The CEO explained that other action on that particular ward included a full ward deep clean.
3.8	Continuing the theme of IPC, NED Sir Norman Williams flagged significant concerns about a male toilet close to the Hyde Park room which had been blocked for several months and he noted that the disabled toilet was now also out of order. He asserted that failure to complete basic plumbing tasks was a significant IPC risk in itself and asked what was being done to resolve this. There was a general feeling amongst the NEDs that a lot of work was being done to fix identified problems but they were unsure to what extent this work was being effective and closing down the issues. The CEO agreed that more needed to be done to provide stronger assurance though greater triangulation of information from different sources, for example the new ward dashboards, was improving the visibility of issues. It was agreed that swifter decisive action was needed to "nip things in the bud" as soon as problems appeared and to prevent them from growing into significant ongoing issues. The CN accepted the challenges made by the NEDs and confirmed that the availability of a decant ward with the closure of Dalby meant that quicker progress could be made on ward refurbishments, and it would also be used to facilitate deep cleaning of whole wards as soon as Dalby had been refurbished.
3.9	The COO presented the performance aspects of the report and confirmed that the Trust's performance against the four hour emergency target had improved in June. Six out of the eight cancer standards were met in April though diagnostic performance was still below the 99% standard. However some improvements were being made.
3.10	He explained that it might be necessary to use private/other providers to meet demand, particularly for Ear Nose and Throat (ENT) and Dermatology and agreed to present a report to the next Board meeting which would cover the quality and governance aspects of the provider to provider agreements.
TB.06.07.17/37	**Present a report to the Board on the use of other providers to manage demand. The report to cover the quality and governance aspects of provider to provider agreements and the circumstances in which these arrangements were needed. LEAD: Chief Operating Officer**
3.11	The DHROD briefly updated the Board on Workforce performance, noting that his team was currently focusing on measures to reduce sickness and was running a pilot with a specialist company which was delivering good results. He also advised that the Trust had been identified as one of eighteen with staff retention issues and would receive support from NHSI to address this.
Elective Care Recovery Programme (ECRP) Update	
3.12	The ECRPD presented an update on the implementation of the ECRP, including actions to return the Trust to national reporting of the standard and to deliver the 18 week Referral to Treatment (RTT) standard.
3.13	The ECRPD drew the Board's attention to a number of key issues: i. the increasing size of the patient waiting lists which indicated that more needed to be done more to treat patients more quickly. ii. the trend for patients waiting 52 weeks or more was rising. iii. a significant backlog in the typing of clinical letters following outpatient appointments at Queen Mary's Hospital (QMH). iv. an auto discharge function on the QMH patient administration system (PAS) that had now been turned off.
3.14	She explained the steps which were being taken to address the issues which included a refreshed programme of work with clear actions to mitigate the risks and improved governance arrangements. Resourcing remained a key factor: staff with the right skills to validate records were difficult to find and whilst Cymbio was making good progress with

	validating records, this was an expensive resource to use and further investment was required.
3.15	The Board expressed considerable concern about a number of aspects of the growing waiting lists and the general slow progress, wanting to see much faster progress. The Board resolved to maintain a strong focus on RTT and asked that future reports particularly explain performance against a number of key metrics and risks including re-booking patients.
3.16	The Board received the report, noting the refresh of the plan including revisions to the governance, architecture and reporting arrangements, and the timescales for completion.
National Inpatient Survey (NIS) 2016 Results	
3.17	The CN provided a brief introduction to the NIS results for 2016 drawn from inpatients who were surveyed in July 2016. The report also included a comparison of the Trust's results over the past six years and a comparison of results with other London Trusts; the results had already been published on the CQC website.
3.18	Whilst the responses to most questions were in line with the national average, the Trust fared worse on four questions: i. Did you ever use the same bathroom or shower areas as patients of the opposite sex? ii. In your opinion, how clean was the hospital room or ward that you were in? iii. Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way that you could understand? iv. Did hospital staff discuss with you whether you would need any additional equipment in your home or any adaptations to your home, after leaving hospital?
3.19	The CEO advised that further investigation was required to understand the issues around same sex breaches as this had not previously been identified as an issue. In response the CN confirmed that the results of the NIS had been integrated into the workstreams which supported the QIP so they would get greater focus. The survey results had been widely shared internally and were very much part of the Trust's quality improvement agenda.
3.20	The Chairman emphasized that the national average was not good enough and the Board concurred that the Trust had to be much more ambitious in its aims. The Board received the report.
4. FINANCE	
Month 2 Finance Report	
4.1	The CFO presented the report advising that it was based on the financial plan currently agreed with NHSI to deliver a year-end deficit of £28.5m though discussions were underway to revise this to a £45m year-end deficit and run rate balance.
4.2	Based on the revised plan, financial performance was on trajectory though income was £4m lower than expected which was offset by a corresponding reduction in pay spend. The volume of work remained broadly the same though the Trust was earning less income; the reasons for this were under investigation. Of an approved capital programme of £43m, around £9m had been spent. Particularly throughout July and August there would be a continued focus on meeting agreed savings targets. Whilst it was still relatively early in the financial year, there was still much work to be done. A key priority was improving financial systems and processes and data quality.
4.3	The Board received the report.

Report from Finance & Performance Committee (FPC)	
4.4	The FPC Chair advised that the meeting had considered the performance issues discussed earlier in the meeting, including the MRSA cases, and that less time than usual had been spent discussing the FRP as this had been discussed in detail at a Board workshop. She advised that Board that performance indicated that the Trust was broadly on plan to achieve a £45m year-end deficit and hoped that an agreement could soon be reached with NHSI to officially change the agreed year-end position to £45m deficit as until then the Trust would have to continue to report on a plan that it was no longer performing against (ie one which delivered a £28.5m year-end deficit). At the end of M2, the deficit position was £18m and she strongly encouraged the Executive to do more to show an improvement in the financial position and demonstrate more clearly the "green shoots" of recovery.
4.5	There was a brief discussion about the significant variance in the flex and final position in M1 though the Board was assured that this was unlikely to recur in future months. However the CFO confirmed that data capture and coding was a key area of focus to understand better estimates could be made of the likely monthly income position.
5. WORKFORCE AND COMMUNICATION	
Freedom to Speak Up Guardian Report	
5.1	DHROD presented the report which updated the Board on the Freedom to Speak Up Guardian (FTSUG) and Listening into Action Service (LIAiSE) services which were important initiatives to enable staff to raise concerns.
5.2	He advised that both services were still in their infancy and more work was needed to publicise their existence to staff. Further for an organisation the size of the Trust, a network of FTSU champions was needed to make the service more available to more staff – particularly as bullying and harassment was regularly reported as a key concern in the Staff Survey.
5.3	Whilst the Board was pleased to receive an update, and was assured that the Trust was compliant with guidance in respect of FTSU, it requested that future reports were more descriptive about the work of the outputs and outcomes of both services. This was agreed.
Staff Engagement Plan	
5.4	The HROD explained that a different approach was being taken to address the issues raised in the recent Staff Survey. A number of staff from across the organisation had been engaged in café style events to talk about the key findings of the survey and what actions they would like to see put in place to address them. The events were well attended and followed a structured format to draw together key themes on which activity should be focused in the main priority areas which were: i. improving staff engagement ii. addressing bullying and harassment, and iii. improving equality and diversity.
5.6	The Board received the update noting that the results of the 2016 Staff Survey did not make comfortable reading. The Executive was cautioned against having a plan which was too extensive, suggesting instead that it should be focused on three or four areas which could easily be tracked and measured and reported through the workforce element of the IPR. This was agreed.
5.7	The Board also noted that simple changes in staff attitude could be made by showing more appreciation (eg by sending Thank You cards) and reminding staff of what actions had been taken in response to staff feedback, eg You Said, We Did.
5.8	The Board welcomed the suggestion for a Board level champions for equality and diversity (to include gender, ethnicity and disability) and a paper will be presented to the Board in regards to a way forward. In addition, the Board asked for more regular reporting on

	equality, diversity and inclusion, probably through the workforce element of the IPR.
TB.06.07.17/38	**Regularly report on staff engagement and metrics on equality, diversity and inclusion in the workforce element of the IPR.** **LEAD: Director of HR & OD**
Communications Strategy	
5.9	The Communications Strategy was presented for review which was broadly supported. The Board noted that it did not cover patient and public involvement though this was being considered as part of the External Review of Governance. Generally it was felt that strengthening links with patients and patient groups and patient stakeholders (such as Healthwatch) would be very beneficial.
Guardian of Safe Working Quarterly Report	
5.10	Dr Sunil Dasan presented the Guardian of Safe Working (GSW) latest quarterly report which indicated a reduction in the number of reported exception episodes. He noted however that as many medical rotas had an average working week of over 47 hours, a failure to schedule in time of in lieu could result in the 48 hour working time limit being breached which would incur a fine. There had been four breaches of the 13 hour shift length in Obstetrics and Gynaecology though no fines had been incurred. Further he reported that a number of Educational and Clinical Supervisors are not completing timely exception reports though this was being addressed by the MD and the Divisional Chairs.
5.11	His main concern was a lack of reliable data on rota gaps related to unfilled shifts and he specifically asked the Board to note this. In addition he noted that in some instances, breaks were being missed though he was working with a team from Guy's & St Thomas's on a campaign to encourage staff to take breaks. This served the dual benefit of improving their wellbeing as well as preventing patient safety incidents related to overworking.
5.12	NED Sir Norman Williams asked to what extent the Junior Doctors had accepted the contract; Dr Dasan advised its acceptance was "grudging" though pointed out how important Junior Doctors were in providing the capacity to deliver performance. It was generally accepted that more should be done to make Junior Doctors feel part of the St George's team and that the work of the GSW was an important part of this.
6. CLOSING ADMINISTRATION	
Questions from Public	
6.1	The following issues were raised: i. the acoustics from the room meant that it had been difficult to hear all of the Board discussions - the Chairman asked that an alternative venue was sought for Board meetings where possible. ii. different discharge arrangements for patients when services had been outsourced from the NHS - the COO advised that he was something that he was aware of and seeking to resolve. iii. When confirmation about the new control total for 2017-18 would be sought from NHSI (£45m year-end deficit) - the CFO advised that this would be discussed at the end of the month.
Summary of Actions	
6.2	To avoid a repeat of the whole meeting, the Chairman suggested in future that actions

	were highlighted with each item.
Any New Risks or Issues	
6.3	The Board was in agreement that there would be no formal Board meeting in August and the next meeting would take place on Thursday 07.09.17 which was also the day of the Annual Members' Meeting.
Items for Future Meetings	
6.4	The Board noted a forthcoming assessment of winter resilience arrangements and asked for this to be added to the next agenda.
TB.06.07.17/39	**Discuss the Trust's Winter Resilience Plans at the September Board meeting. LEAD: Chief Operating Officer**
Any Other Business	
6.5	The CEO and Board offered their congratulations to Chairman for receiving her OBE in the Queen's Birthday Honours.
6.6	With no further items of business, the Chairman closed the meeting.

Date and Time of Next Meeting: Thursday 7 September 2017, from 10:00

Trust Board Action Tracker - 07.09.17

Action Ref	Theme	Action	Due	Revised Date	Lead	Commentary	Status
TB.05.01.17/08	**Overseas Visitors and Migrant Cost Recovery Pilot**	Board to receive an evaluation report on the pilot programme to recover costs in two clinical areas (maternity and an elective service) from overseas visitors and migrants who use NHS services but are not entitled to free care. Report to be received in June 2016.	~~TB.08.06.17~~	~~TB.10.08.17~~ Q2 2017-18	CFO	This is on the 07.09.17 is on the Agenda by the CFO	Proposed for Closure
TB.09.02.17/16	**Local Escalation Plan**	Updated Local Escalation Plan to be circulated to the Board following its approval by the CEO and Chair on behalf of the Board.	Sep-17		COO	As this action links to guidance issued by NHS England relating to winter resilience it is suggested that the COO presents the Local Escalation Plan for Board approval in October 2017 as part of the Trust's 2017-18 Winter Plan.	Proposed for Closure
TB.04.05.17/31	**IG Toolkit**	Receive a regular report on the IG Toolkit going forwards and progress on compliance on new IG Toolkit.	Q2		CIO	A report was presented to EMT advising on the implecations of the new General DATA regulations in July and will receive further update as the Trust develops it complaince against IG Toolkit. It is advised that this action is managed by EMT and when next IM&T is presented to Board the Board also receive a briefing on IG regulations.	Proposed for Closure
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.05.10.17		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.06.07.17/37	**Managing Demand**	Present a report to the Board on the use of other providers to manage demand. The report to cover the cost, quality and governance aspects of provider to provider agreements and the circumstances in which these arrangements were needed.	FPC.30.08.17		COO	It was agreed to take this paper to the Finance & Performance meeting on 30.08.17.	Proposed for Closure
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	These metrics will be included in the workforce section of IPR.	Open
TB.06.07.17/39	**Winter Resilience**	Discuss the Trust's Winter Resilience Plans at the September Board meeting.	TB.07.09.17		COO	On agenda	Proposed for Closure

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 September 2017	**Agenda No.**	1.5
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Jacqueline Totterdell, CEO		
Report Author:	Paul Sheringham, Head 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, 7 September 2017

1. PURPOSE

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

2. CQC VISIT

2.2 Since the last Trust Board meeting in July we have received the report from the CQC following their focused inspection in May 2017.

2.3 The inspection, which took place over three days, assessed the progress we made towards meeting the requirements of the Section 29a Warning Notice issued after their detailed inspection in June 2016.

2.4 These related to best interest decisions about patients; the management of medicines; the way we manage and investigate serious incidents; and improvements to our estate and premises and ensuring we meet the fit and proper persons requirements.

2.5 In their inspection report, the CQC found that significant improvements had been made in these areas. For example, we've made a huge amount of headway with improving our estate, including closing six buildings at St George's that were not fit for purpose; relocating our Renal services, so patients were no longer in an unsafe environment, replacing our energy centre; and starting a theatre refurbishment programme.

2.6 The CQC noted there had been improvements in monitoring prescriptions and the risk of these going missing had been reduced. 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 and 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.

2.7 Since their inspection, we have introduced tighter controls around the fit and proper persons requirement and, for the avoidance of doubt, all of our current directors are 'fit and proper', and have undergone all the relevant checks.

2.8 All improvements noted by the inspectors reflect the hard work and commitment of our staff who always want to do their best for patients.

2.9 However, the inspectors confirmed that we still need to make improvements – particularly with regard to some of our systems and processes and, most important of all, management of referral to treatment data, which remains a major priority for the Trust. These are issues that we are taking very seriously, as they are important for providing safe and effective care for our patients. We will have the opportunity to reflect on the full report later in this meeting.

3. ELECTIVE CARE RECOVERY PROGRAMME

3.1 Following on from the discussions at the last board meeting, one of our absolute priorities over the last month has been to continue to address the Referral to Treatment (RTT) issue and ensure that we are getting patients who require our care treated as soon as possible. We are in the process of revising the programme to ensure it is embedded into our day to day operational structures. Whilst we have made some progress we are fully aware that there is a lot more to do.

3.2 We are currently appointing a new RTT recovery director. I would like to thank Diana Lacey who is leaving at the end of September for her dedication and her work on this programme.

3.3 At the next meeting we will present the Board with the revised RTT action plan for review.

4. CHANGES TO THE WANDSWORTH INTEGRATED SEXUAL HEALTH SERVICE (WISH)

4.1 You will be aware and possibly seen in the media that St George's will no longer be providing Wandsworth Integrated Sexual Health Services as of 1 October. This was discussed at Board earlier this year.

4.2 Responsibility for the running of Wandsworth Integrated Health Services will transfer to Central London Community Healthcare NHS Trust (CLCH) from 1 October.

4.3 We will continue to provide specialist inpatient and outpatient HIV care as usual as this service is not included within Wandsworth Integrated Health Services.

4.4 Concerns regarding the new clinical model proposed by CLCH were raised in a letter to the commissioner (Wandsworth Local Authority). A letter written by Rosena Allin-Khan MP for Tooting to Jeremy Hunt, was picked up by the Evening Standard. The letters implied that the new clinical model would be unsafe.

4.5 The responsibility for commissioning the service and ensuring that the new provider delivers a safe service ultimately lies with Wandsworth Council. In the last week of August the Trust met with Wandsworth Local Authority, the commissioners from the three affected boroughs (Wandsworth CCG, Merton and Sutton CCG and Richmond CCG) and CLCH to discuss the issues and the concerns raised in the letters by clinicians.

4.6 Wandsworth Local Authority responded that extensive consultation was undertaken on the service model, both London-wide and locally, prior to the commencement of procurement and acknowledged there will be a transition period. CLCH has committed to improving engagement with the Trust and stakeholders during and after the period of transition and mobilisation.

4.7 As the outgoing provider, we have confirmed that we will no longer be providing the service as of 1 October and that we are working with CLCH to ensure the best possible transition for both our patients and staff.

5. ALL STAFF BRIEFINGS AND TEAM TALK

5.1 In early August I ran three staff briefings attended by 300 staff. The briefings were a follow up from similar sessions I held when I joined the Trust as Chief Executive in May.

5.2 At the previous sessions, I asked staff to write down their thoughts about the Trust on post-it notes. The notes showed some clear themes about working life at the Trust.

These included:

Positives

- Team-working
- Staff commitment to the Trust
- High quality patient care
- 'Family feel'
- Professional and dedicated staff

Challenges

- Leadership
- Broken systems and processes
- Behaviours and cultures at the Trust
- Finance and resources

5.3 I'm very pleased to see that our staff retain a strong commitment to the Trust and state that providing high quality patient care is a positive part of working at St George's. I'm also confident that we are addressing the challenges raised by staff though either our Recovery Plan, Quality Improvement Plan, Elective Care Recovery Plan or new Staff Engagement Group.

5.4 We also launched Team Talk in August which is an opportunity for staff to meet with Gillian and I. The monthly round table event is open to any member of staff who would like to meet with us to discuss any issues, ideas or observations they might have about working at the Trust.

5.5 Ten members of staff attended the event and were very open and honest about their issues, which ranged from staff and patients smoking onsite to the relationship with their line managers. Both Gillian and I were pleased to have had the chance to talk to staff and hear their thoughts about working at St George's.

6. RISK

6.1 As part of the Board's external review of governance, Deloitte has been reviewing the Trust's risk handling arrangements and supporting the Board identifies its strategic risks and develops a Board Assurance Framework. This will be presented to the Board for review at its October meeting alongside an updated Corporate Risk register.

7. RECOMMENDATION

7.1 To receive the report for information.

Meeting Title:	Trust Board		
Date:	8 September 2017	**Agenda No**	2.1
Report Title:	South West London STP and Acute Provider Collaborative		
Lead Director/ Manager:	Jacqueline Totterdell, CEO		
Report Author:	Professor Andrew Rhodes, Chief Medical Officer		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	Transformation of both planned care and emergency care pathways is developing through the work of the SW London STP and the SW London providers Acute Provider Collaborative. The Trust Board needs to be appraised of these developments and to support the active participation of SGUH in leading on these pathway changes.		
Recommendation:	This paper invites the Trust Board to consider the strategic approach of SGUH to be active and to lead on developments within the STP and APC and to support this stance and direction of travel.		
Supports			
Trust Strategic Objective:	1. Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. 2. Refresh the Trust's strategy, to develop a sustainable service model with a clear and consistent message. 3. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safety, Effectiveness, Responsive, Caring and Well Lead		
Single Oversight	All		

Framework Theme:			
Implications			
Risk:			
Legal/Regulatory:	Five Year Forward View		
Resources:	N/A		
Previously Considered by:	N/A	**Date**	

1.0 PURPOSE

1.1 This paper updates the Trust Board on how the SW London's Sustainability and Transformation Plan (STP) has developed and also how the local providers are working together within a SW London Acute Provider Collaborative (APC).

1.2 St George's University Hospitals NHS Foundation Trust (SGUH) is currently in an economically challenged position and considers transformation of many of its key services to be vital in order to become clinically and financially sustainable.

1.3 SGUH is embracing the opportunities that the collaborative sector-wide working offers and is positioning itself to be leading on future developments of these plans.

1.4 This paper invites the Trust Board to consider this strategic approach to be active and to lead on developments within the STP and APC and to support this stance and direction of travel.

2.0 BACKGROUND

2.1 The Five Year Forward View (5YFV) from NHS England set out an ambitious vision for how NHS services should be delivered. A number of health economies ("footprints") were established across England and challenged to produce a Sustainability and Transformation Plan (STP) to deliver the 5YFV.

2.2 Sustainability and Transformation Plans (STPs) are a relatively new requirement and development for the NHS. The purpose of the STP is for *"every health and social care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View"*. The emphasis is on developing a plan that meets the needs of local populations and is not focused on individual organisations.

2.3 St. George's is in the South West London STP, whose constituent organisations are:

1. The four acute trusts (St. George's, Croydon, Kingston and Epsom & St. Helier)
2. The six CCGs (Wandsworth, Merton, Sutton, Croydon, Richmond and Kingston)
3. The six Local Authorities (as per CCGs above)
4. Six GP Federations (again, mirroring CCGs above)

5. Two mental health trusts (SWL & St. George's and South London & Maudsley NHS Foundation Trust)
6. Four community providers (Central London Community Healthcare, Hounslow & Richmond Community Healthcare Trust, Royal Marsden NHS Foundation Trust, Your Healthcare)

2.4 In South West London, a draft STP was approved by Boards and Governing Bodies of NHS organisations in June 2016 though further changes were made following feedback from NHS England and NHS Improvement in August 2016. The SGUH Trust Board endorsed the submission of the SWL STP subject to several qualifications on 20th October 2016

2.5 In addition to participating in the local STP, St. George's also participates in a provider collaborative with the three other local trusts- Croydon, Kingston and Epsom & St. Helier.

3.0 AIM OF THE STP

3.1 The STPs are expected to address 'national challenges', but the emphasis is on creating a clear vision and plan for the area and answering the following:

1. How will you close the health and well-being gap?
2. How will you drive transformation to close the care and quality gap?
3. How will you close the finance and efficiency gap?

3.2 Local health systems are required to *"develop their own system wide local financial sustainability plan as part of their STP".*

3.3 STPs will be assessed on their quality (particularly the scale of their ambition and track record of progress already made), the quality of local process and stakeholder engagement, the strength and unity of local leadership and partnerships, and the confidence in the plausibility of delivery.

4.0 DEVELOPING A STRATEGY

6.1 Since the publication of the SW London STP document in November 2016, a series of public engagement events have been held as well as more in-depth conversations with key stakeholders. As a result, the STP programme Board is now updating its approach and primary focus.

6.2 Key findings included that there is a need to strengthen the focus on keeping people healthy and getting involved earlier, as soon as vulnerable people start

to become ill at home so that they don't need to be admitted to hospital. If people do go to hospital, there is a need to get them home, so they can recover more quickly in their own bed, with the right care and support.

6.3 To achieve this focus on keeping people well, the SW London STP has recognised that a local approach works best. The NHS working jointly with Local Authorities and local people within boroughs will plan care based on people's health and care needs from local-communities upwards.

6.4 The STP will be working with its partners in Surrey, and London borders. By the end of November these health and care systems will have reviewed the feedback from local people over the last 6 months, analysed their local data and identified their challenges. They will then set out how they plan to work together to improve services for local people, and be clinically and financially sustainable into the future. The STP will need to take advice from the local stakeholders and build on engagement to date to involve local people in planning services going forward. If any proposals would mean significant change, the statutory organisations would consult local people, with advice from Overview and Scrutiny groups in each area, and our Health Watch partners.

6.5 NHS England has recently outlined ambitions for STPs to evolve into 'accountable care systems' (ACSs), and proposed that these ACSs might become ACOs but only after 'several years'. Eight areas of England have now been identified to lead their development. The language of accountable care comes from the United States, where ACOs have taken shape in the wake of Obamacare as an attempt to improve care and reduce growing health care costs. While the term ACOs is relatively new, they represent the most recent manifestation of well-known integrated systems, such as Kaiser Permanente, which have a much longer pedigree. They come in a variety of forms ranging from closely integrated systems to looser alliances and networks.

In the case of the NHS, ACOs and ACSs (terms often used interchangeably to describe very similar set ups) can be thought of as comprising three core elements.

1. They involve a provider or, more usually, an alliance of providers that collaborate to meet the needs of a defined population.
2. These providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population.
3. ACOs work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years.

The most ambitious plans for ACOs in England extend well beyond health and social care services to encompass public health and other services. In Greater Manchester, for example, the aim is to use all public resources to improve health care while also tackling the wider determinants of health. This work, and that of other STPs, points to the emergence of population health systems, which seek to integrate care and to improve the broader health and wellbeing of the local population.

5.0 LOCAL TRANSFORMATION BOARDS

4.1 A key task to support the delivery of the SW London's STP is to develop, bottom up, the health and care model for each sub-region of SWL's STP that reflects the shift of care to community settings. The key objective of this work is to understand whether organisations within the local delivery units are sustainable following the transformation, and inform what services need to be delivered on each of hospital site going forward.

4.2 Local Transformation Boards (LTB) are responsible for delivering this sub-regional health and care model.

4.3 This work needs to align with the wider SW London model, and build on the change plans that are being developed locally to drive forward the implementation of an out of hospital model

4.4 The delivery of the STP is at borough level, however, to maximise opportunities of scale, design and coordination, local delivery will be undertaken on a sub-regional basis, led by CCGs.

4.5 Each sub-region will have a Local Transformation Board and local PMO across commissioners and providers holding the local system to account for delivery of transformation initiatives.

4.6 The initial aim of the Wandsworth and Merton (W&M) LTB is to deliver the ask of the STP in the form of the seven questions set out below:

1. What are the local needs for health and care services, including underlying rates of growth in that need?
2. What are the core elements of the local health and care model that will deliver the change set out in the STP?
3. What is the bottom-up quantification of key elements of the health and care model, including quantification of activity, capacity, workforce and finance?

4. What is the impact of the out of hospital proposals on acute activity, capacity and income?
5. What are the estates requirements for the future health and care model?
6. What are the detailed delivery plans and implementation timeline for each element of the health and care model?
7. What are the implications for contracts, system incentives, organisational forms and IT developments to enable implementation and sustainable operation of the health and care model?

6.0 Governance structure

Figure 1 SW London STP Governance Arrangements

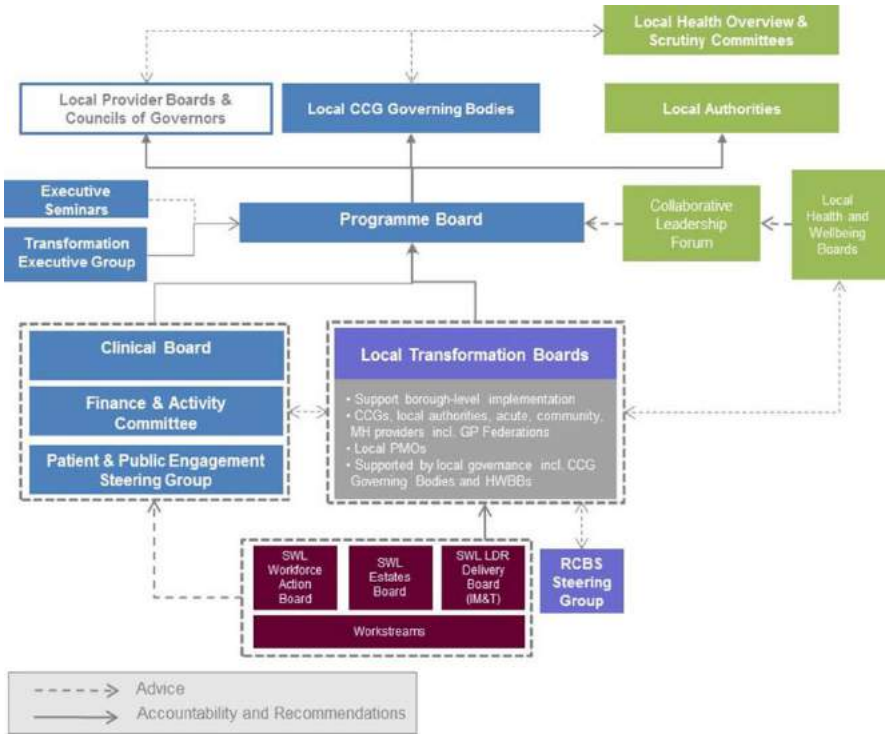
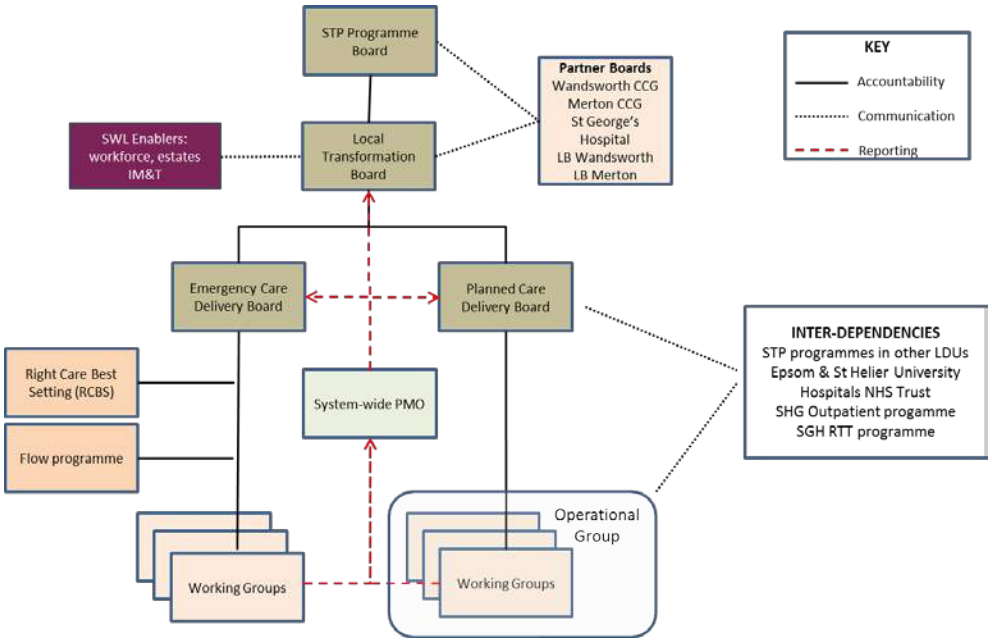


Figure 2 Merton and Wandsworth Governance



7.0 DELIVERING THE STRATEGY

7.1 Each LTB has set up a Planned Care Delivery Board and an Emergency Care Delivery Board. These boards are tasked with developing the transformation required to achieve clinical and financial sustainability across the sector.

7.2 SGUH is represented in each of these boards and their working groups.

7.3 Planned Care Delivery Board.

The LTB has been tackling the planned care transformation through a Planned Care Delivery Board that is chaired by Dr. Andrew Murray, chair of Merton CCG.

Over the last nine months work has commenced on the Local STP plans for Merton & Wandsworth for delivery of the planned care agenda. A large amount of the preparatory work was initially led by the CCG however SGUH now has full sight of the plans and has agreed the pathways and is requesting inclusion of Gastroenterology as a further pathway.

Work has been undertaken in each of the following schemes to agree the baseline data and estimate the number of referrals that will be directed away from the Hospital.

1. Older Peoples
2. Neurology
3. ENT
4. Dermatology
5. MSK
6. Diabetes
7. Diagnostics Cardiology
8. Diagnostics Gynaecology
9. Respiratory
10. Gastroenterology

7.4 Emergency Care Delivery Board

The LTB has been tackling the emergency care transformation through an Emergency Care Delivery Board that is chaired by Dr. Nicola Jones, chair of Wandsworth CCG.

As part of an NHSI requirement, local urgent and emergency care systems are required to implement a number of actions, to enable sustainable change and performance, these include:

1. A comprehensive front-door streaming model by October 2017
2. Support to Care Homes to ensure that they have direct access to clinical advice, including on-site assessment.
3. Implement the recommendations of the Ambulance Response Programme by October 2017
4. Standardisation of WIC, MIU and UCC to a single type of centre which offers high quality service
5. Roll out evening and weekend GP appointments, to 50% of the public by March 2018
6. Increase the number of 111 calls receiving clinical assessment by a third by March 2018

SGUH is actively supporting these processes wherever it can as improved delivery of emergency care pathways is clearly in both the Trusts and its patients better interests.

SGUH internal process are completely aligned to these schemes within the programme of work entitled ‘the unplanned and admitted patient care work stream.’

8.0 SOUTH WEST LONDON ACUTE PARTNERSHIP COLLABORATIVE (APC)

8.1 In autumn 2014, the Clinical Commissioning Groups in South West London (SWL) asked the four acute providers for their views on how the acute providers might work together to improve the clinical and financial position of the acute sector. Following discussion, the four acute providers agreed to collaborate to look at this.

8.2 The SWL Acute Provider Collaborative was set up at the end of 2014, following the ending of the Better Services Better Value programme which had not managed to agree a way forward on reconfiguration of the acute sector in SWL. The commissioners then invited the four acute trusts to work together to identify a way forward on reconfiguration.

8.3 In 2015 the four acute trusts drafted a report entitled' *Report to Commissioners: Delivering Clinical and Financial Sustainability in the Acute Sector in South West London'*. The report was endorsed by the Boards of all four trusts, and was submitted to the SWL commissioners on 31st July 2015. The commissioners responded to the APC report on 22nd October inviting the acute providers to continue developing and implementing shared working on productivity and on clinical networking across the four sites. Commissioners also laid out a number of areas for further work, including development of the clinical model for the acute sector, and intermediate care.

8.4 In this report the four trusts agreed to work together on
- Shared productivity projects
- Moving from 5 to 4 A&Es in SWL (with services continuing on all sites)
- Clinical networking.

8.5 The APC has evolved over the last three years from being the only forum that brought the providers together to think about systemic issues, to sitting alongside the STP. The STP itself has changed significantly and over the summer of 2017 has expanded massively, gaining what is now a large and very senior programme office with supporting governance structures in all the sub-regions.

8.6 The APC remains the main way to drive the collaborations between the providers on the productivity side. It also has an important role as a way to bring together the CEOs to discuss wider system issues.

