# Trust Board Meeting

**Date and Time:** Thursday 3 November 2016, 10:00 – 13:00
**Venue:** Boardroom H2.8, 2nd Floor, Hunter Wing

**PATIENT STORY**

*The Board will hear of the experiences of a patient who gave birth at St George's Hospital. Her story provides the Trust with opportunities for learning and the patient has already actively supported the Trust to make a number of improvements.*

| Time | Item | Subject | Action | Lead | Format |
|---|---|---|---|---|---|
| **OPENING ADMINISTRATION** | | | | | |
| **10:15** | **1.1** | **Welcome and Apologies** | - | Chairman | - |
| | **1.2** | **Declarations of Interest** | - | All | Verbal |
| | **1.3** | **Minutes of Meeting held on 6 October 2016** | Approve | Chairman | Paper |
| | **1.4** | **Schedule of Matters Arising** | Review | All | Paper |
| | **1.5** | **CEO's Report** | Inform | CEO | Verbal |
| | | | | | |
| **PATIENT SAFETY, QUALITY AND PERFORMANCE** | | | | | |
| **10:30** | **2.1** | **Trust Quality Improvement Plan** | Assure | DQG | Paper |
| | **2.2** | **Performance & Quality Report** | Review | COO/CN | Paper |
| | **2.3** | **Workforce Performance Report** | Assure | DHR&OD | Paper |
| | **2.4** | **Referral to Treatment (RTT) Access Policy** | Approve | COO | Paper |
| | | | | | |
| **FINANCE** | | | | | |
| **12:00** | **3.1** | **Month 6 Finance Report – including Update on Cost Improvement Programme** | Assure | DOF | Paper |
| | **3.2** | **Report from Finance & Performance Committee** | Inform | Chair of Committee | Verbal |
| | | | | | |
| **GOVERNANCE & RISK** | | | | | |
| **12.20** | **4.1** | **Corporate Risk Report** | Review | DQG | Paper |
| | **4.2** | **Quarterly Report on Serious Incidents 2016-17** | Review | DQG | Paper |
| | | | | | |
| **ITEMS FOR INFORMATION** | | | | | |
| **12.45** | **5.1** | **Use of Trust Seal** | Inform | Chairman | - |
| | **5.2** | **Questions from the Public** | - | - | - |
| | | | | | |
| **CLOSING ADMINISTRATION** | | | | | |
| **12.55** | **6.1** | **Reflection on Meeting** | - | All | Verbal |
| | **6.2** | **Any Other Business** | - | All | Verbal |
| **13:00** | | **Close** | | | |

**Resolution to move to closed session**

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

**Date and Time of Next Meeting: Thursday 1 December 10:00 – 13:00**

**Trust Board (Public)**
**Purpose, Membership, Quoracy and Meetings**

| | |
|---|---|
| **Trust Board (Public) 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. |

| **Membership and Those in Attendance** | | |
|---|---|---|
| | | |
| **Members (Voting)** | **Designation** | **Abbreviation** |
| Sir David Henshaw | Chairman | Chairman |
| Simon Mackenzie | Chief Executive | CEO |
| Margaret Pratt | Chief Financial Officer | CFO |
| Andrew Rhodes | Medical Director | MD |
| Suzanne Banks | Chief Nurse | CN |
| Sir Norman Williams | Non-Executive Director | Name/NED |
| Sarah Wilton | Non-Executive Director | |
| Jenny Higham | Non-Executive Director (University Rep) | |
| Gillian Norton | Non-Executive Director | |
| Stephen Collier | Non-Executive Director | |
| Ann Beasley | Non-Executive Director | |
| | | |
| **Members (Non-Voting)** | | |
| Mark Gordon | Chief Operating Officer | COO |
| Karen Charman | Director of Human Resources & Organisational Development | DHR&OD |
| Iain Lynam | Chief Restructuring Officer | CRO |
| Larry Murphy | Chief Information Officer | CIO |
| Richard Hancock | Director of Estates & Facilities | DE&F |
| Paul Moore | Director of Quality Governance | DQG |
| Justin Richard | Divisional Chair, CWDT | DC/CWDT |
| Lisa Pickering | Divisional Chair, MedCard | DC/MC |
| Tunde Odutoye | Divisional Chair, SCTN | DC/SCNT |
| Alison Benincasa | Divisional Chair, CSD | DC/CSD |
| Thomas Saltiel | Associate Non-Executive Director | Name/NED |
| | | |
| **Secretariat** | | |
| Fiona Barr | Corporate Secretary and Head of Corporate Governance | Corp Sec |

| | |
|---|---|
| **Trust Board (Public) Quoracy:** | The quorum for any meeting of the Committee shall be at least one third of the Directors present including not less than one Non-Executive Director and one Executive Director. |

| **Trust Board (Public) Dates in 2016-7** | | | |
|---|---|---|---|
| Thursday 1 December 10:00 – 13:00 | Thursday 5 January 10:00 – 13:00 | Thursday 9 February 10:00 – 13:00 | Thursday 9 March 10:00 – 13:00 |

St George's University Hospitals NHS
NHS Foundation Trust

# *Minutes* Trust Board

**Minutes of the meeting Trust Board of St George's University Hospitals NHS Foundation Trust, held on Thursday 6 October 2016 in Richmond & Barnes Rooms at Queen Mary's Hospital commencing at 9.30am.**

**PRESENT**

| | | |
|---|---|---|
| Sir David Henshaw | DH | Chairman |
| Simon Mackenzie | SM | Chief Executive Officer |
| Nigel Carr | NC | Chief Finance Officer |
| Andrew Rhodes | AR | Medical Director |
| Suzanne Banks | SB | Chief Nurse |
| Karen Charman | KC | Director of Workforce |
| Richard Hancock | RH | Director of Estates |
| Larry Murphy | LM | Chief Information Officer |
| Mark Gordon | MG | Chief Operating Officer |
| Iain Lynam | IL | Chief Restructuring Officer |
| Jenny Higham | JH | Non-Executive Director |
| Gillian Norton | GN | Non-Executive Director |
| Thomas Saltiel | TS | Associate Non-Executive Director |
| Sir Norman Williams | NW | Non-Executive Director |
| Sarah Wilton | SW | Non-Executive Director |
| Chris Rolfe | CR | Associate Director of Communications |
| Justin Richards | JR | Divisional Chair, Children's and Women's, |
| Alison Benincasa | AB | Divisional Chair, Community Services |
| Luke Edwards | LE | Head of Corporate Governance |
| Richard Coxon | RC | Membership & Engagement Manager [minutes] |

**APOLOGIES**

Paul Moore
Tunde Odutoye
Lisa Pickering

| **Agenda Item** | **Action** |
|---|---|

**Patient Story – Christine Travers**

The Chair introduced Christine Travers to give personal insight of her story of being a patient at St George's. Ms Travers has been a patient at St George's for 16 years after giving birth to her third daughter there. She lives near Battersea Park and thinks of St George's as her local hospital where the staff know her. She has had experience as an inpatient and attends the outpatient asthmatic clinic.

Areas where she thinks there could be improvement include letters stating she had attended appointments with her 'carer' who were

actually her support worker, despite her correcting them. Also the doctors and nurses don't always use accessible language to allow for her disabilities which she finds frustrating. She does not like being given medicine in capsule format as she finds them difficult to swallow and has asked for liquid medicine or caplets but staff don't seem to listen or explain why this is not possible. When she had an asthma attack she was taken by the ambulance to the Chelsea & Westminster Hospital when she would have preferred to go to St Georges. It was explained that the ambulance crew are obliged to take patients to nearest A&E for treatment.

The Board thanked Ms Travers for sharing her story with them and agreed they would look into the issues raised.

**1 Welcome and Apologies**

The Chair opened the meeting. Apologies were received from Lisa Pickering, Paul Moore and Tunde Odutoye.

**2. Declarations of Interest**

No declarations of interest, pecuniary or non-pecuniary, were received.

**3. Minutes**

The Board considered the minutes of the last meeting held on 1 September and noted some minor changes as to who was present.

**Resolved** that the Board**:** approved the minutes as a true and accurate record as amended.

**4. Key Issues**

Key issues are covered in agenda.

**5. Matters Arising**

The matters arising were covered in the agenda.

**6 PATIENT SAFETY, QUALITY AND PERFORMANCE**

**6.1 Performance & Quality Report**

MG presented the performance report highlighting that performance against the cancer two week standard was 93% in July against the standard. Urgent care attendances are up 4-5% year on year and we are one of the highest performance trusts in London. At peak times we are dealing with 30 patients an hour so need to bring in support from our departments to meet demand. There is an integrated discharge team to ensure more efficient discharge of patients.

There is an escalation plan coming out on Monday which gives more fluidity with beds and would be monitored daily. August was busier than any of the winter months. TS asked why this was. MG responded that in August more patients with strokes were admitted and more patients over 80 years old with respiratory problems.

Ward rounds are now held early in the day so that patients for discharge can be identified and is being universally driven. Every patient has to have an expected date of discharge plan to be reviewed daily. NW agreed with this approach.

SB introduced the quality element of the report. The Board will notice the changes to the report which is a work in progress. Infection control is performing well with no cases of MRSA in nearly a year and two cases of c diff in July 2016.

Both safeguarding adults and children rates are below target when taken from MAST (52.3%). However in July, manual data collection shows a substantial improvement at 90.32% so work is being undertaken to ensure that electronic data is up to date and correct.

**Resolved:** that the Board noted the update.

**6.2 Workforce & Performance Report**

KC introduced the report which showed that vacancy and turnover rates have both decreased. Workforce stability shows a 1.9% increase over a 12 month period.

There is an increased use of bank and agency staff which will be addressed by greater controls particularly the use of Agency staff. We are also working collaboratively with other trusts within SW London to agree lower charges with agencies and shared bank staff. The good news this week is that bank and agency staff costs have come down.

DH stated that the overall staff head count was up over last year when there had been no increase in activity output. There was a greater need for business control and accountable management.

KC reported that there is a trust wide hold on recruitment with only essential clinical staff being recruited which is reviewed weekly. We need the right size workforce for the trust as a whole. It was also important to note that it is important that staff are released for training and ensuring that there was appropriate cover in place.

SW asked whether the previous issue of staff 'acting up' for long periods had been resolved and KC confirmed that it had.

**Resolved:** that the Board noted the report.

**6.3 Quality Committee Report**

NW presented an update report as chair from the Quality Committee having dropped 'Risk' in the title. One new Never Event (wrong site surgery) was declared in August and stated that his aim was for us to be the first trust in the UK to never have a Never Event.

The number of complaints received continues to increase month on

month since November 2015, which has impacted on turnaround time. A lot of work that needs to be done to improve in this area. He would like the St George's endoscopy services to continue improve so that is can receive JAG re-accreditation.

GN thought that the new committee was working well with a lot of work to be done but the revamped performance report is very helpful but a work in progress.

**Resolved:** the Board noted the report.

### 6.4 RTT

MG updated the Board on the key actions to be undertaken by the Trust in order to recommence national reporting of RTT Performance data.

There are three main areas of focus for RTT.

Stream one: Immediate data validation of current pathways and local reporting. Our main weakness that has been identified is staff inputting data into system in different ways. On 10.10.16, stream 1 commences and central a management hub has been established for anyone employed in inputting patient data. Members of the IT team have been seconded to help train and retrain staff.

Stream two: Re-establishment of systems, processes and training.

Stream three: Forward management and validation process. This will involve re-establishment of Cerner systems. Cerner will conduct full training package for all Trust staff. Checks in system and validation process will be regularised. This includes forward management and validation process. The programme board will be led by DH and MG will lead on entire project.

NW asked about the timeline to complete this project. MG responded that it was difficult to agree a date but will know with a week after meeting with CQC.

**Resolved:** the Board noted update.

## 7. TRANSFORMATION

### 7.1 Update from Turnaround Board

IL introduced the item. We are coming to the end of a hand over from KPMG who have been providing consultancy support and replacing with our own resources. There is a predicted shortfall for the CIP programme for the year and recovery actions to be put in place to provide new CIPs to begin the recovery process.

**Resolved:** that the Board noted update.

**7.2 Interim Resourcing**

IL presented a paper on interim resourcing. There is a significant difference between temporary and interim staff. Interim staff number 98 which are staff here for more than a month. The figure differs from the one previously reported as there were individuals not previously identified, such as those in SWL Pathology. It is not expected that this number will grow but the mix might change depending on skills need. The final member of KPMG will finish on the 14.10.16.

**Resolved:** that the Board noted update.

**7.3 Estates Report**

RH presented report on areas identified by the CQC which raised a lot of concerns which require action to be taken.

Water safety management – CQC require us to demonstrate that we are compliant in relation to water outlet flushing across the Trust and that we have robust assurances in place across our systems and processes for the avoidance of legionella.

Renal Services, Buckland Ward, Knightsbridge Wing – plans are in place to relocate inpatients to Champneys Ward during November 2016. Knightsbridge Ward will not be in use beyond Christmas 2016 and will be demolished in early 2017. A mobile dialysis unit has been placed onsite for outpatients to continue receiving dialysis treatment, operational from 25.10.16.

Lanesborough Wing – CQC require assurance that systems and processes are sufficiently robust for mitigating the risks associated with both the management of fire and legionella infections. The LFB re pleased with Trusts current progress and we have a signed accord with them that they are satisfied with the fire safety of the Trust. Fire doors are being replaced and continue upgrade of fire extinguishers and alarm systems.

Outpatient Department – plans are currently in place to move three services to communities which will substantially reduce patient footfall and address overcrowding raised by CQC.

Theatres – theatres five and six have been refurbished with theatres three and four to be refurbished in the next phase once business case approved.

**Resolved:** that the Board noted update.

**7.4 Project Update – Gibraltar & Overseas Patients**

The Board also discussed recent press coverage about St George's proposals to introduce checks for maternity patients from overseas in line with national guidelines. The Board re-stated the importance of making sure women weren't disadvantaged as a result, and that more

work needs to be done to assess the practical and logistical challenges of administrative staff carrying out checks of this kind, were a pilot project to be undertaken.

**Resolved:** that the Board noted update.

## 8. FINANCE

**8.1** NC summarised the report for the Board. The trust was £7.5m deficit in month five which was £6.6m adverse to plan. This includes a Non-Pay overspend of £3.1m, excess pay costs of £1.3m and below plan SLA income (£2.3m; mainly attributable to the STF (£1.5m) and low activity volumes).

The year to date deficit is now £34.9m and forecast outturn is £55.5m. These values are £19.7m and £38.3m worse than plan respectively.

GN felt concerned that we would not be able to meet our target with only a few months left in the year. NC felt that there was still time and figures for month six show activity has increased.

**Resolved:** that the Board noted update.

**8.2 Report from the Audit Committee**

SW presented report from Audit Committee. Despite progress having been made, driven by our newly appointed internal audit firm TIAA, there remain 52 overdue actions. These have been targeted to complete before the November Audit meeting. The automated on-line tracker system now implemented by TIAA, which should make it easier and more efficient to manage the outstanding actions.

The Audit Committee had expressed concern at both the volume of SFI waivers sought and the nature of the requests. The Head of Procurement is closely reviewing and will report progress to next meeting.

**Resolved:** that the Board noted update.

DH asked to take this opportunity to thank Nigel Carr at his last meeting for all his outstanding work at the Trust.

## 9. Governance and risk

### 9.1 Risk and Compliance Report

SM updated the Board on the progress of the work to review the corporate risk register (CRR). The CRR continues to be rebuilt and reassessed accordingly. This work remains on-going at time of report.

The core operational risk exposure has been grouped under the following risk areas:

- Timely access to Clinical Services/Patient Harm
- Insufficient Resilience/Unstable Critical IT/Estates Infrastructure
- Unsustainable Financial Position
- Inadequate Governance/Reputation Loss

DH felt that we now had a good grip on the risk register which was focused.

**Resolved:** that the Board noted update.

### 9.2 ICT Approach

LM introduced this paper to highlight the risk of the existing technical platform (ICT infrastructure). It is recommended that we use the Microsoft Azure Cloud storage to provide the back up solution for the Trusts email. This is a safe and approved solution.

ICT is currently procuring a Strategic Business Partner to assist in the creation of a five-ten year ICT strategy and support its delivery.

GN noted that even with enhance firewalls there were risks from staff. LM responded that there were sufficient restrictions in place to ensure that this was not a problem. All patient data is held on Cerner and Rio which is not affected by this.

SW noted that other trusts have similar problems and asked if we had spoken to or tried partnering with other trusts who successfully use cloud storage and tried and tested technology. DH felt that we needed to get on with this and could not wait to form partnerships with other trusts.

**Resolved:** that the Board noted and agreed.

### 9.3 Board Assurance Framework

LE introduced the board assurance framework (BAF) paper. The CQC had raised concerns that the lack of BAF and wider governance arrangements, in their current format, were not sufficiently robust to ensure that the board and executive had oversight of the risks which were likely to impact on the organisations ability to provide safe and effective care. The emerging picture the BAF describes is that the current level of risk is high or very high for seven of the ten strategic risks.

DH thought that good progress had been made and is a work in progress.

**Resolved:** that the Board noted and agreed.

**9.4 Fit and Proper Person Assessment Revised Policy**

LE stated that the CQC had identified this as another area of concern that the trust was not fully discharging its duties under the Fit and Proper Person requirements as set out in the Health and Social Care Act. The assessment has been completed for the current Board and the files have been reviewed to ensure they are up to date and necessary documentation is held on file. The policy has been revised and strengthened for future compliance.

**Resolved:** that the Board noted and agreed.

DH thanked LE for all his support before he leaves the Organisation.

**9.5 A Framework of Quality Assurance for Responsible Officers and Revalidation**

AR presented this report to provide assurance to the Board that doctors working in the designated body remain up to date and fit to practise. In April 2016 medical revalidation entered its fourth year. Due to the phased implementation of revalidation submissions across England, this means that a much smaller number of doctors are scheduled to revalidate over the next two years which provides an opportunity to focus more closely on the requirement for all doctors to undertake a professional appraisal every year, irrespective of the date of their next revalidation, as well as improving the quality of appraisal. The Board authorised submission of the annual return to NHS England.

**Resolved:** that the Board noted and agreed.

## 10. Items for Information

**10.1 Use of the Trust Seal**
Not used this month.

**10.2. Questions from the Public**

DH reported that the Governors had yesterday unanimously approved the appointment of three Non-Executive Directors. These appointments will be formally ratified at the Council of Governors meeting on the 13.10.16.

HH asked about fire warden training across the Trust. RH confirmed that we had the required number of trained fire wardens within the Trust who received annual training. We are in the process of setting

up a mock ward within the Education Centre to enhance this training. The LFB visited the day after the CQC and were completely satisfied.

AB noted that the patient story gives something to everyone to take back to their respective service.

**10.3 Key Reflections**

DH noted we were experiencing tough times awaiting publication of the CQC Report and there is much work to do. However, improvements are being made.

**11. Date of next meeting**

The next scheduled meeting of the Board to be held in public will be on the 3 November 2016 in Boardroom H2.5 at St George's Hospital.

St George's University Hospitals NHS
NHS Foundation Trust

**Matters Arising/Outstanding from Trust Board Public Minutes**

**3 November 2016**

| Action No. | Date First Raised | Issue/Report | Action | Due Date | Responsible Officer | Status at November 2016 |
|---|---|---|---|---|---|---|
| 7.5 | 5 May 16 | PPI/PPE Action Plan | Board agreed with the Strategy. JH to set out an action plan working with Patient representatives. | Sept 16 deferred to October 16 | S Banks / H Tonge | Covered by Suzanne Banks during the Integrated Performance Report update to the Board in October 2016. Action Closed. |
| 6.1 | 2 June 16 | Patient Safety, Quality and Performance (Quality Report) | EOLC strategy will be developed and the Board will be updated in 3 months on the longer term plans. | Nov 16 | S Banks/H Tonge | Draft EOLC considered at EMT.24.10.16 and will return to EMT in December 2016 for final approval. Action proposed for closure. |

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO THE TRUST BOARD** ***November 2016***

| | |
|---|---|
| **Paper Title:** | Trust Quality Improvement Plan (QIP) |
| **Sponsoring Director:** | Paul Moore.<br>Director of Quality Governance |
| **Author:** | Anne O' Connor.<br>QIP Project Lead |
| **Purpose:**<br>*The purpose of bringing the report to the board* | To advise and update the Board on the<br>• CQC 29A Warning notice progress<br>• Progress against the QIP |
| **Action required by the board:**<br>*What is required of the board – e.g. to note, to approve…?* | For assurance. The Board of Directors are invited to:<br>• note the current position of the overall QIP;<br>• note and consider the progress to address compliance concerns set out in the warning notice; and<br>• advise on any additional action required. |
| **Document previously considered by:**<br>*Name of the committee which has previously considered this paper / proposals* | **Quality Committee and Executive Management Team** |

**Executive summary**

**I. Key messages**

**<u>Section 29A Warning Notice</u>**

A lot of action has been taken to address at pace identified compliance concerns. This work is progressing well overall. However, at time of this report, there remains some work to be concluded to meet the requirements of the Warning Notice by 30/11/16 as follows:

(i) Demonstrate compliance with and implementation of the requirements of the Mental Capacity Act, Deprivation of Liberty Safeguards and documentation of best interest decision making on Allingham, Dalby, Gwynne Holford and Rodney Smith Wards;
(ii) The Division of Surgery must improve performance in respect of serious incident management;
(iii) The 3.5 year timeline for completion of refurbishment works to all theatres has been agreed in principle by the CQC, although this may be subject to availability of capital.
(iv) Relocation of the Renal services to be concluded as planned;
(v) Agreeing with NHSI an RTT recovery plan. The works needed to address the underlying defects and review cases for potential harm is progressing, but slowly.
(vi) Addressing the gaps in water safety management with respect of flushing routines in water outlets for Pseudomonas prevention;
(vii) The requirements to establish an integrated acute and community end of life service, with a clear strategy, governance arrangements, KPI monitoring and reporting, remains on-going.

Appendix 2 sets out the Trust position with regards to all Section 29A matters.

**Action Taken / Planned**

A Quality Improvement Programme (QIP) has been designed, which currently contains actions across 10 workstreams. The workstreams directly address:

- legacy CQC actions (i.e. those actions not delivered prior to CQC inspection in June);
- actions required to address the concerns highlighted during the CQC's feedback to the Trust in June-16; and
- actions required to address matters highlighted in the Section 29A Warning Notice.

Additional actions identified following publication of the CQC's final report will also be incorporated into the QIP.

**Summary of QIP Workstreams Actions**

A total of 10 work streams are involved in the QIP, into which 164 actions are incorporated. Of those actions:

- 27 (16%) have been completed and reported as embedded (subject to internal verification);
- 137 (84%) remain active. Of the active actions 16 (10%) are red, 16 (10%) amber and 105 (64%) Green. (See table 1 for breakdown of actions by workstream).

We set out in appendix 1, a summary of the workstream progress with exception reporting those matters rated Red or Amber. Further information is available on the individual workstream summaries on request.

**CQC Report Update**

A Quality Summit will be held on 2nd November which will be led and chaired by CQC. The CQC will present first to set out their findings and explain their judgements. The Trust will then present a response followed by a broader discussion involving wider stakeholders to discuss the way forward.

**Key risks identified:**
Failure to make the improvements set out in the Warning Notice could result in the CQC:

- Requiring NHS Improvement, to make an order under Section 65D (2) of the National Health Service Act 2006 (appointment of trust special administrator)
- Prosecution of the accountable person.

| | |
|---|---|
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | **All** |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | **All** |

**Equality Impact Assessment (EIA): Has an EIA been carried out? ( Yes / No)**
**If yes, please provide a summary of the key findings**

**If no, please explain you reasons for not undertaking and EIA.**

## Summary of all QIP Workstreams
## Overview report

**Executive Lead:**
Title: Director of Quality Governance
Name: Paul Moore

| Reporting Period: | Action BRAG rating analysis | | | | | | |
|---|---|---|---|---|---|---|---|
| | R | A | G | B | B/G | Active Actions | Assurance Actions |
| (October 2016) | | | | | | 137 | 27 |
| | 10% | 10% | 64% | 16% | 0 | Total Actions in Workstream | |
| | | | | | | 164 | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.

### 1. Executive Summary:

A total of 10 work streams are involved in the QIP, into which 164 actions are incorporated. Of those actions, 27 (16%) have been completed and reported as embedded (subject to internal verification) and 137 (84%) remain active.
Of the active actions 16 (10%) are red, 16 (10%) amber and 105 (64%) Green. (See table 1 for breakdown of actions by workstream). We set out in appendix 1, a summary of the workstream progress with exception reporting those matters rated Red or Amber. Further information is available on the individual workstream summaries on request.

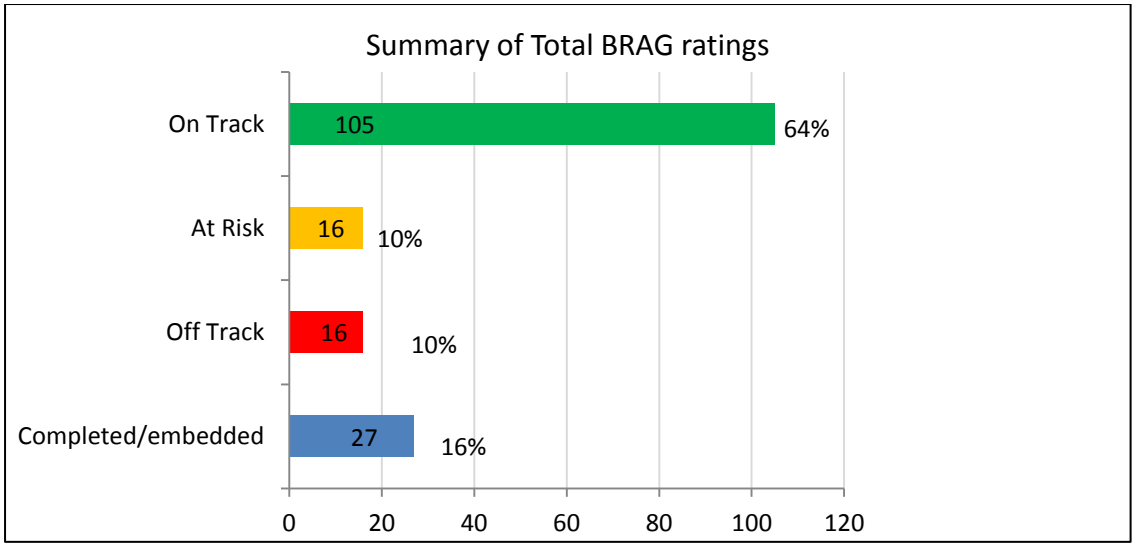


*Fig 1: Summary of BRAG ratings by workstream*

| Workstream | BRAG analysis | | | | Total by WS | Overall BRAG | Exec Lead |
|---|---|---|---|---|---|---|---|
| | B | R | A | G | | | |
| **Medicines Management** | 1 | 1 | | 21 | 23 | Amber | Medical Director |
| **End of Life Care** | 1 | | 1 | 13 | 15 | Red | Chief Nurse |
| **Governance** | 3 | 1 | 3 | 16 | 23 | Amber | Director of Quality Governance |
| **Human Resources** | 4 | | 4 | 13 | 21 | Amber | HR Director |
| **Estates** | 11 | 5 | 4 | 7 | 27 | Red | Estates and Facilities Director |
| **Radiation Safety** | | | | 12 | 12 | Green | Medical Director |
| **Referral To Treatment** | 1 | 4 | 4 | 6 | 15 | Red | Chief Operating Officer |
| **Safeguarding and MCA** | 1 | | | 3 | 4 | Green | Chief Nurse |
| **Gwynne Holford** | 4 | 3 | | 8 | 15 | Red | Chief Nurse |
| **Bedrails** | 1 | 2 | | 6 | 9 | Red | Chief Nurse |
| | **27** | **16** | **16** | **105** | **164** | | |

*Table 1: Summary of BRAG ratings by workstream.*

*Appendix 1: QIP Workstreams summary reports*

## I. Estates Workstream Overview report

| QIP Work stream: Estates | | Executive Lead: Title: Director Of Estates & Facilities Name: Richard Hancock | | | | | Workstream Lead: Name: Richard Hancock | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** | **Reporting Period:** (October 2016) | **Action BRAG rating Analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **16** | **10** |
| | | **5↑** | **4↑** | **7↓** | **11↑** | **0** | **Total Actions in Work stream** | |
| | | | | | | | **27** | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.