8.7 In April 2017 the St George's Trust board approved a paper that had been provisionally agreed by all CEOs and trust Chairs via the APC Board that suggested the development of a single governance structure for all collaborative projects:

1. All projects to have a Programme Board, including relevant executive representatives from all trusts, and chaired by a CEO-level SRO
2. All projects to be hosted within a trust, with the Trust's own board taking responsibility for day to day oversight
3. Above this, a Collaborative Board consisting of all Chief Executives, and chaired in rotation by the CEOs, to meet bimonthly and have oversight of all the collaborative projects
4. Across all strategic and collaborative issues, a Strategic Oversight Group including all trust Chairs and CEOs, to meet quarterly and have oversight of all strategic issues, including reconfiguration and the STP

8.8 This paper also suggested that the expectations of partners in any collaboration should be formalised, to include a formal statement of:

1. The duties and expectations of a host organisation, including responsibilities and accountabilities
2. The implications of committing to join a collaborative project: the level of commitment at each stage of a project, and the financial implications if a trust chooses to leave after formally signing up to collaboration.

8.9 The acute providers currently collaborate on a number of major projects

SWL Elective Orthopaedic Centre (SWLEOC)	all acutes	Hosted by ESTH
SWL Pathology (SWLP)	all acutes except ESTH	Hosted by SGUH
Procurement	all acutes	Hosted by Croydon
Staff banks	all acutes plus South West London and St George's Mental Health trust (SWLSTG)	Hosted by ESTH

- **Productivity**. The acute trusts are working together on establishing a shared procurement service, and a shared approach to staff banks. The APC also led a review by PWC into whether there was any mileage into sharing other back-office functions; the conclusion was that savings would be very small and the amount of effort disproportionate.

- **Procurement**. Work has commenced with the other trusts in SW London on collaborative procurement. This is initially focusing on the review of pricing between organisations and opportunities to standardise and consolidate consumables and equipment. These activities will look to exploit opportunities from other procurement initiatives, such as the London Procurement Programme as well as lessons from the work of Lord Carter and the Model Hospital. Resources within the Trust's Procurement Department have been strengthened to support this work. PWC have been engaged by the four trusts in trusts in SW London to support this work.

- **Staff Banks**. The staff banks project started in 2015. The aim was to reduce the very heavy reliance on agency staff within SWL, particularly given that many agency nurses are actually substantively employed staff at other SW London trusts. The aim of the project was to make it more attractive for substantive (and other) staff to work on bank, and less attractive to work for agency.

  St George's, in collaboration with Kingston, Epsom and St Helier and SW London Mental Health Trust have agreed to launch the new SW London Collaborative Staff Bank with effect from 9th October 2017. We will then have a single set of harmonised Band 2 and band 5 pay rates across the patch that reflect market rates. Further work is being undertaken to look at harmonising the specialist rates. The new bank arrangements will make it much easier for staff to see and book shifts through the use of Smartphone technology.

- **Number of A&Es**. In January 2016, when the Sustainability and Transformation Plan was announced, the APC report formed the basis of the 'hypothesis' for the STP. The STP undertook a number of pieces of work to test whether the trusts would be able to deliver sufficient workforce to support four A&Es and their associated clinical interdependencies.

- **Emergency care.** A piece of work is being started about how the sector can work differently with its workforce for Emergency Care and is being led by SGUH.

- **Pathology.** The changes to management arrangements in point 8.7 will be subject to legal advice so the Board can ensure the Trusts responsibilities are clear and its risks minimised

9.0 CONCLUSIONS

9.1 In January 2017, a new SRO was appointed for the SW London STP (Sarah Blow). Since then a number of significant changes to the direction of the STP and the work that the trusts were doing collaboratively have been made. In particular, work has stopped on the work-strands that had been focused around reconfiguration at a SWL level and shifted the emphasis to creating a sustainable system in each of the sub-regions in SWL. The focus has since been on developing the clinical model for the acute providers: which services need to be provided on each site, and what workforce standards need to be met to deliver these.

9.2 SGUH recognizes the importance of the work that the STP is doing and understands that this transformative approach is vital in order to achieve a clinically and financially sustainable position for many of its services.

9.3 SGUH is thus positioning itself to actively participate in these processes and to drive the agenda by getting its employees to be in key positions within all the work streams.

9.4 The Trust Board is asked to consider these issues and support this strategic direction that the SGUH is taking.

REPORT TO THE BOARD FROM: Quality Committee

COMMITTEE CHAIR: Sir Norman Williams

DATE OF COMMITTEE MEETING: 26.07.17

1.0 MATTERS FOR THE BOARD'S ATTENTION

1.1 The Committee received a briefing on the work being done to prepare the Trust for a full-scale inspection by the Care Quality Commission (CQC). In addition to making improvements to the areas already highlighted by the CQC as needing attention, performance on each ward was being monitored through a new "dashboard" of measures. There had also been a serious drive to improve the use of ward "information boards" to raise awareness of the ward's performance against key metrics eg complaints, serious incidents and pressure ulcers.

1.2 Measures had been put in place to reduce Never events in the operating theatre environment by introducing multidisciplinary training of teams which involved the understanding of human factor science.

1.3 A comprehensive review into the nursing establishment had been conducted by the Chief Nurse. This process involved the engagement of the Ward Sister/Charge Nurses in reviewing the acuity and dependency data for their areas to agree staffing levels, matched against national and speciality guidance. This process identified the equivalent of 54wte that could safely be removed from ward budgets. This resulted in the saving of £3.9m to close the budget gap and a further £1.5m of savings to contribute to the Trust cost improvement plan. The wards and departments reviewed had had safe staffing levels when compared to national or speciality specific guidelines, and the process was supported by colleagues from NHSI.

1.4 The Committee was joined by Dr Maurizio Cecconi who gave a presentation on the improvements being made to identify deteriorating patients and escalate their care. The presentation set out improved learning from adverse events and decisions about end of life care as well as the work that had been done to raise training and awareness on Early Warning Scores and indications that a patient was deteriorating.

1.5 The Committee was informed that the Trust had received an alert from NICOR (National Institute for Cardiovascular Outcomes Research) concerning performance. An external independent review is being commissioned to investigate if there was a problem and if so recommend measures of redress.

1.6 An update on Learning from Patient Deaths was presented by Dr Nigel Kennea. Excellent progress was noted, St George's being one of the leading trusts in this national initiative.

1.7 The Committee was also joined by Dr Peter Riley, Consultant Microbiologist and Lead Consultant for Infection Prevention & Control who presented the results of a root cause analysis investigation into the four recent cases of MRSA bacteraemia. The investigations concluded that lapses in care were not responsible for the MRSA cases though there was good evidence that the MRSA colonisation and subsequent development had taken place whilst the patients were receiving care at the Trust. Audit data on infection control had demonstrated deficiencies in the practice of basic infection prevention and control actions. Hand hygiene training and audits had been put in place as well as a PISA (period of increased surveillance) process. Measures had also been taken around screening of high risk patients and the insertion of central lines particularly in theatre.

1.8 The Committee received and discussed the Annual Report on Adult Safeguarding. There was a need to ensure that safeguarding was integrated between community and secondary care and that medical staff training needed to be improved. Members were informed that in order to

improve performance it had been necessary to create additional posts.

1.9 A briefing on the planned improvements to the Trust's complaints handling arrangements was also considered though a fuller discussion was planned for the meeting in September.

2.0 RECOMMENDATION

2.1 To receive the update from the QC.26.07.17 for information and assurance.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 September 2017	**Agenda No**	3.2
Report Title:	CQC unannounced section 29a focussed inspection report (May 2017) and response		
Lead Director/ Manager:	Chief Nurse & Director of Infection Prevention and Control		
Report Author:	Paul Linehan – Head of Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The CQC full report has been received by the Trust and is attached in appendix A. The CQC found that significant progress has been made against the section 29a warming notice but also identified areas that required continued focus and improvement. The CQC have lifted the warning notice but improvement notices remain for regulations 5, 12, 15 and 17. The specific areas of concern for which the Trust was required to submit an action plan and response by 29 August are: 1. Regulation 5 Fit and Proper Person Requirement Regulation • Not all directors had all the required FPPR checks carried in accordance with this regulation. 2. Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • RTT data remained inaccurate and two patients had been seriously harmed as a result of delays to their follow up appointments. 3. Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • Replacement box filters were stacked in the plant room by the side of theatres 5 and 6 vent plant, allowing for possible contamination of the “new filters”. • New transformer units were needed to meet power demands. 4. Regulation 17 HSCA (RA) Regulations 2014 Good governance • There were gaps in assurance with regards to estates maintenance. • The provider had to be prompted to ensure that individual PGDs had been signed by each health professional working under the direction in accordance with the Human Medicines Regulations 2012. • The governance and reporting arrangements needed to be strengthened to provide the board with increased oversight of ECRP delivery. • The head of internal audit had only limited assurance on the Trust’s annual report. • Priority 1 [internal audit] recommendations remained outstanding beyond the agreed deadlines, and several deadlines had been put back.		

Recommendation:	The Board is asked to consider the Trust's response to the CQC setting out the action taken, and planned, to address these concerns.		
Supports			
Trust Strategic Objective:	ALL		
CQC Theme:	Well led, Safe, Caring, Effective and Effective		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	CQC Regulatory Framework - (Health & Social Care Act 2015) Further enforcement action may be applied against the Trust by the CQC if substantial assurance is not provided regarding matters of concern raised by the CQC in their formal Section 29a focused inspection feedback report to the Trust. The following paper describes the actions the Trust has already taken or is undertaking to address the matters of concern raised by the CQC. Appendix B provides a high-level action plan which will be monitored through the Quality Delivery Board meeting.		
Resources:	Some additional resources are required and these are summarised in this paper.		
Previously Considered by:	EMT	**Date**	21/08/17
Equality Impact Assessment:	N/A		
Appendices:	Appendix A – CQC report Appendix B – Action plan and progress (sent to the CQC 29 August) Appendix C – Tabulated action plan		

St George's University Hospitals NHS Foundation Trust

Quality Report

Blackshaw Road
Tooting
London
SW17 0QT
Tel: 020 8672 1255
Website: www.stgeorges.nhs.uk

Date of inspection visit: Unannounced visits on 10, 11 and 22 May 2017.
Date of publication: This is auto-populated when the report is published

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

St George's University Hospitals NHS Foundation Trust is a combined health care service. The trust provides secondary and tertiary acute hospital services and community services to the local population. The trust employs around 8,500 WTE staff and serves a population of 1.3 million across Southwest London.

This is a report on the focused inspection we undertook on 10, 11 and 22 May 2017. The purpose of this inspection was to follow up on a Section 29A Warning Notice, which we issued in August 2016, following a comprehensive inspection of the trust in June 2016.

We checked whether the trust was meeting the requirements of the Warning Notice. As a result, there is no rating of this inspection. The Warning Notice required the trust to make significant improvements in certain areas because:

- There were unsafe and unfit premises where healthcare was provided and accommodated staff.
- There was a lack of formal mental capacity assessments and best interest decision-making and some patients had decisions made for them that they were capable making themselves.
- The design and operation of the governance arrangements were not effective in identifying and mitigating significant risks to patients.
- Risks to the delivery of high quality care were not being systematically identified, analysed and mitigated.
- Staff were not being held to account for the management of specific risks.
- There was a lack of processes in place to provide systematic assurance that high quality care was being delivered; priorities for assurance had not been agreed and were not kept under review. Effective action had not been taken when risks were not mitigated.
- The data used in reporting, performance management and delivering high quality care was not robust and valid.
- There were not suitable arrangements in place for ensuring directors were fit and proper.

We found that the trust had partially met the requirements of the Section 29A Warning Notice. The trust had made significant improvements regarding; mental capacity act assessments/best interest decisions /deprivation of liberty safeguards, some elements of premises and equipment, medicines management and managing incidents. However, the trust is still required to make further improvements with regards to the fit and proper persons' requirement, estates maintenance, accuracy of the referral to treatment data and governance.

Over key findings were as follows:

- Systems and processes that operate effectively in accordance with good governance remain weak.
- The head of internal audit only had limited assurance on the trust's annual report.
- Eleven Priority 1 recommendations remained outstanding beyond the agreed deadlines, and several deadlines had been put back.
- The trust had made significant progress with regards to addressing legionella/pseudomonas risks in the water system.
- There had been improvements in monitoring FP10 prescriptions and the risk of these going missing had been reduced.
- Authorised Patient Group Directions were in place in the radiography department and most radiographers had appropriately signed them, following our prompting during the visit.
- 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.
- The Wandle Unit had been demolished and building work had commenced on the construction of a new building.
- Fixed wire testing had been carried out by the trust in accordance with BS7671.
- Planned preventative maintenance and work programs had been developed and introduced to help reduce the thermo-regulation problems of Lanesborough theatre 1 occurring in the future.
- Governance around estates management had improved and there were annual reports for all services.

Summary of findings

- Replacement box filters that prevent contamination of the theatre air handling units, were stacked in the plant room by the side of theatres 5 and 6 vent plant, allowing for possible contamination of the “new filters” Theatre plant rooms we visited were untidy and cluttered with numerous water leaks.
- There were still gaps in assurance with regards to estates maintenance, but the trust had plans within a reasonable timetable to mitigate these.
- New transformer units, which are used to increase or decrease the alternating voltages in electric power applications, were needed to meet power demands. This was because there was a risk of power failure at St George's Hospital.
- Serious incidents were now being reported within internal and external KPI deadlines.
- Mental Capacity Act and Deprivation of Liberty Safeguards training, understanding and application had improved on the areas where we had concerns.
- Referral to treatment data was still inaccurate and still not being reported to NHS England. A recovery programme and Clinical Harm Review Group was making progress, but it could take up to two years to be fixed. So far, two cases of serious harm to patients had been identified, as a result of delays in making their follow up appointments.
- On some risk registers, there were no ‘action due date’ and there should be. Also, the concerns identified as part of the Workforce Race Equality Standard (WRES) was not on the Human Resources corporate risk register.
- There was a WRES reporting template and action plan on the trust’s website dated July 2016, which was in the process of being updated. We saw the new action plan, but this was a work in progress and still had to go through a number of checks before it could be uploaded on the website.
- 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 meet the Fit and Proper Person Requirement Regulation (Regulation 5, HSCA, 2014).

Importantly, the trust must:

- Ensure that it has systems and processes that operate effectively in accordance with good governance.
- Strengthen governance and reporting arrangements, so as to provide the board with increased oversight of Elective Care Recovery Programme delivery.
- Continue to address the gaps in assurance with regards to estates maintenance.
- Continue with the recovery programme and Clinical Harm Review Group with regards to RTT data.
- Ensure it meets the Fit and Proper Person Requirement Regulation.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to St George's University Hospitals NHS Foundation Trust

St George's University Hospitals NHS Foundation Trust, is a teaching trust with two hospital locations; St George's Hospital, Tooting, and Queen Mary's Hospital, Roehampton. The main acute site is St George's Hospital, which provides general and specialist services and has an emergency department. Queen Mary's Hospital does not have an emergency department. We visited both locations during this inspection.

St George's University Hospitals NHS Foundation Trust has 1,083 beds; 995 at St George's and 88 at Queen Mary's. The beds at St George's Hospital comprise of 871 general and acute, 67 maternity, 57 critical care. The beds at Queen Mary's Hospital comprise of 46 for people with limb amputations who require neurorehabilitation and 42 for sub-acute care, treatment and rehabilitation of older people.

The hospitals are both in the London Borough of Wandsworth. The lead clinical commissioning group is Wandsworth, who co-ordinates the commissioning activities on behalf of the other local clinical commissioning groups such as Merton and Lambeth.

Our inspection team

Our inspection team was led by:

Inspection Manager: Roger James, Care Quality Commission

The team included four CQC inspectors, an assistant inspector and two specialist advisors with backgrounds in governance and estates.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held including the trust's action plan, its written confirmation to us about meeting the requirements of the Warning Notice, performance data, board minutes and minutes from a variety of governance meetings.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We spoke with a range of staff in the trust including nurses, allied health professionals, administration and other staff. We observed the environment in which care was being delivered, reviewed policies and other documents and also interviewed senior members of staff at the trust.

Facts and data about this trust

Both St George's and Queen Mary's Hospitals are based in the London Borough of Wandsworth and serve a population of 1.3 million people.

St George's offers a range of local services, including: an emergency department, medicine, surgery, critical care, maternity, paediatric services and outpatient clinics. The hospital is also a major trauma centre and provides specialist services in neurology, cardiac care, renal transplantation, cancer care and stroke.

Queen Mary's Hospital has two adult community rehabilitation wards, one for people with limb amputations and the other for older people.

The trust also provides community health services for the people Wandsworth.

In the 2011 census, the proportion of residents in Wandsworth who classed themselves as white was 71.4 %.

Summary of findings

Our judgements about each of our five key questions

	Rating

Are services at this trust safe?

Cleanliness and Infection Control

- During the inspection in June 2016, we found that legionella and pseudomonas aeruginosa had been detected within the water supply system. There was poor control of water temperature, exposure of patients to low usage water outlets and poor compliance by ward staff completing records to demonstrate water outlets were flushed.
- Significant steps had been taken by the trust to address legionella/pseudomonas control. An external review by an independent consultant in January/February 2017, found a considerable amount of work had been undertaken by the trust to put in place arrangements to help ensure the delivery of safe water for the trust's patients, visitors and staff. The report published in April 2017, stated that water temperature monitoring arrangements represented good practice and exceeded standards witnessed at other trusts.
- However, it was noted that the estates department recognised the additional resourcing that ongoing effective water risk management was likely to require and as a result, a water safety manager, a team of engineers and plumbers, were to be appointed to assist.
- We saw minutes of the monthly operational water meeting and water safety committee. These showed good oversight of water safety and completion of the actions log as required.
- Despite the improvements being relatively recent, the trust stated that they were now fully compliant. Samples of water temperature/flushing documentation were presented. We noted that regular flushing of low usage water systems by staff was now happening and there was chlorination of water, where problems had been found through water testing.

Medicines management

- At the last inspection, we found that the serial numbers of prescriptions (FP10s) for prescribers were not always monitored. This meant that there was a risk of controlled stationery going missing and liable for abuse by staff obtaining medicines illegally.
- A new system had been in place since July 2016, where specialty outpatient clinic staff collected the FP10s from the pharmacy, with a form that listed all of the serial numbers. This

form was then completed by the clinic staff with the name of the doctor using the prescription and the patient it was prescribed for. We visited the rheumatology clinic and saw the completed forms for the previous month. One prescription had been listed as missing on these forms, but there was evidence to show that this had been followed up with the doctor responsible.

- A monthly audit was carried out by the pharmacy team on the provision of FP10s and we saw these audits completed from November 2016 to April 2017. Where clinics had not been compliant with the policy requirements, there had been actions documented about how this was followed up. We were able to see from the audits, that there had been improvement in monitoring prescriptions since our last inspection and that the risk of these going missing had been reduced.
- At the last inspection we found that radiographers were administering medicines without appropriately authorised Patient Group Directions (PGDs) in place. PGDs are documents permitting the supply of prescription-only medicines to groups of patients, without individual prescriptions.
- We visited both the scanning departments and found that there was now a folder located in each department containing ten PGDs for the medicines that radiographers could administer. However, the individual PGDs had not been signed by each health professional working under the direction. Instead, a cover sheet with all signatures for all ten PGDs had been used. This was not in accordance with the Human Medicines Regulations 2012. We raised this with the provider and when we returned on a visit ten days later, found that eight radiographers had signed the individual PGDs appropriately.
- A 'back to floor' audit had been started at the beginning of May 2017 by the pharmacist team that audited PGDs throughout the hospital. We saw a record of one audit undertaken for the vascular team that demonstrated that their PGDs had been checked and were compliant with the regulations.

Environment and equipment

- At the previous inspection, during heavy rainfall, we noted rain water running down walls and over electrical sockets on the renal unit in Buckland Ward. Action was taken to close the area off when this was highlighted to the trust and some remedial work to the roof had been made. The trust had relocated the whole ward in December 2016. Twenty three in-patient beds were now being provided in Champneys Ward and outpatients were receiving dialysis at two mobile units located within the hospital grounds.

Summary of findings

- Staff we spoke with explained that the relocation had been challenging. There had been a reduction in bed numbers. Some staff had been required to be flexible and some moved to other locations to work. There were challenges finding sufficient storage space on the ward and in the mobile units; and renal services were no longer located together. However, senior nurses spoke highly of their staff's professionalism during the period of change and stated that they were proud of the way that they had coped with the challenges.
- Safety of patients had been considered as part of the re-location and this was demonstrated by a specific protocol that was followed in the event of a patient deteriorating in the mobile unit. The protocol took into account the unusual environment of the unit and had been adjusted following rehearsals to make it work better.
- Staff recognised that patients using renal services had a great deal of disruption over the period of change. They engaged with patients through a variety of sources, such as meeting with the renal patients association and pro-actively providing information about the forthcoming annual general meeting. Staff also heard patients' views through consulting with the local Healthwatch, an organisation that gathers and represents the views of the public on matters of health and social care.
- During our visit in June 2016, we found 18 out of 31 theatres were not being properly maintained and needed rebuilding or extensive refurbishment. There had been a lack of capital investment in theatre complexes in Lanesborough Wing, St James' Wing and Paul Calvert. This caused many disruptions to the theatre schedule. We also found that the theatre air handling units in St James' Wing were failing intraoperatively.
- During this inspection, the trust's engineer told us and we saw that two new theatre vent plants had been installed for theatres 5 and 6 in October / November 2016.
- The vent plants were connected to a laminar flow ventilation system giving flexibility of use for the theatres. We noted that the vent plants were due for box filter replacements with the filters being a little "dirty" but still within their operating parameters (replacement filters were available). Replacement box filters prevent contamination of the theatre air handling units. The vent plant appeared to be in good order and HTM 04:01 compliant.
- The replacement box filters were stacked in the plant room by the side of theatres 5 and 6 vent plant, allowing for possible

contamination of the “new filters”. These filters should be stored in a clean, dry environment, away from the plant room to prevent contamination and damage, according to the manufacturer’s instructions.

- Theatres 5 and 6 had been refurbished since the previous inspection and formed part of a multi-million pound capital program to refurbish all the trusts operating theatres. The capital program was scheduled to last 3.5 years and was currently in progress.
- During the inspection in June 2016, we found that the maternity staff room was unfit for purpose. There was water ingress caused by condensation leaks. Half of the room was cordoned off as dangerous, because ceiling tiles had fallen as a result of the water ingress.
- During this inspection, we found that issues with the maternity staff room had been resolved. Midwives reported this was done quickly after the last inspection and there were no further water leaks. Staff told us that the estates department were responsive to addressing the matter.
- We visited the maternity staff room and new replacement tiles had been installed and were satisfactory. The damage to the ceiling tiles was caused by water leakage from the plantroom above. We observed that the plantroom floor had been re-sealed to prevent any future leak penetration of the concrete slab to the floor below, and that previously leaking water pumps had been replaced. There was however, evidence of new leaks on various steam valves, giving the potential for future leak penetration. This did appear to be in the process of being repaired and was confirmed by the trust’s engineer.
- In the previous inspection, two-thirds of the Wandle Unit was condemned by the Trust Fire Safety Advisor/Officer as a serious fire hazard, but one-third of the building was being occupied by 20 to 25 staff at any one time.
- During this inspection, we found that the Wandle Unit had been demolished and building work had commenced on the construction of a new building.
- In the previous inspection, St George’s Hospital fixed wire testing was non-compliant in 131 of the 169 areas monitored by the trust.
- We found on this inspection, that fixed wire testing had been carried out by the trust in accordance with BS7671 (a small sample was seen). This identified the areas of concern and there was now a five year rolling programme of fixed wire installation compliance by an external contractor. The first year was scheduled to be completed by the end of 2017, and then move onto a 20% cycle of testing to ensure continuous testing.

Summary of findings

- All back-up generators were life expired and there were two rental generators in the garden to support Lanesborough Wing.
- The thermo-regulation of Lanesborough theatre 1 was a day to day operational problem which was dealt with shortly after it was identified to the trust's estates department. Planned preventative maintenance and work programs had been developed and introduced to help reduce this type of problem occurring in the future.
- The trust now had an Estates Strategy to 2021. This included: demolition programme for worst buildings; stabilise the urgent safety infrastructure; move higher acuity activity to new accommodation where buildings were demolished; migrate lower acuity off site or towards Lanesborough Wing.
- At the previous inspection, there were no annual reports on some safety areas such as electrical wiring since 2010. During this inspection, governance around estates management had improved. There were now annual reports for all services : heating, water, ventilation, electrics, water and power supply. The local CCGs and chief executive were aware of the issues and their severity.
- Authorising engineers were now in post. These appointed authorised persons and competent persons were in line with good practice. All statutory duties were assigned to a Responsible Person.
- There was an appointed compliance person in the estates department, in order to provide internal assurance.
- There were continuing extreme risks on the corporate risk register. These included: theatre ventilation breakdowns/ failures; poor performance of mechanical and electrical services to theatres; potential interruption to electrical supply; minimal five yearly electrical testing not done.
- The air circuit breakers which were being used were no longer supported by manufacturers and meant there was a risk of power failure. The trust was aware of this and knew that new transformer units were needed to meet power demands.
- We found at St George's Hospital, that there was a battery power contingency for dips in power (which occurred every time the local train operator turned off the power as a result of a rail incident at Clapham Junction).
- During this inspection, only one fixed boiler of five at St George's Hospital was working, so there were two truck-based boilers onsite, until the fixed boilers can be repaired.
- The lifts in Lanesborough Wing had been fixed and there was a new maintenance contract. There were no longer daily failures of the lifts.

- There was a trained fire marshal on each roster (senior nurse) and there were plans to audit and replace fire doors where necessary.
- There were still gaps in assurance with regards to estates maintenance, but the trust had plans within a reasonable timetable to mitigate these.

Incidents

- During our visit in June 2016, we found there were delays in investigations into serious incidents (SIs). Staff did not always log SIs within 24 hours on Strategic Executive Information System (STEIS) and did always set up panels promptly and therefore exceeded the deadline for investigation reports to be sent to the commissioners within 60 days.
- During this inspection, we reviewed the Patient Safety Quality Board, notification of SI reports between August 2016 and February 2017. These reports listed the number of SIs by type and division. Since October 2016, all SIs were now being reported within internal and external KPI deadlines. The trust was required to notify the local CCG of all SIs within 48 hours and send investigation reports within 60 days.
- A senior nurse told us that staff reported incidents on datix immediately on the day that they occurred. This was in keeping with the trust's Serious Incident Policy (2017), which required staff to report all incidents that had the potential to be an SI, as soon as possible and ideally within 24 hours.
- A senior member of staff told us the trust met the 48 hour reporting standard to the CCG in most cases. They stated that if it was not clear that an incident was an SI, it would be taken to the Serious Incident Divisional Meeting, which took place on Mondays. In such circumstances, there could be a delay in notifying the CCG within 48 hours.
- A senior member of staff told us that every incident was quality assured by divisional governance teams. This was a new process, which was implemented following our previous inspection. This process had led to an improvement in the timeliness of staff reporting incidents.

Are services at this trust effective?

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- At the previous inspection we found that most nursing staff did not have a good understanding of the legal requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. On some wards, there had not been mental

capacity assessments and best interest decisions recorded for patients who may have lacked capacity to make specific decisions for themselves. This was not in accordance with the Mental Capacity Act 2005. There was also a lack of recognition that the use of bed rails to prevent patients' falling from bed and the use of mittens to prevent patients removing their nasogastric tubes, should have been done with patient's consent or an assessment of their capacity. These concerns related to Allingham, Dalby and Rodney Smith medical wards at St George's Hospital and Gwynne Holford Ward at Queen Mary's Hospital.

- Since the inspection, there had been a programme of work across the trust to train and educate staff on understanding of the MCA. This had included face to face training and 'e-learning'. Risk assessments had been introduced for bed rails and the use of mittens. Training had focussed on the four wards identified by the previous inspection and also other areas that were considered high risk. There had been eight drop-in 'face to face' sessions for staff and it was estimated that 100 staff had attended these. Bespoke training had also been provided for site managers and pharmacists. Staff on wards named in the CQC report confirmed that they had face to face training and completed e-learning. A new role of designated lead for mental capacity had been introduced in June 2016 and was being covered on a temporary basis.
- Most staff on wards we visited were able to discuss the MCA and show us where they could locate the policy and a flow chart for assessment if they needed to refer to it. One member of staff was unsure about the policy, but stated that they would request support from their manager.
- A database was kept of the number of referrals for support with safeguarding and mental capacity. This had been a combined data base, but was now split so it was clearer to monitor. The lead had noticed an increase in the amount of MCA referrals to around 30 a month. Referrals were followed up by a lead calling the ward to discuss the referral and support staff. If a Deprivation of Liberty application was required, this would be completed by the safeguarding and MCA leads, so that they had complete oversight of the numbers within the hospital and were able to monitor them.
- In October 2016, the trust carried out a baseline audit of compliance with MCA, Deprivation of Liberty Safeguards and recording of best interest decisions on Allingham, Dalby, Gwynne Holford and Rodney Smith Wards.

Summary of findings

- The results were consistent with our current findings and were informing the programme of training that was underway. An e-learning module for MCA and best interest decision-making had been developed and went live in November 2016. At the time of this report, there was:
  - 82% completion by staff on Allingham Ward
  - 90% completion by staff on Dalby Ward
  - 77% completion by staff on Rodney Smith Ward
  - 97% completion by staff on Gwynne Holford Ward
  - 100% completion by matrons and heads of nursing serving the wards above
  - 52% completion by medical staff serving the wards above
- An audit completed in January 2017, showed that MCA related practice across the wards remained variable, however it identified clear evidence of good practice on Gwynne Holford Ward. The recommendations from the audit included using best practice identified to drive improvement, regular training and an audit cycle.
- We visited Gwynne Holford Ward during the inspection and saw evidence of changes that had been made in the ward to increase awareness of the MCA. A large notice board was dedicated to MCA, for staff to refer to. This included an MCA flow chart, a display of the five principles of the MCA, and the Deprivation of Liberty Safeguards assessment guide. There was a statement which was as a reminder to staff in relation to the MCA, which was “No decision about me, without me”.
- Training provided to staff on Gwynne Holford Ward was led by a clinical psychologist and had included one day full day of initial training, including scenarios and role play. Plans were being made for a refresher training package.
- On Gwynne Holford Ward, we saw there were four patients with Deprivation of Liberty authorisations and all records were in date. We checked six records of patients with bed rails in place and all had completed bedrail assessment sheets. On the bed rails assessment, there was no area to document the patient’s consent to rails where appropriate. Four records had free text added to the form to state the patient had consented. We spoke to one of the patients where their consent for bed rail use was not documented and they stated that they were happy for the bed rails to be in place. We saw two records where there had been best interest decisions made for patients and there was clear documentation that this had happened. We also saw that bed rail monthly audits were completed and action plans stated if improvements were required.
- Staff on Gwynne Holford Ward were able to provide a recent example of a patient that had a Deprivation of Liberty

authorisation in place and who wished to return home from hospital. They explained how the patient had been supported to attend the court of protection with staff from the ward in order for a judge to determine appropriate care. The patient had been able to speak with the judge directly during this hearing and this demonstrated the ward staff's adherence to their statement 'No decision about me, without me.'

- We also visited Allingham, Dalby, and Rodney Smith Wards at St George's Hospital. We saw evidence of MCA and Deprivation of Liberty Safeguards understanding among staff, awareness of consent to treatment and what constituted restraint. Staff were aware that some patients needed support and time to make decisions.
- Staff assessed a person's mental capacity to consent to care or treatment either when admitted through A&E or when admitted to the ward. The assessment was recorded in the patient notes. Patients with dementia or delirium had an identifier on their notes and on the patient board, so as to inform staff.
- We saw that when people lacked the mental capacity to make a decision, multidisciplinary groups of staff, usually involving a social worker and where possible the family, made 'best interests' decisions. All staff were aware that best interest decisions were made by the multidisciplinary team.
- Staff we spoke with understood how to seek authorisation for Deprivation of Liberty Safeguards.
- Staff told us the use of restraint (bed rails, mittens) when people lacked mental capacity was monitored at least weekly. For example, a person with delirium would not necessarily need any restraint once the confusion had passed.
- We noted that in the trust's action plan update to us in November 2016, it stated that the MCA Policy had been developed and approved by the chief nurse. The policy was accessible to staff via the Policy Hub on the Intranet.
- MCA and Deprivation of Liberty Safeguards had been incorporated within training programmes which had commenced in October 2016.

Are services at this trust caring?

This key question was not inspected.

Are services at this trust responsive?

Access and flow

- During the inspection in June 2016, we noted that data quality systems were not fit for purpose and impacting on reliability of data for referral to treatment (RTT), specifically the incomplete

pathway. As a result, the trust wrote to NHS Improvement and NHS England, to inform them of their intention to temporarily cease national reporting of the RTT data. This was because the trust could not guarantee the data being reported was robust and accurate.

- During this inspection, we noted that a recovery programme was established. This programme had a board which was chaired by the chief executive officer and supported by NHS Improvement. A large number of patients (around two million) had been identified, dating back to 2014, where the trust was not able to say with certainty that these patients had been treated or were at the correct stage of their care pathway. These patients were being validated by an external company with the highest risk patients being validated first.
- Given that many more patients attend the St George's site, initial work to rectify issues focused mainly on that hospital. However, it was always the trust's intention to do a more fundamental review of the operational processes at Queen Mary's Hospital.
- In April 2017, out of the 7118 validations completed, 3068 patients had been found to have been treated but had no discharge letter, 216 patients had been re-booked onto a pathway and 576 patients needed follow-up appointments. Executive managers stated that there was some spare capacity within the outpatient plan to incorporate these extra follow up appointments.
- A separate clinical harm review group, chaired by a deputy medical director from NHS England, reviewed patients that may have been harmed as a result of the data issues with referral to treatment. The clinical harm review group looked for patients that may have been harmed by reviewing incidents, GP alerts, those who had waited over a year for treatment and those that had not seen a clinician for more than six months.
- By April 2017, over 3300 validations had been completed. Between August 2016 and April 2017, the group had reviewed 126 cases and found that no harm had occurred in 110 and low harm in 14. In two cases, serious harm had occurred and in both cases there had been a delay in making a follow up appointment for the patient.
- In December 2016, three patients were treated over 100 days in the lung, breast and urology pathways. Complex diagnostic pathways and patient choice continued to be themes in these breaches.