**Exception Report: Red / Amber Actions**

| Action (Number then action narrative) | Target Completion Date | Status | Explanation for RAG rating | Expected completion date |
|---|---|---|---|---|
| 5.2.1<br>Relocate renal service Renal ward in St James Wing - to be relocated - Trust to identify and approve appropriate ward closure and impact to revenue | 30/09/16 | | Have not met time line<br>Phased plan to relocate services<br>Moves have started. Acute bed wards not expected to move until mid-November. Difficulty finding a contractor, now on site & is on schedule.<br>Day dialysis complete<br>Acute beds due to move end Nov<br>Need to identify accommodation for transplant OPD. | 30/11/16 |
| 5.3.1<br>Relocate 15% outpatient services in Lanesborough Wing within 3 months | 30/09/16 | | Have not met timeline<br>Difficulty with phlebotomy services | 30/11/16 |

| | | | | |
|---|---|---|---|---|
| 5.5.7<br>Divisional Directors of Nursing to ensure that there is a nominated nurse for each ward who acts as the Fire Warden and receives relevant fire awareness and evacuation preparedness training and that this is then cascaded to the wider nursing team, with lessons learned being built in | 31/07/16 | | Cannot be assured that there is a named fire warden on duty for each shift each ward/area.<br><br>QIP Board: Need to agree if this action is just for Lanesborough or trust wide. | 31/07/16 |
| 5.9.1<br>Recruit an interim water manager whilst the permanent post is recruited to. | 31/08/16 | | Appointment made, but recruitment suspended as per Trust recruitment freeze. | 30/11/16 |
| 5.9.5<br>Daily flushing carried out and documented for pseudomonas prevention | 31/08/16 | | Returns show poor compliance in clinical areas, ranging from 48% - 100% (although there is an improvement from previous periods with lows of 20%) | 30/11/16 |
| 5.1.3<br>Immediately initiate survey and inspection of fixed wiring in Buckland. | 30/11/16 | | Infrastructures including circuits have all been tested and repaired.<br>Outstanding area of testing is Buckland Ward - due to clinical risk - clinicians don't want power turned off as high risk patients require continuous power supply. | 30/11/16 |
| 5.7.2<br>Design and implement a maintenance schedule for air handling unit. This will have to include some theatre down time to allow the work to happen. | 30/11/16 | | Not on existing PPM contract as theatres cannot be closed down. PPM regime scheduling agreement with COO and service. Planned maintenance of theatres 5 & 6 to start in September 2017. | 30/11/16 |

| | | | | |
|---|---|---|---|---|
| 5.9.2<br>Replace the 2 agency Band 2 water flushers with 4 Band 1 flushers" | 31/08/16 | | Using a blended team of some permanent and agency staff within current head count.<br>11/10 - This has been done but is not sustainable due to high attrition rates – A contract with a third party is currently under negotiation to carry out flushing. Returns for September 100% compliant. Require 3 months 100% audit results to turn green. | 30/11/16 |
| 5.9.4<br>Twice weekly flushing carried out and documented for Legionella prevention | 31/08/16 | | 100% compliance since September. Require 3 months evidence to turn green. | 30/11/16 |

| Risk/Issue to Highlight to QIB | Mitigating Action | Status |
|---|---|---|
| 5. CQC Section 29A Warning Notice<br>**7.1 & 5.7.2**<br>Theatre refurbishment and PPM of air handling units.<br>Down time within theatres will be required in order to carry out necessary refurbishment and PPM. This programme will have to be phased with two theatres at a time being out of action and taking approximately 5 months to complete.<br><br>**5.9.1-5.9.4**<br>Inability to demonstrate assurance of how the risk of water contamination and infection is being managed.<br>Insufficient capacity within the Estates and Facilities team carry out necessary testing under the regulations.<br>In addition a schedule of sink replacements is required | Scheduling of theatre refurbishment with Director of Estates and Facilities and Director of Operations<br><br>Plan to contract 3rd party contractor as using Band 1& 2 flushers not sustainable due to high attrition rate.<br>Plan to recruit to an interim water manager, but this post has been frozen under recent Trust recruitment freeze | Active, Green until 30/11/16 |

**Recommendations Regarding Delivered and Embedded Actions**

| Action (Number then action narrative) | Status | Comments |
|---|---|---|
| 5.1.1<br>Immediately repair known leaks to the roof on Buckland Ward, Knightsbridge Wing | | Completed and confirmed to CQC in Chief Executive's Letter 07/07/2016.<br>Cleared Gutters and drains. Vegetation pruning and removal of tree and roots. |
| 5.1.2<br>Close beds in those areas within the Ward affected by the ingress of water and declare those areas unusable until the electrical works have been certified. | | Completed and confirmed to CQC in Chief Executive's Letter 07/07/2016.<br>Beds have now been removed, the area has been zoned off and secured, this area has been taken out of use. |
| 5.4.1<br>Continue weekly fire alarm testing, routine servicing and independent testing | | Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016 Work has been completed certificates supplied |
| 5.7.3<br>Replace 2 faulty air handling units in St James Wing theatres. | | Completed. Air handling units installed. |
| 5.4.2<br>Introduce fire compartmentation to second floor Plant Room Lansborough Wing | | Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016 Work has been completed certificates supplied |
| 5.4.3<br>Complete audit and replacing where necessary fire extinguishers to all locations including plant rooms | | Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016 |
| 5.4.4<br>Upgrade fire compartmentation, including fire doors, to the vertical escape routes in Lanesborough Wing | | Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016 |
| 5.5.8<br>Targeting high risk areas initiate a series of table top fire exercises covering two clinical areas each week. | | Confirmed in Chief Executive's Letter to CQC 07/07/2016.<br>11/10 - This has been complete 30/09/16.<br><br>This will become a rolling programme across all clinical areas. |

| | | |
|---|---|---|
| 5.5.9<br>Complete fire risk assessments for whole site and verify mitigation plans are in situ and accessible to staff | | Confirmed as completed in Chief Executive's Letter to CQC 07/07/2016. This action was a requirement for Lanesborogh Wing however this is being rolled out across the site. |
| 5.5.10<br>Fire Safety Advisors to meet London Fire Brigade Inspection Team and invite LFB to undertake independent inspections to provide further assurance. Fire Brigade inspecting officers Matthew Swanepoel & Carol Campbell have met with Estates. | | Completed inspection and sign off 31/08/16 from London Fire Brigade<br>MOU between SGHT and LFB |
| 5.8.1<br>Replace ceiling tiles<br>Replace fixed lighting<br>Repair cause of condensation leaks from hot water tank above maternity staff room. | | Complete 31/08/16 |

## II. Workstream Overview report HR

| QIP Work stream: HR | | Executive Lead: Title: Executive Director of Human Resources & OD Name: Karen Charman | | | | | Workstream Lead: Name: Karen Charman | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** | **Reporting Period:** (October 2016) | **Action BRAG rating Analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **17** | **4** |
| | | **0↓** | **4↓** | **13 ↑** | **4↑** | **0** | **Total Actions in Workstream** | |
| | | | | | | | **21** | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue- subject to CQC confirmation.

| **Exception Report: Red / Amber Actions** | | | | |
|---|---|---|---|---|
| **Action** (Number then action narrative) | **Target Completion Date** | **Status** | **Explanation for RAG rating** | **Expected completion date** |
| 4.2.1 We will ensure fair and transparent opportunities for all staff at all levels in the organisation | 31/12/16 | | FFPT Raised concern about transparency and equity. Policy to be updated. FFPT & staff survey indicated staff not satisfied with practice. Requires additional work | 31/12/16 |
| 4.2.3 We will expand our apprentice programme to support work opportunities in the communities we serve and achieve over 200 placements by April 2017-18 | 31/03/17 | | No transfer forecasting to achieve 200 placements by April 2017 as levy is not operative until after April 2017. Funding challenge | 2017/18 |

| | | | | |
|---|---|---|---|---|
| 4.4.2<br>We will review our Bank and Agency/temporary staff process to become more proactive and efficient and exceed the required targets whilst driving quality | 31/03/17 | | Remains challenging.<br>Requires deep dive (diagnostic) agreed plan and implementation plans. | 31/03/17 |
| 4.5.1<br>We will introduce e rostering for our Doctors in training to fairly monitor working hours and offer maximum opportunities to work across the Trust. | 31/12/16 | | Challenges raised to business case viability. Reverted to paper base rostering. | 31/12/16 |

| Risk/Issue to Highlight to QIB | Mitigating Action | Status |
|---|---|---|
| None<br>CQC issued 29A warning notice which includes the following:<br><br>There are not suitable arrangements in place for ensuring directors are fit and proper | Points addressed in 4.1.2 above | This has now been addressed and completed. |

**Recommendations Regarding Delivered and Embedded Actions**

| Action<br>(Number then action narrative) | Blue Action Form Submitted?<br>Yes / No | Comments |
|---|---|---|
| 4.1.2.<br>Ensure all current Executive Director and Non-Executive Director personal files, are compliant with Fit and Proper Persons requirements. | | All complete and reported to the Board.<br>Requirement under S29A Warning Notice. |
| 4.1.3<br>Implement appropriate restrictions imposed by the Chairman on any Directors where documentation is incomplete | | As for point 4.1.2 |
| 4.2.1<br>We will ensure fair and transparent opportunities for all staff at all levels in the organisation | | Acting up policy published |

| | | |
|---|---|---|
| 4.8.1<br>Workforce Race Equality Standard presented to and approved by the Board | | Completed and signed off by the Board in August2016 |

**Changes to previous QIP**

| |
|---|
| 4 (Green) recruitment and selection workstream included onto HR workstream. R&R closed down |

## III. RTT Workstream Overview report

| QIP Work stream: RTT | | Executive Lead: Title: Chief Operating Officer Name: Mark Gordon | | | | | Workstream Lead: Name: Karen Brown | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** | **Reporting Period:** (October 2016) | **Action BRAG rating Analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **14** | **1** |
| | | **4↔** | **4↓** | **6 ↔** | **1↓** | **0** | **Total Actions in Work stream** | |
| | | | | | | | **15** | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.

**Exception Report: Red / Amber Actions**

| Action (Number then action narrative) | Target Completion Date | Status | Explanation for RAG rating | Expected completion date |
|---|---|---|---|---|
| 8.1.4 Create a RTT Recovery Programme Project Brief to define the requirements of the RTT Recovery Programme which incorporates the key points of the MBI report. | 30/09/16 | | Initial plan rejected by NHSI. Plan resubmitted 11/10. Red as outside target completion date | 30/11/16 |
| 8.1.9 Phase 2 procurement process. 'External expertise to provide a suite of informed analytical tools that provide a daily accurate and auditable view of performance following the detailed review (Cymbio dashboard). | 30/08/16 | | 11/10 - Advice from NHSI is to concentrate on the immediate need and not the plan for the dashboard. For review in the future.<br><br>Unable to take action, decision required from Board. | |

| | | | | |
|---|---|---|---|---|
| 8.1.10<br>Secure external site based expertise to provide immediate system based validation of the high priority cohorts through the use of automated software algorithms. | 30/08/16 | | Off track as needs to go through NHSI procurement process, which has not yet started. | 30/11/16 |
| 8.1.11<br>When system based validation is inconclusive assess for clinical Harm through the established clinical harm work stream. | 04/07/16 | | Dependent on 8.1.10. Off track. However work has started on cardiac and general, 520 cases reviewed to date. Backlog to be determined. | TBC |
| 8.1.5<br>From approval of RTT plan develop a series of PIDs which work in collaboration to meet each phase agreed by NHSI. | 30/10/16 | | First PID complete - diagnostics. Remaining PIDS dependent on project plan sign off by NHSI | TBC |
| 8.1.14<br>Establish an External Clinical Harm Review Group : chaired by and with representation from external partners to ensure sufficient governance and oversight of the clinical harm process and accountability for delivery through the Board's quality committee(s). | 04/07/2016 | | Group established, chaired by Deputy Medical Director NHSI. Reliant on 8.1.10 to obtain validated information. Currently reviewing cancer pathway, cardiac and general (590 patients). This is currently a manual exercise.<br>concern around the potential volume that will need to go through the process once validation takes place. ? capacity to deal with the large volume in a timely manner. | TBC |
| 8.1.15<br>Identify and secure the necessary resources to undertake the clinical prioritisation (depending on the scale of clinical review required) | TBC | | Identified RTT template from Kings for RCA to include Risk Assessment for Clinical Harm. This is used for all Patients on a cancer pathway 104 days & 52 weeks. The Trust has started this work. | TBC |
| 8.1.16<br>Set up and run clinical review clinics (to be overseen by the clinical harm review panel) | TBC<br>based on validation commencing | | Risk Assessment for all Patients on the waiting list according to the High Risk Stratification process is being undertaken whilst waiting for NHSI business case approval.<br>Estimates could run between 7,000-8,000 patients per month. These clinics will be run through clinical service areas. | TBC |

| Risk/Issue to Highlight to QIB | Mitigating Action | Status |
|---|---|---|
| The risk of harm arising as a direct consequence of extended waiting times for patients remains high.<br><br>Included in the CQC Section 29A Warning notice | High-risk cases being validated and reviewed by a clinical panel. Clinical intervention being directed by the Clinical Panel on a case-by-case basis. | Risk remains high. |
| 8.1.5<br>Develop a series of PIDs to support project plan brief.<br>G to A 30/11/16 | Phasing will be agreed with NHSI. 30/10/16<br><br>First PID - diagnostics complete. Remaining PIDS dependent on 8.1.4 | |

**Recommendations Regarding Delivered and Embedded Actions**

| Action<br>(Number then action narrative) | Status | Comments |
|---|---|---|
| 8.1.1<br>Source and employ a director level appointment to lead the recovery team and significant turnaround work for this | | Programme director in post |

**Removal of actions from workstream**

| |
|---|
| 8.1.13<br>Reconfigure the current PAS systems to be the single repository of patient data against which RTT can be managed and measured. This is not manageable within the QIP |
| 8.1.3 (Now aligned with Recovery programme Board (8.1.2), removed |
| 8.1.7 (Removed, ongoing action) Communication strategy |

## IV. EOLC Workstream Overview report

| QIP Work stream: EOLC | | Executive Lead: Title: Chief Nurse Name: Suzanne Banks | | | | | Workstream Lead: Name: Hazel Tonge Alison Ludam | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** Due to high risk of breaching 29A time requirement. | **Reporting Period:** (October 2016) | **Action BRAG rating analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **14** | **1** |
| | | **0** | **1** | **13** | **1** | **0** | **Total Actions in Workstream** | |
| | | | | | | | **15** | |

**Key**

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- Off track but recovery action planned to bring back on line to deliver by target date.
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- Blue subject to CQC confirmation.

**Note:**
Due to the requirement to resubmit the plan for this workstream, the 'clock' has restarted on the time scales for actions within it, therefore 13 of the 15 areas are currently green, 1 is Amber.
However, the overall risk of failure to comply with the Section 29A Warning notice by 30/11/16 is high (red). It is unlikely that the strategy, (which incorporates; integrated working, leadership and Governance) will be developed and agreed by that date. A revised action plan with incremental dates will need to be discussed and agreed with the CQG

| **Exception Report: Red / Amber Actions** | | | | |
|---|---|---|---|---|
| **Action** (Number then action narrative) | **Target Completion Date** | **Status** | **Explanation for RAG rating** | **Expected completion date** |
| 2.1.1 Develop an outline of an integrated EoLC strategy which includes : governance framework, best practice framework and standards of practice, key controls, KPI's enablers for change (including education and training). | 31/10/2016 | | Compliance with the Section 29A Warning notice is required by 30/11/16. Although a draft strategy may be developed by the 31/10, it is unlikely that it will be agreed with the acute and community services and commissioners which is necessary in order to take it forward and embed it by 30/11/16, when compliance is required under the Notice. | 31/10/2016 |

| Risk/Issue to Highlight QIB | Mitigating Action | Status |
|---|---|---|
| CQC 29A Warning notice included:<br>1. EOLC service provision and the lack of integration across acute and community services<br>2. Lack of outcome measures and activity data monitoring | New QIP submitted 10/10 including an outline of an integrated EOLC strategy. This strategy requires additional work with more focus on integrated working and will also require discussions with internal and external stakeholders.<br>There is a very high risk of breaching the 29A target date of 30/11/16 | |

**Recommendations Regarding Delivered and Embedded Actions**

| Action<br>(Number then action narrative) | Status | Comments |
|---|---|---|
| 2.1.3<br>Executive and NED executive lead identified | | 10/10 - Sarah Wilton (non - exec director) has been identified and agreed as NED executive lead |

## V. Medicines Management Workstream Overview report

| QIP Work stream: Medicine Management | | Executive Lead: Title: Medical Director Name: Andy Rhodes | | | | | Workstream Lead: Name: Chris Evans | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** | **Reporting Period:** (October 2016) | **Action BRAG rating analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **23** | **1** |
| | | **1** | **0** | **21** | **1** | **0** | **Total Actions in Work stream** | |
| | | | | | | | **23** | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
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- Blue subject to CQC confirmation.

| **Exception Report: Red / Amber Actions** | | | | |
|---|---|---|---|---|
| **Action** (Number then action narrative) | **Target Completion Date** | **Status** | **Explanation for RAG rating** | **Expected completion date** |
| 1.1.1 Establish, conduct and analyse across St George's NHS Foundation Trust the 12 point audit, outlining the trends and developing local actions and accountability for Medicines safety in all areas. | 31/07/16 | | Plan to go live with electronic reporting in October 2016.<br><br>4/10 - Improvement in Sept (80% from 45% ), but still a number of non-compliance. Better control from Oct due to new electronic audit.<br><br>Emphasis will be to escalate to CN and DDN and hold staff to account | 31/10/16 |

| **Risk/Issue to Highlight to QIB** | **Mitigating Action** | **Status** |
|---|---|---|
| 1.10.1 Administration of contrast media by radiographers without PGD included in CQC 29A warning notice | 14 PGD's drafted and signed off. 2 for Neurology have clinical sign off, awaiting Trust sign off. | Green as within time scale for completion date of 30/12/16 |

**Recommendations Regarding Delivered and Embedded Actions**

| **Action** (Number then action narrative) | **Blue Action Form Submitted? Yes / No** | **Comments** |
|---|---|---|
| 1.8.1 Medicines reconciliation | | Sept 90% at 24 hours -100% at 48hours compliant |

## VI. Governance Workstream Overview report

| QIP Work stream: Governance | | Executive Lead: Title: Director of Quality Governance Name: Paul Moore | | | | | Workstream Lead: Name: Sal Maughan | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** | **Reporting Period:** (October 2016) | **Action BRAG rating analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **20** | **3** |
| | | **1↑** | **3↑** | **16↓** | **3↔** | **0** | **Total Actions in Workstream** | |
| | | | | | | | **23** | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
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- Completed / On track to deliver by target date.
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- Blue subject to CQC confirmation.

**Exception Report: Red / Amber Actions**

| Action (Number then action narrative) | Target Completion Date | Status | Explanation for RAG rating | Expected completion date |
|---|---|---|---|---|
| 3.6.4 Devise a training, accreditation and mentoring programme for SI panel chairs | 30/09/16 | | Missed target date. Accreditation process complete but not signed off at SIDM. To be addressed on 17/10/16<br><br>(Note this was signed off 21.10.16 and will be updated on the next version of the QIP to the QIP Board) | 30/11/16 |
| 3.1.4 Refresh, further develop and keep under regular review the Board's appetite for taking risk | 30/09/16 | | Interim risk appetite statement - not agreed at board in July. Will require further development<br>NEDS & interim appetite agreed. To be discussed at RMC on 14/10/16 | 30/11/16 |
| 3.1.5 Communicate appetite for taking risk (and the boundaries within which they can operate) to senior leaders and front line teams | 30/09/16 | | Subject to 3.1.4 being achieved<br>See above | 30/11/16 |

| | | | | |
|---|---|---|---|---|
| 3.6.8<br>Review process and mechanism for review of adverse incidents with clear accountability and performance management | 30/09/16 | | 11/10 - Meeting held with DDNGs and DGMs to confirm accountability. New reporting mechanism to ensure visibility of performance & review - through PSQB report. System cleansed to ensure correct adverse incident notification circulation lists in use. Cannot be assured of performance management on Datix. | 30/11/16 |

| Risk/Issue to Highlight to QIB | Mitigating Action | Status |
|---|---|---|
| CQC Section 29A Warning notice listed a number of requirements under the Governance umbrella. All but Incident management has been dealt with through the other work streams.<br><br>Re: Incident management: The CQC highlighted delay in logging serious incidents on STEIS and in carrying out investigations into this category of incident. | 3.6.1-3.6.8<br><br>Time frame to implement plans, including policy review, RCA training, increasing pool of investigators and Datix focus group by 30/09/16 | Active, Green |

**Recommendations Regarding Delivered and Embedded Actions**

| Action<br>(Number then action narrative) | Blue Action Form Submitted? Yes / No | Comments |
|---|---|---|
| 3.1.1<br><br>Establish and appoint a Director of Quality Governance to lead on governance, risk management and the Quality Improvement Plan | | In post 04/07/16 |
| 3.6.5<br>Upgrade Datix system to enhance functionality and feedback mechanisms to reporters | | Upgraded 28/07/16 |
| 3.6.6<br>Appoint Datix Administrator to support enhanced training programme for staff around Datix use | | In post 31/08/16 |

**Changes to previous QIP**

3.8.1 Clinical guideline mechanisms in place, issue with access through IT system. CQC had no issues with this area.

3.4.2 Communication plan re: QIP part of general communications to Trust via tested systems (e.g. staff intranet. - Removed

## VII. Gwynne Holford Workstream Overview report

| QIP Workstream: Gwynne Holford | | Executive Lead: Title: Chief Nurse Name: Suzanne Banks | | | | | Workstream Lead: Name: Helene Anderson June Allen | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** | **Reporting Period:** October 2016 | **Action BRAG rating analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **12** | **3** |
| | | **3↑** | **0↓** | **8↓** | **4↓** | **0** | **Total Actions in Workstream** | |
| | | | | | | | **15** | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
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- Blue subject to CQC confirmation.

| **Exception Report: Red / Amber Actions** | | | | |
|---|---|---|---|---|
| **Action** (Number then action narrative) | **Target Completion Date** | **Status** | **Explanation for RAG rating** | **Expected completion date** |
| 10.1.4 Recruit into posts and work with the HR recruitment team to move the recruitment of all Bands from 2-8a forward | 30/07/16 | | Outstanding posts are: 1 band 6, 1 band 7 & 13 band 5. 1 ward receptionist awaiting VCP. This action has turned red due to the number of outstanding band 5 vacancies. On-going efforts to recruit to these posts continue. | TBC |
| 10.1.2 Immediate identification of staff to be relocated from other areas across the Trust to increase establishment on GH | 01/07/2016 | | Two staff identified. Induction requested. 3 RNs being deployed - some risk remains 1 Band 5 relocated to date. | 30/09/2016 |
| 10.1.7 Trial the allocation of a dedicated pharmacist to facilitate patients to self-administer medications which will negate the need for nurses to undertake current extensive medication rounds | 30/08/16 | | Anticipated to have recruited a trainee pharmacist in August 2016. Waiting to hear back in regards to trainee pharmacist - never got the name – concerns that this post may be frozen. No assurance of completion | |

| Risk/Issue to Highlight to QIB | Mitigating Action | Status |
|---|---|---|
| CQC Section 29A Warning Notice Ensure the correct application of , MCA, best interest, DoLs and restraint (cot sides) | In association with the Safeguarding and Bed rails/ prevention of falls work streams implement MCA and DoLs policy and audit programme to monitor compliance. | Green until 30/11/16 |

**Recommendations Regarding Delivered and Embedded Actions**

| Action (Number then action narrative) | Status | Comments |
|---|---|---|
| 10.1.1 To ensure safe staffing levels on Gwynne Holford by utilising the therapies for basic care e.g. washing and dressing. | | Process implemented |
| 10.1.3 Sign off at VCP for seconded posts to make substantive | | All roles approved and at various stages of recruitment |
| 10.1.6 Agree authorisation with DDNG for booking agency 2 months in advance with block bookings and explore the off framework agencies. | | Authorised and process in use. |
| 10.3.1 Provide medication safety at all times Install PODs to all bedside lockers | | PODS installed. |

**Changes to previous QIP**

| |
|---|
| 10.5.2 (Walkie Talkie) Removal off QIP as no longer relevant due to recruitment of ward receptionist to control the risk. |

## VIII. Bed rails and Falls Workstream Overview report

| QIP Work stream: Bed Rails & Falls | | Executive Lead: Title: Chief Nurse/Director of Estates Name: Richard Hancock | | | | | Workstream Lead: Name: Hazel Tonge & \|Paul Courtman | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** | **Reporting Period:** (October 2016) | **Action BRAG rating analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **8** | **1** |
| | | **2↑** | **0↔** | **6↑** | **1** | **0** | **Total Actions in Workstream** | |
| | | | | | | | **9** | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.

| **Exception Report: Red / Amber Actions** | | | | |
|---|---|---|---|---|
| **Action** (Number then action narrative) | **Target Completion Date** | **Status** | **Explanation for RAG rating** | **Expected completion date** |
| 11.1.1 Review current business plan for bed frame to consider need for ultra low bed frames, urgency of replacement and resubmit. | 30/09/16 | | "20 year plan previously agreed at rejected by IDDG requiring revised business plan to review rentals and improve the rental system. This may not happen for a few months as even if changes to the rental system occurred overnight, there is a need to run the new system for quite a few months to see if it has made any difference. Currently no approved bed replacement plan." | TBD |
| 11.1.2 Review current information available on access to bed rails out of hours | 30/09/16 | | Pictorial Guide and posters now produced and has been distributed to all wards. Pictorial guides in Care Folders, posters to be put up in bedrail storage areas. Training of porters to commence end 10/2016. Red as passed action date. | 30/09/16 |

| Risk/Issue to Highlight to QIB | Mitigating Action | Status |
|---|---|---|
| None<br>CQC Section 29A warning notice in relation to MCA & DoLs and the use of bed rails, managed under the MCA/safeguarding workstream. | Initiated as part of back to the Floor programme in Aug.<br>Audit tool to be developed further for Sept Audit | Active |

**Recommendations Regarding Delivered and Embedded Actions**

| Action<br>(Number then action narrative) | Status | Comments |
|---|---|---|
| 11.1.4<br>Audit bed rail availability, use and application This should be undertaken bi-annually in both Acute and Community | | Corporate team and Physio lead have undertaken an audit of bedrails |

## IX. Safeguarding/MCA and DoLs Workstream Overview report

| QIP Work stream: Safeguarding/ MCA and DoLs | | Executive Lead: Title: Chief Nurse | | | | | Workstream Lead: Name: Hazel Tonge & David Flood | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** | **Reporting Period:** (Oct 2016) | **Action BRAG rating analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **3** | **1** |
| | | **0** | **0** | **3↔** | **1↔** | **0** | **Total Actions in Workstream** | |
| | | | | | | | **4** | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.

| **Exception Report: Red / Amber Actions** | | | | |
|---|---|---|---|---|
| **Action** (Number then action narrative) | **Target Completion Date** | **Status** | **Explanation for RAG rating** | **Expected completion date** |
| None | | | | |

| **Risk/Issue to Highlight to QIB** | **Mitigating Action** | **Status** |
|---|---|---|
| Non compliance with the MCA and DoLs compliance is included in the CQC Section 29A warning notice (Sept 2016.) raising the level of risk within this work stream. | New MCA policy includes DoLs. This will be underpinned by an audit and training programme for clinical staff. | Open. |

**Recommendations Regarding Delivered and Embedded Actions**

| **Action** (Number then action narrative) | **Blue Action Form Submitted? Yes / No** | **Comments** |
|---|---|---|
| 9.1.2 Ratify safeguarding policy upload to the intranet | | Completed and available on the Trust intranet. |

## X. Radiation Safety Workstream Overview report

| QIP Work stream: Radiation Safety | | Executive Lead: Title: Executive Medical Director Name: Andy Rhodes | | | | | Workstream Lead: Name: Andy Irvin | |
|---|---|---|---|---|---|---|---|---|
| **Overall BRAG** | **Reporting Period:** (October 2016) | **Action BRAG rating analysis** | | | | | | |
| | | **R** | **A** | **G** | **B** | **B/G** | **Active Actions** | **Assurance Actions** |
| | | | | | | | **12** | **0** |
| | | **0** | **0** | **12** | **0** | **0** | **Total Actions in Workstream** | |
| | | | | | | | **12** | |

**Key**

- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Blue subject to CQC confirmation.

**Note:**
Due to the requirement to resubmit the plan for this workstream, the 'clock' has restarted on the time scales for actions within it, therefore 12 of the 12 areas are currently green. Actions have been developed under the headings of; Policy (including governance arrangements), Implementation, Monitor and audit. The 29A Warning notice in relation to radiographers administrating contrast medium without a PGD, is managed through the Medicines Management workstream.

| Exception Report: Red / Amber Actions | | | | |
|---|---|---|---|---|
| **Action** (Number then action narrative) | **Target Completion Date** | **Status** | **Explanation for RAG rating** | **Expected completion date** |
| None | | | | |

| Risk/Issue to Highlight to QIB | Mitigating Action | | Status | |
|---|---|---|---|---|
| None | | | | |

*Appendix 2; Section 29A Warning Notice summary compliance update*

Annex (a) sets out the Trust's position with regards to all Section 29A matters. This does show a great deal of progress which ought to be noted. However, the extent to which gaps identified are recoverable depends upon the level of engagement of senior colleagues with the QIP and agreement on the actions to be taken including:

a) the Trust should be able to demonstrate improvements in MCA/DOLS compliance on those wards highlighted providing an audit is undertaken within the next two weeks and the outcomes reported;
b) the Division of Surgery should be able to address the backlog of serious incidents before the 30th November 2016,
c) the CQC have agreed in principle a plan for theatre refurbishment extending 3-4 years into the future, but the Trust would need to be clear that it has access to the capital required to undertake this work;
d) the CQC may accept that transacting Renal Unit moves is complicated and requires more time to conclude so as not to exposure patients to greater risk of harm;
e) Current progress on RTT may be deemed insufficient to demonstrate to CQC that we have improved in accordance with the strict interpretation of the Warning Notice.
f) Compliance with flushing routines for Pseudomonas must be maintained at 100%.
g) The CQC may accept that integrating end of life services across community and acute services is a significant undertaking and further time might be needed to achieve this goal. However, our plans are being developed to be more compelling.