Summary of findings

- We found that the trust achieved compliance against all of the cancer standards in December 2016. This is an improvement, because the trust was not meeting the two week wait and 62 day cancer standards in 2015/16 and in response a “Cancer Action Plan” was implemented.
- Cancer clinical harm Root Cause Analyses (RCAs) were completed for all patients and none were assessed as coming to harm against the agreed assessment criteria.
- Cancer services were participating in the Data Quality Kite mark initiative taking place in the trust. To date, no risks within their data had been identified.
- The number of patients waiting over 52 weeks for treatment at the trust had increased to an average of 40 per month.
- Themes arising from the analysis of breaches included delays in diagnostic pathways, compounded by the frequent cancellation of appointments, long stages of treatment waits particularly for dermatology and gastroenterology in the non-admitted phase and then long waits for treatment.
- In March 2017, 42, 52-week breaches were predicted. All 52 week breaches were automatically subject to a clinical harm review.
- There was oversight and monitoring of the recovery programme and clinical harm review group by stakeholders, including NHS England, NHS Improvement and commissioners.
- Training had started for staff in inputting data onto the system, in order that the problems with data quality did not occur again. In April 2017, 189 users had completed training and errors had reduced over the last 12 months. To further reduce errors and support training, standard operating procedures were being developed for five priority areas and there was a plan to roll these out within the next month. A training needs assessment was being completed and this was two thirds completed at the time of the inspection.
- The board were told in January 2017, that the RTT data issues could be fixed, but will require the whole organisation to engage. Independent external experts had approved this approach and estimated that the recovery programme would take up to two years.
- At the board meeting in February 2017, it was reported that the trust’s performance against the RTT standard had reduced, though proactive measures were being taken to improve data quality, and service managers were closely monitoring lists with patients who had waited in excess of 52 weeks.

Summary of findings

- At Queen Mary's Hospital, work by an external company found significant data quality issues at each step in the patient pathway. The company made several recommendations in order to improve the RTT functionality.
- The report on Queen Mary's Hospital highlighted a number of systems and processes that presented a level of clinical risks which had the potential to cause clinical harm to patients. These included: an incomplete understanding of patient waiting times; difficulty in determining how many patients are waiting, for how long and for what; and clinicians not always having access to patient information. The trust had acknowledged that the issues raised throughout the report were of significant concern and had taken a number of immediate steps to ensure that patients referred to the hospital remained safe. These included: switching off the auto discharge function, strengthening the referral to triage process with daily reporting of key performance indicators (KPIs) to the hospital director and redistribution of staff and daily reporting of the letter backlog to the hospital director, to ensure that it remained below the agreed standard of 10 days.
- The Elective Care Recovery Programme (ECRP) Report which went to the board after the inspection in June 2017, highlighted a few issues including that there was a lack of clarity about demand and capacity and, as a result, the trust's ability to reduce at pace the backlog of patients currently waiting for treatment. The report also stated that the governance and reporting arrangements needed to be strengthened to provide the board with increased oversight of ECRP delivery.

Are services at this trust well-led?

Governance, risk management and quality measurement

- During the previous inspection, we found that the risk management process was inadequate.
- During this inspection, we reviewed the latest corporate and divisional risk registers. There were mostly robust arrangements for identifying, recording and managing risks and taking action as appropriate. The risks we had identified were reflected on the registers. However, whilst general bullying and harassment was on the Human Resources corporate risk register, the concerns identified as part of the Workforce Race Equality Standard (WRES) was not. Also, on some registers, there were no 'action due date' and there should be, in accordance with actions being SMART (Specific, Measurable, Achievable, Realistic and Time-specific).

- The internal audit committee report dated 25 May 2017, which went to the June 2017 board, stated that the committee was very concerned that Priority 1 recommendations remained outstanding beyond the agreed deadlines, and that several deadlines had been put back. It was agreed that deadlines for completing these recommendations can in future only be put back by agreement with the CEO. The trust told us following the inspection that there were four Priority 1 audit actions overdue, with a further three being due for completion by the end of June 2017. There was evidence that there was a plan in progress to complete the required internal audit Priority 1 actions.
- The report also stated that the head of internal audit (HOIA) confirmed that the trust's annual report could only be one of limited assurance, based on an aggregated assessment of the individual assurance rating to each of the 20 plus internal audits undertaken in 2016/17. The audit committee noted its understanding of the position, but reminded the executive that the trust must move to a position, through its recovery plan, to ensure that the HOIA opinion for 17/18 must be one of at least reasonable assurance. We were told by the trust following the inspection, that their internal audit programme for 2017/18 will be revisiting many areas previously audited and with the improvement work undertaken from the earlier internal audit reports, there was a reasonable level of assurance that the aggregated outturn for the 2017/18 Internal audit programme will show significant improvement.
- The audit committee reported that a considerable amount of detailed editing, re-wording, cross-checking and corrections were required to all the documents requiring audit committee approval, and that the narrative style and presentation and formatting of the documents was not yet of a satisfactory standard. If papers were not prepared and produced in a satisfactory manner, sub-committees of the board cannot fully function and therefore raises our concerns about organisational governance. We were told by the trust following the inspection that a robust process had recently implemented for the submission of papers that supported timely circulations of documents and papers to senior committee members. This process ensured that there was sufficient time for committee members to read papers and assimilate information, so that they could make better and more informed decisions.
- During our inspection in June 2016, we found no evidence that leadership, management or governance supported or enabled a high quality community end of life care (EOLC) service. There was no vision, strategy, board lead, specialist local lead, or set

of values for community end of life care. There was not a consistent approach to EOLC in the acute hospital service and the community services division and there was no trust oversight of EOLC services in the community.

- During this inspection, we found the trust had taken steps to address these concerns. The End of Life Care Strategy (2016-2020) was approved by the board in December 2016 and launched to staff and public during the first week of our inspection, which was national 'Dying Matters' week. The strategy set out six ambitions for palliative and end of life care, which were based on key national policies and trust values. The implementation plan had 16 objectives linked to the strategy's identified actions, indicators, and desired outcomes. The trust had also nominated a non-executive director for EOLC.
- The EOLC steering group was set up to develop and oversee the implementation plan for the strategy, and had met monthly since November 2016. The governance structure for EOLC outlined the reporting lines of the steering group to the trust executive board and to other trust committees. Members of the group had questioned whether there was a quorum, because there had been no representation from one of the divisions.
- The EOLC steering group monthly meetings were regularly attended by a board member, a lay representative, members of the local commissioning group, community providers, and trust staff with a remit in EOLC. A community services division EOLC lead consistently attended the meetings, but the other three trust divisions did not always send a nominated EOLC lead. The minutes of the meetings indicated that attendees received updates and contributed to discussions about the implementation plan and made suggestions about adding to or amending the plan. The trust EOLC leadership group worked between the group meetings to prioritise actions and hold divisions to account for implementing the plan.
- The EOLC leadership was headed by the chair of community health services, who worked closely with the trust clinical lead for EOLC. The chief nurse appointed in January 2017, was the executive director responsible for end of life care. The three EOLC senior leaders demonstrated a knowledge of and commitment to a strategy that focused on service delivery for people at the end of life. They reported to us that they had regular meetings with divisional leads to discuss progress with divisional action plans and to monitor their delivery.
- We found that the trust EOLC strategy had addressed inconsistencies in approaches by expecting all four trust divisions to identify EOLC leads and link workers and to take action to meet the objectives of the implementation plan. A

divisional action plan identified milestones so that each division's progress towards achieving objectives were measured within a set timescale. An early milestone was to identify link staff in each team or area by March 2017. The community services division had a named link person and they met regularly with other staff to review EOLC development work across the division. Another milestone was having EOLC as a standing item at divisional governance boards and that action plans should be monitored at these meetings. The community services division had reached this milestone at the time of our inspection.

- There was also a senior leaders' action plan. This included developing a trust wide training plan for EOLC using funding obtained from Health Education England. The actions included a training needs analysis. The trust was piloting a trust wide care plan for the last hours and days of patients' lives. There were electronic and paper versions and a version for the community that took into account the differences to the frequency of checks by trust staff when patients were in their own home. Monthly meetings between acute and community staff had started in March 2017.
- During our inspection in June 2016, we found no evidence of activity data collection, outcome measures, audit or benchmarking for community end of life care services.
- The EOLC strategy implementation plan addressed the lack of data. It also listed a number of indicators to measure progress in meeting objectives, such as the number of staff trained. A performance scorecard of agreed key performance indicators had been developed.
- The EOLC strategy outlined expectations for improved data collection, but many of these were in the development stage at the time of our inspection. For example, there were plans to identify EOLC patients, with their consent, using 'coordinate my care', an electronic record for use by all relevant services. There would also be a record of the patient's preferred place of death. However, this had not yet been integrated into the trust's IT electronic patient record. The use of an electronic EOLC care plan at St George's Hospital was expected to provide data on whether staff were following standards of care. Because community services did not use electronic recording, the division was considering other methods of auditing, for example, through visits by senior staff to patients' homes.
- There were regular audits of Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) orders at the hospital to check that the trust was following expected practice. DNACPR forms in the

community were completed by GPs, but there were plans for the community services division to work with GPs to ensure good practice in documentation and communication with patients and relevant parties.
- The trust had implemented a review of all deaths at the hospital, which provided information about whether the patient had received appropriate EOLC. The community services division relied on reviews of patient notes in their homes to gather information.
- The trust was increasingly developing tools that would enable them to benchmark themselves against other NHS trusts. In November 2016, the local bereavement survey was discontinued and the trust adopted a survey used across London. Community services were also planning to enable more relatives of patients dying at home to complete a bereavement survey. However, because EOLC services in the community were provided by different services, including the local hospice, the results would not only reflect the trust's services. The trust also planned to benchmark their Chaplaincy/spiritual care workforce against national standards.

Equalities and Diversity – including Workforce Race Equality Standard

- During the inspection in June 2016, it was identified that the Workforce Race Equality Standard (WRES), for 2015 had been published without having been presented to the board and had not received board approval, despite this being required.
- During this inspection, we saw that an action plan had now been put in place for the WRES and this had been discussed with the board.
- Minutes from the board meeting in November 2016, showed that the director of workforce and organisational development (DWOD) at the time, drew the board's attention to the WRES. They reminded the board that the workforce department had prepared a WRES action plan with input from an internal WRES steering group and the staff network advisory group. The action plan was formally approved by the board in November 2016. The action plan was developed in order to address the deficits identified by the WRES reporting, annual staff survey and our previous inspection visit.
- There was a WRES reporting template and action plan on the trust's website dated July 2016, which was in the process of being updated. We saw the new action plan, but this was a work in progress and still had to go through a number of checks before it could be uploaded on the website.

- We reviewed the Workforce Information Report, which was discussed at the board in May 2017. This showed that a disproportionate number of black and ethnic minority (BME) staff, were subject to formal disciplinary procedures, (61%, when making up 42% of staff). Further analysis was being undertaken to understand the reason for this disparity. There was an internal WRES group, which was undertaking action to reduce the incidence of disciplinary cases against BME staff.
- The new director of human resources and organisational development took up his post in the first week of May 2017. We were told that the trust had pinpointed WRES as an area to focus on. They would start with data analysis and use the data to update the action plan.

Fit and Proper Persons

- During the previous inspection, we found that there was inadequate compliance by the trust with meeting the Fit and Proper Person Requirement (FPPR). We found on this inspection that there was still the lack of an effective system to manage the risks regarding fit and proper persons being employed.
- A review of executive and non-executive director personnel files was conducted by the trust and presented to the board in October 2016.The review identified that all records of executive and non-executive directors were compliant against the regulation, with the exception of one person, where it was stated a renewal of the disclosure and barring service checks (DBS) was required.
- Before the inspection, we were provided with an update from the then interim chief executive officer, in a letter dated 30 November 2016. This stated that all current board members had met the FPPR regulation and the board was assured of full compliance. The letter stated that the board received assurance of full compliance with FPPR at their meeting held on 26/09/16.
- We reviewed the executive and non-executive directors' files to assess compliance with the Fit and Proper Person Requirement Regulation. Overall, we found that this was not being managed effectively, because qualifications, DBS clearance, references, disqualified director's and insolvency checks missing from some files. The records we reviewed included five of the nine board members who were listed in the October 2016 review and were still employed by the trust at the time of our inspection.
- A new policy for fit and proper persons had been agreed by the board in October 2016. This policy met the requirements for the regulation. However, on our inspection, the newly appointed director of human resources and organisational development

presented us with an amended policy. This policy stated that in exceptional circumstances, a director may start work before all components of the FPPR regulation had been met. This policy had been amended in May 2017 (the month of our inspection) and had not yet been formally agreed by the executive directors and the board. It was due to be taken to the EMT on the last day of our inspection as 'any other business'.

- The new director of human resources and organisational development had made the amendment early in his appointment. This was following an inspection he made of the executive files and told us that the recent significant and fast change to the trust board meant that an exceptional process was required in the policy, as otherwise there would be 'no executive team in place'.
- Following the inspection, an internal CQC management review decided that the trust was continuing to fail meet the Fit and Proper Person Requirement (Regulation 5, HSCA, 2014). It was decided for senior CQC staff to raise the issue again with the trust chair, the improvement director for the trust and NHS Improvement, before consideration was given to further enforcement action.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

- Ensure that it has systems and processes that operate effectively in accordance with good governance.
- Strengthen governance and reporting arrangements, so as to provide the board with increased oversight of Elective Care Recovery Programme delivery.
- Continue to address the gaps in assurance with regards to estates maintenance.
- Continue with the recovery programme and Clinical Harm Review Group with regards to RTT data.
- Ensure it meets the Fit and Proper Person Requirement Regulation.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors **The provider was not meeting this regulation because:** **1. Not all directors had all the required FPPR checks carried in accordance with this regulation.** **Regulation 5**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment were not always provided in a safe way because:** **1. RTT data remained inaccurate and two patients had been seriously harmed as a result of delays to their follow up appointments.** **Regulation 12 (2) (a) (b)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Some premises and equipment were not properly maintained or suitable for the purpose for which they were being used because:** 1. Replacement box filters were stacked in the plant room by the side of theatres 5 and 6 vent plant, allowing for possible contamination of the “new filters”.

This section is primarily information for the provider

Requirement notices

2. New transformer units were needed to meet power demands.

Regulation 15 (1) (a), (c), (e)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes were not established and operated effectively because:** 1. There were gaps in assurance with regards to estates maintenance. 2. The provider had to be prompted to ensure that individual PGDs had been signed by each health professional working under the direction in accordance with the Human Medicines Regulations 2012. 3. The governance and reporting arrangements needed to be strengthened to provide the board with increased oversight of ECRP delivery. 4. The head of internal audit had only limited assurance on the trust's annual report. 5. Priority 1 recommendations remained outstanding beyond the agreed deadlines, and several deadlines had been put back. Regulation 17

Report on actions you plan to take

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

Account number	RJ7
Our reference	INS2-3683110370
Trust name	St George's University Hospitals NHS Foundation Trust

Regulated activity(ies)	**Regulation**
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors
	How the regulation was not being met:
	The provider was not meeting this regulation because: 1. Not all directors had all the required FPPR checks carried in accordance with this regulation. Regulation 5

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

The Trust has recently carried out a thorough review of all our HR files for FPPR qualifying officers and can confirm that all of our Directors have all the FPPR checks in place, in accordance with Regulation 5.

We have also asked Internal Audit (IA) to:

a) Review our FPPR compliance and
b) Review our HR policies and procedures.

Internal Audit has completed the review of Trust FPPR compliance and returned a finding of 'reasonable assurance' with a number of routine control recommendations which the Trust is acting upon.

Who is responsible for the action?	Harbhajan Brar – Director of Human Resources and Organisational Development

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
The Trust are implementing new operational procedures, (including a flow chart & verification checklists) with under pinning guidance notes to ensure lapses in process compliance do not arise again. The HR Director will also provide the Board with a quarterly FPPR compliance assurance report; as directed by NHSI. The Trust has also responded in some detail to the concerns that both NHSI and CQC raised in recent correspondence on matter.	
Who is responsible?	Harbhajan Brar – Director of Human Resources and Organisational Development
What resources (if any) are needed to implement the change(s) and are these resources available?	
No additional resources required. The strengthening of process to assure full and continuous compliance with *'Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: Directors'* is being implemented within existing resources.	
Date actions will be completed:	End of August 2017

How will people who use the service(s) be affected by you not meeting this regulation until this date?
The Trust will ensure that all of our Directors meet and are compliant with the requirements under the CQC Fit and Proper Person regulatory requirements and in line with Trust Policy.

Completed by: (please print name(s) in full)	Harbhajan Brar
Position(s):	Director of Human Resources and Organisational Development
Date:	18 August 2017

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
	How the regulation was not being met:
	Care and treatment were not always provided in a safe way because: 1. RTT data remained inaccurate and two patients had been seriously harmed as a result of delays to their follow up appointments. Regulation 12 (2) (a) (b).

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

Two separate but related reports from MBI Consulting Limited (MBI) document the issues that have contributed to inaccurate RTT data at both St. George's and the Queen Mary's Hospital site.

A Director led Elective Care Recovery (ECR) programme for Queen Mary's Hospital and a separate ECR programme for St George's have been established to address the wide ranging but different issues for each site. Each has a number of work streams including a review of potential clinical harm, training staff to input data accurately, correction of inaccurate data and reducing the number of patients waiting for treatment. The programmes are managed through a shared Programme Management Office (PMO) and report to the Finance and Performance Committee and Trust Board.

The programmes provide an unequivocal focus on patient safety and aim to return the Trust to national reporting and delivery of the RTT standards.

Who is responsible for the action?	Diana Lacey Programme Director, Elective Care Recovery.

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

1. Standard Operating Procedures are being developed. A mandatory programme of role based training for data entry will be established and training uptake monitored. A data quality dashboard will provide assurance of data accuracy and will highlight where data entry is consistently inaccurate so that corrective action may be taken.

2. Historic data is being corrected by an external supplier (Cymbio). Key Performance Indicators are monitored weekly including quality assurance of the data corrections.

3. Waiting list backlog clearance plans are being developed. Ensuring demand and capacity are balanced when the backlog of waiting patients has reduced, with robust management of Patient Tracking Lists (PTLs) will ensure that the 18 week RTT standard is consistently met. A suite of Key Performance Indicators including patients waiting over 52 weeks with or without a

management plan, patient tracking list (PTL) size and backlog reduction will be established.	
Who is responsible?	1. Diana Lacey, Programme Director, Elective Care Recovery 2. Ellis Pullinger, Chief Operating Officer

What resources (if any) are needed to implement the change(s) and are these resources available?

Significant resources are required to implement the changes detailed in the two ECR programmes.

1. Programme Leadership is provided by the appointment of Diana Lacey as Director for the Recovery Programme; additional executive support is provided by the Medical Director, Chief Operating Officer and Chief Information Officer as executive sponsors for the work streams.

2. The Clinical Harm work stream requires management, administrative support to track patients, and clinicians to undertake harm reviews. A fully established team is in place.

3. Resource is available for the correction of inaccurate data through the contract with Cymbio to validate and correct the records of the patients who are most at risk of harm if their treatment is delayed; and the Trusts internal validation team which has been substantially expanded from 11wte to 31 WTE. Additional resource and expertise will be sourced as required.

4. The Trust has commissioned Ernst Young (EY) to undertake a training needs assessment and recommend the resource requirements to deliver the training plan which will report and be considered by the Trust in early September 2017.

Date actions will be completed:	Complete resolution of the RTT issues is a two / three year programme

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Patients will continue to be at risk of clinical harm if their treatment is delayed. This risk is being mitigated by

- Prioritising the validation of the records of those patients thought most likely to come to harm as a consequence of a delay to their treatment;
- Increasing volume of internal validation activity to cleanse data until the training programme completes and we are assured that data entry is robust and reliable and;
- Review of capacity management to ensure patients are booked for treatments soon as possible.

Completed by:(please print name(s) in full)	Diana Lacey
Position(s):	Programme Director Elective Care Recovery
Date:	18 August 2017

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
	How the regulation was not being met:
	Some premises and equipment were not properly maintained or suitable for the purpose for which they were being used because: 1. Replacement box filters were stacked in the plant room by the side of theatres 5 and 6 vent plant, allowing for possible contamination of the "new filters". 2. New transformer units were needed to meet power demands. Regulation 15 (1) (a), (c), (e)

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

1. Storage of replacement box filters:
    a. Filters will no longer be stored in plant rooms but in our Central Stores.
    b. Hire a new mechanical manager who will be in charge of the cleanliness of plant rooms.

2. Transformer units and generators
    a. For the electrical supply, we are now underway with our Lanesborough Wing mains electrical replacement project. This will be followed next year with the St. James Wing electrical replacement project. All electrical infrastructure; generators, converters and switches will be replaced wholesale with new, greater capacity units. We are reducing the current load and helping to reduce the associated risk by installing LED bulbs whenever and wherever we can.

Who is responsible for the action?	Richard Hancock Interim Director of Estates and Facilities

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

1. Storage of replacement box filters:
    a. The new Mechanical Manager is in post and will ensure plant rooms are clean and uncluttered.

2. Transformer units and generators
    a. This will be run as a major capital project monitored by the PMO with regular reporting.
    b. An electrical safety committee will be established and this will report to the capital programme management group.
    c. Equipment is designed for a 50 year working life and will become part of planned preventative maintenance (PPM) following project handover and when all acceptance

criteria have been met.	
Who is responsible?	Richard Hancock - Interim Directors of Estates and Estates
What resources (if any) are needed to implement the change(s) and are these resources available?	
1. Storage of replacement box filters: New Mechanical Manager in post who is responsible for assessing tasks, activities and work breakdown structure. An output of this work will be the resource requirement and will allow us to assess whether we have enough internal resources. 2. Transformer units and generators Requires a project team and dedicated specialist electrical contractors.	
Date actions will be completed:	Storage of replacement box filters: **Completed** Lanesborough Wing electrical replacement project will be completed by August 2018 St James Wing electrical replacement project will be completed by August 2019

How will people who use the service(s) be affected by you not meeting this regulation until this date?
For general power supply, we monitor our demand and our power suppliers are capable of providing what is needed, including at our peak times, we are also able to increase this with our power supplier if necessary. As part of our Lanesborough and St James Wing electrical upgrade projects we are installing new generators and upgrading our electrical infrastructure. Whilst these projects are underway, to assure back up power requirements are met we have rented two standby generators which are sufficient to provide power covering our maximum demand.

Completed by: (please print name(s) in full)	Richard Hancock
Position(s):	Interim Directors of Facilities and Estates and Facilities
Date:	18 August 2017

Regulated activity(ies)	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Systems and processes were not established and operated effectively because: 1. There were gaps in assurance with regards to estates maintenance. 2. The provider had to be prompted to ensure that individual PGDs had been signed by each health professional working under the direction in accordance with the Human Medicines Regulations 2012. 3. The governance and reporting arrangements needed to be strengthened to provide the board with increased oversight of ECRP delivery. 4. The head of internal audit had only limited assurance on the Trust's annual report. 5. Priority 1 recommendations remained outstanding beyond the agreed deadlines, and several deadlines had been put back. Regulation 17

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

1. <u>Gaps in assurance with regards to Estates Maintenance</u>
   a. Build all planned preventative maintenance (PPM) schedules in to our Estates Helpdesk centre. For example air handling unit filters to be automatically maintained by Vokes Limited, third party company.

   b. Relaunching Estates Helpdesk: better user interface and greater responsiveness by acknowledging logged calls and assigning a service level agreement (SLA) response rating, for example one day, two days, three days. Also start a stopwatch that will alarm if the call has not been dealt with in the agreed period and create an automated escalation.

2. <u>Patient Group Directions (PGDs)</u>
   The PGD process has been strengthened to ensure all staff individually sign PGD forms. The PGD template includes additional space to accommodate all the names and signatures of healthcare professionals. The Chief Radiographer is responsible for assuring compliance with PGD a member of the PGD Approval Group (PAG).

3. <u>Elective Care Recovery Programme (ECRP) governance</u>
   The Trust has revised the ECRP programme governance structure. Reports are regularly received from the work stream through the weekly Elective Care Recovery Programme Board, and monthly Delivery Board to the Trust Executive Management Team and the Finance and Performance Committee into the Trust Board. The Programme has Executive Level membership, and the delivery work streams are sponsored by the Trust's senior management team to provide challenge and gain the necessary level of assurance.

4. Annual Report assurance
   The Trust annual report received only '*Limited Assurance*' from the Internal Auditor as a result of the number of an insufficient number of the assurance reports undertaken in the year 2015/16 reaching a level of *'Reasonable Assurance'* or higher. The Trust has strengthened its governance systems and the audit cycle in place for 2017/18 should demonstrate this through a higher level of completed Internal Audit reports attaining a level of *'Reasonable Assurance'* or higher and that recommendations are actioned in full by the stipulated date.

5. Completion of actions in response to internal audits
   The Trust's audit committee now actively manages completion of Priority 1 Internal Audit recommendations as a standing agenda item. This process ensures timely completion of Priority 1 actions.

Who is responsible for the action?	Elizabeth Palmer Director of Quality Governance and Richard Hancock, Interim Director of Estates and Facilities

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

1. Gaps in assurance with regards to estates maintenance
   a. Estates Helpdesk manager to report to Director of Estates and Facilities with weekly reports
   b. KPI's will be in place for sufficient targets and monitoring
   c. Planet system will have automated escalation alarms for logged calls that pass their deadlines
   d. Active management and monitoring of the required actions through the Trust responsible management committees and groups.
2. Patient Group Directions (PGDs)
   Regular audit of clinical areas where PGDs are used to audit the names and signatures of healthcare professionals using the PGD's. This audit is part of the "Back to the Floor" audit by Pharmacy staff.
3. Annual report assurance and completion of actions in response to internal audits
   Audit Committee review of internal audit reports and delivery of action plans.

Who is responsible?	Elizabeth Director of Quality Governance Richard Hancock Interim Director of Estates and Facilities

What resources (if any) are needed to implement the change(s) and are these resources available?

No additional resources needed for these governance actions.

Date actions will be completed:	1. PGD process now fully compliant with individual practitioner signatures being recorded and documented. **Completed May 2017** 2. The Trust has revised the ECRP programme governance structure. Reports are regularly received from the Elective Care Recovery Programme and

	monthly Delivery Board to the Trust Executive Management Team and Finance and Performance Committee into the Trust Board. **Completed August 2017** 3. The Trust has strengthened its governance systems and the internal audit cycle in place for 2017/18 should demonstrate this through a higher level of completed Internal Audit reports attaining a level of *'Reasonable Assurance'* or higher. **Completed August 2017** 4. The Trust's audit committee now actively manages completion of Priority 1 Internal Audit recommendations as a standing agenda item. This process ensures timely completion of Priority 1 actions. **Completed August 2017**

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Actions have been completed.

Completed by: (please print name(s) in full)	Avey Bhatia Richard Hancock Harbhajan Brar Diana Lacey
Position(s):	Chief Nurse & Director of Infection Prevention and Control Interim Director Estates and Facilities Director of Human Resources and Organisational Development Elective Care Recovery Programme Director
Date:	18 August 2017

ID No.	Issue	Action	Priority	Management Response	Responsible Director	Lead	Due Date	Status
CQC 1	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors 1. Not all directors had all the required FPPR checks carried in accordance with this regulation.	Review all Executive HR files and ensure appropriate completion of CQC Regulation 5 Fit &Proper Person Report requirement. Ensure HR process going forward maintains compliance with CQC Regulation 5 requirements.	High	The Trust has recently carried out a thorough review of all our HR files for FPPR qualifying officers and can confirm that all of our Directors have all the FPPR checks in place, in accordance with Regulation 5. Internal audit have undertaken a review of the Trust's compliance with CQC Regulation 5 Fit & Proper Person requirements against the following criteria: a) Review our FPPR compliance and b) Review our HR policies and procedures. Internal Audit has completed the review of Trust FPPR compliance and returned a finding of *'reasonable assurance'* with a number of routine control recommendations which the Trust is acting on.	Director of Human Resources and Organisational Development	Director of Human Resources and Organisational Development	31/08/2017	Completed
CQC 2	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 1. Referal to Treatment (RTT) data remained inaccurate and two patients had been seriously harmed as a result of delays to their follow up appointments.	Ensure systems are in place to reduce the potential for harm to patients awaiting treatment by Trust 1. Standard Operating Procedures are being developed. A mandatory programme of role based training for data entry will be established and training uptake monitored. A data quality dashboard will provide assurance of data accuracy and will highlight where data entry is consistently inaccurate so that corrective action may be taken. 2. Historic data is being corrected by an external supplier (Cymbio). Key Performance Indicators are monitored weekly including quality assurance of the data corrections. 3. Waiting list backlog clearance plans are being developed. Ensuring demand and capacity are balanced when the backlog of waiting patients has reduced, with robust management of patient tracking lists (PTLs) will ensure that the 18 week RTT standard is consistently met. A suite of key performance indicators including patients waiting over 52 weeks with or without a management plan, patient tracking list size and backlog reduction will be established.	High	A Director led Elective Care Recovery (ECR) programme for Queen Mary's Hospital and a separate ECR programme for St George's have been established to address the wide ranging but different issues for each site. Each has a number of work streams including a review of potential clinical harm, training staff to input data accurately, correction of inaccurate data and reducing the number of patients waiting for treatment. The programmes are managed through a shared Programme Management Office (PMO) and report to the Finance and Performance Committee and Trust Board. The ECR programme is making progress with strengthening procedures at Queen Mary's Hospital. The programmes provide an unequivocal focus on patient safety and aim to return the Trust to national reporting and delivery of the RTT standards.	Programme Director, Elective Care Recovery Chief Operating Officer	Programme Director, Elective Care Recovery	2019 2-3 year programme	On track
CQC 3	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Some premises and equipment were not properly maintained or suitable for the purpose for which they were being used because: Replacement box filters were stacked in the plant room by the side of theatres 5 and 6 vent plant, allowing for possible contamination of the "new filters".	Filters will no longer be stored in plant rooms but in Central Stores. Recruit a new mechanical manager who will be responsible for the cleanliness of plant rooms.	High	The replacement filters are now kept in Central Stores The new Mechanical Manager is in post and will ensure plant rooms are clean and uncluttered.	Interim Director of Estates and Facilities	Interim Director of Estates and Facilities	01/06/2017	Completed
	New transformer units were needed to meet power demands.	Lanesborough Wing mains electrical replacement project is underway. Next year (2018) the St. James Wing electrical replacement project starts. All electrical infrastructure; generators, converters and switches will be replaced wholesale with new, greater capacity units. Reduction of the current load and the associated risk is being reduced the associated risk by installing LED bulbs whenever and wherever we can.	High	This is a major capital project monitored by the PMO with regular reporting. An electrical safety committee will be established and this will report to the capital programme management group. Equipment is designed for a 50 year working life and will become part of planned preventative maintenance (PPM) following project handover and when all acceptance criteria have been met.	Interim Director of Estates and Facilities	Interim Director of Estates and Facilities	Lanesborough Wing - 31 August 2018 St. James Wing – 31 August 2019	On track
CQC 4	Regulation 17 HSCA (RA) Regulations 2014 Good governance 1. There were gaps in assurance with regards to estates maintenance.	Build all planned preventative maintenance (PPM) schedules in to our Estates Helpdesk centre Relaunching Estates Helpdesk: better user interface and greater responsiveness by acknowledging logged calls and assigning to an SLA rating i.e. one day, two days, three days.	High	The Estates Helpdesk manager to report to Director of Estates and Facilities with weekly reports. KPI's will be in place for monitoring. Planet system will have automated escalation alarms for logged calls that pass their deadlines. Active management and monitoring of the required actions through the Trust responsible management committees and groups.	Interim Director of Estates and Facilities	Interim Director of Estates and Facilities	August 2017	On track

	2. The provider had to be prompted to ensure that individual PGDs had been signed by each health professional working under the direction in accordance with the Human Medicines Regulations 2012.	Strengthen PGD process to ensure every member of staff using the PGD signs the PGD form.	High	The PGDs have been signed as necessary, the process has been strengthened. The Chief Radiographer is responsible for assuring compliance with PGD process and is a member of the PGD Approval Group (PAG).		Chief Radiographer	May 2017	Complete
	3. The governance and reporting arrangements needed to be strengthened to provide the board with increased oversight of ECRP delivery.	Review elective care recovery programme governance.	High	The Trust has revised the ECRP programme governance structure. Reports are regularly received from the work stream level through the weekly Elective Care Recovery Programme, and monthly Delivery Board to the Trust Executive Management Team and Finance and Performance Committee into the Trust Board.	Chief Operating Officer	Programme Director, Elective Care Recovery	August 2017	Complete
	4. The head of internal audit had only limited assurance on the trust's annual report.	Strengthen governance systems for internal audit reports	High	The Trust has strengthened its governance systems and the audited cycle in place for 2017/18 should demonstrate this through a higher level of completed Internal Audit reports attaining a level of 'Reasonable Assurance' or higher.			August 2017	Complete
	5. Priority 1 recommendations remained outstanding beyond the agreed deadlines, and several deadlines had been put back.	Audit Committee to monitor completion of audit recommendations. Priority 1 internal audit recommendations to be standing agenda item for Audit Committee.	High	The Trust's audit committee now actively manages completion of Priority 1 Internal Audit recommendations as a standing agenda item.		Trust Secretary	August 2017	Complete

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 September 2017	**Agenda No**	3.3
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:	Avey Bhatia, Chief Nurse & Director of Infection Prevention and Control Andrew Rhodes, Medical Director		
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 before publication.		
Supports			
Trust Strategic Objective:	ALL		
CQC Theme:	Well led, Safe, Caring, Effective and Responsive		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	CQC Regulatory Framework - (Health & Social Care Act 2015)		
Resources:			
Previously Considered by:	Quality Committee Clinical Quality Review Group (CCG)	**Date**	
Appendices:	Appendix A: Outstanding Care, Every Time – Our Quality Improvement Plan 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 a new 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 now need to look at our longer term ambitions as part of our quality improvement journey.

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.

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.

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 everyday 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 will be 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 working closely with NHS Improvement, through an Improvement Director who is supporting the Trust to support 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 12**.

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 staff feel are necessary to provide the communities we serve with safe, effective, compassionate and high quality care. 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 our recent progress and 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 external 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

How we will implement the Quality Improvement Plan

Our Quality Improvement Plan (QIP) sets the objective 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

For the Trust to manage and track the success of an ambitious Quality Improvement Plan and to align it with the two other change programmes at the Trust, the Financial Recovery programme and the Elective Care Recovery programme/Referral to Treatment (RTT), in May 2017 we revised the plan and how we supported it.

The QIP is now made up of three improvement programmes:

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

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

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

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

Each improvement programme has an identified programme lead with a workstream lead assigned to each individual workstream. Each individual workstream has one or more delivery projects led by clinical and non clinical staff. The following pages show how each workstream is divided into supporting projects that will help us as wes strive to provide consistent outstanding care, every time. Each section outlines what is important for us to address, what we plan to do and how we will know we have been successful.

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	Ambulatory Care	SAFER	4 hour ED target	
	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 HI programme			
	ENGAGEMENT	Staff Engagement			

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.

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 hospitals 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 by:

Indicator	Threshold
Hand Hygiene Audit compliance	95%
Fall resulting in moderate or above harm	0
VTE risk assessment completed	95%
Grade 3 & 4 pressure ulcers per 1000 occupied beds	0
Infection Control Mandatory and Statutory training (MAST) compliance	95%
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 by:

Indicator	Threshold
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 by:

Indicator	Threshold
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

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

Indicator	Threshold
In hospital (All) Cardiac Arrest Rate/1000 admissions	50% reduction by April '18 from baseline of 14 (April 17)
Early Warning Score (EWS) compliance	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 administration of medication, room temperature monitoring and ePrescribing Chemotherapy
- 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 by:

Indicator	Threshold
Pharmacists actively prescribing	80%
Medication take out to (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


St George's Healthcare NHS
Staff Nurse
Plastic & Reconstructive Surgery

Flow & Clinical Transformation

The Flow and Clinical Transformation Improvement 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.

FLOW & CLINICAL TRANSFORMATION

WORKSTREAMS

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

PROJECTS

Ambulatory Care	Theatre Environment	Environment	RTT programme
SAFER	NATSSIPS	Efficiency	
4 hour Emergency Department target	Efficiency		

Unplanned and Admitted care

Aim: Improve the timeliness of emergency care for patients. Admit patients to the right ward or place of care first time and ensure a positive patient experience.

We will:

- Ensure we involve front line staff, patients and partners to identify issues and solutions to problems with patient flow
- Be guided by questions that focus on identifying the root cause of a problem
- Establish underlying principles to reduce variation, improve reliability, increase consistency and increase responsiveness to problems in patient flow
- Improve Emergency Department four hour performance
- Improve transfer of care from the acute setting into community settings
- Ensure patients are in the right bed at the right time.

How we will achieve this:

- Comprehensive analytic assessment of Length of Stay (LoS) performance versus peer Trusts, attainment and ward discharge metrics
- Review of bed capacity and demand model
- Implement the SAFER (a standardised way of managing patient flow through hospital) model across all wards
- Improved ward management and discharge metrics
- Design and implement new pathways and implement ward discharge targets.

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

Indicator	Threshold
Emergency Department 4 hour target	95%
Ambulance handover time 15min	100%

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 by:

Indicator	Threshold
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 by:

Indicator	Threshold
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%


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.

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 by:

Indicator	Threshold
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
- 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.

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

Indicator	Threshold
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%

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.

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 embedded practice from actions resulting from incident investigations
- 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 by:

Indicator	Threshold
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	2400
Incidents reported – clinical	13,000
Serious Incidents declared	90
Serious Incidents investigations >60 days	0
Never Events declared	0

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 by:

Indicator	Threshold
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%

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.

To ensure our current and future leaders are supported and developed to deliver high quality, compassionate care, and that we ensure our staff are at the centre of the changes we are making and incorporate their views into everything we do.

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 aid the transformation 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 by:

Indicator	Threshold
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 of training 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 by:

Indicator	Threshold
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	**50% reduction on 16/17 data**
A reduction in the number incidents related to failure to identify deteriorating patients.	**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 four 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 by:

Indicator	Threshold
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:

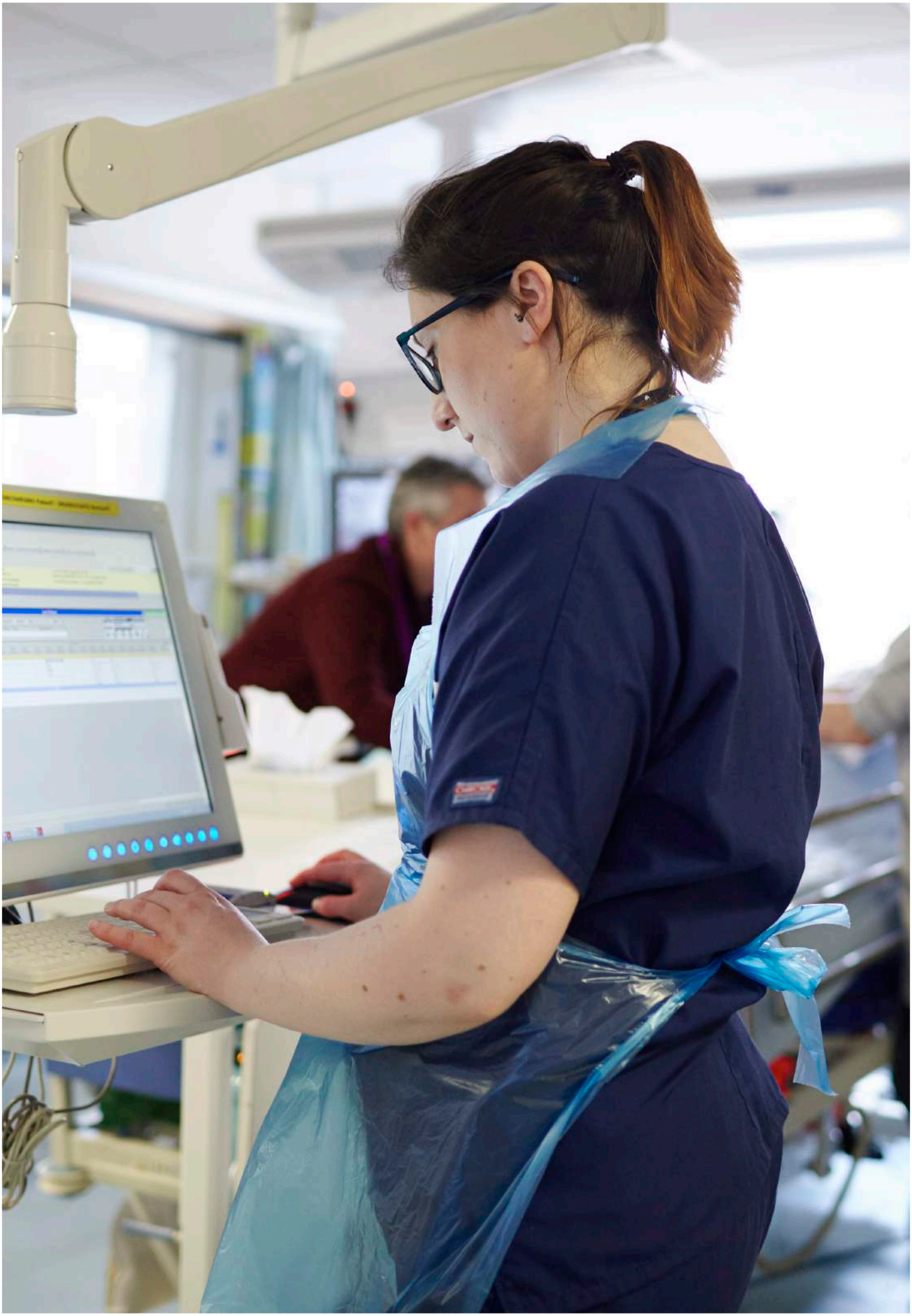
- Create the right conditions and environment in which staff will enable the Trust to deliver a continuously improving culture
- Engage staff with the overarching QIP objectives and run localised engagement events to support the delivery of each workstream

How we will achieve this:

- Run a Quality Improvement Week in October 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 by:

Indicator	Threshold
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**



How will we know our **Quality Improvement Plan** is working, ensure robust governance and measure and communicate our achievements

How we will implement the quality improvement plan - Governance arrangements

To deliver the Quality Improvement programme at pace, a robust governance structure has been established. Each programme of work has developed a Terms of Reference (ToR) and is held accountable through the Quality Delivery Board which ultimately reports to the Board via the Finance and Quality Delivery Board.

Quality Improvement programme		Role
SGH BOARD	Monthly	■ Sets the objectives and benefits to be delivered by the programme and provides the resource to support this ■ Delegates decision making authority to the Delivery Board within agreed parameters ■ Seeks assurance that the programme is delivering in line with its Terms of Reference as well as the strategic objectives of the Trust
FINANCE AND QUALITY DELIVERY BOARD	Weekly / bi-weekly	■ Provides challenge to the Quality Delivery Board and holds it to account ■ Ensures alignment of the Financial Recovery and Quality Improvement Programme
QUALITY DELIVERY BOARD **Chair:** Medical Director **Members:** Programme SROs	Weekly / bi-weekly	■ Has authority from the Board to make decisions and provide steer on the scope of the programme within agreed parameters ■ Programme SRO is accountable to the Quality Delivery Board for delivering the agreed benefits of the programme ■ Holds the workstreams and PMO to account
PROGRAMME GROUP MEETINGS **Chair:** Programme SROs **Members:** Workstream Leads	Monthly	■ 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
WORKSTREAM MEETINGS **Chair:** Workstream Leads **Members:** PMO, Programme, Project Leads	Weekly	■ 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

The structure on the previous slide ensures robust governance arrangements through which the Quality Improvement Plan (QIP) will be managed. A summary of the responsibilities of the divisions and executives are outlined below:

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 divisional triumvirates (management teams consisting of three people usually a senior manager, senior doctor and senior nurse) and Trust Leads are responsible for the development of the QIP (identification of outcomes, associated KPI's and their trajectories and actions required to deliver the outcomes) for their span of responsibility. They are also responsible for the successful delivery of those KPIs within the timeframes stated, and for ensuring that the QIP is updated on a regular basis, and any issues are escalated appropriately and within a timely manner
- 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.

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

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 2016

- 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


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

What does success look like?

The programme level dashboard is used to report to the Board on a monthly cycle. Each programme level workstream has their set of threshold numbers which populate the programme view to provide an overall picture of our progress and success.

Safe & Effective Care

Indicator Description	Source	Target	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	YTD
Harm Free Care to patients (New Harms)	Rate	≥ 95%	98%	98%	98%	98%	55%								89%
Fall resulting in moderate or above harm	Datix/ Rate	0	3	4	3	5									15
VTE risk assessment completed (Safety Thermometer)	Rate	≥95%	95%	96%	96%	96%									96%
Grade 3 & 4 pressure ulcers	Datix/ PST/ Rate	0	2	1	0	1									4
MRSA bacteraemia reported	Rate	0	2	0	2	0									4
Hand Hygiene Audit compliance	Rate	≥ 95%	95%	96%	95%	93%									95%
Carers who would like to stay overnight with patient, who actually stayed beside patient	Rate	100%	New metric	New metric	New metric	New metric									
Number of Carers passports issued per month	Rate	≥15/ month	New metric	New metric	New metric	New metric									
Early Warning Score (EWS) compliance	Rate	≥85%	95%	95%	94%	94%									94%

Flow and Clinical Transformation

Indicator Description	Source	Target	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	YTD
ED 4 Hour target	Info	≥95%	91%	90%	92%	90%									91%
Ambulance handover times 15 Mins	Info	100%	46%	48%	52%	49%									49%
Ambulance handover times 30 Mins	Info	100%	96%	97%	97%	97%									97%
Outpatient Friends & Family Test	Rate	≥95%	92%	94%	95%	91%									93%
Theatre Never Events	Rate	≤0	0	0	1	1									2
WHO checklist compliance (Quaterly Clinical Audit)	C Audit	100%	100%	100%	100%										100%

Quality & Risk

Indicator Description	Source	Target	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	YTD
Compliance with 25 working day complaint response for non-complex complaints (green)	Complaints	≥95%	80%	85%	79%										82%
Compliance with 40 working day complaint response for all amber complaints	Complaints	≥95%	64%	54%	64%										61%
Compliance with 60 working day complaint response for all red complaints	Complaints	≥95%	100%	100%	100%										100%
Complaints that require a second response	Complaints	≤8%	19%	8%	11%										13%
Duty of Candour completed for all incidents (as graded on Datix) at moderate harm and above	PST	100%	100%	100%	97%	98%									99%
Duty of Candour completed within 10 working days, for all incidents at moderate harm and above - (By March 2018)	PST	100%	51%	76%	69%	69%									66%
"Incidents reported – non clinical (By March 2018)"	PST	≥2400	69%	69%									66%		731
"Incidents reported – clinical (By March 2018)"	PST	≥13000	895	929	992	985									3801
Serious Incidents declared - (By March 2018)	Datix/Rate	≤90	5	6	8	11									30
SI investigations >60 days	Datix/PST	≤5	184	206											0
Never Events declared (By March 2018)	Datix/Rate	0	0	0	1	1									2

These indicators collectively aim to monitor the key areas of improvement identified in order to be a Trust which is sustainability set up to achieve the standards set by CQC across the five key areas:

Ensuring services are safe

e.g. including improvements in estates and on the wards

Ensuring services are effective

e.g. including improvements in pain assessment, dementia awareness and staff engagement

Ensuring services are caring

e.g. including staff continuing to deliver care in a kind and professional manner

Ensuring services are responsive

e.g. including significant improvements in RTT and Accident and Emergency

Ensuring services are well led

e.g. including appointment of new members to the executive team and strong leadership across several departments.

If you have any questions about this plan or Outstanding Care, Every Time or would like to comment or make a suggestion regarding its implementation, contact the Communications Department at: communications@stgeorges.nhs.uk

Meeting Title:	Trust Board		
Date:	7 September 2017	**Agenda No**	3.5
Report Title:	Mortality Monitoring - Learning for Deaths Update		
Lead Director/ Manager:	Professor Andrew Rhodes, Chief Medical Officer		
Report Author:	Dr Nigel Kennea, Chair Mortality Monitoring Committee, Associate Medical Director		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Discussion Update		
Executive Summary:	The paper summarises implementation of the 'Learning from Deaths' framework launched in March 2017, and includes a draft version of the proposed Policy which outlines the review process. It also provides data for April to July 2017 and includes learning, progress and challenges to work going forward.		
Recommendation:	• For the Trust Board to be updated on work to date implementing the 'Learning from Deaths' national framework including plans for approving the policy responding to deaths of patients in their care in September 2017. • To note the specialty areas where mortality signals are present. • To take assurance that SGUH has a robust process for assessing deaths and from learning any lessons that arise from them.		
Supports			
Trust Strategic Objective:	Data to help strengthen quality and safety work, as well as improve experience of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	This work will identify issues impacting on care quality day to day, and will identify risks that are escalated to trust and divisional governance teams. The new 'Learning from Deaths' framework represents a significant change in process that requires resource, even with a mature mortality monitoring process. There is a risk that published mortality data		

	and learning will not only be used for quality improvement, and that identifying problems in care could lead to adverse publicity.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by Care Quality Commission and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:	There are resource implications associated with these works that are being worked through and can be discussed with this paper.		
Previously Considered by:	Quality Committee	**Date**	26/07/17
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		

MORTALITY MONITORING - LEARNING FOR DEATHS UPDATE

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Board with a summary of implementation of the Learning from Deaths framework and an update on information and learning identified through independent case record review of deaths between April and July 2017.

2.0 IMPLEMENTATION OF THE LEARNING FROM DEATHS FRAMEWORK

2.1 Policy

The framework stipulates that Trust's must publish their policy relating to responding to deaths of patients in their care in September 2017.

The SGUH policy has been prepared by the Mortality Monitoring Committee (MMC) and will be reviewed again at MMC on 30th August and submitted to the Patient Safety and Quality Board for final ratification on 20th September 2017. The policy will then be published on our website as required by the framework. This will enable the Trust to be compliant with the Framework.

2.2 Selection of validated mortality review tool

The Trust has been actively involved in the Royal College of Physicians development of the Structured Judgement Review (SJR) process. We participated in the pilot of the SJR tool and nine clinicians have been formally trained in the review methodology. The AMD has completed additional training and is involved with the national training rollout. As such we are able to provide in-house training to our clinicians.

We have created a secure online version of the SJR, with some additional data fields to enable us to gather additional information which will be of use locally in developing our understanding of mortality and in identifying and tracking areas for improvement.

At the invitation of the RCP we have recently completed a pilot of the DATIX platform for the SJR. At present this platform does not allow entry of patient identifiers or date of admission / death and so is unlikely to be of greater value than our current system.

2.3 Independent case record review

Three members of the MMC have been undertaking independent case record review since April 2017, with 404 completed to date. More detail is given in section 3.0 and

4.0 of this report. These reviews are in addition to the local M+M processes and feed directly into service reviews and other Trust governance processes (including Divisional governance and serious incident declaration). There is triangulation with incident reporting (DATIX), complaints, and serious incident declaration in all deaths where review identifies potential avoidable factors.

2.3 **Reporting**

There is an expectation that from Q3 2017/18 trusts will publish information on deaths, reviews and investigations via a quarterly agenda item and paper to the public board meeting. We have been collecting this data since April 2017 and providing data to the board and subcommittees since that time. Included in section 3.0 of this report is a summary of data for April to July 2017 and the suggested dashboard is included as Appendix 1.

2.4 **Identification of Non-Executive and Executive Directors**

Professor Sir Norman Williams is the Non-Executive Director with oversight of mortality monitoring and progress related to actions and learning derived from case note review. Professor Andy Rhodes is the responsible Executive Director. Clear leadership and accountability for the review process and outcomes is stipulated in the policy.

2.5 Immediate priorities for case review process

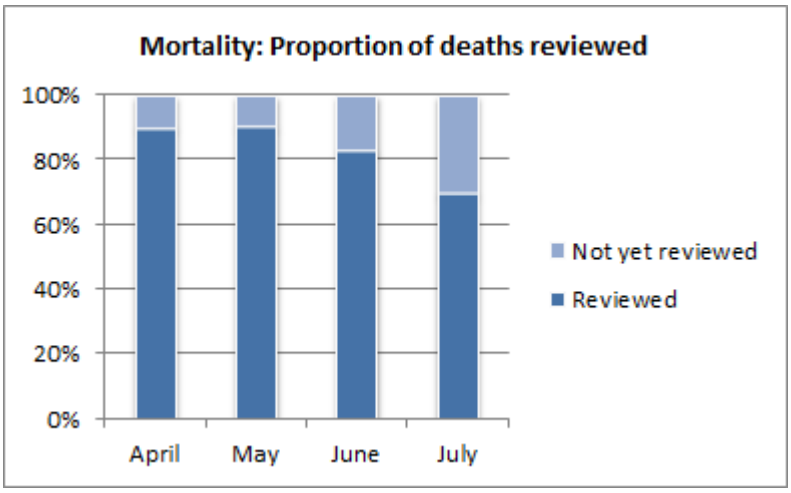
- Refine fields added to SJR to strengthen the quality and impact of our data locally
- Implementation of SJR tool for all mortality reviews requested by MMC
- Make training available to clinicians on use of SJR methodology
- Implement a robust approach to monitoring all escalations to risk and the clinical teams.
- Complete the restructure of the Clinical Effectiveness (CE) Department to allow the CE manager to specialise in mortality governance.
- Take forward any recommendations agreed following the Assurance Review of Mortality conducted in July 2017 by TIAA.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

3.1 The following analysis includes all deaths and does not consider deaths of patients with learning disabilities separately; however, this is required for the national dashboard. A draft of the National Quality Board dashboard is shown in Appendix 1.

3.2 Overview of April to July 2017

In the 4 months April to July 2017 there have been 485 deaths. Since April 2017 members of the MMC have carried out independent review of deaths, using a locally developed online screening tool and structured review tool based on RCP tool. To date 404 (83.3%) deaths have been reviewed using this approach. We have set an initial target of reviewing 70% of deaths each quarter and achieved 87.7% in Q1.



In 15.1% of the cases reviewed, one or more problems in healthcare have been identified. It should be noted that not all of these problems will have led to harm and may include recognised complications of treatment.

Problems in healthcare	APRIL	MAY	JUNE	JULY	TOTAL
No	87	108	81	67	**343**
Yes	21	11	20	9	**61**

Reviewers felt that the problem did not lead to harm in 33.7% of cases, probably led to harm in 44.6% and did cause harm in 21.7%. The most commonly occurring problem as defined by the structured judgement review is related to the operation or invasive procedure (n=19), followed by problems related to treatment and the management plan (n=16).

Problems in healthcare	Yes - no harm	Yes - probably harm	Yes - harm
Assessment, investigation or diagnosis	1	2	0
Medication/IV fluids/electrolytes/oxygen (other than anaesthetic)	5	4	1
Related to treatment and management plan	4	7	5
Infection control	2	3	3
Operation/invasive procedure	5	9	5
Clinical monitoring	1	5	4
Resuscitation following a cardiac or respiratory arrest	2	3	1
Other	11	8	1
TOTAL	**31**	**41**	**20**

A judgement regarding avoidability of death is made for all reviews. The large majority (93.8%) of deaths were assessed as being definitely not avoidable, and no deaths were thought to be definitely avoidable. Over the four months a total of 8 deaths (2.0%) were judged to be more than likely avoidable, for that moment in time. All such cases have been escalated to risk, and services for investigation and learning.

Avoidability of death judgement score	APRIL	MAY	JUNE	JULY	TOTAL
1 = Definitely avoidable	0	0	0	0	**0**
2 = Strong evidence of avoidability	1	1	2	1	**5**
3 = Probably avoidable (more than 50:50)	1	0	1	1	**3**
4 = Possibly avoidable but not very likely (less than 50:50)	2	2	2	1	**7**
5 = Slight evidence of avoidability	5	3	2	0	**10**
6 = Definitely not avoidable	99	113	94	73	**379**

4.0 THEMES AND LEARNING

4.1 Good Practice

High numbers of cases demonstrate good care, clear multi-professional communication and recognition of end of life. A high proportion of patients who have died have a DNACPR in place (73%).

The trust now has documented reviews both local and centrally, in almost all patients that die in the Trust - this information is on a secure database. The MMC is supporting the improvement of local mortality review meetings; this has resulted in better

dialogue, better documentation and improved processes in a number of areas (examples include orthopaedics, stroke, cardiology, critical care, interventional neuroradiology).

There is a dialogue directly between the MMC and Risk teams to identify any cases that require more detailed information. Reviewing deaths in the bereavement office allows timely escalation both to the clinical team, in order to support family, and risk team where issues of care may have been identified. Bereavement office support has improved death certification and Coroners referral processes.

4.2 **Examples of learning identified, areas to strengthen and actions taken:**

- Responsible consultant not always easily visible in the notes
  This has been escalated to Divisional teams for action. The AMU was identified as not always documenting consultant responsible.

  Action: Care group lead has been alerted with local education / action required. Compliance seems to be improving; this will be monitored.

- DNACPR discussions
  Although a high number of patients have good and early discussions about resuscitation and DNACPR, reviews continue to identify patients where such discussions should have occurred, or could have occurred earlier.

  Action: These cases are raised to the specific clinical teams to consider in their M+M meetings. This theme is also one of the focuses of the End of Life (EOL) steering group.

- Community renal dialysis patients
  Several issues of communication (including unfiled email correspondence) between community dialysis and hospital teams were identified including opportunities to consider DNACPR discussions, in some elderly frail patients.

  Action: Renal team have informed MMC that they are now piloting a complex patient MDT forum for similar patients to ensure communication between community and hospital teams is robust and documented in a more formal manner. The unit is trying to address DNAR with patients and make advanced directives for those who are at high risk of dying within one year, in line with Trust EOL group objectives.

- Fracture Neck of Femur (#NOF) and Falls
  Reviews have identified two patients where there is significant learning; both cases related to the medical management of their comorbidities (heart failure and hypoadrenalism). There has been education in the team and learning shared. The importance of the orthogeriatric team in both the care and learning has been

highlighted. MMC is identifying all deaths following #NOF and escalating to risk all that occur following inpatient fall.

- Out of ICU cardiac arrests
  MMC identifies and discusses all 'Out of ICU arrests' with the Deteriorating Adult Group'; this group reports to PSQB. There have been deaths where opportunities to discuss end of life have been missed (all highlighted to clinical teams), and some patients where there appears a failure to recognise deterioration, or escalate; these cases have all been identified to Risk team and declared as SI where appropriate. These cases are being investigated and there has been learning related to criteria for ITU discharge.
  Action: ITU medical review of patients on the ward soon after ITU discharge
  Action: cardiac surgery: EWS documentation, ward management of diabetes, and escalation.
  These actions will be highlighted in the SI reports once completed, and followed through trust processes.

- Stroke - thrombolysis and thrombectomy
  MMC have requested information related to several patients with stroke. MMC identified one such case who bled following the thrombolysis he had on transfer from another hospital and had also probably completed his infarct prior to thrombectomy. This was not identified because he was not rescanned on arrival at this hospital.
  Action: It has been agreed to rescan all patients transferred from other hospitals, including CT perfusion; it should help prevent futile thrombectomies. All data are submitted to the national SSNAP data registry which is publicly available.

- Potential delay in surgery pending investigations
  One patient had a delay in urgent cardiac surgery because surgeons wanted further information about cancer prognosis. Patient deteriorated whilst waiting operation. Importance of good multispecialty communication highlighted to prevent delays, and specific case discussion occurred in M+M to improve communication and case leadership going forward.

5.0 SERVICES POTENTIALLY OPEN TO EXTERNAL SCRUTINY OF MORTALITY

5.1 Orthopaedics - #NOF

The National Hip Fracture Database (NHFD) report (September 2017) will show St George's as a mortality outlier for the calendar year 2016. The MMC had already identified the need for careful mortality review in this area in September 2016 through analysis of the Dr Foster platform. All cases have been reviewed locally and the MMC has reviewed and validated the information. Data have also been reviewed by

commissioning teams at CQR in March 2017. The orthopaedic team have worked exceptionally hard to improve the position in terms of best practice care and tariff. There has been by the strengthening of medical input (orthogeriatric) into these patients. The mortality position is improving (this can reviewed to April 17 on the NHFD website). There is a need for ongoing review of patients managed outside of orthopaedic wards, and to monitor all inpatient falls resulting in #NOF.

It is essential that the Board and management teams are continuously aware of these #NOF patients, and 'best practice performance', at a time where theatre capacity and anaesthetic cover arrangements have been especially challenged. There is a risk that estates issues and the theatre refurbishment programme in St James' and Lanesborough wings, and subsequent loss of theatre capacity in Paul Calvert theatres (Orthopaedic) to accommodate non-orthopaedic cases will have a direct impact on our trauma including #NOF patients.

5.2 **Cardiac Surgery / CTICU**

The Trust appears to have higher than expected mortality in the cardiac surgery national audit data (3 years to 2016). Although mortality may not reach outlier status by the next report, deaths are being reviewed in detail to determine any learning, along with a wider programme of work to strengthen clinical and governance processes in cardiac surgery and between cardiac surgery and CTICU.

5.3 **Trauma - intracranial injury**

Dr Foster platform indicates we are an outlier for mortality related to intracranial injury. This is a result of the high proportion of patients admitted with unsurvivable injuries. Case note review by MMC and the service, as well as national audit (TARN) data has not identified concerns with care in this group.

5.4 **Sepsis**

Notification has been received from CQC that due to an improving position our outcomes for sepsis will not be investigated as an outlier.

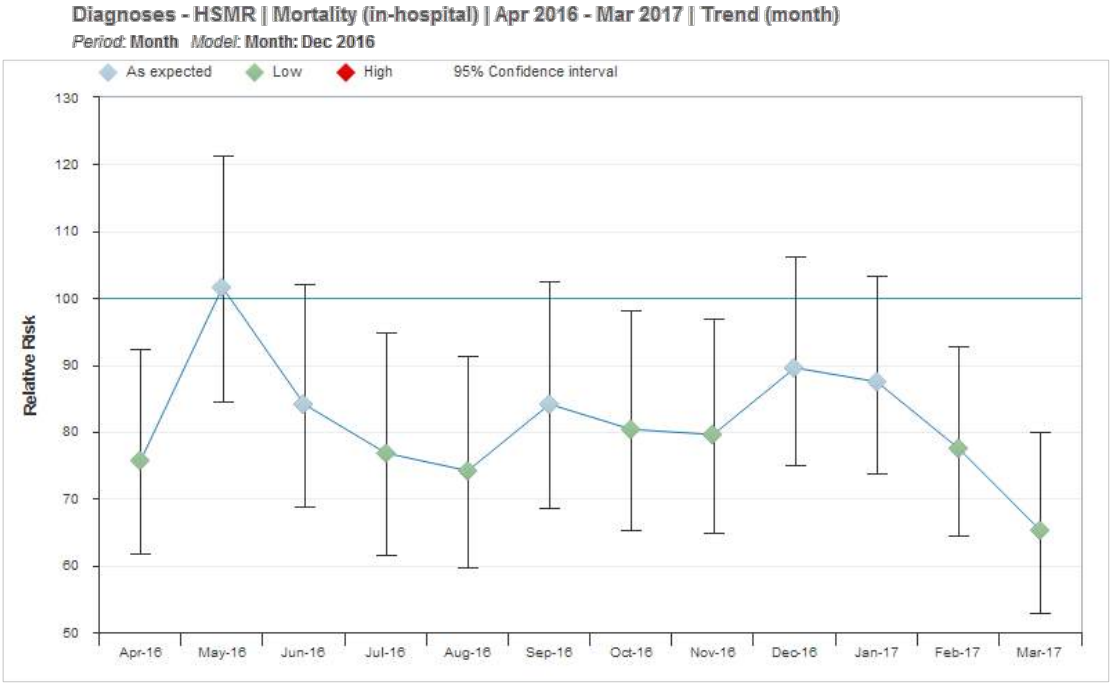
6.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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

Both SHMI and HSMR remain better than expected. Although these data are encouraging they do not relate directly to quality of care. The trust should aspire to remain better than expected although the risk adjusted scores may vary both according to St George's mortality and nationally benchmarked figures. For this reason continuing to expect a downward trend is unrealistic.

Analysis	Period	Score	Banding
HSMR	June 2016 – May 2017	79.7	Significantly better than expected
Weekday emergency admissions	June 2016 – May 2017	81.3	Significantly better than expected
Weekend emergency admissions	June 2016 – May 2017	76.4	Significantly better than expected

Figure 1 SGUH Hospital SMR (HSMR) rates



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

The SHMI for January 2016 to December 2016 was published on 22nd June 2017. For this period our mortality is 'lower than expected' at 0.84. We are one of 15 trusts nationwide in this category.

Appendix 1: Draft NQB Dashboard for 2017/18 YTD – data to July 2017

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - July 2017-18

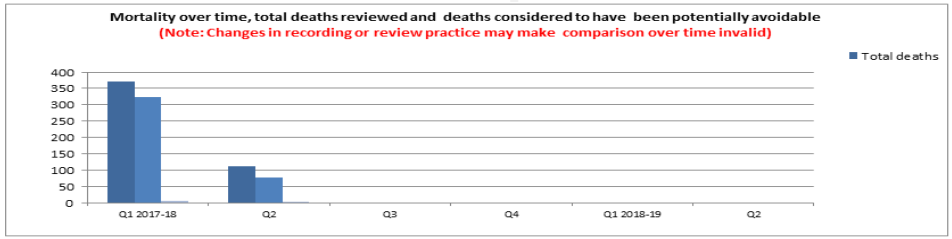
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
111	121	76	100	2	3
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
111	370	76	324	2	6
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
481	0	400	0	8	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

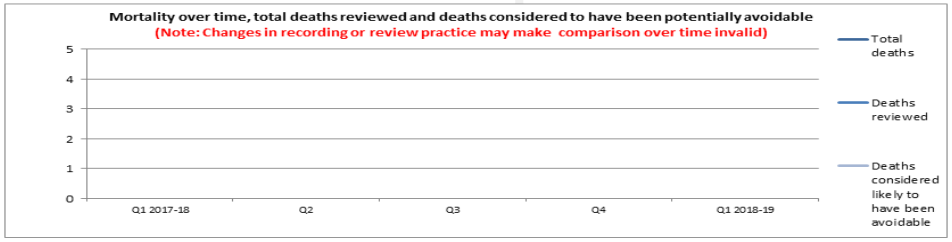
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	1	1.3%	This Month	1	1.3%	This Month	1	1.3%	This Month	0	0.0%	This Month	73	96.1%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	1.3%	This Quarter (QTD)	1	1.3%	This Quarter (QTD)	1	1.3%	This Quarter (QTD)	0	0.0%	This Quarter (QTE	73	96.1%
This Year (YTD)	0	0.0%	This Year (YTD)	5	1.3%	This Year (YTD)	3	0.8%	This Year (YTD)	7	1.8%	This Year (YTD)	9	2.3%	This Year (YTD)	376	94.0%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology (Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process)

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	4	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	0	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Meeting Title:	Trust Board		
Date:	7 September 2017	**Agenda No**	3.6
Report Title:	A Framework of Quality Assurance for Responsible Officers (RO) and Revalidation – Annual Report to the Board.		
Lead Director/ Manager:	Professor Andrew Rhodes, Medical Director		
Report Author:	Ms. Karen Daly, Responsible Officer and Associate Medical Director Nicola McDonald, Revalidation support officer		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	As a Designated Body, St George's University Hospitals NHS Foundation Trust and its Responsible Officer (RO) have statutory responsibilities that are monitored by NHS England. These responsibilities include the oversight of annual appraisal of the medical employees of the trust and the monitoring of their fitness to practice. This report contains the annual audit submission made to NHS England and a statement of compliance that the Trust Board is asked to sign off. **Key messages** In April 2017 medical revalidation entered its fifth year. Following the phased implementation of revalidation submissions across England (20% doctors in year 1 and 40% each in year 2 and 3), the majority of licensed doctors should have been revalidated by March 2016. Less numbers are scheduled to revalidate until April 2019. Several areas of the medical appraisal and revalidation process have been identified as needing to be tightened up in order to ensure that the medical personnel are fit to practice at our institution. This paper describes some of those areas.		
Recommendations:	The Board are asked to accept this annual report, which follows an annual audit submitted to NHS England in May 2017, covering the period 1 April 2016 to 31 March 2017. The Board are asked to approve the "statement of compliance" confirming that St George's University Hospitals NHS Foundation Trust is in compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).		
Supports			

Trust Strategic Objective:	1. Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. 2. Refresh the Trust's strategy, to develop a sustainable service model with a clear and consistent message. 3. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safety, Effectiveness, Responsive, Caring and Well Lead		
Single Oversight Framework Theme:	Medical workforce support and development		
Implications			
Risk:	Failure to develop the current system will contribute to poor medical engagement and failure to retain medical staff. There will be limited alignment of medical staff development with Trust strategy and objectives.		
Legal/Regulatory:	If we do not improve our appraisal systems there is a risk that recommendations to GMC for revalidation are not robust and we will also invite scrutiny from NHSE. This leaves the trust open to regulatory challenge and potential legal challenge.		
Resources:	The paper describes a number of areas where additional resources may be required in future. These will be requested through the standard trust processes.		
Previously Considered by:	Executive Directors	**Date** 24/8/2017	
Equality Impact Assessment:	NA		
Appendices:	• NHSE Annual Organisational Audit comparator report 2016/2017		

A Framework of Quality Assurance for ROs and Revalidation – Annual Report to the Board.