## Annex (a): Section 29A Position as at 14/10/16

### Actions Reported as Completed and Embedded[1] - Blue

| Area(s) | Progress |
|---|---|
| **Estates: 2 failing air handling units** in St James Wing Theatre<br><br>Executive Lead: Director of Estates & Facilities | 2 air handling units replaced in St James Wing, serving theatres 5 & 6.<br><br>Service contract are in place from 01/04/2016. |
| **Estates: Maternity Staff room** unfit for purpose<br><br>Executive Lead: Director of Estates & Facilities | Repairs to the staff room, including ceiling tiles, have been completed. |
| **Estates: Wandle Unit** unfit for purpose<br><br>Executive Lead: Director of Estates & Facilities | Wandle Unit commenced demolition September 2016. |
| **Governance: Workforce Race Equality Standards** 2015 not put before the Board<br><br>Executive Lead: Director of HR & OD | Presented and signed off by the Board August 2016 |
| **Governance: Inadequate compliance amongst Board members with Fit and Proper Persons Test**<br><br>Executive Lead: Director of HR & OD | • All current Board members 100% compliant.<br>• Policy and procedures have been revised, updated and approved by the Board 06/10/16. The Board received assurance of full compliance with FPPT at their meeting held on 06/10/16. The files are available for re-inspection by the CQC. |

### Actions on track and expected to deliver as planned – Green

| Area(s) | Progress |
|---|---|
| **Estates:** Assure fixed wire installation compliance across the SGUH site**.**<br><br>Executive Lead: Director of Estates & Facilities | • Rolling programme of fixed wire installation compliance by external contractor. Schedule to complete end of 2017, then move onto 20% cycle testing to ensure continuous cycle of testing.<br>• Please note: systems require shut down during testing. |
| **Governance:** Radiographers administering contrast media | • Immediate action taken in August 2016 by the Director of Quality Governance to suspend |

[1] These actions are subject to verification.

| | |
|---|---|
| without authorised PGD in place<br><br>Executive Lead: Medical Director | administration of contrast media by Radiographers, unless and until there is an authorised PGD in place or, on a case by case basis, contrast prescribed by a medical practitioner. The PGD for contrast media was approved and authorised by the Chief Pharmacist and practice reinstated during September 2016.<br>• 14 PGD's have been authorised and are signed off. Awaiting final sign off by the Chief Pharmacist for 2 PGDs in Neurology. This remains on track to be concluded by 31/10/16 |
| **Governance:** Risk management process insufficient - lack of action, lack of accountability<br><br>Executive Lead: Director of Quality Governance | • The Board have considered and agreed a set of interventions to enhance governance at their meeting held in July 2016. The following has been implemented following the Board's decision:<br>• An Executive Director of Quality Governance has been appointed on a temporary basis to lead the further development of governance at the Trust<br>• A new Committee structure has been put in place, with emphasis on management committees and adopting the '*three lines of defence*' model of assurance<br>• PSQB, DPR and QIP Board has been established and held their inaugural meetings<br>• To support implementation, a moratorium on non-operationally essential committees has been in place since August 2016. We continue to monitor this.<br>• The Corporate Risk Register has been completely rebuilt and has been reported to the Board of Directors in the new format since July 2016<br>• Risk Management policy (including roles and responsibilities) has been completely revised, consulted on and approved. The policy is available on Trust website.<br>• Risk management process has been simplified and brought into line with the British Standard Code of practice for Risk Management and Enterprise-wide Risk Management Standards (COSO)<br>• Risk scoring methodology has been simplified for ease of use<br>• Risk escalation framework and frequency of review of risks has been simplified and currently being rolled out across all areas – reporting of extreme risks to the Board will commence following review and validation of divisional and corporate risk registers as part of the rolling programme of review being undertaken by the Risk Management Committee<br>• Good Governance Master classes rolled out across the organisation, reaching out to all areas. This work continues. 223 senior leaders have received training to date.<br>• Divisional risk registers are undergoing reconstruction |

| | |
|---|---|
| | with good progress in all divisions and corporate functions<br>• Migration of divisional risk registers into Datix was concluded in August 2016<br>• Risk Management Committee established, chaired by the Chief Executive, and has commenced scrutiny and systematic review of risk profiles across the organisation, and is using the meeting to hold colleagues to account for control of risk<br>• Risk Management Committee is more inclusive – involving Internal Audit and divisional representatives<br>• Board Assurance Framework developed and reported to the Board of Directors at their meeting held on 30/09/16. The BAF will now be used to set agenda's for the Board's assurance committees.<br>• The Director of Quality Governance requires at least 3 months of demonstrable improvement before moving this to embedded action (Blue). |
| **Governance:** Mental Capacity Act<br>a. **MCA Policy** require updating, Checks and regular audits of compliance insufficient<br>b. **Awareness** amongst staff of care interventions that might constitute restraint - bed rails and use of mittens to prevent removal of NG tube<br>**c. Recording of MCA and Best Interest Decisions**<br><br>Executive Lead: Chief Nurse | • MCA Policy is under final revision to then be signed off by the by the Chief Nurse. On final approval it will be available on the Trust Policy Hub.<br>• Training on MCA/DOLS is mandatory for all new clinical staff. Existing staff are expected to update every year. Training will be via classroom or via e-learning |
| **Governance:** Monitoring **serial numbers for FP10 prescription pads** - particularly in OPD<br><br>Executive Lead: Medical Director | • A Standard Operating Procedure has been created, communicated to staff and training sessions currently being delivered to staff.<br>• Post training audit being conducted Oct/Nov. |

### 3.1 Actions off track but recoverable (if effective action taken) – Amber

| Area(s) | Progress |
|---|---|
| **Governance**: MCA Compliance on Allingham, Dalby, Gwynne Holford and Rodney Smith Wards<br><br>Executive Lead: Chief Nurse | • Awaiting audit results before being able to demonstrate implementation and compliance. The audits follow training on the policy and its implementation. Planned for end January 2017. |
| **Governance**: Timeliness in reporting SI's, especially surgery Division | • Meeting held with DDNGs and DGMs to confirm accountability. New reporting mechanism to ensure visibility of performance & review - through PSQB |

| | |
|---|---|
| Executive Lead(s): Director of Quality Governance | report. System cleansed to ensure correct adverse incident notification circulation lists in use.<br>• Weekly SI tracker has been developed to monitor performance more directly. This is now shared with divisional and corporate teams and reported weekly to SIDM to drive accountability. Progress has been made to address underlying delays in conclusion of SI's in all divisions except the Division of Surgery.<br>• The Division of Surgery has not sufficiently improved its position on SI management. This has been escalated but not yet resolved. This can be recovered by 30th November 2016, but only if rapid and effective action is taken by the Divisional leadership team to prioritise conclusion of outstanding cases. This was to be escalated at DPR on 17/10/16 by the Director of Quality Governance. |
| **Estates: Water Safety Management: Legionella Prevention**<br>Twice weekly flushing carried out and documented for Legionella prevention<br><br>Executive Lead: Director of Estates & Facilities | • 100% compliance since September following escalation and intervention by the Executive. Require 3 months evidence to turn green.<br>• Significant improvement can be demonstrated from September 2016. |

**Actions Off Track or Failed To Deliver On Time (Unlikely to Deliver by 30th November 2016) - Red**

| Area(s) | Progress |
|---|---|
| **Estates: Theatres**<br>a) 16 theatres requiring complete refurbishment. Maintenance and refurbishment of Operating Theatres<br>b) Lack of capital investment in Lanesborough, St James's and Paul Calvert Theatres<br>c) Thermoregulation on Lanesborough Theatre 1.<br><br>Executive Lead: Director of Estates & Facilities | • Schedule of refurbishment and repairs agreed with COO, theatres and maintenance department. Work to commence November 2016. Two theatres at a time will take approximately 5 months to complete with theatres out of commission during this period. Estimated time to complete 16 theatres 3.5 years.<br>• On-going PPM schedule with theatre down time required. |
| **Governance: Relocate renal service**<br>Renal ward in St James Wing - to be relocated - Trust to identify and approve appropriate ward closure and impact to revenue<br><br>Executive Lead: Director of Estates & Facilities | • The Director of Estates has reported that there has been some difficulty finding a contractor available to undertake the work during summer months. Contractors now on site & work is underway.<br>• Day dialysis have been relocated to Champneys<br>• Further refurbishment of Champney's ward which will house the inpatient renal service once is expected to complete in early December.<br>• Need to identify accommodation for transplant OPD. |

| | |
|---|---|
| **Governance: Waiting list management** - tracking patients - Data Quality and implications for compliance with national access targets (RTT, Cancer)<br><br>Executive Lead: Chief Operating Officer | • Updated project plan submitted to NHSI 10/10/16 awaiting approval. Requires sign off before validation process can commence. The recovery work is dependent on validation process being in place.<br>• Clinical service areas will need to review as yet unconfirmed numbers of cases per month via Review Clinics to review for potential for clinical harm.<br>• The clinical harm review panel has commenced reviewing cancer, cardiology and surgical breaches. 520 case have been reviewed to date through manual review of case records<br>• Clinical intervention is being directed by the Clinical Review Panel on a case-by-case basis.<br>• Training staff on use of RTT with correct protocols has commenced<br>• Project manager in place to oversee and run recovery plan.<br>• It is highly unlikely, given the challenges putting together an RTT recovery plan, that the Trust will be able to demonstrate significant improvement in RTT backlog and potential for clinical harm as required by the Warning Notice by the 30th November 2016. |
| **Estates: Water Safety Management** (Pseudomonas)<br><br>Executive Lead: Director of Estates & Facilities | • In respect of pseudomonas water safety management, returns continue to show poor compliance with daily flushing in clinical areas, although there is an improvement from previous periods.<br>• Water Safety Manager to be recruited.<br>• Action has been taken to escalate compliance with flushing requirements.<br>• The Trust is not yet able to demonstrate that is has effective control over mitigating actions to minimise pseudomonas contamination of the water supply in clinical areas. |
| **Governance**: Fragmentation of hospital and community end of life care teams, inadequate leadership and governance, and the absence of joint working<br><br>Executive Lead: Chief Nurse | • A draft strategy has been developed and approved for consultation with stakeholders. |

St George's Healthcare NHS
NHS Trust

*Appendix 3:*

## 1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

Headline outcomes for the Equality Delivery System (EDS)

- Better heath outcomes for all
- Improved patient access and experience
- Empowered, engaged and well-supported staff
- Inclusive leadership at all levels

| Service/Function/Policy | Directorate / Department | Assessor(s) | New or Existing Service or Policy? | Date of Assessment |
|---|---|---|---|---|
| **Corporate** | Governance | Paul Moore | Existing | 15 Oct 2010 |
| **1.1 Who is responsible for this service / function / policy? Paul Moore** | | | | |
| **1.2 Describe the purpose of the service / function / policy?** *Who is it intended to benefit? What are the intended outcomes?* | | | | |
| **1.3 Are there any associated objectives?** *E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives* | | | | |
| **1.4 What factors contribute or detract from achieving intended outcomes?** | | | | |
| **1.5 Does the service / policy / function / have a positive or negative impact in terms of the protected groups under the Equality Act 2010. These are Age, Disability ( physical and mental), Gender-reassignment, Marriage and Civil partnership, Pregnancy and maternity, Sex /Gender, Race (inc nationality and ethnicity), Sexual orientation, Region or belief and Human Rights**<br><br>No | | | | |
| **1.6 If yes, please describe current or planned activities to address the impact.** | | | | |
| **1.7 Is there any scope for new measures which would promote equality?** | | | | |
| **1.8 What are your monitoring arrangements for this policy/ service** | | | | |
| **1.9 Equality Impact Rating [low, medium, high]**<br><br>**2.0. Please give your reasons for this rating** | | | | |

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO Trust Board:** *November 2016*

| | |
|---|---|
| Paper Title: | Quality Report to Month 6<br>September 2016 |
| Sponsoring Director: | Andrew Rhodes- Medical Director Suzanne Banks Chief Nurse and Infection Prevention and Control<br>Mark Gordon - Chief Operating Officer |
| Authors: | Hazel Tonge – Deputy Chief Nurse Sal Maughan – Head of Governance Peter Riley- Infection Control Lead Corporate Nursing Team<br>Divisional Directors Nursing/ Governance<br>Trust Safeguarding Leads<br>Head of Performance |
| Purpose: | To inform Trust Board about Quality Performance for Month 6. |
| Action required by the board: | To note key areas of emerging risk and mitigating actions noted. |
| Document previously considered by: | QRC |

**Executive Summary**

Performance is reported through the key performance indicators (KPIs) as per the Monitor Risk Assessment Framework. The trust is performing positively against a number of indicators within the framework, however existing challenges continue in particular: ED 4 hour target, RTT, and cancelled operations on the day by the hospital for non-clinical reasons. Cancer waiting time targets have been achieved in July and August and on target to achieve September STF and national targets, however there remains a challenge for the Trust to maintain sustainability going forward.

Key Points of Note for the Board in relation to September Performance:

- All cancer national standards met in July and August. STF trajectory standard was also met for the 62 day standard.
- Diagnostic waiting time's standard achieved both against the national target and STF trajectory.
- Trust is not meeting the RTT national standard however in September backlog of patients waiting greater than 18 weeks reduced by 654 patients also seeing a reduction in the total waiting list size in comparison with previous months.
- Continued non-compliance against the cancelled operations at last minute target. However, actual number of cancellations has seen a reduction in the last three months.

**Points for Assurance**

Cancer 14 day and 62 day standards performance on track to achieve national and STF targets for September.

Diagnostic waits greater than 6 weeks are observing a week on week reduction. Plans for additional capacity have been put in place for challenged modalities, in particular MRI and Neurophysiology which are showing a positive impact.

New daily Chief Operating Officer led Performance Control meetings in place focusing on key issues and risks for the day, performance against key standards and activity plans.

New Flow Programme is being finalised to address local ED and system challenges to support performance improvement

**Emerging Risks and Mitigating Actions:**

Cancer performance sustainability. In particular the TWR and 62 day standard with challenges in areas of staffing, skin demand, and diagnostic capacity. Proposal for staffing have been put forward for executive approval and action plans to increase diagnostic capacity for key modalities are being implemented.

ED performance was not achieved in September against the STF trajectory however the Trust did achieve Q2 trajectory. The Trust has recovered against STF trajectory in October however not yet a complete month and remains a risk. This is being reviewed daily at performance control meetings and throughout the day, with defined escalation and exec oversight processes in place.

RTT backlog reduction. This will be addressed by the RTT recovery programme.

The trust shows the quality governance score against the Monitor risk assessment framework of 2 and the Monitor imposed additional license conditions in relation to governance remain.

The report lists by exception those indicators that are being underachieved and provides data and reasons for why targets have not been met, remedial actions being taken and forecasted dates for when performance is expected to be back on target**.**

**Key points of note for the Board in relation to September Quality performance:**

- Mortality indicators remain better than expected
- Safety thermometer for this month was 95.65% which in line with the national average (95%)
- There has been an improvement in terms of active SIs being closed down in a timely way. However there are still 4 outstanding in the SNCT division
- The number of PSIs each month is increasing month on month with an increasing proportion of incidents moderate or above severity 5.3%
- No falls resulting in severe harm / moderate harm this month
- No grade 3 or 4 for three consecutive months
- Safeguarding Level 3 children has improved at 89% for the Trust based on manual data, although adult safeguarding is below target at 83.2%

- Complaints performance has declined for August compared to July.

**Points for assurance:**

HSMR remains better than expected: June 15 – May 16 = 88.9 [weekend emergency admissions = 94.4 (as expected); weekday emergency admissions = 86.6 (better than expected)]. SHMI April 15 – March 16 = 0.90 which is lower than expected. SGH is one of 16 Trusts in England in this banding. Raw mortality within usual limits.
Safety Thermometer results for September shows 95.65% of our patients received harm free care which is above target and national average (94.07%).

There has been a reduction in Serious Incidents (SIs) declared Apr–Oct: 55 compared with 84 SIs declared Apr-Oct 15/16, this represents a 35% decrease. However, there are four currently overdue SI reports within STN&C Division.

There have been three trust apportioned C. Diff episodes in September with a cumulative total of 12, which is below the trust threshold of 31 for the year. No MRSA cases this year to date.

Safeguarding children level 3 compliance, according to manual count, has improved to 89% Trust wide, above target (85%).

Nursing workforce fill rates is 95.44% as reported to unify Safe Staffing.

**Emerging risks and mitigating action:**

There has been a Dr Foster Imperial Unit Outlier Alert for Coronary Atherosclerosis and other heart disease. An investigation by CCAG is underway.

Safeguarding children's compliance Level 3 for one division, STNC, is only achieving 81%. Further analysis is being undertaken to validate this data. Safeguarding adults Trust wide is 83.2%. The Safeguarding leads are working with each division to identify areas to receive targeted training to improve compliance.

The number of complaints received continues to increase month on month since May 16. The top themes are: clinical treatment, communication and appointment delay/ cancellation. Overall complaints performance has declined in August having improved for the second consecutive month in July and remains inconsistent: Exception reports have been requested by the Deputy Chief Nurse from the Senior Nursing Team, and a complaints review will be completed October 31st 2016.