1.0 PURPOSE

1.1 Each year every designated body (DB) is required to submit a standard annual organisation audit (AOA) to NHS England for comparison against responses from designated bodies of a similar type, as well as all designated bodies in England. The AOA forms part of the Framework of Quality Assurance (FQA), to the Higher Level Responsible Officer (NHS England London) and the overarching programme of quality assurance of the systems and processes underpinning medical revalidation

1.2 As a Designated Body, St George's University Hospitals NHS Foundation Trust and its Responsible Officer (RO) have statutory responsibilities that are monitored by NHS England. The purpose of this paper is to satisfy the Board that the Trust works within a Framework of Quality Assurance and to confirm to NHS England that the Trust is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and confirm by submitting a signed Statement of Compliance.

2.0 BACKGROUND

2.1 Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

2.2 Medical Revalidation is a process, not a single event. By providing specific types of supporting information at each annual appraisal over the revalidation cycle, each doctor should, through reflection and discussion at appraisal, have demonstrated their practice against all 13 attributes outlined in the GMC's separate guidance, *Good medical practice Framework for appraisal and revalidation*.

3.0 GOVERNANCE ARRANGEMENTS

3.1 Every licensed doctor is responsible for updating the GMC with their DB details via their GMC online account. Each DB can then view who has connected to their organisation via the GMC revalidation portal "GMC Connect", and view each doctor's revalidation history and revalidation submission date to maintain internal appraisal and revalidation databases.

The Revalidation Support Officer (RSO) reviews these connections monthly. The RO submits revalidation recommendations via this portal.

3.2 The Trust does not currently use an electronic Revalidation Management System (RMS), therefore the RSO routinely sends doctors reminders of when their appraisal is due, manually updates records and databases and manually produces data reports for appraisal and revalidation.

4.0 MEDICAL APPRAISAL

4.1 *Appraisal and Revalidation Performance Data*

4.11 The RSO maintains an appraisal and revalidation spreadsheet of all licensed doctors who have connections to SGH and therefore SGH is responsible for supporting their appraisal. This spreadsheet, used in conjunction with the Medical Appraisal Guide (MAG) form, provides the overview of the medical revalidation process. The RSO saves each appraisal that is received by email, updates the doctor's ESR and updates the spreadsheet.

4.12 Using the appraisal and revalidation spreadsheet, each month the RSO produces a report of who is due/overdue an appraisal in order to send reminders to doctors and to produce a report of who is overdue to circulate to Clinical Leads to manage. The RSO records reasons for delayed/missed appraisals and escalates to the RO and Medical Director as appropriate. Any early concerns of non-engagement i.e. outside of 4-week revalidation notice period is escalated to the GMC.

4.13 The RSO compiles data for the quarterly appraisal reports and the annual organisation audit to NHS England.

4.14 The Medical Appraisal Annual Organizational Audit (AOA) submitted to NHS England for 2016/2017 recorded 805 doctors with a prescribed connection to St George's University Hospitals NHS Foundation Trust NHS Trust (SGH) as of 31st March 2017. The AOA recorded the appraisal compliance for all doctors with a prescribed connection as 82.2%. This is slightly lower than the national average; however compliance has increased each year (81.5% in 2015/2016 and 62.7% in 2014/2015). There are a few key indicators of the AOA that show that we are deviant to the norm and these are addressed in this report together with a set of suggestions of how to improve performance going forward.

4.2 *Appraisers*

4.21 The Trust currently has a pool of 138 trained medical appraisers which means we are within the national guidelines of between 1:5 and 1:20 per connected doctor. The Trust delivered two new appraiser workshops in 2016. In addition, all existing appraisers were asked to complete an e-learning package for refresher training. It is anticipated that we will run one new appraiser workshop per year, and make refresher e-learning mandatory on a 3-yearly basis.

4.3 Quality Assurance

4.31 The current process for quality assuring appraisals is that each individual appraisal file is reviewed by the RO prior to a revalidation recommendation being submitted to the GMC. The RO completes a revalidation checklist for each recommendation that is made. This provides assurance that:

- The appraisal "inputs" provided are available and appropriate.
- The appraisal "outputs" i.e. agreed personal development plan (PDP), appraisal summary and output statements are complete and to an appropriate standard
- Key items identified within the appraisal "inputs" as needing discussion during the appraisal are included in the appraisal "outputs"

4.4 Access, Security and Confidentiality

4.41 Doctors should use the Medical Appraisal Guide (MAG) form for their annual appraisal. The instructions within the MAG reminds Doctors to take care to abide by local confidentiality, data security and information governance protocols to remove all personally identifiable data. Once the MAG is agreed by appraiser and appraisee, it is sent to the RSO to keep on file and is only shared with the RO and others as appropriate.

4.5 Clinical Governance

4.51 The RSO checks DATIX and provides information of complaints within the appraisal period to each individual doctor prior to their appraisal. Confirmation is sent to individuals that they have/have not been named in any complaints. This ensures appropriate reflection where applicable. This process is not robust as to date the Trust has not recorded complaints against individual clinicians and has no central record of incidents and serious incident investigations that can reconcile back to individuals.

4.52 Doctors are asked to obtain information on complaints from other organisations they work in, to ensure appropriate reflection where applicable.

4.53 Transfer of information requests are sent to other organisations in which individuals work, prior to revalidation, to confirm they have no fitness to practice concerns.

4.54 Transfer of information may be sent to the RO or person with clinical governance responsibility, for any other organisations in which a doctor works, to notify any fitness to practice concerns.

5. REVALIDATION RECOMMENDATIONS

The number of revalidation recommendations between April 2016 and March 2017 totalled 85.

- 83 Recommendations were submitted on time.
- One recommendation was submitted late due to an administration error
- One recommendation was submitted late as the doctor did not update their designated body details until after their submission date.
  - The number of recommendations to revalidate totalled 52.
  - The number of recommendations to defer totalled 33.
  - There were no recommendations of Non-Engagement.

6. RESPONDING TO CONCERNS AND REMEDIATION

6.1 Medical Staff at St George's are monitored under the Maintaining High Professional Standards policy. This is the disciplinary policy for Medical and Dental Staff. In addition to this policy, there is a monthly meeting attended by the Medical Director, the Deputy Director of HR, Associate Medical Director (HR), Medical HR Manager and Divisional HR Manager (where appropriate) whereby current or possible formal cases are monitored to ensure sufficient progress. The RO meets regularly with Liaison Officers from the GMC and NCAS.

7. RISK and ISSUES

7.1 Key Findings from the AOA

Overall, the responses provided in the AOA were in line with DBs across England. However, there were some areas that showed SGH as an outlier.

7.11 The Designated Body and the Responsible Officer

RO has sufficient funds, capacity etc to carry out responsibilities of the role

SGH response to this statement was "No" compared to 93.9% of DBs who answered "yes". From attending network meetings such as RO networks and the London meetings attended by other Revalidation Support Officers (RSOs), it appears that DBs of a similar size have additional resources to SGH, for example, an electronic revalidation and appraisal systems to support administrative tasks that are currently manually carried out by the RSO.

DB has commissioned/undertaken an independent review of its processes

SGH response to this statement was "No" compared to 80.8% of DBs in the same sector who answered "yes". NHSE (London) Higher Level RO is required to carry out an independent verification review at least once per revalidation cycle for each DB in their region. The HLRO team visited SGH in March 2016 where they identified good areas of practice and suggested some areas for development. It is anticipated that SGH will undergo an internal audit and potentially a peer review with a DB of similar size and sector.

7.12 Section 2 - Appraisal

Every doctor has an explanation record for missed appraisal

A formal explanation for every doctor is not recorded; however, a note is made where an explanation is given. The current process is to circulate a monthly audit of overdue appraisals to Clinical Leads; however, it is only when a doctor is 3 months overdue that a formal explanation would be required by the RO.

Quality assuring a sample of inputs and outputs

Quality assurance is currently only provided by the RO and RSO reviewing the available data. There is no process embedded into our system to provide external quality assurance of this methodology.

Appraisers are supported in their role

Appraisers are suitably trained; however, there is currently no mechanism for monitoring and managing the performance of appraisers including appraisal calibration events and feedback from doctors on their appraisers.

7.13 Section 3 – Monitoring Performance

Monitoring fitness to practise of doctors

SGH response to this statement was "No" compared to 96% of DBs in the same sector who answered "yes". This answer arose from the observations of the RO of the functioning of the existing processes in the Trust and discussion with the responsible officers of other Trusts and the NHSE and NHSI representatives. In addition, the recent case of a rogue breast surgeon from

an external trust who had not been identified by their internal systems has precipitated some additional scrutiny of our processes. Although our systems to identify such behaviours and poor practices have evolved over time, it was reflected on that they could be considerably strengthened.

7.2 Additional findings

7.21 Policy and Guidance

- There is inconsistent ownership of the process of appraisal by Clinical Leads.
- There is no clear process for allocation of appraiser to doctor
- There is a lack of understanding by individual doctors and Clinical Leads of what is deemed an acceptable reason for delaying/missing an appraisal.
- There is no clear escalation process set out for doctors who do not engage in annual appraisal.
- Although significantly improved from previous years, some individual doctors and Clinical Leads remain unclear on the appraisal process for non-training non-Consultant grade doctors, particularly when they have come out of/going into training.

7.22 Appraisal and Revalidation Performance Data
The RSO currently uses an Excel spread-sheet to record completed appraisals. This makes it extremely difficult to produce data on appraisal and revalidation for the Trust and the quarterly and annual audits that NHS England requires.

7.3 Quality Assurance

7.31 The Trust needs to improve the quality of medical appraisal to comply with national regulations for medical appraisal and revalidation, including the statutory duty of the Trust as a Designated Body and of the RO to make recommendations to the GMC about a doctor's revalidation status.

7.32 Quality assessment of appraisal inputs (supporting information and reflection provided by Doctor) and outputs (agreed PDP, appraisal summary and statements provided by appraiser) only takes place shortly before revalidation when the RO reviews the portfolio. This is time consuming and not sustainable now that there are several years to review.

7.33 There is no mechanism for monitoring and managing the performance of appraisers.

7.4 Clinical Governance

Triangulation of the information held by the risk, governance and complaints bodies need to take place.

8.0 NEXT STEPS

8.1 The RSO is currently working with the RO and Medical HR Manager to update the Medical Appraisal Policy and align to the NHS England policy. This will clarify who is responsible for what and who they are accountable to. It will also outline processes and associated timescales for having an appraisal, requesting a postponement of appraisal and escalating early concerns of non-engagement. From this, the RO can begin to implement a quality assurance process to improve both inputs and outputs of the appraisal.

8.2 The RO is working with the clinical divisions to appoint a series of senior appraisal leads who will assist the RO in the appraisal process and provide leadership and support to the Trust appraisers. This team will work together to develop a quality assurance process for the revalidation and appraisal mechanisms.

8.3 The RSO is liaising with the RO and ICT Business Engagement Lead to develop the case to procure an electronic appraisal management system. This will enable accurate reporting of medical appraisal data as well as reduce the administrative burden on the RSO, allowing them to implement other required processes i.e. for quality assurance.

8.4 A Medical Appraisal Revalidation advisory group will be set up to triangulate data to support the RO with making recommendations.

9.0 RECOMMENDATIONS

9.1 The Board are asked to accept this annual report and audit. This report will be shared with NHS England along with the quarterly information reports and annual audit.

9.2 The Board are asked to approve the “statement of compliance” confirming that St George’s University Hospitals NHS Foundation Trust, as a designated body is in compliance with the Revalidation regulations.

Appendix 1.

1.1.1 Statement of Compliance

Designated Body Statement of Compliance

The board of St George's University Hospitals NHS Foundation Trust can confirm that:

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Comments: RO appointed in May 2016 – training attended in November 2015.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Comments: The GMC Connect database is reviewed in full on a monthly basis and on a day to day basis in case of a new connection with imminent revalidation due.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Comments: Yes. In order to meet national requirements of 1:5 to 1:20

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Comments: Carried over from previous year, SGH still needs to implement a quality assurance process to include recruitment of appraisal leads and appraiser feedback and calibration events.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: The MAG is used for all medical appraisals (excluding doctors with training no.). There is an escalation process for doctors who go three months overdue their annual appraisal.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Comments: A number of separate systems are inspected in order to aid decision making. These include: MAST compliance and complaints. An external system (Equiniti) is used for MSF. More work is required to ensure that appraisal inputs include relevant clinical outcomes (National audit etc.) and a system is in development to assure the Trust that there is appropriate reflection on significant events.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: Formals processes to include referral to occupational health, MHPS, NCAS and/or GMC liaison.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

9.

Comments: Where doctor works for multi-organisations, information is transferred from RO to RO using the MPIT form.

10. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: Medical Staffing Team carry out the 6 NHS Employment Check Standards that outline the type and level of checks employers must carry out before recruiting staff into NHS positions.

11. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: Yes.

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

Dr Mike Prentice
Revalidation Lead
NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

PA Contact Details:
Tracy.calvert@nhs.net
Tel: 0113 825 3052

21 July 2017

Our Ref: 896
Publications Gateway Reference 06810

Ms Karen Daly
Responsible Officer
St George's Healthcare NHS Trust

Dear Ms Daly

Medical Revalidation Annual Organisational Audit (AOA) Comparator Report for: 896 - St George's Healthcare NHS Trust

I am writing to thank you for submitting a response to the NHS England 16/17 Annual Organisational Audit (AOA) exercise.

Please find enclosed a report that sets out your response to the exercise. The report also compares your organisation's submission with that of other designated bodies across England, both in a similar sector and nationwide.

The AOA exercise is designed to help designated bodies assure themselves and their boards (or equivalent management bodies) that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, and the arrangements for medical appraisal and responding to concerns, are in place and functioning effectively. Similarly, it provides a mechanism for assuring NHS England that the systems in place are functioning effectively and consistently.

In this the fourth year of the AOA, and the eighth consecutive year of monitoring medical revalidation, I am pleased to report a continuing upward trend, not only in the overall appraisal rate, but also the improvement of the system in general. I would like to thank you once again for your continued work to ensure that thorough revalidation and clinical governance processes are in place across the healthcare system.

On reviewing the results presented below, designated bodies should produce an action plan to address any development needs that are identified. If you need support in improving any element of your revalidation systems, your local revalidation team (contact details below) can help you.

Your higher level responsible officer	Dr Vin Diwaker
Your local revalidation team's lead contact	Ray Field
Your local revalidation team's contact details	england.revalidation-london@nhs.net

Board-level accountability for the quality and effectiveness of these systems is important and this report, along with the resulting action plan, should be presented to the board, or an equivalent management body. Including the report in an NHS organisation's Quality Account is also good practice.

This letter has been sent to the responsible officer recorded in the AOA return at 31 March 2017. If you are no longer the responsible officer, please pass this report on to the new responsible officer immediately, or to the Chief Executive of the organisation. If there are any changes to notify, or you have any queries, please contact your local revalidation team.

Please note that for transparency and openness, your submitted AOA return will be shared with your higher level responsible officer and some elements of the return will be shared with the appropriate regulatory bodies.

A more detailed report including the anonymised results of all organisations involved in this AOA exercise will be published in the autumn.

I would like to take this opportunity to thank you for providing assurance to your higher level RO, and to NHS England, of your processes.

Further information on revalidation can be found at www.england.nhs.uk/revalidation

Yours sincerely

Dr Mike Prentice
Revalidation Lead
NHS England

cc: Your higher level responsible officer

cc: Your local revalidation team's lead contact

YOUR ANNUAL ORGANISATIONAL AUDIT

Analysis is based on the total of 821 returns from designated bodies (DBs) to the 2016/17 Annual Organisational Audit (AOA) exercise for the year ending 31 March 2017 which had been received by NHS England by 21 July 2017

The following information is presented as per your own AOA submission.

Name of designated body:	St George's Healthcare NHS Trust
Name of responsible officer:	Ms Karen Daly
Sector:	Acute hospital/secondary care foundation trust
Prescribed connection to:	NHS England (Regional Team - London)

Please note:

a) In some instances, data was not suitable for comparative reporting. In these cases your own response may be reported, but comparative data is not. An explanation is given for this within the report. If you require further information on these areas, please contact your local revalidation lead:

Ray Field at england.revalidation-london@nhs.net.

b) Only the questions asked are presented below. Please refer to AOA 2016/17 for the full indicator definitions if required.

2016/17 AOA indicator SECTION 1: The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 821
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.4	A responsible officer has been nominated/appointed in compliance with the regulations.	Yes	98 (99.0%)	816 (99.4%)
1.5	Where a conflict of interest or appearance of bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?	N/A	This question is not applicable to many DBs	
1.6	In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.	No	93 (93.9%)	801 (97.6%)
1.7	The responsible officer is appropriately trained and remains up to date and fit to practice in the role of responsible officer.	Yes	98 (99.0%)	813 (99.0%)
1.8	The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.	Yes	98 (99.0%)	816 (99.4%)
1.9	The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.	Yes	99 (100.0%)	808 (98.4%)

2016/17 AOA indicator SECTION 1 (cont.): The Designated Body and the Responsible Officer		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 821
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
1.10	The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.	Yes	99 (100.0%)	813 (99.0%)
1.11	The governance systems (including clinical governance where appropriate) are subject to external or independent review.	Yes	99 (100.0%)	801 (97.6%)
1.12	The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation. (*including peer review, internal audit or an externally commissioned assessment)	No	80 (80.8%)	655 (79.8%)

2016/17 AOA indicator SECTION 2: Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 821
2.1	**Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017**	No. of doctors (in organisation)	Total no. of doctors (in SAME sector)	Total no. of doctors (across ALL sectors)
2.1.1	Consultants	506	26270	50102
2.1.2	Staff grade, associate specialist, specialty doctor	19	5258	11974
2.1.3	Doctors on Performers Lists	0	5	46345
2.1.4	Doctors with practising privileges	0	0	2377
2.1.5	Temporary or short-term contract holders	280	6452	17825
2.1.6	Other doctors with a prescribed connection to this designated body	0	456	6823
2.1.7	**Total number of doctors with a prescribed connection**	805	38441	135446

2016/17 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 821
		Completed appraisals (Measure 1a & 1b)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2017 who had a completed annual appraisal between 1 April 2016 – 31 March 2017**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	435 (86.0%)	90.9%	91.7%
2.1.2	Staff grade, associate specialist, specialty doctor	16 (84.2%)	84.3%	87.0%
2.1.3	Doctors on Performers Lists	N/A	100.0%	95.2%
2.1.4	Doctors with practising privileges	N/A	N/A	87.4%
2.1.5	Temporary or short-term contract holders	211 (75.4%)	71.5%	78.8%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	80.5%	91.2%
2.1.7	**Total number of doctors who had a completed annual appraisal**	662 (82.2%)	86.6%	90.7%

2016/17 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 821
		Approved incomplete or missed appraisal (Measure 2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2017 who had an Approved incomplete or missed appraisal between 1 April 2016 – 31 March 2017**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	10 (2.0%)	4.5%	4.7%
2.1.2	Staff grade, associate specialist, specialty doctor	0 (0%)	8.4%	7.4%
2.1.3	Doctors on Performers Lists	N/A	0.0%	4.2%
2.1.4	Doctors with practising privileges	N/A	N/A	10.3%
2.1.5	Temporary or short-term contract holders	5 (1.8%)	17.1%	12.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	7.0%	6.4%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	15 (1.9%)	7.2%	6.0%

2016/17 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 821
		Unapproved incomplete or missed appraisal (Measure 3)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2017 who had an Unapproved incomplete or missed annual appraisal between 1 April 2016 – 31 March 2017**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	61 (12.1%)	4.5%	3.5%
2.1.2	Staff grade, associate specialist, specialty doctor	3 (15.8%)	7.3%	5.6%
2.1.3	Doctors on Performers Lists	N/A	0.0%	0.6%
2.1.4	Doctors with practising privileges	N/A	N/A	2.3%
2.1.5	Temporary or short-term contract holders	64 (22.9%)	11.4%	8.6%
2.1.6	Other doctors with a prescribed connection to this designated body	N/A	12.5%	2.4%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	128 (15.9%)	6.2%	3.3%

2016/17 AOA indicator SECTION 2 (cont.): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 821
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
2.2	Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded.	No	This question is not applicable to many DBs	
2.3	There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group).	Yes	98 (99.0%)	799 (97.3%)
2.4	There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.	No	97 (98.0%)	801 (97.6%)
2.5	There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.	Yes	97 (98.0%)	793 (96.6%)
2.6	The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection.	Yes	98 (99.0%)	806 (98.2%)
2.7	Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.	No	96 (97.0%)	793 (96.6%)

2016/17 AOA indicator SECTION 3: Monitoring Performance and responding to concerns SECTION 4: Recruitment and Engagement		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 821
		Your organisation's response	No. of DBs in same sector and (%) that said 'Yes'	No. of DBs in all sectors and (%) that said 'Yes'
3.1	There is a system for monitoring the fitness to practice of doctors with whom the designated body has a prescribed connection.	No	95 (96.0%)	809 (98.5%)
3.2	The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health and fitness to practice concerns) which is ratified by the designated body's board (or an equivalent governance or executive group).	Yes	99 (100.0%)	808 (98.4%)
3.3	The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.	Yes	99 (100.0%)	802 (97.7%)
3.4	The designated body has arrangements in place to access sufficient trained case investigators and case managers.	Yes	93 (93.9%)	765 (93.2%)
4.1	There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).	Yes	98 (99.0%)	813 (99.0%)

2016/17 AOA indicator SECTION 5: Comments		Your organisation's response
5.1	1.6 Currently have Responsible Officer, 1 admin support and no electronic appraisal management system. Business plan being put together for electronic appraisal management system. Review of appraisal policy should progress to having a/several appraisal leads to support RO. 2.1 The current system/process does not record that an appraisal took place in accordance with all 3 parameters to include under "1a". There is currently no formal process for the RO to agree missed appraisals, so other than those on maternity leave or sabbatical, we include under "3". 2.2 A formal explanation for every doctor is not recorded, however a note is made where an explanation is given. The current process is to circulate a monthly audit of overdue appraisals to clinical leads, however it is only when a Dr is 3months overdue that a formal explanation would be required by the RO. 2.3 We have answered "yes" but the policy is currently under review. 2.4 RO quality assures at point of revalidation submission, however need to implement processes in line with QAMA. 2.7 Appraiser are suitably trained, however need to implement processes in line with QAMA. 3.1 Can answer "yes" to most criteria under this heading, however, more reactive to data signals externally.	

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Trust Board – 7th September 2017
Reporting period - July 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	
		Jul-16	Jul-17	Variance	Plan Jul-17	Variance	YTD 16/17	YTD 17/18	Variance	Plan YTD	Variance
ED	ED Attendances	14,194	14,092	-0.72%	14,715	-4.23%	55,790	56,336	0.98%	57,910	-2.72%
Inpatient	Elective & Daycase	4,278	4,223	-1.29%	4,426	-4.59%	16,927	18,077	6.79%	17,932	0.81%
	Non Elective	4,164	3,932	-5.57%	4,374	-10.11%	16,528	15,810	-4.34%	17,188	-8.02%
Outpatient	OP Attendances	52,365	53,264	1.72%	50,659	5.14%	215,308	213,007	-1.07%	205,106	3.85%

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

Source: SLAM

Executive Summary – July 2017

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- One patient suffered a Never Event in July 2017 reporting two cases year to date. There were 11 Serious Incidents (SI's)
- Patient safety thermometer- % of patients with harm free care (all harm) further deteriorated to 93.8%
- In July the Trust reported two patients with hospital attributable Clostridium Difficile Infection, which brings the trust year to date total to 5 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 July reporting a performance of 89.76% of patients admitted, discharged or transferred within four hours of arrival, this was also below the improvement trajectory agreed with NHSI
- Six out of eight cancer standards were met in June, the two standards not achieved are 14 day standard and breast symptomatic
- 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

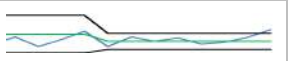
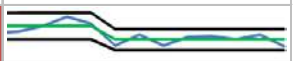
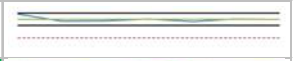
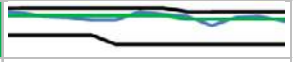
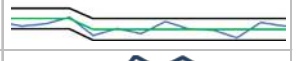
Patient Experience

- The Friends and Family Test (FFT) recommendation rate for inpatients was 96.6% in July and remains above threshold, providing a level of assurance for patient experience

Workforce

- Staff sickness remains above the trust target of 3%
- Mandatory and Statutory Training (MAST) compliance and staff appraisal rates have improved

Patient Safety

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)
Number of Never Events in Month	0	1	0	0	0	0	0	1	0	0	0	1	1	
Number of SIs where Medication is a significant factor	0	0	0	0	2	0	1	0	0	0	0	0	1	
Number of Serious Incidents	N/A	8	4	7	10	4	8	6	8	5	6	8	11	
Serious Incidents - per 1000 bed days	N/A	0.59	0.30	0.52	0.76	0.30	0.58	0.46	0.56	0.37	0.43	0.58	0.80	
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.0%	95.6%	96.5%	95.8%	93.7%	94.7%	93.7%	94.5%	94.6%	94.3%	94.7%	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%	
Percentage of patients who have a VTE risk assessment	95%	96.7%	96.3%	96.2%	95.9%	95.9%	96.8%	96.5%	96.3%	95.3%	96.2%	96.3%	95.8%	
Number of Patient Falls	N/A	140	155	128	154	116	161	137	154	105	125	124	139	
Number of patient falls- per 1000 bed days		10.26	11.76	9.46	11.69	8.79	11.76	10.48	10.70	7.87	9.01	8.94	10.12	
Attributable Grade 2 Pressure Ulcers per 1000 bed days	N/A	1.69	1.90	2.51	0.76	1.44	0.95	2.14	1.39	1.27	0.50	2.02	1.67	
Attributable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00	0.00	0.00	0.00	0.00	0.08	0.22	0.15	0.21	0.15	0.07	0.00	0.07	
Number of overdue CAS Alerts	0	1	1	1	1	1	1	1	1	1	1	0	0	

Briefing

- One patient suffered a Never Event in July 2017, bringing the trust total to two, year to date.
- The Trust declared 11 serious incidents in July 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 threshold of 95%. This was due to 86 harms being reported across 1,381 patient's. 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.

St George's University Hospitals NHS
NHS Foundation Trust

Infection Control

Indicator Description	Threshold	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)
MRSA (Incidences in month)	0	0	0	1	0	0	0	1	0	2	0	2	0	
Cdiff Incidences (in month)	31	2	3	6	4	4	3	4	3	1	1	1	2	
MSSA	N/A	0	4	6	5	0	7	2	2	3	2	4	4	
E-Coli	N/A	1	6	5	3	2	6	3	11	4	2	1	9	

Briefing

- There were two patients reported who suffered with a hospital acquired Clostridium Difficile Infection in July.
- C Diff threshold for 2017/18 remains the same as the previous year at 31 cases. There have been five 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 July, the Trust year to date total remains at four.

Actions:

Root cause analysis is under way for the two C diff incidences detected in July. 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	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
Hospital Standardised Mortality Ratio (HSMR)	100	85.3	84.3	88.9	84.1	84.1	84.1	83.3	82.5	83.5	81.3	81.3	79.7	
Hospital Standardised Mortality Ratio Weekday Emergency	100	88.1	83.2	86.6	84.2	82.4	82.4	81.1	79.2	80.1	78.2	78.2	81.3	
Hospital Standardised Mortality Ratio Weekend Emergency	100	0.92	0.87	0.94	0.92	0.87	0.87	0.87	0.84	0.86	0.83	0.83	0.76	
Summary Hospital Mortality Indicator (SHMI)	100	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.86	0.84	0.84	0.84	
Emergency Readmissions within 30 days following non elective spell (one month in arreas)	TBC	10.9%	10.5%	10.7%	10.8%	11.7%	10.7%	12.2%	11.3%	12.8%	11.8%	13.8%	12.07%	

Briefing

- Latest HSRM and SHMI data for the Trust shows mortality remains lower than expected for our patient group when benchmarked against national comparators
- Readmission rates following an emergency spell remain above internal threshold, predominantly within non elective spells. A data quality review is underway as there appears to be some data quality issues.

Maternity

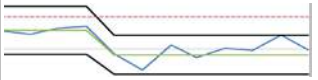
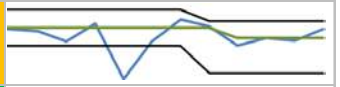
- Maternity indicators continue to be monitored and reviewed by the Divisional Governance process

Indicator Description	Threshold	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
C Section Rate - Emergency and Non Elective	28%	23.0%	24.4%	26.8%	26.1%	28.4%	28.8%	29.6%	34.1%	29.9%	29.1%	24.6%	29.5%	
Admission of full term babies to neo-natal care		7	4	13	1	2	2	7	2	11	2	16	21	

Actions: To be confirmed at the Finance and Performance Committee Meeting

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	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
4 Hour Operating Standard	95%	92.74%	92.24%	93.21%	93.50%	89.14%	86.63%	90.59%	89.09%	90.50%	89.68%	92.12%	89.76%	
Patients Waiting in ED for over 12 hours following DTA	0	0	0	0	0	1	0	1	0	0	1	0	0	
Ambulance Turnaround - % under 15 minutes	100%	53.2%	56.1%	52.1%	53.8%	49.9%	46.9%	52.4%	50.2%	46.0%	48.4%	51.9%	48.9%	
Ambulance Turnaround - % under 30 minutes	100%	97.4%	97.2%	98.2%	97.8%	96.6%	96.4%	98.1%	97.6%	96.1%	96.7%	96.5%	97.4%	
Ambulance Turnaround - number over 60 minutes	0	0	0	0	0	0	0	0	0	0	1	0	0	

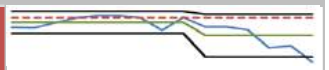
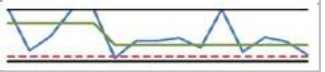
Briefing

- The Four Hour Operating Standard was not achieved in July reporting a performance of 89.76%, this was also below the improvement trajectory agreed with NHSI.
- Ambulance turnaround performance continues to be stable with turnaround times under 30 minutes improve, however further improvements to be gained.
- Much work is underway to further improve patient flow (expanding space for ambulatory care) and thus improve patient safety and experience

Actions

- Weekly “Communications Cell” in place to review the previous week’s performance and share lessons learned and agree actions.
- Initial assessment area has been expanded with a focus on streaming patients through to the most clinically appropriate flow, either primary care, urgency care or an ambulatory pathway.
- 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 Medical and Cardiothoracic Division supported by clinicians throughout the Trust is in progress which will aim to reduce emergency admissions, reduce length of stay and 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	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Trend (12 months)
Cancer 14 Day Standard	93%	93.1%	95.1%	94.2%	93.2%	85.7%	93.3%	87.9%	87.9%	86.0%	75.4%	76.6%	67.4%	
Cancer 14 Day Standard Breast Symptomatic	93%	93.8%	94.2%	96.0%	98.9%	94.8%	93.2%	94.0%	93.4%	87.2%	82.7%	84.1%	62.9%	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	100%	100%	93.8%	98.8%	96.0%	96.0%	95.1%	100.0%	94.6%	96.4%	95.9%	94.2%	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	98.4%	100.0%	100%	99%	100%	100%	100%	100%	
Cancer 31 Day Diagnosis to Treatment	96%	97.6%	97.4%	96.2%	97.2%	96.9%	96.6%	96.4%	97.5%	96.7%	96.4%	96.4%	96.8%	
Cancer 62 Day Referral to Treatment Standard	85%	90.2%	86.6%	88.3%	88.8%	80.0%	85.2%	87.7%	86.6%	86.3%	89.0%	87.3%	85.4%	
Cancer 62 Day Referral to Treatment Screening	90%	95.0%	95.8%	92.0%	96.2%	92.7%	92.7%	93.0%	96.2%	92.6%	92.7%	92.4%	92.5%	

Briefing

- The national standard to see all suspected cancer patients within 14 days of referral was not achieved at Trust level including within nine tumour groups, reporting a Trust performance of 67.4% in June
- There is a significant capacity shortfall in Urology and Lower Gastrointestinal, the later seeing a 31% increase in referrals within the last 3 months.
- 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

- 14 Day Standard and breast symptomatic recovery plan submitted to NHSI with the standards targeted to be achieved from August 17 in all tumour groups except Lower GI where compliance not expected to be achieved until October.
- Increased leadership and management support given to TWR office. Additional staff from central booking office provided to help clear backlog.
- Additional consultants have now been appointed for dermatology – summer plan in place and additional sessions being provided to clear all backlog. Compliance expected from August.
- FNA capacity issue raised with commissioners to identify a system wide solution to identify local health system solution to support Croydon.