The number of staffing alerts for community has increased dramatically for September. The DDNG has daily sitreps in place to review patient visits, and is reprioritizing on a daily basis. An active recruitment plan is in place in this division. Anecdotal evidence suggests that safe staffing audit or datix forms are not being completed consistently. A review is being undertaken of the safe staffing process to ensure the safe staffing policy is used effectively.

| | |
|---|---|
| **Risks identified:**<br>Complaints performance (on BAF)<br>Infection Control Performance (on BAF)<br>Safeguarding Children Training compliance Profile (on BAF) Staffing Profile (on BAF) | |
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | |
| **Equality Impact Assessment (EIA): Has an EIA been carried out?**<br>**If no, please explain you reasons for not undertaking and EIA.** Not applicable | |

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St George's University Hospitals NHS
NHS Foundation Trust

# Performance Report
## For Trust Board

**Month 6 – September 2016**


***Excellence in specialist and community healthcare***

# CONTENTS

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# Performance against Frameworks

*Excellence in specialist and community healthcare*

# 1. Executive Summary - Key Priority Areas September 2016*

St George's University Hospitals NHS
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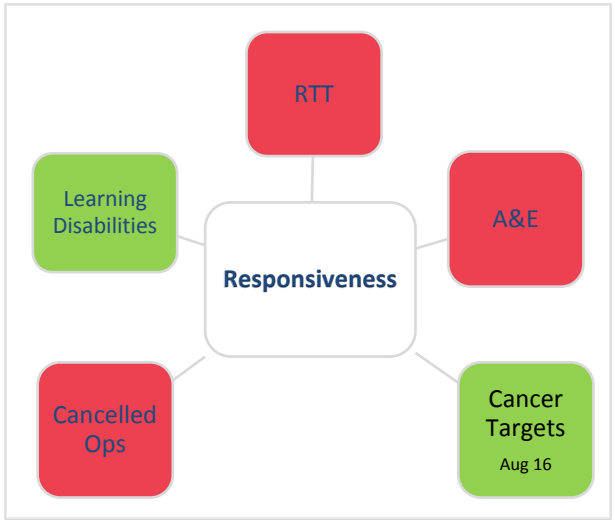
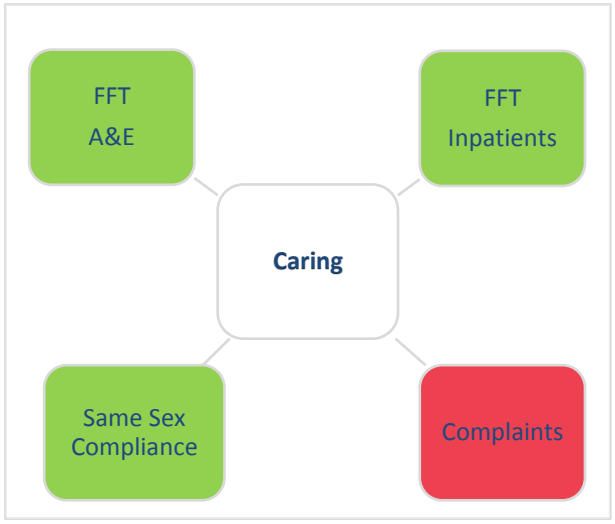
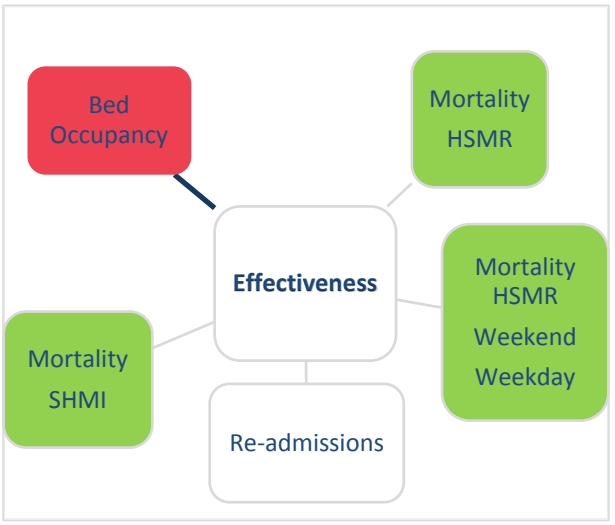
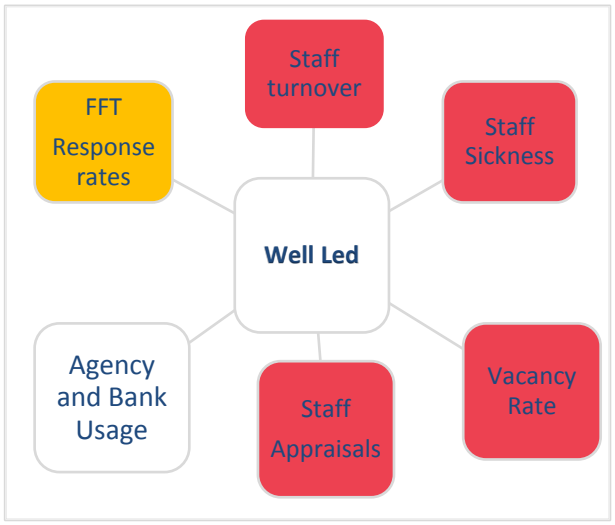







The above shows an overview of September 2016 performance for key areas within each domain and also as detailed in the Monitor Risk Assessment Framework.

These domains correlate to those of the CQC intelligent monitoring framework.

The overview references where the trust may not be meeting 1 or more related targets. (*Note Cancer RAG rating is for August 2016 as reported one month in arrears)

This report is produced in line with the trust performance management framework which encompasses the Monitor regulatory requirements.

# 2. Monitor Risk Assessment Framework KPIs 2016/17: September 2016 Performance (Page 1 of 1)

St George's University Hospitals NHS
NHS Foundation Trust

| | Metric | Standard | Weighting | Score | YTD | Aug-16 | Sep-16 | Movement |
|---|---|---|---|---|---|---|---|---|
| ACCESS | Referral to Treatment Admitted | 90% | N/A | N/A | | 62.30% | 64.51% | 2.21% |
| | Referral to Treatment Non Admitted | 95% | N/A | N/A | | 85.60% | 82.77% | -2.83% |
| | Referral to Treatment Incomplete | 92% | 1 | 1 | | 85.61% | 86.68% | 1.07% |
| | A&E All Types Monthly Performance | 95% | 1 | 1 | 93.10% | 92.70% | 92.20% | -0.50% |
| | **Metric** | **Standard** | **Weighting** | **Score** | **YTD** | **Q1** | **Q2** | **Movement** |
| | 62 Day Standard | 85% | 1 | 0 | 83.10% | 80.60% | 88.50% | 7.90% |
| | 62 Day Screening Standard | 90% | | | 92.20% | 91.50% | 95.50% | 4.00% |
| | 31 Day Subsequent Drug Standard | 98% | 1 | 0 | 100% | 100% | 100% | 0.00% |
| | 31 Day Subsequent Surgery Standard | 94% | | 0 | 98.20% | 97.80% | 100.00% | 2.20% |
| | 31 Day Standard | 96% | 1 | 0 | 97.70% | 97.80% | 97.50% | -0.30% |
| | Two Week Wait Standard | 93% | 1 | 0 | 89.40% | 88.30% | 93.70% | 5.40% |
| | Breast Symptom Two Week Wait Standard | 93% | 1 | | 91.60% | 90.80% | 93.60% | 2.80% |

| | Metric | Standard | Weighting | Score | YTD | Aug-16 | Sep-16 | Movement |
|---|---|---|---|---|---|---|---|---|
| OUTCOMES | Clostridium( C.) Difficile - meeting the C.difficile objective (de minimise of 12 applies) | 31 | 1 | 0 | 9 | 2 | 2 | 0 |
| | **Certification of Compliance Learning Disabilities;** | | | | | | | |
| | Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are reasonably adjusted to meet the health needs of these patients? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| | Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| | Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| | Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| | Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| | Does the Trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? | Compliant | 1 | 0 | Yes | Yes | Yes | |
| | **Data Completeness Community Services:** | | | | | | | |
| | Referral to treatment | 50% | 1 | 0 | | 56.7 | 54.9 | -1.8 |
| | Referral Information | 50% | 1 | 0 | | 87.2 | 87.1 | -0.1 |
| | Treatment Activity | 50% | 1 | 0 | | 73.7 | 72.2 | -1.5 |
| | **Trust Overall Quality Governance Score** | | | | | 3 | 2 | -1 |

September 2016 Performance against the risk assessment framework is as follows:

The trust's quality governance rating is 'Red' as the trust has a governance score of 2 and Monitor have imposed additional license conditions in relations to governance.

Areas of underperformance for quality governance are:

- A&E 4 Hour Standard
- RTT (Non Reporting)

Further details and actions to address underperformance are further detailed in the report.

*Cancer Data is reported a month in arrears. Q2 relates to July and August-16.

| Legend | |
|---|---|
| ↑ | Positive Performance Change |
| ↓ | Negative Performance Change |
| → | No Performance Change |

| MONITOR GOVERNANCE THRESHOLDS | |
|---|---|
| | **Green:** a service performance score of <4.0 or <3 consecutive quarters' breaches of a single metric |
| | **Governance Concern Trigger and Under Review :** a service performance score of >=4.0 or 3 consecutive quarters' breaches of single metric with monitor undertaking a formal review, with no regulatory action. |
| | **Red:** a service performance score of >=4 and >=3 consecutive quarters' breaches of single metric and with regulatory action to be taken |

# 2. Trust Key Performance Indicators 2016/17: September 2016 Performance (Page 1 of 1)

St George's University Hospitals NHS
NHS Foundation Trust

**RESPONSIVENESS**

| Metric | Standard | YTD | Aug-16 | Sep-16 | Movement |
|---|---|---|---|---|---|
| Referral to Treatment Admitted | 90% | | 62.30% | 64.51% | 2.21% |
| Referral to Treatment Non Admitted | 95% | | 85.60% | 82.77% | -2.83% |
| Referral to Treatment Incomplete | 92% | | 85.61% | 86.68% | 1.07% |
| Referral to Treatment Incomplete 52+ Week Waiters | 0 | 30 | 7 | 6 | -1 |
| Diagnostic waiting times > 6 Weeks | 1% | | 0.84% | 0.99% | 0.15% |
| A&E All Types Monthly Performance | 95% | 93.1% | 92.7% | 92.2% | -0.50% |
| 12 Hour Trolley Waits | 0 | 0 | 0 | 0 | 0.00% |
| Urgent Ops Cancelled for 2nd time (number) | 0 | 0 | 0 | 0 | 0.00% |
| Proportion of patients not treated within 28 days of last minute cancellation | 0% | | 10.00% | 4.40% | -5.60% |
| Certification against compliance with requirements regarding access to health care with a learning disability | Compliant | Yes | Yes | Yes | |

| Metric | Standard | YTD | Jul-16 | Aug-16 | Movement |
|---|---|---|---|---|---|
| 62 Day Standard | 85% | 83.10% | 90.20% | 86.60% | -3.60% |
| 62 Day Screening Standard | 90% | 92.20% | 95.00% | 96.20% | 1.20% |
| 31 Day Subsequent Drug Standard | 98% | 100% | 100% | 100% | 0.00% |
| 31 Day Subsequent Surgery Standard | 94% | 98.2% | 100.0% | 100.0% | 0.00% |
| 31 Day Standard | 96% | 97.70% | 97.60% | 97.40% | -0.20% |
| Two Week Wait Standard | 93% | 89.40% | 93.10% | 94.30% | 1.20% |
| Breast Symptom Two Week Wait Standard | 93% | 91.60% | 93.80% | 93.50% | -0.30% |

**EFFECTIVENESS**

| Metric | Standard | YTD | Aug-16 | Sep-16 | Movement |
|---|---|---|---|---|---|
| Hospital Standardised Mortality Ratio (DFI) | 100 | | 84.3 | 88.9 | 4.60 |
| Hospital Standardised Mortality Ratio - Weekday | 100 | 0 | 83.2 | 86.6 | 3.4 |
| Hospital Standardised Mortality Ratio - Weekend | 100 | 0 | 87.2 | 94.4 | 7.2 |
| Summary Hospital Mortality Indicator (HSCIC) | 100 | 0 | 0.90 | 0.90 | 0.0 |
| Bed Occupancy - Midnight Count General Beds Only | 85% | | 97.9% | 98.5% | 0.6% |
| LOS - Elective | | | 5.2 | 4.3 | -0.9 |
| LOS - Non-Elective | | | 4.3 | 4.2 | -0.10 |

**CARING**

| Metric | Standard | YTD | Aug-16 | Sep-16 | Movement |
|---|---|---|---|---|---|
| Inpatient Scores - Friends & Family Recommendation Rate | 60 | | 95.20% | 94.38% | -0.82% |
| A&E Scores - Friends & Family Recommendation Rate | 46 | | 85.10% | 83.10% | -2.00% |
| Number of complaints | | | 94 | 95 | 1 |
| Mixed Sex Accommodation Breaches | 0 | 0 | 0 | 0 | 0.0 |

**SAFE**

| Metric | Standard | YTD | Aug-16 | Sep-16 | Movement |
|---|---|---|---|---|---|
| Clostridium Difficile - Variance from plan | 31 | 9 | 2 | 0 | -2 |
| MRSA Bacteraemia | 0 | 0 | 0 | 0 | 0 |
| Never Events | 0 | 2 | 1 | 0 | -1 |
| Serious Incidents | 0 | 51 | 8 | 4 | -4 |
| Percentage of Harm Free Care | 95% | | 95.0% | 95.7% | 0.7% |
| Medication Errors causing serious harm | 0 | 6 | 0 | 0 | 0 |
| Overdue CAS Alerts | 0 | 1 | 1 | 1 | 0 |
| Maternal Deaths | 1 | 0 | 0 | 0 | 0 |
| VTE Risk Assessment | 95% | | 96.74% | 96.30% | -0.44% |
| No Safeguarding referals | | | 98 | NA | |
| No MCA referrals | | | 22 | NA | |
| Pressure Ulcers Serious incident - numbers of Grade 3 and 4 avoidable | 19 | 2 | 0 | 0 | 0 |
| Pressure Ulcers - grade 2 | 436 | 168 | 23 | 25 | 2 |
| Falls incident per 100 bed days | 3.1% | | | | |