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Brain	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%	100.0%	66.7%	100.0%	100.0%	100.0%	0.0%	100.0%
Breast	91.4%	96.2%	95.6%	98.6%	96.1%	95.1%	93.0%	96.1%	89.9%	92.3%	88.7%	84.7%	69.5%
Childrens	100.0%	100.0%	100.0%	100.0%	100.0%	55.6%	100.0%	100.0%	100.0%	90.0%	66.7%	80.0%	66.7%
Gynaecology	96.7%	89.3%	90.1%	93.3%	89.8%	93.0%	95.7%	76.0%	75.4%	87.1%	64.6%	66.7%	75.6%
Haematology	92.0%	88.0%	93.8%	96.3%	95.2%	90.9%	100.0%	100.0%	100.0%	95.8%	76.2%	96.9%	76.9%
Head & Neck	90.6%	94.8%	97.4%	94.5%	95.4%	96.3%	95.9%	98.4%	97.4%	97.9%	90.9%	84.9%	82.4%
Lower Gastrointestinal	93.2%	93.4%	98.4%	95.3%	94.4%	93.6%	98.3%	95.7%	95.7%	90.5%	75.1%	90.7%	44.4%
Lung	87.2%	92.1%	88.1%	100.0%	97.9%	94.9%	100.0%	98.2%	100.0%	100.0%	96.2%	91.1%	91.2%
Skin	84.5%	91.7%	92.3%	92.1%	86.3%	59.8%	79.4%	67.1%	67.7%	57.4%	29.4%	48.1%	26.9%
Upper Gastrointestinal	91.5%	95.9%	88.3%	87.9%	100.0%	98.6%	96.6%	87.8%	95.3%	94.2%	88.8%	96.1%	93.8%
Urology	91.2%	93.0%	97.5%	90.5%	95.8%	96.3%	96.9%	98.1%	95.0%	98.4%	96.1%	90.1%	82.3%

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Brain	100.0%	-	-	-	100.0%	100.0%	-	-	-	100.0%	50.0%	-	0.0%
Breast	100.0%	82.6%	100.0%	100.0%	100.0%	100.0%	86.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Childrens	100.0%	-	-	-	-	-	-	-	100.0%	-	-	-	-
Gynaecology	75.0%	100.0%	66.7%	60.0%	100.0%	80.0%	92.3%	100.0%	100.0%	50.0%	100.0%	90.9%	100.0%
Haematology	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	70.0%	80.0%	66.7%	100.0%	100.0%	100.0%	100.0%
Head & Neck	50.0%	75.0%	66.7%	80.0%	85.7%	50.0%	100.0%	63.6%	72.7%	75.0%	58.3%	85.7%	46.2%
Lower Gastrointestinal	40.0%	75.0%	100.0%	83.3%	83.3%	66.7%	93.3%	76.5%	66.7%	71.4%	-	62.5%	100.0%
Lung	63.6%	100.0%	84.6%	100.0%	69.6%	68.8%	66.7%	80.0%	78.6%	73.7%	85.7%	85.7%	64.3%
Skin	95.7%	100.0%	95.7%	96.8%	92.3%	80.0%	100.0%	100.0%	95.5%	100.0%	93.3%	96.4%	95.7%
Upper Gastrointestinal	50.0%	66.7%	37.5%	100.0%	66.7%	85.7%	100.0%	50.0%	11.1%	100.0%	100.0%	100.0%	100.0%
Urology	80.0%	94.9%	87.0%	81.3%	93.5%	72.7%	70.4%	85.2%	87.9%	83.9%	90.0%	67.9%	81.8%

Diagnostics

Indicator Description	Threshold	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
6 Week Diagnostic Performance	1%	0.8%	0.9%	0.8%	0.7%	2.2%	5.1%	2.8%	2.9%	4.1%	3.3%	2.6%	2.7%	
6 Week Diagnostic Breaches		51	56	57	50	151	372	219	222	313	248	197	190	
6 Week Diagnostic Waiting List Size		6,085	6,258	6,834	6,878	6,906	7,358	7,871	7,678	7,559	7,443	7,584	6,989	

Indicator Description	Threshold	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
MRI	1%	2.1%	1.9%	1.0%	1.1%	1.7%	9.6%	4.3%	3.3%	2.6%	1.1%	0.6%	0.8%	
CT	1%	0.0%	0.3%	0.0%	0.0%	0.1%	0.6%	0.0%	0.7%	1.5%	0.5%	0.2%	0.2%	
Non Obstetric Ultrasound	1%	0.2%	0.0%	0.0%	0.1%	1.0%	3.0%	1.9%	3.0%	4.0%	2.5%	0.3%	1.1%	
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%	0.0%	0.6%	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%	0.0%	4.5%	2.5%	6.5%	10.1%	11.3%	4.6%	
Echocardiography	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%	1.2%	9.4%	2.0%	3.0%	
Electrophysiology	1%	0.0%	100.0%	25.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	75.0%	75.0%	
Peripheral Neorophys	1%	4.5%	3.4%	1.2%	2.6%	0.4%	0.5%	0.0%	0.5%	0.0%	0.0%	0.0%	0.8%	
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%	0.0%	50.0%	47.1%	80.0%	15.4%	0.0%	52.6%	55.0%	65.5%	75.6%	64.4%	64.2%	
Colonoscopy	1%	0.0%	0.0%	2.3%	1.4%	3.6%	20.2%	5.7%	8.7%	5.7%	4.7%	0.5%	1.8%	
Flexi Sigmoidoscopy	1%	1.6%	1.4%	5.3%	0.0%	10.5%	20.8%	12.0%	8.4%	6.7%	0.0%	1.1%	4.9%	
Cystoscopy	1%	6.9%	11.3%	2.8%	10.6%	28.3%	14.4%	9.9%	2.6%	15.0%	11.5%	24.4%	14.0%	
Gastroscopy	1%	0.0%	0.0%	4.0%	0.9%	7.2%	10.1%	3.2%	4.5%	12.7%	10.0%	9.2%	11.2%	

Briefing: In July 2.7% 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	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
Number of on the Day Cancellations		52	59	52	103	60	104	91	63	65	47	56	47	
Number of on the Day cancellations re-booked within 28 Days		42	56	49	88	45	92	89	56	61	45	52	43	
% of Patients re-booked within 28 Days	100%	80.8%	94.9%	94.2%	85.4%	75.0%	88.5%	97.8%	88.9%	93.8%	95.7%	92.9%	91.5%	

Briefing

- The number of patient procedures cancelled on the day has decreased in the month of July reporting 47 cancellations. Of the patients cancelled 91.5% (43) 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.

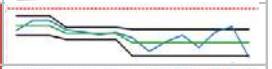
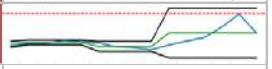
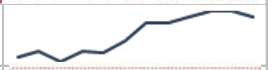
Patient Voice

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
Emergency Department FFT - % positive responses	90%	85.1%	83.1%	86.6%	84.4%	82.3%	85.0%	86.3%	82.8%	85.2%	83.0%	85.2%	83.9%	
Inpatient FFT - % positive responses	95%	95.6%	94.4%	95.4%	97.5%	95.9%	96.2%	96.9%	96.7%	95.8%	97.3%	96.0%	96.6%	
Maternity FFT - Antenatal - % positive responses	90%	80.0%	No Responses						100%		85.7%	100.0%	100.0%	
Maternity FFT - Delivery - % positive responses	90%	100%	95.0%	93.0%	100%	87.0%	89.0%	93.0%	97.0%	88.2%	100.0%	100.0%	95.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	88.0%	96.0%	92.0%	95.0%	95.0%	95.0%	93.0%	90.0%	94.1%	97.9%	95.4%	87.1%	
Maternity FFT - Postnatal Community Care - % positive responses	90%	87.0%	100%	93.0%	100%	100%	100%	100.0%	100%	100%	100%	100%	100%	
Community FFT - % positive responses	90%	96.9%	93.2%	88.2%	96.5%	94.7%	96.6%	96.2%	93.0%	93.0%	97.6%	96.3%	94.5%	
Outpatient FFT - % positive responses	90%	90.7%	86.9%	87.6%	94.9%	92.3%	94.8%	91.7%	88.1%	92.6%	95.6%	96.6%	94.2%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints		94	91	67	92	56	85	73	79	63	76	75	61	

- ED Friends and Family Test (FFT) – The score has decreased slightly in July reporting 83.9% , meaning that the percentage of patients recommending the service decreased. 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, however significant improvements have been made with the percentage of patients responding increasing by 22.41% in July.
- The Trust complaints performance has remained consistent, however is below the Trusts internal target reporting on average 65% of complaints being responded to within 25 working days, this has been variable amongst different care groups. The number of patient complaints have reduced to 61 in the month of July.

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. To reduce our response times to patients following a complaint the complaints management team have been incorporated into the Quality Improvement Plan focusing on responsiveness and engagement, quality of responses and learning and improving the service

Workforce

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
Trust Level Sickness Rate	3%	3.4%	3.5%	3.6%	3.8%	3.7%	4.2%	3.8%	3.3%	3.2%	3.4%	3.4%	3.6%	
Trust Vacancy Rate	10%	16.3%	15.7%	15.0%	14.7%	15.3%	15.1%	15.1%	15.4%	16.3%	17.0%	17.1%	16.1%	
Trust Turnover Rate* Excludes Junior Doctors	10%	18.5%	18.5%	18.5%	18.0%	18.1%	18.4%	18.5%	19.1%	19.1%	19.1%	18.8%	18.4%	
Total Funded Establishment		9,741.99	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	
IPR Appraisal Rate - Medical Staff	90%	82.4%	81.5%	82.2%	80.5%	76.0%	79.2%	81.3%	77.3%	82.4%	82.0%	74.2%	84.8%	
IPR Appraisal Rate - Non Medical Staff	90%	69.9%	69.0%	66.2%	65.6%	64.1%	67.5%	70.4%	72.8%	80.3%	78.2%	76.1%	76.1%	
% of Staff who have completed MAST training (in the last 12 months)		79.0%	80.0%	78.3%	80.0%	79.7%	81.9%	85.0%	85.0%	85.9%	87.0%	87.0%	86.0%	
Ward Staffing Unfilled Duty Hours	10%	5.4%	4.8%	5.1%	5.7%	6.2%	4.6%	6.2%	4.8%	5.5%	4.8%	5.8%	TBC	
Safe Staffing Alerts	0	5	5	9	11	11	11	7	2	0	0	1	2	

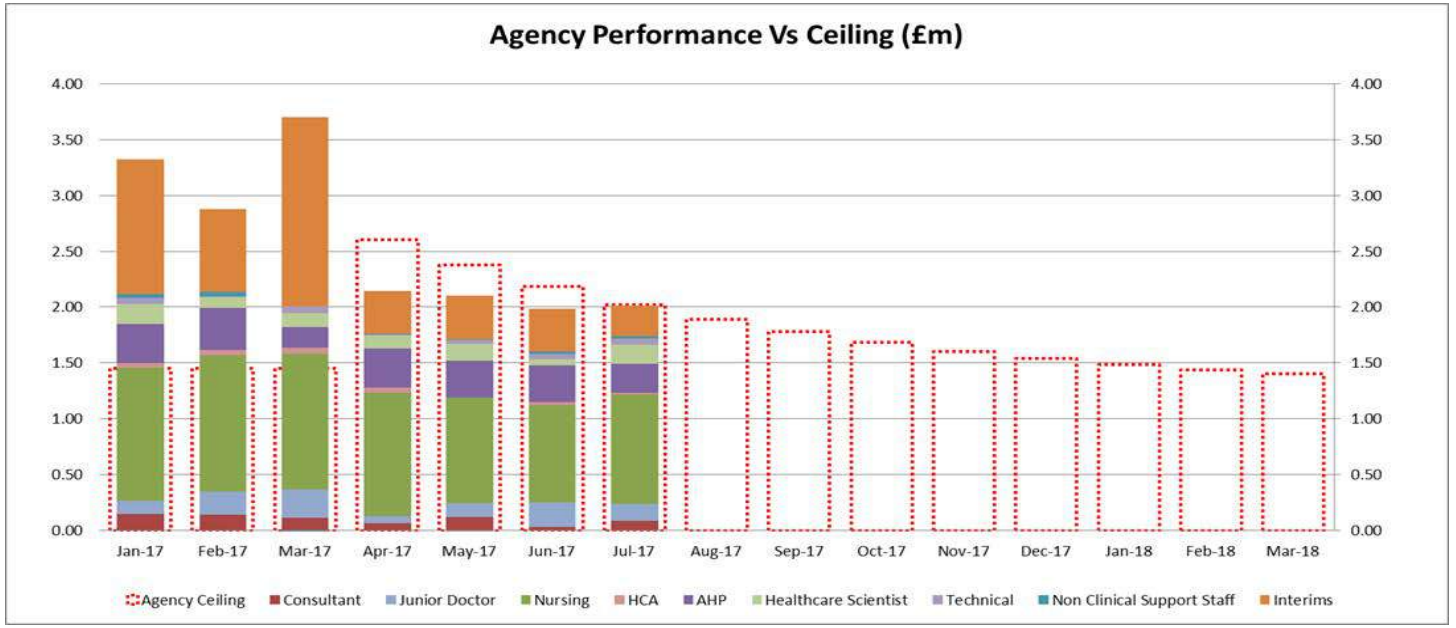
Briefing

- Funded Establishment decreased by 68.98 WTE to 9,878.79 WTE in July
- Vacancy Rate across all staff group has seen a reduction to 16.1%
- Turnover has fallen slightly to 18.4% for all staff groups.(excludes Junior doctors on rotation).
- Sickness has increased to 3.6% compared to 3.4% in the month previous
- Mandatory and Statutory Training figures for July 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 in June, however July shows a higher compliance and there has been an on-going improvement in the last year.

Actions To be updated at Finance and Performance Committee

St George's University Hospitals NHS
NHS Foundation Trust

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 July, the monthly target set was £2.02m.Total agency cost in June was £2.01m or 5.0% of the total pay costs
- In Q4 2016/17, the average agency cost was 8.1% of total pay costs
- Agency cost increased by £0.03m compared to June. In 2017/18 YTD, the Trust has performed better than the planned target by £0.97m

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Board meeting		
Date:	7 September 2017	**Agenda No**	4.3
Report Title:	Winter Preparedness 2017-18		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Brendan McDermott, Head of Operations		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Assurance		
Executive Summary:	This report updates the Board on the Trust's preparedness for winter 2017-18 including: • Capacity management planning and the Trust's Cold Weather Plan, and engagement to support effective implementation • Supporting delivery of local healthcare system-wide resilience planning co-ordinated by the A&E Delivery Board, aligned to NHSE and NHSI priorities		
Recommendation:	The Trust Board is asked to receive and note the winter plan.		
Supports			
Trust Strategic Objective:	• Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience. • Deliver our Transformation Programme to ensure the Trust meets its operational and financial targets.		
CQC Theme:	Well-led Safe Effective Responsive		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led) Quality of Care (Safe, Effective, Caring, Responsive) Operational Performance Strategic Change		
Implications			
Risk:	The Trust does not have necessary inpatient bed capacity within Medicine to meet significant surges in demand during winter 2017-18.		
Legal/Regulatory:			
Resources:			
Previously Considered by:	EMT	**Date**	
Equality Impact Assessment:	N/A		
Appendices:			

Winter Preparedness Planning 2017-18
Trust Board, 7 September 2017

1.0 PURPOSE

1.1 To provide an overview of the Trust's planning and preparedness for winter 2017-18.

2.0 CONTEXT

2.1 Local and national health systems must develop robust plans to meet recognised challenges during winter. This includes ensuring there is enough capacity to meet demand, flu planning, and the reform and redesign of the wider Urgent and Emergency Care system.

The Trust develops plans to ensure we can meet anticipated increased demand during the winter period, and continue to deliver safe care and quality services.

In July 2017, NHSE and NHSI wrote to local A&E Delivery Board Chairs and CEOs of Acute Trusts and other providers and key stakeholders setting out priorities to build resilience for this winter:

- Ensuring there is enough capacity to meet the pressures of winter
- Reforming and redesigning the wider Urgent and Emergency Care system
- Flu planning

The Trust's Winter Preparedness planning is undertaken in alignment with the local A&E Delivery Board, which is required to submit overarching system-wide winter plans which reflect NHSE and NHSI priorities:

- Demand and capacity plans
- Front door processes and primary care streaming
- Flow through the Unplanned and Emergency Care pathway
- Effective discharge processes
- Planning for peaks in demands over weekends and bank holidays
- Ensuring the adoption of best practice as set out in the NHSI guide; 'Focus on Improving Patient Flow'

3.0 CAPACITY PLANNING FOR WINTER PRESSURES

This section provides an overview of how the Trust is developing plans to manage winter pressures during 2017-18, and to mitigate the risk of insufficient inpatient bed capacity in Medicine in the event of a surge in demand.

3.1 Surge Capacity

The trust has a well-tested Standard Operating Procedure for day–to-day operations. This has been further updated to include additional actions for the management of surges in demand. The plan clearly defines roles and responsibilities in times of surges. There is currently no plan for the use of escalation beds during winter as there is no identified appropriate area that can be opened at short notice.

A detailed Surge Capacity Plan, incorporating the Winter and Cold Weather plan, is being developed for the winter period. There is a system-wide approach to this planning.

3.2 Delayed Transfers of Care (DTOCs)

DTOCs remain a significant barrier to improving patient care on emergency care pathways and performance against the four hour standard. The Trust has developed a detailed escalation plan for the management of DTOCs. It clearly outlines roles and responsibilities of specific staff at delayed days 2, 3, 4 and 5. A twice weekly meeting with Wandsworth and Merton Social Services meeting will continue throughout winter.

The Trust is continuing to work with local Social Care colleagues to progress the 'Discharge to Assess' model. In the last 3 months 14 patients were discharged via this model in Wandsworth. We now have agreement from Merton SS to progress this model. This further enhances the number of beds that can be released.

3.3 Repatriations

St. George's has an agreed protocol for all hospitals in South West London that patients referred will be repatriated to their local hospital within 48 hrs. For Stroke mimic patients this is 24hrs.The escalation process has been updated and clearly outlines roles and responsibilities at days 1, 2 and 3.

3.4 Emergency Department (ED) Escalation Plan

The ED escalation plan, which will incorporate the Trust response is being updated. It is recognised that ED diverts will not be granted due to capacity issues. For clinical safety reasons a 'Resus redirect' may be requested when the resuscitation room has reached capacity and clinically no patient ready to step-down.

3.5 Critical Care

A detailed escalation plan for critical care has been developed by clinicians. There is no plan to 'Treat & Transfer'. All surges will be managed in-house.

3.6 Stroke Service

William Drummond Ward is the designated HASU with 24 beds. The service aims to go into each night with at least two empty beds to accommodate emergencies. No patients other than those admitted by the stroke team should be admitted to this ward.

3.7 Surgical Assessment

The Nye Bevan unit has a total of 8 beds and trolleys and functions as a surgical assessment unit with a target length of stay of no more than 48 hours.

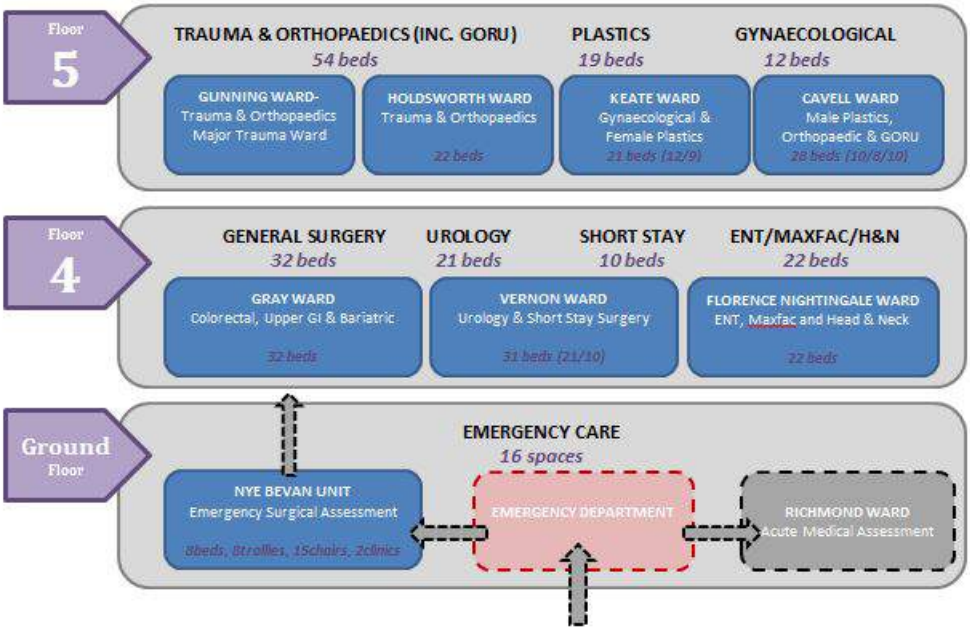
3.8 Trauma

The designated Trauma ward will take all multi-system trauma and should never have any outliers from other specialities.

3.9 Use of specialty wards in Surgical Division

A reconfiguration of speciality beds for Surgery is currently being prepared as part of our demand and capacity work, to ensure we are using our resources in line with patient pathway demand. This is likely to see an increase in the number of T&O beds and reduction in short-stay surgery beds. The diagram below highlights potential new configuration.

Proposed layout of speciality wards in Surgery Division



3.10 Medicines Beds

The Div. of Med. recognises that there is a gap in bed capacity to meet predicted demand, particularly in Q3 and Q4. A detailed capacity plan is being developed which will outline how this gap will be mitigated.

The development of an enhanced Ambulatory Care Unit (see section 4.1) will increase ambulatory capacity to provide patients with more appropriate care. This will also reduce pressure on inpatient beds, with reduced admissions.

We are currently undertaking detailed demand and capacity modelling within Medicine looking across all medicine, specialist medicine and senior health beds and care models

We are working up a detailed capacity model across all wards and specialties based on data from recent years' occupancy, length of stay, demand and other metrics. This will enable us to assess current configuration and whether we need to reorganise our allocations and configuration across specialties to meet predicted patient pathway demand.

3.11 Bed occupancy levels

An important element of managing capacity in the system is optimising the available / occupied beds during the key winter periods. Our aim during the period will be for maintain daily bed occupancy at less than 92%, therefore creating ongoing capacity.

3.12 Additional Mental Health system capacity

In February 2017, South West London and St George's NHS FT, the local specialist mental health provider, opened a six bed acute assessment unit. Based geographically close to us, this also adds specialist capacity into the system and enables patients to be cared for in the most appropriate setting for their needs.

4. REFORMING AND REDESIGNING THE WIDER URGENT AND EMERGENCY CARE SYSTEM (INCLUDING REDUCING DEMAND ON EMERGENCY DEPARTMENT)

The Trust's Unplanned and Admitted Patient Care programme aims to develop further long-term improvements to patient pathways and hospital flow. It aims to embed continuous improvement and efficiencies, alongside innovation. The programme aims to ensure patients receive the right care in the right place at the right time. Its workstreams incorporate a number of improvements that directly support Winter Preparedness for 2017-18. Several of these workstreams are described below relating to specific activity. Further workstreams in the programme are aiming to improve patient experience and processes across Emergency Department, Inpatient processes (including capacity and efficiency) and Discharge processes.

4.1 Ambulatory Care

The Ambulatory Care Unit based on the Acute Medical Unit (AMU) operates across 7 days a week from 09.00 to 21.00 hours Monday to Friday and from 10.00 to 18.00 Saturday and Sunday. The unit has dedicated Consultant cover on weekdays and is Nurse Practitioner-led with support from the on-call Medical team on a weekend.

The service is open to direct referrals from GPs, in addition to referrals from Emergency Department. A CQUIN is in place for 2017/18 to increase the proportion of referrals to Ambulatory Care from the Emergency Department.

Funding has been secured from the Department of Health to support development of an enhanced Ambulatory Care Unit service, to further help reduce pressure on our Emergency Department and reduce unnecessary acute admissions. It will enable all medical patients to be seen in an ambulatory care setting where clinically appropriate, with rapid access to diagnostics and treatment on an extended hour basis

The Ambulatory Care workstream of the Unplanned and Emergency Patient Care programme incorporates these improved facilities to provide a better physical environment for patients and staff; and is also anticipated to include a dedicated Ultrasound facility; new clinical pathways; considering more logical and patient-centred opening times; and improved operational processes so specialties work more closely with the ambulatory team.

The Ambulatory Care Unit should not be utilised as an escalation area. This removes the ability of the service to continue to deliver admission avoidance activity to reduce pressure on bed capacity.

4.2 Paediatric Ambulatory Care

A Children's Ambulatory Care Unit is planned to be opened on Floor 5, Lanesborough Wing, co-located with paediatric inpatients. This will provide sharing of skilled staff, management by paediatric and children's nursing senior staff and maintain the flow of patients from and to inpatient wards if needed.

The service will care for and treat all children and young people up to their 18th birthday who are referred to paediatric medicine with urgent care needs; either from a local GP, from another community healthcare professional or from ED. Pathways will be developed to guide clinicians as to patients that may be acceptable for ambulatory care. Space to develop the unit has been identified by the children's directorate.

The current planned opening date is October 2017. The Unit will be open 12 hours a day between 10am and 10pm, to address peak times for paediatric attendances to urgent care.

The Children's Ambulatory Unit should not be used as an escalation area.

4.3 Older Person's Advice and Liaison (OPAL) Service

The OPAL service provides an in-reach service Monday to Friday to ensure early Comprehensive Geriatric Assessment for patients across AMU, CDU and the Emergency Department.

It ensures frail older patients are assessed as early as possible following their presentation to hospital and, where clinically appropriate, will redirect patients along an appropriate community pathway where it is possible for an acute admission to hospital to be avoided.

The service has been fully established since July 2017, with a second Nurse Practitioner now in post to support the assessment of patients in the Emergency Department and CDU.

4.4 Front door streaming

The Trust has a number of Front Door streaming initiatives in place to ensure patients receive the most appropriate services for their care needs, which are often not best served in A&E. By improving how we stream patients appropriately to primary care and ambulatory care, we can ensure they receive the right are for their condition as rapidly as possible. This also helps prevent unnecessary delays and crowding in Emergency Department.

A workstream within the Unplanned and Admitted Patient Care programme aims to improve the effectiveness of our streaming so patients receive the right care for their needs.

The programme also aims to improve support to high intensity ED users by focussing on their core care needs and developing 'root case' solutions. For example, patients with mental health conditions who regularly attend the Emergency Department will be receiving targeted support to help reduce their reattendance rates through a partnership with specialist mental health provider South West London and St George's Mental Health NHS Trust to provide more timely care and a better patient experience.

Mental health nurses are being recruited by the Emergency Department, and are to be based in ED over seven days on 12 hour shifts. They will, alongside the existing Psychiatric Liaison Service, provide care for all patients who attend ED with a primary mental health condition. They will also work proactively with a group of people who regularly attend ED for their mental health, supporting them to find better solutions at times of crisis.

5. FLU PLANNING

5.1 Flu vaccination programme

This is implemented annually from late September through to March. The Trust achieved 72.7% of all frontline clinical staff vaccinated last year (the target being 75%) which was above the national average of 63.2% reported by Public Health England. A comprehensive Flu Vaccination awareness and take-up campaign is delivered by the communications team. In 2016, an innovative incentive campaign to encourage staff to receive the vaccination

included a partnership with UNICEF whereby the Trust funded vaccination of 17,100 children around the world with the tetanus vaccine.

6. COLD WEATHER ALERTS

Public Health England maintains the Cold Weather Plan for the UK. Every year the Met Office is commissioned to provide a cold weather alerting system that allows forecasting of weather conditions and triggers for the levels of 'action' required as the weather becomes more unsettled and colder. These alerts include a response for the Health sector. The levels range from Winter preparedness and action (Level 1) to 'alert and readiness', (level 2) severe weather 'action' (Level 3) to Major Incident – Emergency response (Government intervention level 4).

St George's receives alerts direct from the Met Office (via the Emergency Planning Liaison officer) and from the Commissioning Support Unit when they anticipate there may need to be a response from acute and community providers. Alerts are disseminated by the EPLO or Head of Operations, with advice on actions for service areas and communications to staff and patients required.

7. COMMUNICATIONS AND ENGAGEMENT

We will undertake a comprehensive engagement campaign to drive awareness, understanding and adoption of necessary actions (as required) across all elements of Winter Preparedness, including delivering the Surge Capacity Plan. This will include:

Internal

- Training sessions for all on-call managers and directors
- Information and briefings through established engagement and communications channels including Hospital Operational Delivery Group, Care Group meetings, eG St George's, Medical Director Consultant briefings, Senior Leaders' Briefing, Core Brief
- Team briefing documents for specific audiences (operational, clinicians)
- Ongoing Unplanned and Admitted Care Programme communications plans

External

- Stakeholder relationships including one to one briefings
- Trust stakeholder bulletin
- Trust GP newsletter, and GP meetings

8. RISKS

There is a predicted bed capacity gap in medicine of 28 beds based on historical date from winter 2016-17. The capacity plan as outlined above (Section 3) will ensure this gap is addressed. However, there is an overall estimated net surplus of beds to meet demand within the Trust.

Further long-term initiatives, and ongoing improvement, as outlined in Section 4, also contribute significantly to increasing our capacity and ensuring we are prepared for winter 2017-18, including through improving patient flow and reducing unnecessary admissions to give more appropriate and timely care.

9. RESOURCES

There is no additional financial resource identified to support capacity planning and implementation for winter 2017-18.

Department of Health capital funding has been gained to support development of the enhanced Ambulatory Care Unit, and an internal business case has been developed covering the project scope and resource required.

10. RECOMMENDATION

That the Board supports this ongoing approach to Winter Preparedness Planning for 2017-18 and continued work with the A&E Delivery Board on system-wide winter planning and submissions to NHSE and NHSI as required.

Author: Brendan McDermott
Date: 29.08.2017

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 4 (July 2017)

Chief Finance Officer
07th September 2017.