**WELL LED**

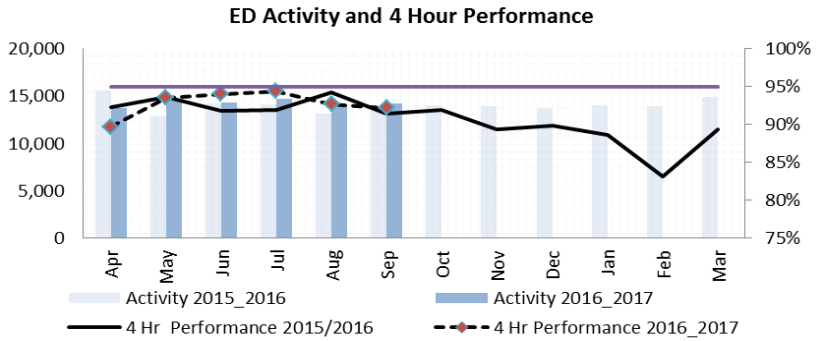
| Metric | Standard | YTD | Aug-16 | Sep-16 | Movement |
|---|---|---|---|---|---|
| Inpatient Response Rate Friends & Family | 30% | | 24.7% | 27.9% | 3.2% |
| A&E Response Rate Friends & Family | 20% | | 22.4% | 24.3% | 1.9% |
| NHS Staff recommend the Trust as a place to work | 58% | 62.0% | | | |
| NHS Staff recommend the Trust as a place to receive treatment | 4 | 3.78 | | | |
| Trust Turnover Rate | 13% | | 18.6% | 18.5% | -0.1% |
| Trust level sickness rate | 3.5% | | 3.4% | 3.6% | 0.20% |
| Total Trust Vacancy Rate | 11% | | 16.2% | 15.5% | -0.7% |
| % of staff with annual appraisal - Medical | 85% | | 82.50% | 81.00% | -1.5% |
| % of staff with annual appraisal - non medical | 85% | | 70.60% | 69.90% | -0.7% |
| Compliance MAST Level 3 adults | 85% | | 83.00% | 85.00% | 2.0% |
| Compliance MAST Level 3 children | 85% | | 76.00% | 89.00% | 13.0% |
| Compliance MAST VTE | | | 46.00% | 50.00% | 4.0% |
| Safe Staffing profile | | | 95.30% | 95.43% | 0.1% |
| Safe Staffing alerts | | | 12.00 | 26.00 | 14.00 |
| CHPD | | | 14.48 | 12.17 | -2.31 |

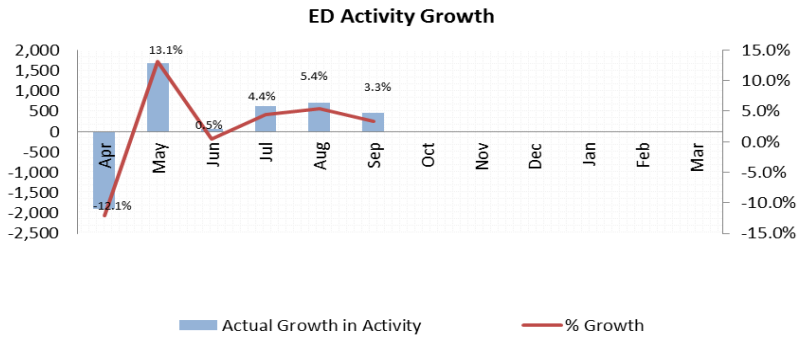
The trust continues to monitor the above key performance indicators following authorisation as a Foundation Trust. The indicators are grouped into domains parallel to that defined by the CQC. The trust is currently reviewing additional indicators for inclusion which will be incorporated in forthcoming reports.

# 3. Trust Key Performance Areas and Activity Comparison to previous year (Page 1 of 2)

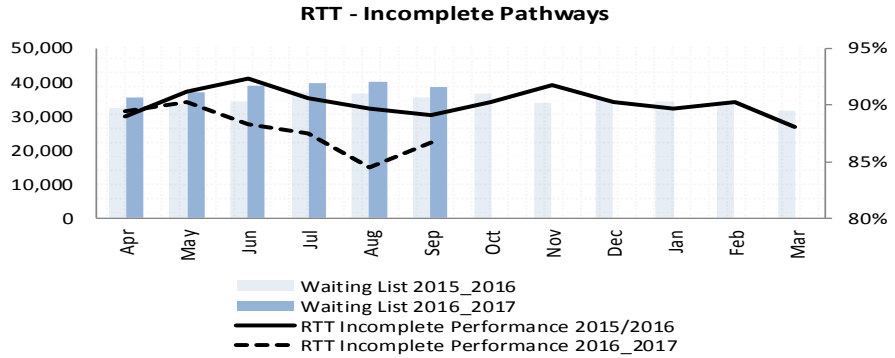
St George's University Hospitals NHS
NHS Foundation Trust

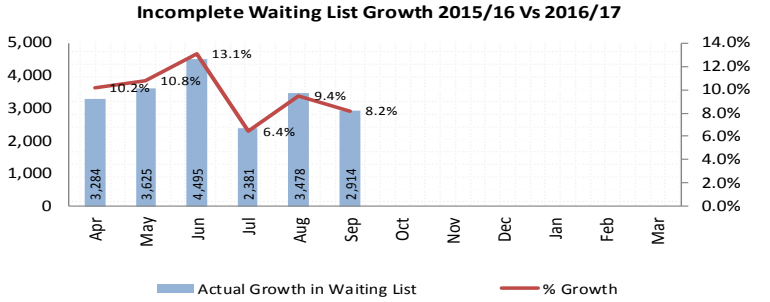
## ED Performance

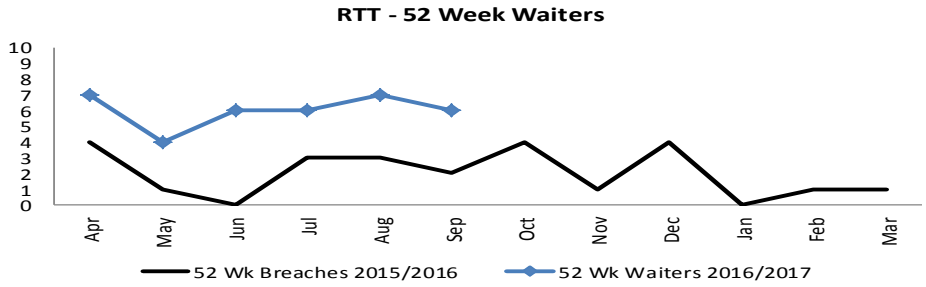


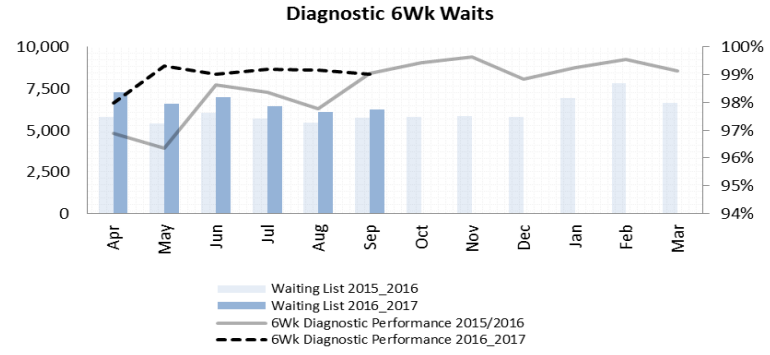




## RTT and Diagnostics

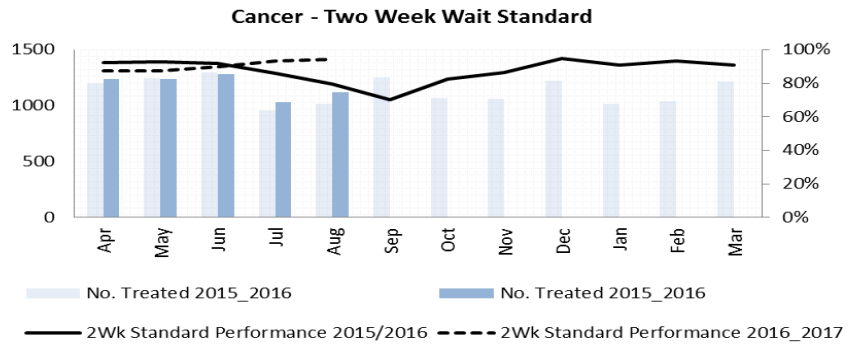


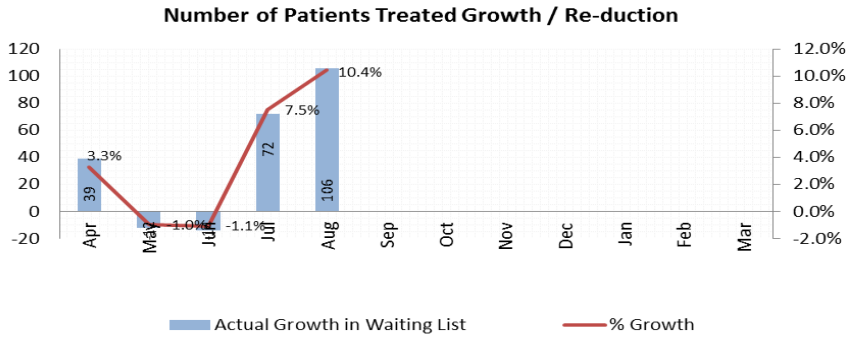



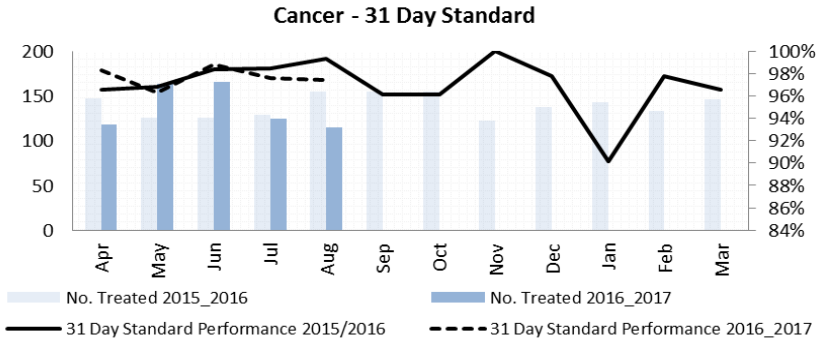



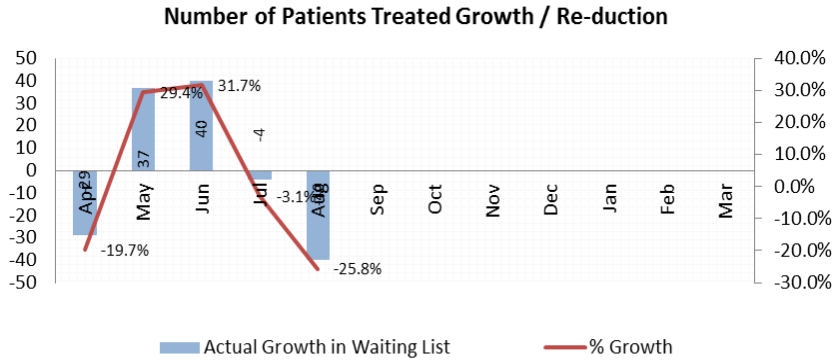
## Cancer - Two Week Wait Standard



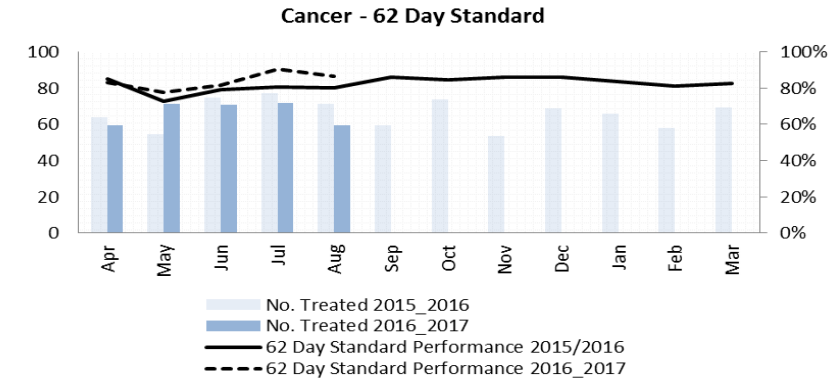



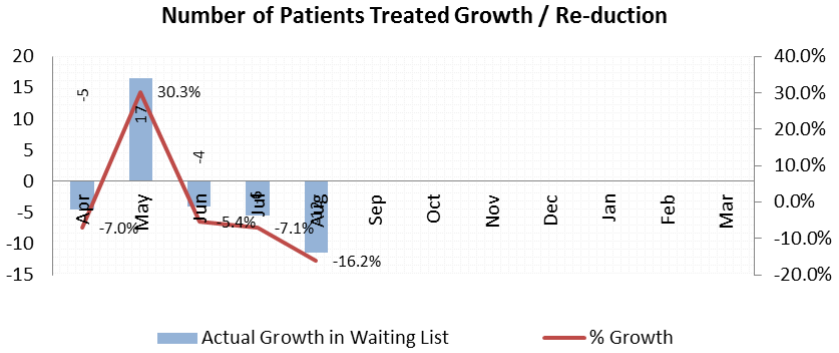

## Cancer - 31 Day Standard




## Cancer - 62 Day Standard



excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

# Performance – areas of escalation

*Excellence in specialist and community healthcare*

# 4. Performance Area of Escalation (Page 1 of 4) - A&E: 4 Hour Standard

St George's University Hospitals NHS
NHS Foundation Trust

| Total time in A&E - 95% of patients should be seen within 4hrs | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lead Director | Aug-16 | Sep-16 | Movement | 2016/2017 Target | Forecast for Sep-16 | Forecast for Oct-16 | Date expected to meet standard |
| FA | 92.70% | 92.20% | -0.50% | >= 95% | R | R | TBC |

| Peer Performance July 2016 (Rank) | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 3 | 2 | 4 | 5 | 1 |
| 92.70% | 93.47% | 91.34% | 88.18% | 96.19% |

## Overview

In August the Trust's ED performance against the 4 hour 95% Standard was 92.20% with a total of 14,261 attendances. The Trust has met the STF trajectory in Q2 with a performance of 93.1% against a trajectory of 92.4% This in line with an acknowledged improvement in performance seen since April 2016.

## Breach Performance

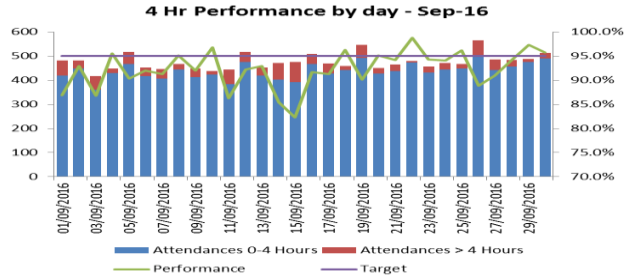
Total of 14,261 patients attended the department in September (3.3% higher than previous year) and a total of 1107 breaches. Treatment decision and wait for specialist opinion remain the highest contributing factors. An increase in the numbers of delayed transfer of care patients (DTOC) in comparison to last month and the number of days delayed have increased significantly. This remains a focus area for the organisation as this has a significant impact on flow through the hospital and impact upon ED flow into the organisation. As at 18/10/2016 there were 25 DTOC and 13 Non-DTOC patients. Overall improvements in Bed flow have focussed more attention on improved specialty support into ED to assist in the management of intense surges of patients.