Executive Summary – Month 04 (July)

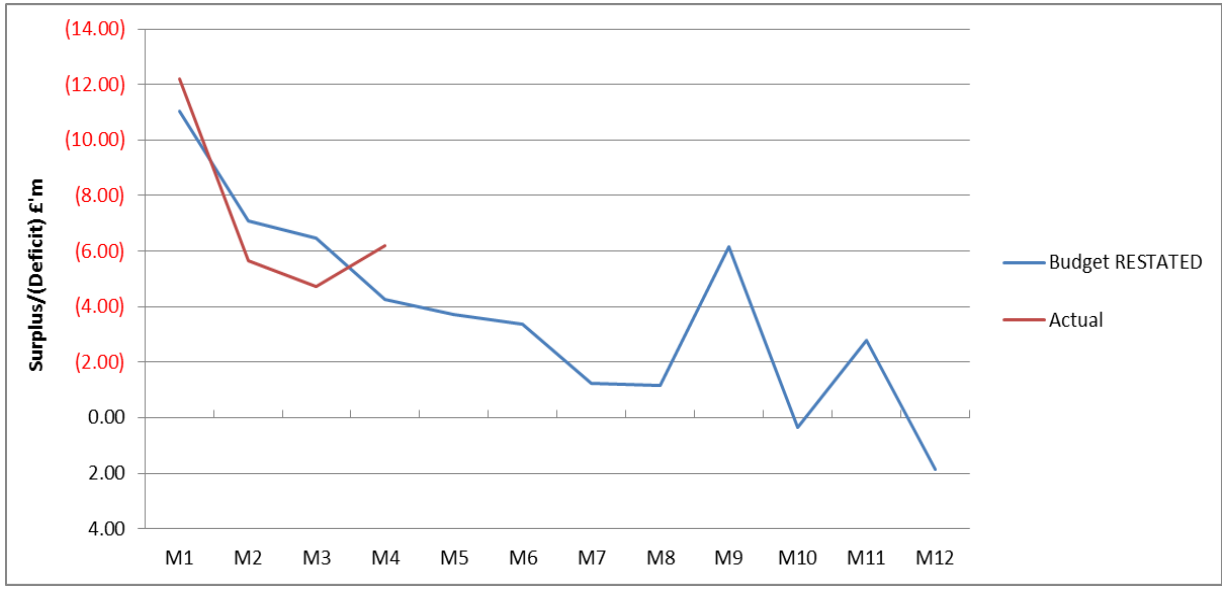
St George's University Hospitals NHS
NHS Foundation Trust

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £28.8m at the end of the July, a favourable variance to plan of £0.03m. However, the over delivery of CIPs totalling £3.0m is supporting this position. If these CIPs were excluded, the underlying position would be £3.0m adverse to plan. Within the position income is adverse to plan, with this being partly offset by expenditure underspends.	£0.03m Fav to plan	£2.0m Fav to plan
Income	Income is being reported at £8.9m adverse to plan year to date, with an adverse movement in month of £1.0m. Included within the month 4 results are £1.6m of income relating to prior periods. Elective and non-SLA income are adverse to plan by £1.7m and £4.0m respectively, with exclusion income £3.0m also being lower than planned but this will be partly offset by reduced expenditure.	£8.9m Adv to plan	£7.9m Adv to plan
Expenditure	Expenditure is £8.9m favourable to plan at month 04, £0.3m adverse in month. The majority of the favourable position is in pay, £6.3m YTD with underspends seen in Nursing, Non Clinical and ST&T categories. Non-pay is £2.6m underspend, with clinical consumables and drugs being the key drivers of this – note some of the favourable position will relate to exclusion underspends noted in income.	£8.9m Fav to plan	£9.2m Fav to plan
CIP	In the current plan £2.8m of CIPs were planned to deliver by the end of July. To date £5.8m of CIPs have been reported; £2.2m of income actions and £3.6m 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 £3.0m adverse position.	£3.0m Fav to plan	£3.7m Fav to plan
Capital	Capital expenditure of £16.4m has been incurred year to date. This is £0.2m below plan YTD. While spend is within plan there are material variances between schemes with some notable areas of overspending offset by underspends in other areas. IMT, medical equipment and other projects are over plan, with underspends in primarily estates offsetting this. The initial forecast for the year indicates an outturn of over £50m, £6m above CRL. The Trust continues to seek additional funding to support this and other expenditure but as yet nothing has been secured.	£0.2m Below plan	£0.65m Ahead of plan
Cash	At the end of Month 04 the Trust's cash balance was £5.1m, which is better than plan by £2m. As at M04 the Trust has borrowed £11.1m of working capital monies from DH compared to £15.9m per the March plan. Better performance on working capital – in particular creditors, has enabled the Trust to avoid borrowing in the first three months of the year. In August the Trust has drawn down working capital support of £8.0m and a further £11.0m has been requested for September, following July's drawdown.	£2.0m Fav to plan	On plan
Financial Risk Rating-Use of Resources (UOR)	At the end of July 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 4 Financial Performance

St George's University Hospitals NHS
NHS Foundation Trust

Provider Cat2	Provider Cat	M4 Budget (£m)	M4 Actual (£m)	M4 Variance (£m)	M4 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %
Income	SLA Healthcare Income	48.4	55.3	6.9	14.3%	220.1	215.2	(4.9)	(2.2%)
	Other Income	10.0	8.8	(1.2)	(12.1%)	39.5	35.5	(4.0)	(10.2%)
Income Total		58.4	64.1	5.7	9.8%	259.6	250.7	(8.9)	(3.4%)
Expenditure	Pay	(49.0)	(40.7)	8.4	17.0%	(168.2)	(161.9)	6.3	3.7%
	Non Pay	(25.8)	(27.0)	(1.2)	(4.7%)	(109.0)	(106.6)	2.4	2.2%
Expenditure Total		(74.8)	(67.7)	7.1	9.6%	(277.1)	(268.5)	8.7	3.1%
Post Ebitda		(2.8)	(2.7)	0.2	6.0%	(11.3)	(11.1)	0.3	2.5%
Grand Total		(19.2)	(6.2)	13.0	67.7%	(28.8)	(28.8)	0.0	0.1%
Prior Month YTD CIP Adjustment		15.0		(15.0)	(100.0%)			0.0	0.0 %
Total after YTD CIP Adjustment		(4.2)	(6.2)	(2.0)	(46.5%)	(28.8)	(28.8)	0.0	0.1%



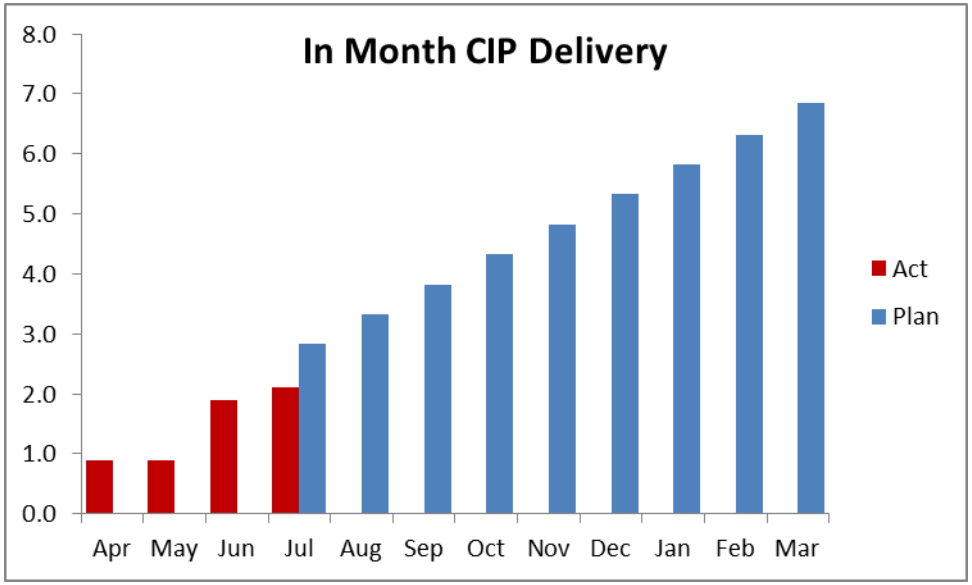
Trust Overview

- Overall the Trust is reporting a deficit of £28.8m at the end of Month 04, a favourable variance to plan of £0.03m.
- **Income** is £8.9m adverse to plan. £5m of the under recovery of income is directly offset with underspends in expenditure (SLA Pass-through £2.7m, commercial pharmacy £0.8m, South West London Pathology £0.8m, and VAT reclaims £0.7m).
- **SLA Income** is £4.9m under plan, owing to shortfalls of £2.7m on pass-through, in £2.4m Elective and £1.3m in Non Elective, offset by £1.5m over performance in Outpatients and Beddays. The £1.6m prior period SLA income catch-up is driven by both price of £0.7m and volume of £0.9m.
- **Other income** under plan by £4.0m; with the key drivers being Pharmacy (£0.9m), Diagnostics (£1.0m) and VAT (£0.7m), all of which are offset by expenditure.
- **Pay** is £6.3m favourable, with all major staff groups underspending with the exception of medical pay.
- **Non-pay** is £2.6m underspent, with the main areas being clinical consumables and drugs. Pass through exclusions are the primary reason for these underspends.
- **CIP delivery** of £5.8m is £3.0m ahead of plan. If this were excluded from the reported position then the overall position would show an adverse variance to plan of £3.0m. This indicates there is overall pressure in the Trusts baseline financial position at month 04, with the primary driver being lower than planned income recovery

ACTION REQUIRED

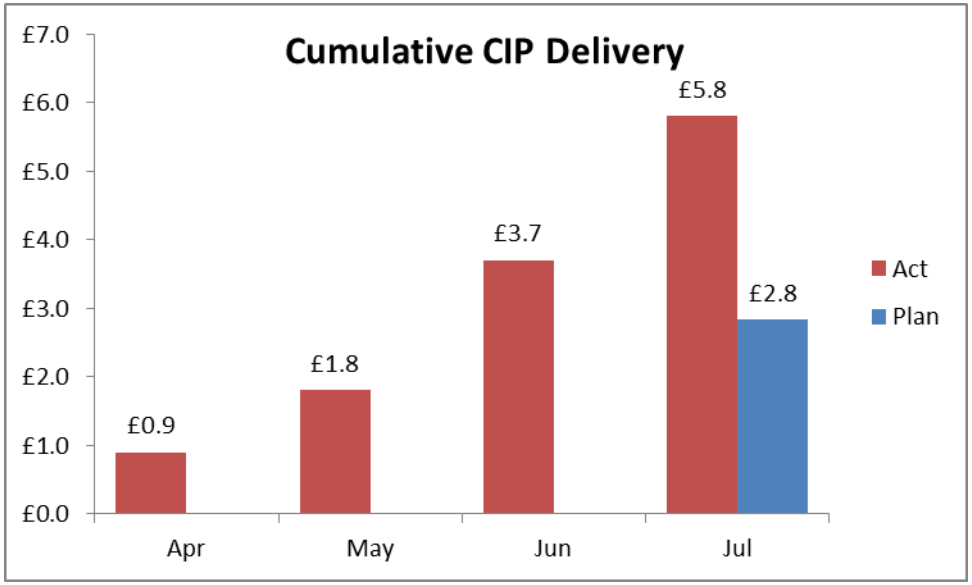
- Validate income recovery; depth of coding and reporting.

2. Month 4 CIP Performance



CIP Overview

- At the end of Month 4, the Trust is reporting the delivery of £5.8m of savings from Cost Improvement Programmes (CIPs)
- The majority of CIPs delivered to date are non pay - £2.5m (43%), pay savings account for a further £1.1m (19%) with income contributing the balance of £2.2m (38%)



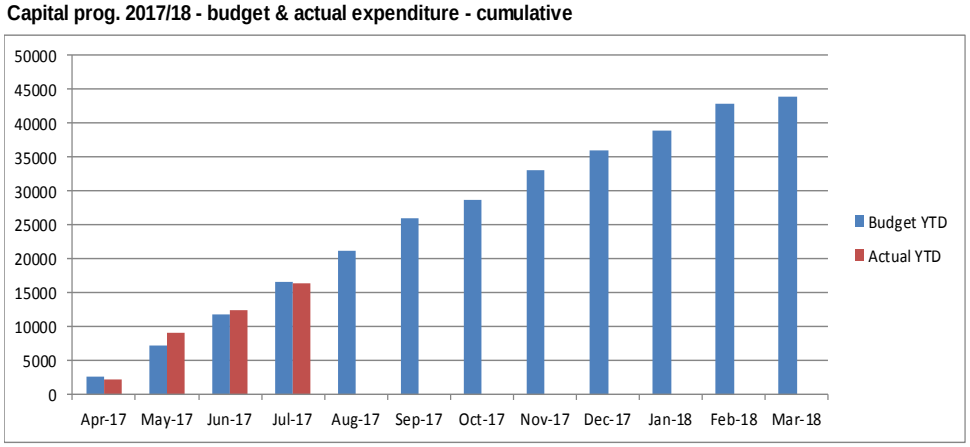
ACTIONS

- The Trust requires CIP plans which deliver £47.0m of savings in 2017/18. Currently plans across all categories (Green, Amber, Red and Pipeline) total £42.2m meaning that a further £4.8m of plans require development
- Currently £28.9m 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
- The Trust is required to deliver a year end deficit of £45m. A key action which underpins this is to understand how CIP delivery will support the achievement of this control total. Additional plans or controls may be required to mitigate any shortfall or pressures

3. Month 4 Capital Programme

Capital expenditure summary M04 2017/18

Spend category	2017/18 Budget	M04 YTD Budget £000	M04 YTD actual £000	*M04 YTD Variance*
Infra Renewal -EPC	**5,555**	**4,905**	**3,802**	*1,103*
Infra Renewal	**10,492**	**2,735**	**1,636**	*1,099*
Med Eqpt	**3,194**	**1,927**	**2,352**	*-425*
Major Projs	**19,684**	**4,021**	**3,694**	*327*
IMT	**2,567**	**2,568**	**3,633**	*-1,065*
Other	**601**	**60**	**1,122**	*-1,062*
SWL PATH	**684**	**156**	**97**	*59*
Contingency	**1,096**	**148**	**0**	*148*
Total	**43,873**	**16,520**	**16,336**	***184***



- The capital budget for 2017/18 is £43.8m. Actual capital expenditure in 2016/17 was £33.8m. The 2017/18 budget includes DH capital loan financing of £16.2m.
- Capital expenditure in July was £3.8m and is £0.2m under spent YTD.
- The IMT budget has been formulated on the expectation that the Trust will secure further DH capital funding of approx £9.6m to finance extensive investment in the IT infrastructure. In the event the amount secured is lower then the Trust will have to re-structure the programme in order to ensure critical IT risks and also medical equipment pressures can be financed within the existing capital budget. A re-forecasting and re-prioritisation exercise is underway to identify how these pressures totalling approx £7m (after slippage on other projects has been taken into account) can be accommodated.
- The Trust has submitted bids for additional, unbudgeted STP capital monies to finance estates infrastructure projects (SJW standby generators, SJW theatres refurbishments) and also new MRI scanners and the upgrade of the Cardiac catheter labs.

4. Month 4 YTD Analysis of Cash Movement

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

		Actual M04 vs Plan M04	
	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	-29.2	-29.2	*0.0*
Depreciation	9.0	8.0	*-1.0*
Interest payable	2.4	2.4	*0.0*
PDC dividend	1.2	1.1	*-0.1*
Other non-cash items	-0.1	-0.1	*0.0*
Operating deficit	**-16.7**	**-17.8**	-1.1
Change in stock	-0.3	-0.7	*-0.4*
Change in debtors	-0.7	-4.9	*-4.2*
Change in creditors	13.3	17.8	*4.6*
Net change in working capital	12.3	12.2	-0.1
Capital spend (excl leases)	-17.5	-14.9	*2.6*
Interest paid	-1.3	-1.3	*0.0*
PDC dividend paid	0.0	0.0	*0.0*
Other	0.0	0.0	*0.0*
Investing activities	-18.8	-16.2	2.7
WCF/ISF borrowing	15.9	11.1	*-4.8*
Capital loans	8.1	11.8	*3.7*
Loan/finance lease repayments	-2.6	-2.0	*0.6*
Closing cash 31.07.17 / 31.03.18	**3.1**	**5.1**	*2.0*

M04 YTD cash movement

- The cumulative M04 I&E deficit was £29.2m – in line with the July plan.
- Within the I&E deficit of £29.2m, depreciation (£8m) does not impact cash. The charges for interest payable (£2.4m) and PDC dividend (£1.1m) 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 £17.8m.
- The operating variance from plan of £1.1m in cash is attributable to the lower depreciation charge.
- Working capital performed overall in line with the July plan.
- The Trust borrowed from working capital facilities in M04 for the first time this year and has borrowed £4.8m less than plan. The Trust has secured £8m borrowing in August and a has requested a further £11m for September to finance the on-going deficit. These working capital borrowings are subject to an interest rate of 6%.
- The Trust has borrowed £11.8m from its capital loan to finance expenditure on the NHSI-financed capital projects and will draw the remaining balance of £4.36m on 29th August.

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5. Balance Sheet as at Month 4 2017/18

St George's University Hospitals NHS
NHS Foundation Trust

Balance sheet JULY 2017

	Jul-17 Plan £000	Jul-17 Actual £000	*Variance £000*	**Explanations of balance sheet variances**
Fixed assets	342,418	344,033	*-1,615*	Lower depreciation charge than plan
Stock	6,885	7,289	*-404*	Year end stock higher than 16/17 plan: movement since y/e in line with 17/18 plan.
Debtors	102,515	106,744	*-4,229*	Collection of 16/17 SLA debt delayed by CCGs pending finalisation of challenges
Cash	4,022	5,121	*-1,099*	Higher opening cash than plan.
Creditors	-131,555	-136,111	*4,556*	Agreed deferral of CNST payments to later in the year.
Capital creditors	-2,534	-6,466	*3,932*	Timing of capital payments has increased capital creditors at M04
PDC div creditor	-1,212	-1,100	*-112*	
Int payable creditor	-1,350	-1,340	*-10*	
Provisions< 1 year	-335	-294	*-41*	
Borrowings< 1 year	-56,920	-56,370	*-550*	Lower drawdowns due to higher opening cash bal & lower capital spend than plan
Net current assets/-liabilities	**-80,485**	**-82,527**	*2,042*	
Provisions> 1 year	-868	-988	*120*	
Borrowings> 1 year	-184,935	-184,356	*-579*	Lower drawdowns due to higher opening cash bal & lower capital spend than plan
Long-term liabilities	**-185,803**	**-185,344**	*-459*	
Net assets	**76,131**	**76,162**		
Taxpayer's equity				
Public Dividend Capital	129,956	129,956	*0*	
Retained Earnings	-144,078	-144,026	*-52*	
Revaluation Reserve	89,103	89,081	*22*	
Other reserves	1,150	1,150	*0*	
Total taxpayer's equity	**76,132**	**76,162**		

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (Q1)	Actual (Q1)
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

- 1 represents the best score, with 4 being the worst.
- At the end of July, 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 M4.

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%

FP Aug 17 – Agenda item 3.2

Capital Expenditure Update Month 4 (July 2017)

Chief Finance Officer

Trust Board 07th September 2017

Development of the capital plan

- As part of the 2017/18 Budget setting process – meetings called comprising a representative cross section to develop a capital programme.
- EMT input; this included COO, Dir of Estates, DDOs, Med Director and CIO.
- Overall capital plan restricted to depreciation plus carry forward of unspent from previous year. This totalled £34m
- Prioritised ‘bids’ from the assembled group within affordable amount. Schemes were prioritised on the basis of Safety and criticality.
- Granted a £16m loan for emergency funding for estate in 2016/17. £6m utilised in 2016/17, so £10m available in 2017/18.
- Resulted in allocation for 2017/18 of £43.9m
- This was reported within the Financial Plan papers but it appears there is a lack of understanding across the EMT.
- Further bids to increase funding by £8.4m for IMT through emergency capital
- Discussions are ongoing with NHSI regarding securing additional funding

Month 4 Year to Date and Year End Forecast

- Year to date, underspent against budget by £0.2m
- Predominantly overspent in Medical Equipment and IMT offset by underspends in Estates
- Current year end forecast is £50.9m
- Overspends would occur predominantly in Medical Equipment and IMT.
- If maintained the Trust will breach its CRL.
- Actions to address could include;
  - Further borrowings to support emergency IMT investment
  - Alternatively, remove or reduce cost of schemes.
- The following table summarises the plan and forecast spend in 2017/18.

Capital expenditure summary M04
2017/18

Spend category	**2017/18 Budget**	M01 actual exp £000	M02 actual exp £000	M03 actual exp £000	M04 actual exp £000	**M04 YTD Budget £000**	**M04 YTD actual £000**	*M04 YTD Variance*	M05 £000	M06 £000	M07 £000	M08 £000	M09 £000	M10 £000	M11 £000	M12 £000	**Forecast received £000**	**Budget £000**	**Variance £000**
Infra Renewal -EPC	**4,875**	13	1,708	1,141	940	**4,225**	**3,802**	*423*	1,250	177	0	0	0	0	0	0	5,229	5,555	326
Infra Renewal	**11,172**	236	591	360	449	**3,415**	**1,636**	*1,779*	1,247	2,015	926	857	794	863	814	760	9,914	10,492	578
Med Eqpt	**6,284**	374	1,663	61	254	**1,927**	**2,352**	*-425*	1,040	950	750	500	490	100	0	0	6,182	3,194	-2,988
Major Projs	**16,642**	972	1,033	928	761	**4,069**	**3,694**	*375*	1,555	1,411	1,517	1,654	1,452	1,181	1,150	1,130	14,744	19,684	4,940
IMT	**2,567**	569	1,909	783	372	**2,568**	**3,633**	*-1,065*	1,028	1,028	1,028	1,028	1,028	1,028	1,028	1,028	11,859	2,568	-9,291
Other	**601**	18	24	19	1,061	**60**	**1,122**	*-1,062*	113	186	249	185	83	115	164	84	2,301	601	-1,700
SWL PATH	**684**	0	0	68	29	**156**	**97**	*59*	31	62	62	62	94	94	94	123	719	684	-35
Contingency	**1,047**	**0**	**0**	**0**	**0**	**100**	**0**	*100*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,096**	1,096
Total	**43,873**	**2,182**	**6,928**	**3,360**	**3,866**	**16,520**	**16,336**	*184*	**6,264**	**5,829**	**4,532**	**4,286**	**3,941**	**3,381**	**3,250**	**3,125**	**50,948**	**43,874**	**-7,074**

Capital Plan Management

- The EMT has been asked to review and confirm the range of bids to be supported and the scale of investment in each area to produce a scenario that comes within the available £43.9m. Actions include;
  - Estates underspends to be maintained and potentially increased
  - IMT schemes to be prioritised and spend phasing reviewed. EMT has asked that IMT expenditure is where possible protected and maintained
  - Review planned forecast overspend on medical equipment.
  - Other project funding to be re-examined – limit funding within available funds or further grant opportunity?
- In parallel to this the Trust needs to seek additional funding from NHSI. Complete the NHSI process for submission of capital programme – 11 September deadline
  - Incorporates IT and Estates strategic investment. Estates plan being finalised for 11th Sept. IMT outlined in following slides.
  - Meetings held between CIO, Director of Estates with Director of Finance Operations
  - EMT approval required before submission

Action agreed by the Finance and Performance Com

- The Trust Board is asked to note the FPC agreed;
  - The proposed approach to manage the overall capital programme given the forecast overspend.
  - Support continued IMT expenditure above allocation. Noting this is at risk unless further capital funding can be secured.
  - In order to mitigate the forecast expenditure progress two parallel actions;
    1. Seek additional capital funds, primarily in relation to IMT.
    2. Identify options to reduce the forecast outturn to within available funds while maintaining higher than originally planned IMT and medical equipment expenditure. This will require other programmes and projects to be reduced/delayed.
  - IMT and Med equip have been prioritised due to their relationship to both quality improvement and RTT.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 September 2017	**Agenda No**	5.4
Report Title:	Evaluation of Overseas Visitors Pilot Study – Obstetrics		
Lead Director:	Andrew Grimshaw, Chief Financial Officer		
Report Author:	Alex Stamp & Madeleine Delaney		
Freedom of Information Act FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	This report set out the findings from the Overseas Visitor' pilot study in Obstetrics. The aim was to establish in real time, the eligibility of patients for free treatment on the NHS. The pilot was part of the Department of Health (DH) and NHS Improvement (NHSI) strategy to recover income from patients who are not eligible for free NHS care. As at 31/12/2016 the overall outstanding Trust debt from overseas visitors is circa £5 million with £1.75 million attributable to Obstetrics 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. This report summarises the lessons learned and challenges encountered during the pilot and outlines how the overall "business as usual" processes can be modified to ensure eligibility is established Trust wide in advance of treatment.		
Recommendation:	Complete pilot in elective speciality and develop a plan for roll-out across Trust. Adequately resource the Overseas Team to support a Trust-wide function of cost recovery Introduce mandatory DH eLearning (MAST) to improve staff knowledge of the legislation regarding entitlement/eligibility to NHS care Provide a further update at the next Trust Board meeting on pilot findings.		
Supports			
Trust Strategic Objective:	Roll-out two forms of identification process to entire Trust.		
CQC Theme:	Well-led. Adhere to national guidelines		
Single Oversight Framework Theme:	Transformation Programme		
Implications			
Risk:	Delay's with treatment and increase in DNA rates		
Legal/Regulatory:	Adhere to DOH guidelines and local policy		
Resources:	Review structure and staffing levels in overseas team for future roll-out		
Previously Considered by:	Executive Management Team	**Date**	21.08.17
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1: SOP for Overseas Visitors		

1.0 PURPOSE

1.1 To establish in real time, the eligibility of patients for free treatment on the NHS rather than retrospectively as previously happened.

1.2 To implement a more evidence based system of checks that could be consistently and objectively applied throughout the Trust, whilst facilitating a more efficient overseas debt collection process.

1.3 To ensure administrative staff follow standard operating processes to determine patient eligibility.

1.4 To increase staff confidence in continuing with the new processes once pilot is completed.

1.5 To share our findings with the DH, NHSI and other Trusts, so that best practice can be embedded going forward.

2.0 BACKGROUND

2.1 The NHS is a residency based healthcare system and eligibility for free NHS hospital care is based on the concept of 'ordinarily resident'. All NHS Trusts have a statutory obligation to establish whether a person is an overseas visitor to whom charges apply or whether they are exempt from charges (Guidance on implementing the overseas visitor's hospital charging regulations 2015)

2.2 The Trust is one of a cohort of 20 trusts identified by the DH and NHSI as having a significant and on-going potential for cost recovery income.

2.3 We were asked to undertake pilot studies in two clinical areas, maternity and an elective service which involved checking documentation from patients to establish their identity and UK residency. It was agreed that the Trust would commence the first pilot in Obstetrics, starting January 30th and once underway to commence the pilot in an elective specialty.

2.4 Neuroscience was chosen as the elective speciality and was due to commence end of April, but delayed due to the general election. The pilot study is now planned for early August and will include Neurology, and Neurosurgery.

3.0 THE PILOT PROCESS

3.1 The difference between the existing policy and the new process is the requirement for all non-emergency patients to provide two forms of identification at the first appointment to establish proof of identity and proof of residency. If patients have been legally resident in the UK for the previous12 months they will be entitled to free NHS care. This is outlined in the attached Standard Operating Procedure (SOP) (Appendix 1).

3.2 Stakeholder communications were planned in advance of and throughout the pilot communicating the message that the pilot followed standard national guidelines. The aim was to minimise any negative perception of the pilot and to ensure patients were treated fairly, consistently and without disadvantaging vulnerable groups.

3.3 Prior to the pilot starting, all frontline staff had training provided by a member of the overseas team in DH Stage One baseline interview questions, as outlined in the Eligibility Checklist (Appendix 2 /3 of SOP).

3.4 The pregnancy pre-registration form was made available on line for patients to complete in advance of their appointment (Appendix 4 of SOP).This minimised the risk of delays in clinic and helped capture important patient information.

3.5 Patients were informed in advance of the list of acceptable documents that were required to show proof of Identity / residency. This information was also available on the Trust website.

3.6 Reception staff were asked to complete the eligibility checklist for all new patients.

3.7 A dedicated member of the overseas team was based in the clinic throughout the pilot to assist with any patient /staff concerns. In addition, a dedicated obstetric database was set up, which enables the monitoring of all new patients in the pilot.

3.8 In addition to the piloting of eligibility checks in Neurosciences, the DH has commissioned Ipsos MORI to carry out research before and during the pilot to establish the impact the eligibility checks have on the organisation and cost recovery.

3.9 During the pilot, no patient was denied treatment due to charging issues.

4.0 SUMMARY OF FINDINGS

4.1 The pilot was conducted over 15 weeks, from January 30th to week ending the 14th May and was evaluated against agreed key performance indicators. A total of 1660 new patients were screened i.e. an average of 110 patients a week.

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4.1.2 Of the 1660 new patients 1005 (61%) proved eligible on presentation of their documents at first appointment. Following investigation by the overseas team, a further 614 patients (37%) were subsequently shown to be eligible for free NHS care. The remaining 41 patients (2%) that still failed to supply relevant documentation were invoiced for their care to the value of £108k. 23 of these patients subsequently provided their documents and credit notes have been issued to cancel the invoice previously sent to these patients.

4.1.3 The remaining 18 patients (1%) who failed to provide eligibility will be followed up by the debt collection agency and this debt will remain on the patient's record until cleared. The debt currently outstanding for the pilot group is circa £45k, which represents 150% of the tariff for treatment provided based on NHS policy.

4.2 During the pilot, the number of patients who presented with two forms of identification increased from 36% to 78% and this number continues to increase. Initially we were relying on patients to download this information from the website themselves. However, once the list of acceptable documents (Appendix 1 of SOP) was included with the patient appointment letter there was a significant increase in patients bringing two forms of identification to their first appointment.

4.3 The use of the eligibility checklist also reduced the volume of incomplete pre-registration forms being returned to the overseas office which in turn reduced the follow up administration tasks of issuing letters, raising invoices and contacting patients. Also, it is estimated that administrative costs of £50 per patient will be saved; circa £80k during the pilot as each invoice raised and each credit note issued is estimated to cost the Trust £25 each to process.

4.4 There was no evidence of an increase in DNA rates during the pilot.

5.0 WHY PATIENTS FAILED TO PROVIDE DOCUMENTATION

5.1 There were many reasons why patients initially failed to provide the two forms of identification. Below are some of the reasons given by patients:

- Did not receive the appointment letter in time
- Did not fully understand what was required
- Forgot to bring documents
- Provided ID in the past, so did not think it was necessary
- Have only one form of ID
- Provided 2 forms, but not from agreed list
- Did not think the requirement applied to UK residents born / living in UK

6.0 CHALLENGES

6.1 A number of challenges were encountered prior to and during the pilot as outlined below:

- Getting commitment from staff to adhere to new processes
- Staff training
- Inadequate staff resources particularly at weekends to administer the checklist.
- Multiple IT systems and lack of integration

6.2 Although compliance with completing the checklist improved during the pilot, administrative staff, failed to ensure that the checklist was accurately completed in approximately 5% of instances. This provides a risk of potential cost recovery being missed.

6.3 A key on-going challenge with the roll-out of the pilot will be to ensure the outpatients and overseas office has sufficient staff resource with the relevant skills to apply the new processes. There are approximately one thousand new appointments seen each month in Neurosciences compared with five hundred in obstetrics. In addition, Neuro patients will have a wider range of complex conditions, so application of the process will require sensitivity, care and attention. Other forms of patient accessible information will also need to be considered. To support the roll out, a business case was put forward to the DoH to cover the cost of 2 WTE band 3 administrative staff to assist in clinic and in the overseas office during the pilot at a cost of £12k for the three months of the pilot. This has now been approved.

7.0 CONCLUSION

7.1 Following the introduction of eligibility checks, 99% of the total patients seen were able to confirm eligibility. The remaining 1% (18 patients) were not eligible and have been invoiced.

7.2 There were no complaints during the pilot as the communication strategy to all stakeholders was well planned and feedback from patients was positive.

7.3 There was an improvement in staff satisfaction, particularly in the overseas team

7.4 The initial findings of the pilot identified that there was no obvious issue with eligibility in obstetrics. However, there is still potential for ineligible receipt of free NHS care particularly in the elective specialities and therefore, it makes sense to extend the pilot to an elective speciality.

8.0 RECOMMENDATIONS:

8.1 Complete the pilot in the elective speciality and plan roll-out to entire Trust.

8.2 Review staffing levels and skill mix within the overseas team to provide a service across the Trust seven days a week.

8.3 Review the IT requirements of the overseas team to ensure they have the appropriate equipment to enable them to recover costs from ineligible patients in an efficient manner.

8.4 Deliver mandatory DH eLearning (MAST) across the organisation to increase staff knowledge of the legislation regarding entitlement/eligibility to NHS care.

8.5 Raise patient and staff awareness of the need to provide two forms of identification when attending St George's for appointments, through the use of signage, audio-visual displays in clinics and the Trust website.

8.6 The Information department to provide a monthly report to the overseas team of all patients booked that month who are known to be overseas and do not have an NHS number.

8.7. The Executive Management Team is asked to acknowledge the contact of this report and the roll out of the pilot to Neurosciences.

Author: **Madeleine Delaney**
Date: **24th July 2017**

Department	**Outpatient Services**
Policy	**Standard Operating Procedure (SOP)**
Sub Department/Service	**Overseas Visitors – Pilot Study**
Version	**0.02**

Revision Control

Version	Authors	Date	Comments
	M Tinsley & M Delaney	**08/06/2017**	

	Signature	Name (print)	Date
Prepared by			
Authorised by			

1. OBJECTIVE

1.1 This Standard Operating Procedure documents the procedure to be followed in order to establish eligibility of patients for free treatment on the NHS. The objective is to identify eligibility in real time, The NHS is a residency based healthcare system and eligibility for free NHS hospital care is based on the concept of “ordinarily resident”. An overseas visitor is any

person who is not "ordinarily resident" in the UK. Nationals of countries outside the European Economic Area (EEA) must also have indefinite leave to remain in the UK in order to be ordinarily resident here. A person who is ordinarily resident in the UK must not be charged for NHS hospital services.

2. SCOPE

2.1 The governing body of the NHS, the Department of Health (DH), has mandated that all NHS Trusts have a statutory obligation to establish whether a person is an overseas visitor to whom charges apply or whether they are exempt from charges. The requirement to confirm eligibility for free treatment is written into the National Health Service (Charges to Overseas Visitors) Regulations 2015 (the Charging Regulations), which came into force on 6th April 2015 and applies to all courses of treatment commenced on or after that date.

3. RESPONSIBILITIES

3.1 It is the responsibility of all staff, particularly reception / administrative staff to identify eligibility prior to treatment commencing. Staff should be aware that these checks are mandatory.

4. PROCESS

4.1 The difference between the existing policies and the new processes is the requirement for all non-emergency patients in the pilot studies to provide two forms of identification at the first appointment to establish proof of identity and proof of residency. This helps identify if the patient is legally resident in the UK for the previous12 months, thereby entitling them to free NHS care

4.2 All patients attending the clinic will be asked in advance of their appointment to provide two documents of identification when they first present for treatment. The list of acceptable documents is outlined in (Appendix 1).

4.3 The outpatient clinic receptionist will check the patient into clinic and using the Eligibility Checklist (Appendix 2 /3) will carry out the DH Stage One baseline interview questions, (Guidance on implementing the overseas visitor hospital charging regulations 2015,- 'the role of staff in cost recovery'). This is to ensure that the patient details and identity documents are correct and valid. All staff will have had training in the interview technique and will know the acceptable documents and the checking procedure.

4.4 If at the Stage One interview the patient is found to be ineligible or if there is a doubt regarding eligibility, the patient must then be referred to the Overseas Patient Team for a Stage 2 interview to further assess eligibility. If at the Stage 2 interview, it is determined that the patient is liable for charges the procedure is explained to the patient / next of kin or an advocate acting on the patient's behalf and the patient will be asked for payment, or a payment plan agreed. In this instance, the Overseas Patient Team will follow the charging policy as outlined in the Trust's 'Overseas Visitors - Stabilise, Treat and Discharge Policy and Procedure'

4.5 Patients who have not provided the correct documentation in clinic will be asked to present documents at the overseas office / email to overseas.check@stgeorges.nhs.uk within 7 days of their first appointment.

4.6 Patients who still fail to provide the correct Identity documents within 7 days will be contacted by the Overseas Team to establish eligibility.

4.7 Obstetric patients must complete the Pregnancy Pre-registration form (Appendix 4) before being seen by the midwife. This is available electronically and is also sent to Obstetric patients in advance of their appointment

4.8 The Pregnancy Pre-registration form is checked by clinic staff to ensure it is fully completed. If it is fully completed, it is then filed in the patient's handheld notes. If it is not completed correctly the reception staff must ask the patient to do so and then file it in the patient notes.

4.9 The Eligibility Checklist must be completed by reception staff for all new appointments.

4.10 If the receptionist is unsure of the patient's eligibility, then a pink sticker is placed on the checklist.

4.11 The checklists with the pink stickers are sent to the Overseas Team daily to ensure prompt follow up and to establish the patient's eligibility for free treatment. Once eligibility of patients is established, the overseas department will send the completed checklist to the scanning department.

4.12 All approved checklists will be kept with the patient health record and later scanned into Electronic Document Management (EDM) by the scanning bureau.

4.13 Patients, who are not eligible for free NHS treatment, will be charged for any treatment given to them. The overseas patient team will discuss payment terms with the patient where applicable.

4.14 No Obstetric patient will be turned away, and no patient visiting St George's will have urgent care delayed due to charging issues.

SOP for Overseas Visitors Pilot Study: Appendix 1

Bringing proof of identity to your appointment

If you do not normally live in the UK, you may need to **pay in advance** for your appointment and any treatment you might need.

Acceptable documents

Documents that can be used as proof of identity:

1. Current signed passport
2. Residence permit issued by UK Border Agency
3. Valid UK photo-card driving licence
4. EU or Swiss National Identity Photo-card
5. Valid armed forces or police photographic Identity Card
6. Photographic disabled blue badge
7. Council issued bus pass (e.g. Freedom Pass) (senior citizens only)
8. ID Citizen Card

Documents that can be used as proof of address:

1. Recent original Utility Bill (gas, electric, water, telephone) (mobile not acceptable) - last 3 months
2. Council Tax Bill (valid for current year)
3. Bank, Building Society or Credit Union statement
4. Recent original mortgage Statement from recognised lender
5. Current council/housing association rent book or tenancy agreement
6. Notification letter from Department for Work and Pensions confirming your right to benefit or state pension
7. Valid Payslip with address

These documents must contain the current address and be dated within the last three months.

SOP Overseas Visitors Pilot Study: Appendix 2

Eligibility Checklist Obstetrics

Has the Pregnancy Pre-registration form been fully completed by the patient?

☐ Yes

☐ No **(please ask the patient to fill the form out completely)**

Has the patient presented 2 forms of ID? (One with photo ID and one to show proof of residency)

☐ Yes

☐ No **(please ask the patient to bring documentation to Overseas Office or email within 7 days to overseas.check@stgeorges.nhs.uk**

Please tick the box which relates to forms of identification the patient has presented.

PROOF OF IDENTIFICATION:

☐ Valid signed passport - UK / EEA Country of issue ----------

☐ Valid signed passport and Visa - Non EEA Country of issue ----------

☐ Residence permit issued by UK Border Agency

☐ Valid full UK photo-card driving licence

☐ EU or Swiss national identity photo-card

☐ Valid armed forces or police photographic identity card

☐ ID citizen card

☐ EHIC card – Please Photocopy for Overseas team

☐ Asylum registration card.

PROOF OF RESIDENCY:

☐ Original utility bill such as gas, electric, water, landline (mobile not acceptable) for last 3 months

☐ Bank, building society or credit union statement or passbook – last 3 months

☐ Current pay-slip with address of residency

☐ Current council or housing association rent book or tenancy agreement or Council tax bill for current year

☐ Notification letter from the Department for Work and Pensions confirming right to benefits / state pension

Have you completed verification of the documentation?

☐ Yes (File Pregnancy Pre-Registration Form in patient hand held notes)

☐ **NO - Apply pink sticker to checklist for collection by Overseas Team daily and (**file the pregnancy pre-registration form in patient hand held notes)

Print Name: ---------- Date: ----------

SOP Overseas Visitors Pilot Study: Appendix 3

General Eligibility Checklist

Has the patient presented two forms of ID? – (One with photo ID and one to show proof of residency)

☐ Yes

☐ No **(please ask the patient to bring documentation to Overseas Office within 7 days or email overseas.check@stgeorges.nhs.uk**

If **yes**, please tick the box which relates to forms of identification the patient has presented.

PROOF OF IDENTIFICATION:

☐ Current signed passport – UK / EEA Country of issue _____

☐ Current signed passport and Visa – Non EEA Country of issue _____

☐ Residence permit issued by UK Border Agency

☐ Valid full UK photo-card driving license

☐ Asylum registration card.

☐ EU or Swiss national identity photo-card

☐ Valid armed forces or police photographic identity card /Council issued bus pass (senior citizens only)

☐ ID citizen card

☐ EHIC card - **Please photocopy for Overseas Team**

PROOF OF RESIDENCY

☐ Original utility bill such as gas, electric, water, landline (mobile not acceptable) for last 3 months

☐ Council tax bill for the current year

☐ Bank, building society or credit union statement or passbook- last 3 months

☐ Evidence of current electoral registration

☐ Current pay-slip with address of residency

☐ Current council or housing association rent book or tenancy agreement

☐ Notification letter from the Department for Work and Pensions confirming right to benefits /state pension

Have you completed verification of the documentation?

☐ **Yes**

☐ **NO (apply pink sticker to check list if 2 forms of ID are not provided. Form is to be collected daily by the Overseas Team for follow up with the patient)**

Staff Member:

Print Name: ---------- Date: ----------

Pregnancy Pre-Registration Form including Self-Referral

St George's University Hospitals NHS
NHS Foundation Trust

Please email, take, post or fax this form to the Antenatal Booking Office
1st Floor Lanesborough Wing, St Georges Hospital, Blackshaw Road SW17 0QT
Email: stgh-tr.stgpregnancyreferrals@nhs.uk Fax: 0208 725 3302 Tel: 0208 725 1914/1710

Step 1: Please read through the form. Complete all sections. Shaded sections are essential.

Step 2: Bring completed form to your appointment, or to the Antenatal Booking office (Mon-Fri only 9am -4pm) or fax/e-mail form (details above).

Step 3: If you attend or have an Early Pregnancy Scan – Please bring the scan report with this self-referral.

Surname:		**Date of Birth: dd/mm/yy**	
First Name:		**Hospital No/MRN** (if known):	
Previous Surname:		**NHS No** (if known):	
Do you usually live in the UK?	☐ YES ☐ NO	**Country of Birth e.g. UK:**	
Address in the UK:			
Post code:		**Email:**	
Telephone number:		**Mobile number:**	
Can we contact you on this number by text messaging?			☐ YES ☐ NO
Address OUTSIDE the UK:			
Postcode:		**Country:**	
Contact telephone:		**Nationality:**	
GP details (if you are registered with a GP in the UK)			
GP Name:			
Practice Name:			
Address:			
Post Code:		**Gender**	**FEMALE**
Marital Status:		**Religion:**	
Do you require an Interpreter?	☐ YES ☐ NO	**Language spoken:**	
First day of your last period Last Menstrual Period (LMP)?		**Please tell us when your baby is due (EDD) / /201**	
Have you had a scan? ☐ YES ☐ NO		**Date scan was done**	**/ / 201**
Height:		**Weight:**	
Do you have any communication needs e.g. hearing loss, visual impairment or learning disability? If yes, please complete and return the 'Accessible Information Needs' form on the website or available with this form			☐ YES ☐ NO
Next of kin details			
Surname:		**First Name:**	

Address:			
Post code:		**Mobile Tel:**	
Home Tel:		**Work Tel:**	

PLEASE COMPLETE THIS SECTION IN FULL

Passport number:	**Country of issue:**	**Passport expiry date:** D D M M Y Y
☐**Current United Kingdom passport**	☐**Current European Union**	
Dual Nationality:	**Date of entry into the UK:**	
Will you return to live in your home country? ☐**YES** ☐**NO**	**If yes, when?**	
☐**Current non-EU passport with valid entry visa**	**Visa No:**	
☐**St**	**Visa expiry date:** D D M M Y Y	
☐**As**		
☐**Other – please state:**		

PLEASE TURN OVER THE PAGE AND COMPLETE ALL SECTIONS

ALL: YOUR STAY IN THE UK – You will be required to provide documentation at your appointment. Please read the patient information leaflet entitled Information for overseas visitors - hospital treatment and paying for care' for more information or contact the Overseas Patients team on 020 8725 4693 or 020 8725 3439

Please tell us about the purpose of your stay in the UK (check all that apply):

☐**Holiday/visit friends or family**	☐**On business**	☐**To live here permanently**	☐**To work**
☐**To study**	☐**To seek asylum**	☐**Other – please state:**	

How many months have you spent OUTSIDE the UK in the last 12 months?

☐ **None**	☐ **Up to 3 months**	☐ **3-6 months**	☐ **Over 6 months**

Please indicate the reason for any absence from the UK in the last 12 months (check all that apply)

☐ **I live in another country**	☐ **A holiday/to visit friends**	☐ **To work**	☐ **To study**
☐ **I frequently commute (business/second home overseas)**		☐ **Other – please state:**	

HEALTH OR TRAVEL INSURANCE DETAILS – If the UK is not your permanent place of residency

Do you have insurance?	☐ YES ☐ NO
Name and address of insurance provider:	
Membership number:	Insurance telephone:
Do you have a non-UK EHIC?	☐ YES ☐ NO

STUDENT DETAILS – If you have come to the UK to study

Name of college/university:								Telephone:							
Course dates	From	D	D	M	M	Y	Y	To	D	D	M	M	Y	Y	Number of hours/week:

Please complete the section below only if you are Transferring Hospital

How many weeks pregnant are you?		**Have you booked at another hospital?**	☐**YES** ☐**NO**
Name of hospital/birth centre you are currently booked at:			

DECLARATION: TO BE COMPLETED BY ALL

This hospital may need to ask the Home Office to confirm your immigration status to help us decide if you are eligible for free NHS hospital treatment. In this case, your personal, non-clinical information will be sent to the Home Office. The information provided may be used and retained by the Home Office for its functions, which include enforcing immigration controls overseas, at the ports of entry and within the UK. The Home Office may also share this information with other law enforcement and authorised debt recovery agencies for purposes including national security, investigation and prosecution of crime, and collection of fines and civil penalties. If you are chargeable but fail to pay for NHS treatment for which you have been billed, it may result in a future immigration application to enter or remain in the UK being denied. Necessary (non-clinical) personal information may be passed via the Department of Health to the Home Office for this purpose.
Please read the leaflet entitled 'Information for overseas visitors - hospital treatment and paying for care' for more information or contact the Overseas Patients team on 020 8725 4693 or 020 8725 3439.

DECLARATION:

☐I have read and understood the reasons I have been asked to complete this form
☐I agree to be contacted by the trust to confirm any details I have provided
☐ I understand that the relevant official bodies may be contacted to verify any statement I have made.
☐The information I have given on this form is correct to the best of my knowledge.
☐ I understand that if I knowingly give false information then action may be taken against me. This may include referring the matter to the hospital's local counter fraud specialist and recovering any monies due.

Signed:	**Date:**

If you are transferring your care, please bring your notes from your current hospital with you.

Meeting Title:	Trust Board		
Date:	7 September 2017	**Agenda No**	6.1
Report Title:	Safeguarding Children Annual Report – April 2016 – March 2017		
Executive Sponsor	Avey Bhatia – Chief Nurse and Director of Infection Prevention and control		
Report Authors:	Belinda Chideme, Named Nurse for Safeguarding Children (Acute Services) Janet Edwards, Named Nurse for Safeguarding Children (Community Services - Wandsworth) Jenny Giles, General Manager for Community Services Dr Sarah Thurlbeck, Named Doctor for Safeguarding Children Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The annual safeguarding report details the systems and processes in place to safeguard children in acute and community services. The report demonstrates the Trust is committed to the safeguarding of children and promoting their welfare in line with the statutory requirements of section 11 of the Children's Act. The key issues to note in the report are: • That there will be sufficient resource in the team when all posts are filled to undertake all aspects of safeguarding with resilience built into the team • The Trust is discharging the required statutory responsibilities as outlined in the Children's Act 2004 • There are clear lines of accountability and responsibility and governance will be further strengthened by the full integration of acute and community safeguarding teams. The new Head of Safeguarding post will be instrumental in achieving this • Training at all levels is good but requires on going focus • Training at all levels including the bespoke training are comprehensive and in line with the requirements of the recommendations in the safeguarding children and young people Intercollegiate document (March 2014) • Provision of supervision for staff needs to be increased to two times per year particularly for staff working in children's areas • The Trust is fully committed to partnership working and is an integral part of the wider Multi Agency Safeguarding Hub (MASH) • All Trust safeguarding policies, procedures and guidance documents are up to date • There are risks related to the different IT systems in both acute and community • The alert system needs to be applied more consistently in the emergency department		

Recommendation:	The Trust Board are asked to receive and discuss this report and raise any concerns in terms of further assurance required.		
Supports			
Trust Strategic Objective:	Delivery of safe and effective care as assessed by the CQC		
CQC Theme:	Regulation 13: Safeguarding service users from abuse and improper treatment		
Single Oversight Framework Theme:	Delivering safe and effective care		
Implications			
Risk:	If proper systems and processes and governance not in place failure to meet statutory requirements and potentially put children at risk.		
Legal/Regulatory:	Compliance with: (i) Heath and Social Care Act 2008 (ii) Section 11 Children's Act 2004 (iii) Working Together 2015 (iv) Regulation 13: Safeguarding service users from abuse and improper treatment		
Resources:	No additional resources required or requested		
Previously Considered by:	Quality Committee Patient Safety and Quality Committee	**DATE**	26/07/17 16/08/17
Equality Impact Assessment:	N/A		
Appendices:	None		

Safeguarding Children and St George's University Hospital Foundation Trust
ANNUAL REPORT 2016/17

1. Introduction

This annual report provides an overview of the services and activities undertaken by the Trust in order to safeguard and promote the welfare of children who access services in all areas, and the children of adult patients who are cared for by the Trust ("See the Adult See the Child"). The Trust acknowledges that safeguarding children is everybody's responsibility and consequently the Trust aims to ensure that all services, departments and individual staff members are provided with appropriate information, training and support in order to be able to fulfil their role and responsibilities in this important area of patient safety. The Trust is mindful of its corporate responsibilities as described in the following:

- The Children Act (1989) section 17 and section 47
- The Children Act (2004) section 10, section 11 and section 13
- Working Together to Safeguard Children, HM Government 2015
- CQC Regulation 13: Safeguarding service users from abuse and improper treatment

Every Trust Board requires an update every year advising of the key issues relating to the safeguarding of children. The Trust Board are reminded that children are defined by the Children's Act (1989 & 2004) as young people up to but not including their 18th birthday.

Clearly there are many services that are accessed by children but the main responsibility for the care and safeguarding of children in the hospital is with the children's directorate. St George's are responsible for community and acute safeguarding and the responsibility on staff is enormous demanding both a proactive and reactive approach, particularly within the community where often the staff are lone workers and need to make quick assessments on the balance of risk.

This report provides assurance that the organisation meets the statutory requirements and makes the following declaration as requested by the Department of Health;

- The organisation meets the statutory requirements in relation to the Disclosure and Barring Service (DBS) checks
- Staff have undertaken training
- Child protection policies are up to date
- Designated and / or named professionals are clear about their role and have sufficient time and support to undertake it
- There is a Board level Executive Director for Safeguarding. The Board reviews safeguarding across the organisation at least once a year to assure it that safeguarding systems and processes are working.

2. Safeguarding children governance arrangements and team

The Chief Executive Officer (CEO) has overall responsibility for the safeguarding of children and there is a clear line of accountability in place. The Chief Nurse, on behalf of the CEO has the responsibility to ensure that health's contribution towards safeguarding children and promoting their welfare is discharged effectively throughout the whole organisation and that

St George's University Hospitals NHS Foundation Trust is represented on the Local Safeguarding Children's Boards (LSCBs).

The Chief Nurse is responsible for;

- Safeguarding children practice and assumes a strategic lead on all aspects of the Trust's contribution to safeguarding children
- Representing STGUH on Local Safeguarding Children's Boards
- Ensuring that appropriate safeguarding processes are in place, including compliance with all legal, statutory and good practice requirements

The Chief Nurse Chairs the Children's Safeguarding Committee at St George's which meets bi-monthly and has multi- professional and multi-agency representation. The Safeguarding Children's Committee reports to the Patient Safety and Quality Committee (PSQB).

The table below (table 1) details the resources in place for dedicated duties related to safeguarding children:

Table 1

Name	Role
Belinda Chideme	Named Nurse, acute children's safeguarding
Janet Edwards	Named Nurse, community children's safeguarding
Maria Hogan	Safeguarding advisor, acute children's safeguarding
Aileen Hamilton	Safeguarding advisor, community children's safeguarding
Barbara Jayson	Safeguarding advisor, community children's safeguarding
Fungai Chakanyuka	Safeguarding advisor, community children's safeguarding
Dr Sarah Thurlbeck	Named Doctor, acute children's safeguarding
Dr Avril Washington	Designated Doctor for Looked After Children (LAC)
Dr Peter Green	Designated Doctor for children's safeguarding Wandsworth CCG and Consultant for child safeguarding St George's Hospital Chairman, Wandsworth Child Death Overview Panel Chairman, National Network of Designated Healthcare Professionals for Safeguarding Children (NNDHP)
Philippa Camps	Specialist Safeguarding Midwife
Sarah Ham	Paediatric Liaison Specialist Nurse
Amanda Dibblin	Looked After Children Nurse
	Looked After Children

In addition to the dedicated resources shown in table 1 there are many other roles which contribute significantly to support the safeguarding children's agenda for example, lead

Consultant in the emergency department and acute Children's Head of Nursing. There is also dedicated (3 WTE) administrative support for safeguarding children across acute and community.

3. Safeguarding policies and procedures

The Trust has appropriate policies and procedures in place for safeguarding children which are available to all staff via the intranet on the Policy Hub. These policies and guidance are regularly reviewed to ensure that they are in date and updated as required in response to any national changes in requirements and legislation.

The policy and guidance documents are detailed in the table below (table 2):

Table 2

Policy/Guideline	Date Issued	Update
Safeguarding Children Information Sharing Policy	May-15	Up-to-date and due for review - Nov-18
Guideline for Ensuring Access to Children and Young People is controlled	Nov-14	Up-to-date and due for review - June 2018
The Management and Care of children and young people who are Looked After Guideline	Jun-15	Up-to-date and due for review - Nov 2018
The Management of Bruises and Marks in Non-ambulant Babies / Children Guideline	May-15	Up-to-date and due for review - May-18
The Initial Management of Suspected Non-accidental Injury Abuse or Neglect Guideline	May-15	Up-to-date and due for review - May-18
Safeguarding infants and children Radiological standards	May 16	Up to date, but under review due to changes in radiology staff
Safeguarding Children Supervision Policy	Jun-12	Up-to-date and due for review – March 2019
Safeguarding Children Managing Allegations against Staff Policy	Sept - 12	Up-to-date and due for review – Nov 2018
DNA guideline / No access to Child/Unseen Child guideline	Sept - 12	Up-to-date and due for review – June 2019
Safeguarding Children Escalation Guidance	Jun-12	Up-to-date and due for review – May 2019
Female Genital Mutilation (New)	2016	Up-to-date and due for review – January 2020
Safeguarding Children and Young People policy	Sep 2012	Up-to-date and due for review - July 2019
Infant/Child Abduction Policy	May 11	Up-to-date and due for review – June 1019
Anorexia Guideline	Sept 2015	Up-to-date and due for review – Sept 2018
Child Death Policy	May 2015	Being reviewed before due date (May 2018) due to changes in national guidance re resuscitation of under 18's

4. Managing allegations against staff

There is a Trust policy in place for managing allegations against staff. The policy states that any allegation made against staff must be reported to the Local Authority Designated Officer (LADO) for investigation. There have been 5 cases requiring a referral to the Wandsworth LADO from 1 April 2016 to 31 March 2017. The Trust has in all cases cooperated fully with the LADO's investigations and recommendations. Two of the cases required police investigation but both cases were subsequently closed by the police.

Staff have been reminded of the constant need for clear communication, documentation and the presence of chaperones.

5. Safeguarding children - regulator concerns and response

The CQC inspection report published in November 2016 raised concerns in relation to safeguarding. These concerns related to access and compliance with safeguarding children's training, the insufficient resources to provide this training and lack of supervision for staff directly involved in children's safeguarding cases.

A safeguarding review was carried out in 2013 which recommended the integration of acute and community children's safeguarding teams, it would appear however that the recommendations from that report although accepted were not implemented. Following the concerns raised by the CQC and in the light of the previous reviews the then interim Chief Nurse requested Capsticks to undertake a further review with a particular focus on the structure of the teams rather than the quality and effectiveness of the teams. The report from this latest review was received by the Trust in February 2017. The recommendations were considered by the new Chief Nurse, were discussed with the relevant subject matter experts and a proposal was taken to the Executive Management Team on the 12th March 2017.

The following changes and recommendations are in various stages of implementation.

- Full integration of acute and community safeguarding teams – this is absolutely essential to provide a seamless service for the children that we serve and ensure we have the right governance in place and oversight of the safeguarding agenda.
- Safeguarding team resources – a new Head of Safeguarding post has been created which will manage both adults and children's safeguarding teams and provides an additional layer of resilience into the teams – this post is currently out to advert.
- An additional band 7 safeguarding advisor has been appointed into the acute team and in additional administrative support has been provided to the team.

6. Training and staff knowledge

Across community and acute there are comprehensive training packages in place which are in line with the recommendations of the Safeguarding children and young people Intercollegiate document (March 2014). Staff are assessed on what level of training is required depending on which department they will be working in, however, all staff are required to have Level 1 training. Level 1 training is part of MAST on line and is mandatory for all staff each year, while level 2 children's safeguarding training is available as both face to face sessions and e-learning. As well as core training the team also deliver bespoke

training for staff groups as required. There is also a weekly session delivered by the named doctor for safeguarding although this session is primarily aimed at paediatric trainees other staff groups are very welcome and to attend. There are three elements to the sessions:

- Case discussions of current and past cases and trainees are encouraged to bring their own experiences to the table
- Formal, although interactive, on a range of topics both specifically medical (e.g. burns) and generic (e.g. report writing)
- A variety of other speakers, from both paediatric and other disciplines including radiology, orthopaedics, emergency department and from outside the Trust e.g. social care and the police.

The programme runs in a six monthly cycle to coincide with the paediatric trainees' placement times (March – August and September – February).

This programme has been highly praised in feedback about training sought from paediatric trainees. It is thought to be the only educational programme of this type, at least in South London. The named doctor delivering the programme has been invited to speak at a conference on paediatric training. Positive feedback has also been received following inspections of child safeguarding practice in the Trust

The table below (table 3) show the various areas covered in safeguarding training.

Table 3

Training – topics covered	
Safeguarding policies, procedures and guidelines	Learning from Serious case reviews and individual management reviews
Signs of abuse	Role of LADO
Child sexual exploitation (CSE) and Human Trafficking	Fabricated Induced illness
Record keeping	Domestic abuse
How to make a referral	PREVENT
Female Genital Mutilation (FGM)	Private fostering
Managing allegations against staff	Mental Health

The current training levels are detailed below in table 4 (July 2017)

Table 4:

Safeguarding Children Level 1	2399	**88%**
Safeguarding Children Level 2	3269	**81%**
Safeguarding Children Level 3	993	**87%**

The target for safeguarding children at all levels is 85%. There are sufficient resources to deliver the training, challenge remains in late cancellations by staff booked on to attend, releasing staff to attend and constant reminders to staff in absolute necessity to attend. One area of particular focus is medical staff in paediatric intensive care unit.

7. Supervision

All staff have access to supervision from the safeguarding children's nurses and clinicians. There is an annual programme of supervision planned for staff but we are working towards having this available for twice a year. Medical staff are able to access supervision from Safeguarding named doctors as required.

8. Safeguarding children activity

Currently there are 2 learning reviews underway and one serious case review which was declared in September 2016. St George's is not directly involved in any of these cases but we are supporting and providing information as requested.

The total number of referrals made by community heath to Multi-agency Safeguarding Hub (MASH) in 2016/17 is 592 and from acute 226. The number of referrals is broadly similar to previous year.

The themes that are initiating the referrals from acute services are:

- Children attending A&E following self-harm
- Children admitted to hospital due to safeguarding concerns
- Alcohol / drug abuse
- Children attending following attempted suicide
- Suspected gang related activity
- Attendances requiring referral to mental health

The themes that are initiating referrals from community services are those listed above but the top issues that are requiring referrals to MASH are:

- Domestic abuse
- Parental Mental Heath

The paediatric Consultants also undertake child protection medicals where non-accidental injury is suspected, this is usually between 20-30 medicals per quarter. These should be completed within 24 hours from the time requested. In Q4 2016/17 74% were completed within 24 hours.

9. Looked after Children (LAC)

The LAC's team's primary function is to carry out health checks on LAC and to advise the London Borough of Wandsworth about the medical aspects of children being adapted (approximately 6 per year).

The team undertake health assessments and immunisations. The major challenge continues to be as a result of updating children and young people that have frequent placement

moves. There are plans in place with keyworkers and carers to ensure that necessary immunisations are received at either Wandsworth immunisation catch up sessions or at their GP surgeries.

10. Child Death Overview Panel

The function of the Child Death Overview Panel (CDOP) is to provide an overview of all child deaths in the Wandsworth area to ensure that there is a rapid response meeting by a group of key multi-agency professionals for the purpose of enquiring into and evaluating each unexpected child death.

From 01 April 2016 to 31 March 2017 the Wandsworth Single Point of Contact has been notified of 15 Wandsworth child deaths. In the same period, the CDOP has reviewed and closed 19 cases. Of these cases, only 1 was found to have modifiable factors.

11. Escalation of cases

There have been 3 cases escalated to Wandsworth, Croydon and Merton children's social care. The reason for escalation was to do with poor interagency working between health and social care with perceived overly high thresholds in social care for accepting referrals.

12. External quality assurance

Section 11 of the Children's Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Wandsworth Safeguarding Children Board (WSCB) has a responsibility to ensure that agencies and organisations that have child safeguarding responsibilities are compliant with Section 11 requirements. The method chosen to test this compliance by WSCB and to assist all agencies in evidencing their commitment to Section 11 is a qualitative survey. The results for the 2016 self-assessment were very good. The results for 2017 are pending and the Chief Nurse was interviewed by the Independent Chair of WSCB as part of this process and assessment.

13. Risks and priorities for 2017/18

In relation to the action plan from the previous year there has been good progress. At the CQC inspection in June 2016 level 3 training figures were reported to be unacceptably low. Since then improved data collection and analysis, together with concerted efforts to ensure attendance at training have resulted in significant improvements.

The areas for continued focus to improve and strengthen our safeguarding activities are detailed below:

1. Maintain the quality and attendance at training
2. Provide safeguarding supervision to staff twice a year and at least once a year to staff working in areas outside of paediatrics
3. Full integration of acute and community teams safeguarding teams
4. Full key performance indicator date for LAC

The key risk that have been identified for community and acute are:

1. IT and information systems – multiple systems that can make it difficult to access and find patient information in a timely manner. This is a particular issue for MASH effectiveness.
2. The use of alerts in A&E, the system in place is effective but requires consistent application and updating.
3. Vacancies amongst Health Visitors – this is being compounded with the pending of Health Visiting services contract and needs support and monitoring of any adverse impact.

14. Conclusion

Systems and processes are in place at STGUH to safeguard children across community and acute services. There is good partnership working and input from health sharing information as required with multiple agencies to detect safeguarding concerns and protect children. There are still risks and areas for improvement as detailed above which the Safeguarding Committee will continue to focus on.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 September 2017	**Agenda No.**	6.2
Report Title:	Fit and Proper Persons Update Report		
Lead Director/ Manager:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Report Author:	Harbhajan Brar, Director of Human Resources and Organisational Development		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	The CQC in their Quality Report into their unannounced visit on the 10th, 11th and 22nd May 2017 stated that "There were not suitable arrangements in place for ensuring directors were fit and proper" under Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors. The CQC determined that the Trust was not meeting this regulation because 'not all directors had all the required FPPR checks carried in accordance with this regulation'. The purpose of this paper is to give the Board full assurance that the Trust is now fully compliant with Regulation 5. Fit and Proper Persons : Directors As part of our on-going assurance processes we asked Internal Audit (IA) to:- a) review our FPPR compliance and b) review our HR policies and procedures. IA have given us 'reasonable assurance' with a number of routine control recommendations which are being acted upon		
Recommendation:	That the Board is asked to note the current assurance around the fit and proper persons assessment. That the Board request that the HRD provide a quarterly update on FPP compliance against Regulation 5 during the year 2017/18 and annually thereafter.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-Led)		
Implications			
Risk:	Failure to meet the FFP requirements could result in further regulatory		

	actions being taken against the Trust		
Legal/Regulatory:	The requirement to meeting the FFP test is outlined in Regulation 5: Fit and Proper Persons		
Resources:	No additional resources required		
Previously Considered by:	Board and Executive Director	**Date:**	September 2017
Equality Impact Assessment:	Not undertaken. Policy applied to every Board member		
Appendices:	Appendix A - Exec and Non Exec FPPR compliance list Appendix B – FPPR Checklist for all Exec Files		

St George's University Hospitals NHS Foundation Trust's Compliance with Regulation 5: Fit and Proper Persons

Trust Board – 7th September 2017

1.0 PURPOSE

1.1 The CQC in their Quality Report into their unannounced visit on the 10th, 11th and 22nd May 2017 stated that "There were not suitable arrangements in place for ensuring directors were fit and proper" under Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors.

2.1 The purpose of this paper is to give the Board full assurance that the Trust is now fully compliant with Regulation 5. Fit and Proper Persons Directors

.

2.0 BACKGROUND

2.1 The Trust was served a Section 29A Warning Notice in August 2016 due to breaches in the implementation of this regulation and subsequently agreed enforcement undertakings with NHS Improvement in November 2016 to make the required improvements.

2.2 The findings from a recent follow-up inspection by the CQC demonstrate that the required improvements have not been made and that it is possible false assurance has been provided both to the Trust Board and regulators since the Warning Notice was issued.

2.3 The Trust Board at its meetings on the 8th June and 6th July had extensive discussions regarding the Trusts on-going failure to ensure that the requirements of the Fit and Proper Persons Regulations (FPPR) were being met.

2.4 The Trust Board asked that a deep dive into FPPR compliance be undertaken by Internal Audit (IA) and that the findings of the Audit be reported back to the Trust Board as soon as practicably possible.

3.0 OUTLINE OF KEY ISSUES

CQC unannounced inspection - May 2017

3.1 The CQC undertook an unannounced follow-up inspection in May 2017 to assess the trust's compliance with the Section 29A Warning Notice, including compliance with the fit and proper persons regulation.

3.2 CQC continue to find non-compliance against this regulation and have also raised wider governance concerns in relation to the false assurance received by the trust Board and regulators.

3.3 Records of all Board members were checked on 22 May 2017. Non-compliance was found in relation to:

- Five out of ten executive files were without a DBS
- Four of ten executive files had no references; one of the remaining six only had one reference
- No evidence of qualifications, other than a self-declaration for one executive director

- No evidence of a disqualified directors check for the Director of Finance and Director of Information
- No evidence of insolvency checks for the former interim Chief Executive, despite assurance being provided to the Board and regulator in October 2016 that this was complete SM
- Two of six non-executive director files had no evidence of references
- One of six non-executive director files had only one proof of identity
- One of six non-executive director files had no evidence of DBS
- Four of six non-executive director files had no evidence of disqualified director's checks. They did hold a record of companies house check.

4.0 NHSI Concerns

4.1 NHS Improvement has indicated that they take the concerns raised by the CQC very seriously. They have said that they are also concerned that the CQC's findings may indicate that the trust has breached the additional licence condition of October 2016.

5.0 NHSI Requirements

5.1 NHSI have considered the options available to them and in advance of considering whether any further regulatory action should be taken, they have asked that the trust agrees to undertake the following by end of June 2017:

- Report the details of CQC's findings to the trust Board
- Review the steps that led to false assurance being received by the trust Board, identify and correct any failings
- As part of the governance review undertake a diagnostic to understand the current gaps in relation to responsibilities, roles and systems of accountability to support good governance and compliance with the regulation
- Share the report from the diagnostic with NHS Improvement including recommendations and actions being taken by the trust to address any gaps
- Ensure that the requirements under regulation five are met for the current executive and non-executive directors and provide evidence of this to the trust Board and NHS Improvement
- Ensure internal audit reviews the application of the FPP regulations on a quarterly basis during 2017/18, with an annual review thereafter with the report being shared with the Board and NHS Improvement.

5.2 In their letter, NHSI have asked that rapid improvements are made to ensure compliance with this regulation and that additional assurance mechanisms are put in place to ensure that the improvements are fully embedded.

5.3 The Trust formally responded to the NHSI letter on 19 June 2017. In the letter we outlined how we intend to undertake all the actions required of us by NHSI.

5.4 As part of the assurance process we asked Internal Audit (on behalf of the Board) to undertake an audit of the Executive and non-Executive files to give the both NHSI and the Trust board full assurance that our FPP test are fully compliant with Regulation 5: Fit and Proper Persons.

6.0 Internal Audit Findings

6.1 The Internal Audit has given a reasonable assurance level (i.e. The system of internal controls is generally adequate and operating effectively but some improvements are required

to ensure that risks are managed and process objectives achieved) on the basis of evidence supplied that all Directors deemed to be within scope of the Fit and Proper Person Requirement have complete the process.

6.2 IA did make a number of further recommendations, which are that:-

- The process would benefit from a process flow chart and standard checklist template to be added to the Policy appendices
- To improve monitoring of compliance going forward, an FPPT spread sheet should be produced and maintained by the Director of HR and presented to the Board routinely
- ID documents should be signed and dated by the verifying staff member
- Evidence of the Right to Work by virtue of being a British citizen to include a passport or birth certificate.

6.3 All the additional IA recommendations have been acted upon.

6.4 A copy of the flow chart and standard checklist is attached as Appendix B and will now be added to the FPPR Policy appendices.

6.5 A signed copy of the standard checklist is on the front of every Director's FPPR file to give assurance that all the required FPPR documents are on file.

6.6 A FPPT spread sheet has been produced (copy attached as Annex A) and will now be maintained by the HR Director and will used to give the Board on-going assurance of compliance

6.7 All ID documents are now signed and dated and all files now contain the correct Right to Work documentation in accordance with the Home Office guidance.

8. Recommendation

It is recommended that the Board:-

8.1 Note the progress made to achieve compliance of the FPP Regulation.

8.2 Note the assurance (supported by the IA findings) that that Board is now fully FFP complaint.

8.3 Request that the HRD provide the Board with a quarterly update on FPP on-compliance against Regulation 5.

Annex A

Name	Fit and Proper Persons Test - Declaration Form	Employment History	References	Professional Registration	Essential Qualifications	Occupational Health	Right to Work	Identity Check	DBS/Criminal Conviction Checks	Search of Insolvency and Bankruptcy Register	Search of Disqualified Directors	Social Media Search	Complete	FPPR Met
Jacqueline Totterdell	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Avey Bhatia	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Andrew Rhodes	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Harbhajan Brar	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Andrew Grimshaw	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
James Friend	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Ellis Pullinger	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Fiona Barr	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Director of Strategy														
Director of Estates														
Director of Corporate Affairs														
Richard Hancock	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Larry Murphy	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Gillian Norton	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Norman Williams	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Ann Beasley	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Jenny Higham	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Sarah Wilton	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Stephen Collier	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

Annex B

Fit & Proper Persons Checklist

Document	Checked by	Date
Fit & Proper Persons Test/Declaration Form		
Employment History		
References		
Professional Registration		
Essential Qualifications		
Occupational Health Clearance		
Right to Work		
Identity Check		
DBS Check/Criminal Conviction Check		
Search of Insolvency & Bankruptcy Register		
Search of Disqualified Directors		
Social Media Search		

FPPT Completed	
HR Director Print Name	
HR Director Signature	
Date	