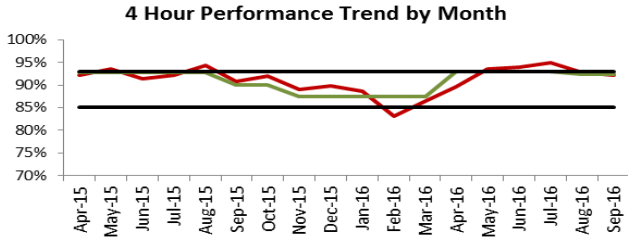
## Improvements

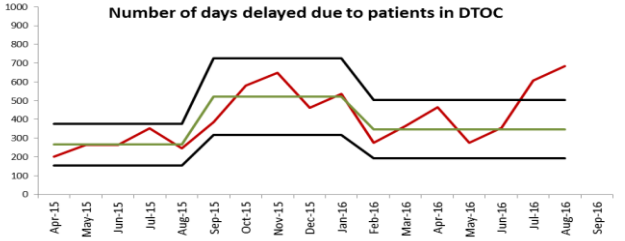
- Significant changes have been made to working systems to improve care (4-5% improvement)
- Enhanced action plan developed to maximise care and performance including the escalation policy.
- Increased engagement through consultant leads from ED to improve response rates
- Significant improvement in 15 minute LAS handover performance since April 2016 from 31% to 62% on the 19th September.
- ED focus on planning exit strategy for each patient at 2 hours, through increase of senior team shop floor time

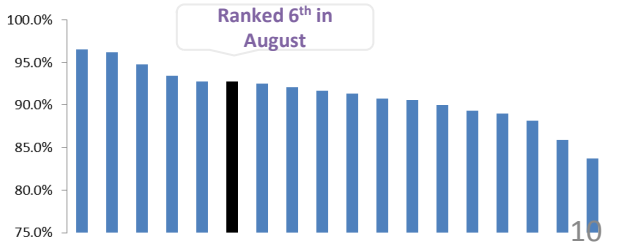
## Actions

- Action plan in place for top 4 breach reasons cohorts including treatment decisions and speciality breaches
- Increase numbers of patients navigated to primary care in line with ED navigation
- New Flow Programme is being finalised to address local ED and system challenges
- Further reduction in LOS through roll out of SAFER Bundle with a greater focus on discharge
- Review of rotas is underway in ED as well as the RATs and urgent care systems.
- Escalation trigger tool to be updated and publicised, with SMS alert to include GM and director on-call mobile phone, plus other ops managers




| Monthly Trajectory | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 |
|---|---|---|---|---|---|---|---|
| Total Attendances | 13,606 | 14,521 | 14,523 | 14,413 | 13,373 | 14,075 | 14,317 |
| Attendances<4 Hours | 12,085 | 13,098 | 13,286 | 13,176 | 12,407 | 13,086 | 13,252 |
| Breaches >4 Hours | 1,521 | 1,423 | 1,237 | 1,237 | 966 | 989 | 1,065 |
| Performance Trajectory | 88.8% | 90.2% | 91.5% | 91.4% | 92.8% | 93.0% | 92.6% |
| Performance Actual | 89.7% | 93.6% | 94.0% | 94.4% | 92.7% | 92.2% | 92.2% |
| Meeting STF Trajectory | ✓ 0.9% | ✓ 3.4% | ✓ 2.5% | ✓ 3.0% | ✗ -0.1% | ✗ -0.7% | ✗ -0.3% |

| Quarterly Actual | Q1 | Q2 | Q3 |
|---|---|---|---|
| Total Attendances | 43,114 | 42,827 | 7,608 |
| Attendances<4 Hours | 39,874 | 39,888 | 7,016 |
| Breaches >4 Hours | 3,240 | 2,939 | 574 |
| Performance | 92.5% | 93.1% | 92.2% |
| Meeting STF Trajectory | ✓ 2.3% | ✓ 0.8% | ✓ 0.0% |

# 4. Performance Areas of Escalation (Page 2 of 4) - RTT Incomplete Pathways

St George's University Hospitals NHS
NHS Foundation Trust

| Referral to Treatment Incomplete Pathways | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lead Director | Aug-16 | Sep-16 | Movement | 2016/2017 Target | Forecast for Sep-16 | Forecast for Oct-16 | Date expected to meet standard |
| CS | 85.61% | 86.68% | 1.07% | 92% | R | R | |

| Peer Performance August 2016 (Rank) | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 4 | 2 | 1 | 5 | 3 |
| 85.6% | 92.3% | 95.8% | 82.2% | 90.5% |

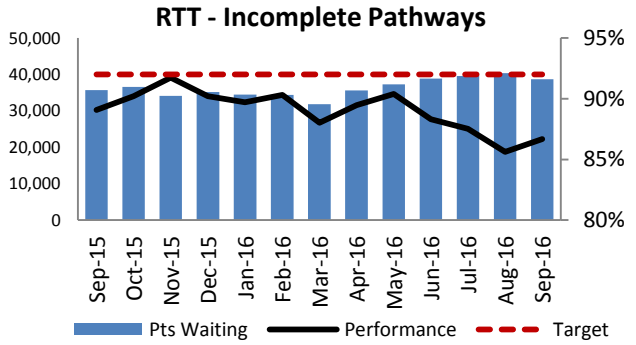
**Overview**

The Trust has been non-compliant against RTT incomplete pathways for a number of months, and recognises the significant scale of the task at hand to regain performance and sustainability going forward and there are a number of actions the Trust is taking as part of the RTT Recovery Programme to ensure this happens. September 2016 performance increased by 1.25% reporting 86.68%, with the number of patients above 18 weeks decreased by 654 patients. The total waiting list size at the end of month has seen a slight reduction of 1,664 patients, There are a number of specialties who remain challenged with performance below target of 92%. The number of 52 week breaches reportable in September performance were 6, consisting of ENT (2), General Surgery (1), Gastroenterology (1), T&O (2).

**Breach Performance**

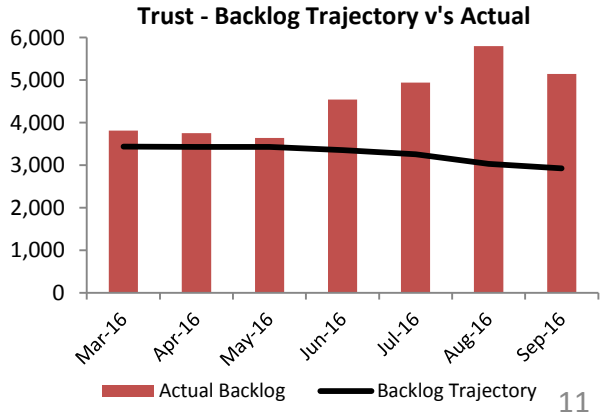
The largest cohort of patients breaching 18 weeks remains within ENT, followed by Trauma & Orthopaedics and General Surgery for admitted pathways and for non admitted Dermatology , ENT and T&O continue to have patients waiting over 18 weeks for an appointment .Over the last month there continues to be a reduction in the backlog of patients waiting , across all of these specialities. The number of reasons for the continued backlog includes late referrals from other Trusts beyond 18 week breach date and many are sent without having been investigated thoroughly and without the correct information to support transfer. During the last month within ENT and General Surgery a number of cases have been accepted back to their originating trust to receive treatment.

This month seven patients waited over 52 weeks for treatment , whilst patient choice was exercised in some cases , delays in appointments and securing dates for treatment continue as common themes.




**Improvements**

- Four clear work streams identified within the RTT Recovery Programme .
- Backlog reduction for admitted incomplete performance.
- Enhanced Leadership and governance and clear accountability at Board level
- Review and refinement of backlog reduction plans by specialty : ENT and General Surgery transferring cases back to originating NHS providers for treatment.
- Revised Access Policy and pilot for on line RTT training launches in November




**Actions**

- ENT contract in place to outsource activity to other providers
- Distribution of flow of referral activity for admitted and non-admitted pathways commenced.
- Next level qualitative technical review
- Prioritisation of activities into projects within programme completed.
- Comprehensive system and RTT training programmes developed
- Roll-Out of Text Reminder Service
- Template Fix engagement and corrections progressing to revised plan.

# 4. Performance Areas of Escalation (Page 3 of 4) - On the Day Cancelled Operations

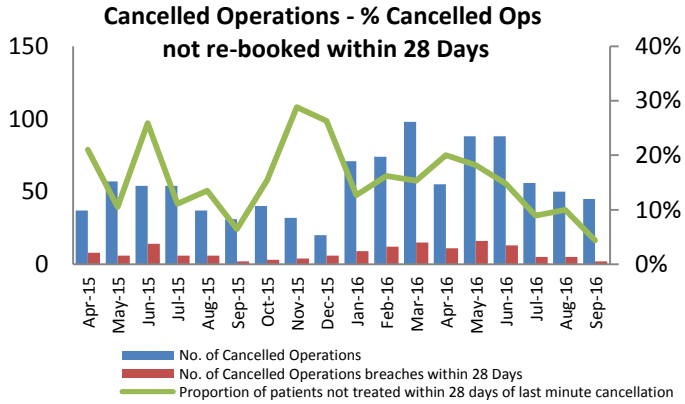
St George's University Hospitals NHS
NHS Foundation Trust

| Proportion of Cancelled patients not treated within 28 days of last minute cancellation | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lead Director | Aug-16 | Sep-16 | Movement | 2016/2017 Target | Forecast for Sep-16 | Forecast for Oct-16 | Date expected to meet standard |
| CC | 8.93% | 4.40% | -4.53% | 0% | G | G | |

| Peer Performance Comparison – Latest Available Q1 2016/17 | | | | |
|---|---|---|---|---|
| STG | Croydon | Kingston | King's College | Epsom & St Helier |
| 5 | 2 | 3 | 4 | 1 |
| 4.0% | 1.0% | 5.3% | 5.0% | 2.0% |

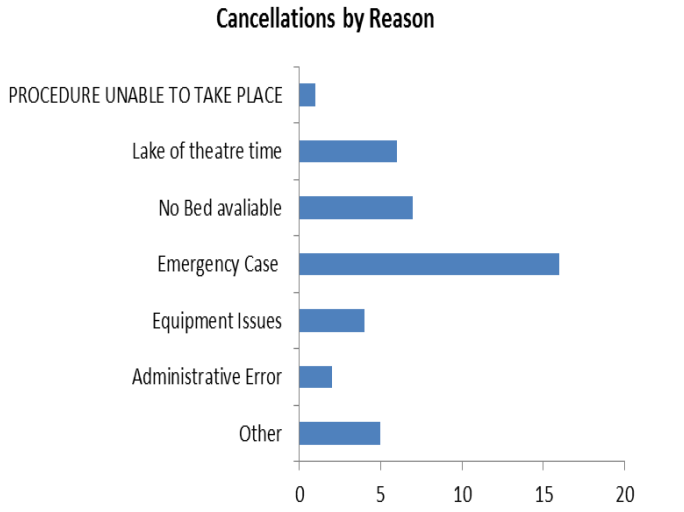
**Overview**

The national standard is that all patients whose operation has been cancelled for non clinical reasons should be treated within 28 days. The Trust reported a total of 45 on the day cancellations in the month of September of which 2 were not re-booked within 28 days accounting for 4.4% of all cancellations. There was a reduction of 5 cancelled operations compared to the previous month. The level of cancellations remain high compared with London Trusts and this remains a priority area for St George's 1) to fully utilise theatre lists, 2) Improved planning with divisions, 3) improved data quality and validation to ensure accurate and timely data, 4) Firm action plans in place to address capacity constraints. It should also be noted that due to the complex nature of many of our patients that a cancellation rate will be expected due to 'on the day' clinical reasons.




**Breach Performance**

Total of 45 on the day cancellations with 2 patients not re-booked within 28 days. The highest proportion of breaches occurred within Cardiothoracic. Cases were cancelled due to bed availability, emergency cases, and list's over running / lack of theatre time.




**Improvements**

- Fortnightly reviews of cases with Directorate leads to ensure efficient forward planning
- Daily Theatre dashboard now in operation to allow improved daily management and analysis
- General Managers now approve all cancelled operations after discussion with Clinical Director and Divisional Director of Operations
- Daily operational meetings chaired by COO with all general management teams
- Morning management focus on bed and theatre flow has led to improved throughput
- St James Theatres 5&6 back in use and operational
- In Cardiac Surgery, cardiologists have agreed to release further capacity to CTICU to increase intensive care capacity to reduce breaches.

**Actions**

- Improvement of Pre-Operative Assessment Routine.
- Increased booking intensity of theatre lists.

# 4. Performance Areas of Escalation (Page 4 of 4)
## - Cancer Standard

St George's University Hospitals NHS
NHS Foundation Trust

**Overview**

All Cancer Standards have been achieved in July and August and are on target to achieve in September therefore achieving the standards for three consecutive months.

**All Cancer Standards Performance Indicators**

| All Cancer Standards | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|
| 14 Day GP Referral (93%) | 86.6% | 87.3% | 90.0% | 93.1% | 95.1% |
| 14 Day Breast Symtomatic (93%) | 94.8% | 95.2% | 85.9% | 93.8% | 94.2% |
| 31 Day First Treatment (96%) | 98.3% | 96.3% | 98.8% | 97.6% | 97.4% |
| 31 Day Subsequent Treatment Surgery(98%) | 100.0% | 94.7% | 96.6% | 100.0% | 100.0% |
| 31 Day Subsequent Treatment Drug(98%) | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| 62 Day Referral (85%) | 83.2% | 77.5% | 81.6% | 90.2% | 86.6% |
| 62 Day Screening (90%) | 93.9% | 84.8% | 94.8% | 95.0% | 95.8% |
| 62 Day Consultant Upgrade (85%) | 100.0% | 100.0% | 100.0% | 90.0% | 100.0% |

**Positive Changes**

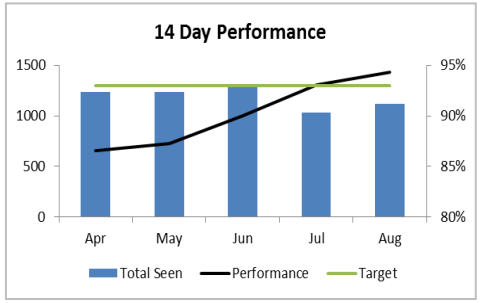
- The 7 day booking programme which includes increasing first contact with patients within 48 hours has seen a positive increase.
- Appointments made within 7 days is also seeing improvement
- A reduction in long waiters has been maintained and continue to be managed and escalated through weekly PTL and performance meetings
- Improved performance of ITT patients referred in treated within 24 days.

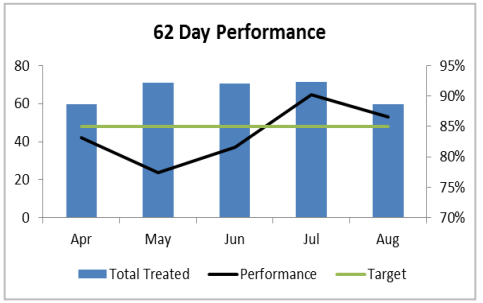
**Continued Actions**

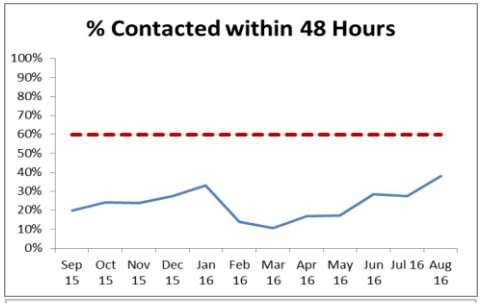
- Head and Neck recovery plan in place and currently being implemented. Early success indicated via a reduction in long waiters and the number of patient tipping over 62+days.
- Approval for recruitment to MDT and data team vacancies.

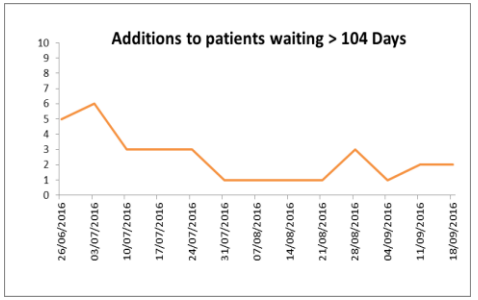
**Risks**

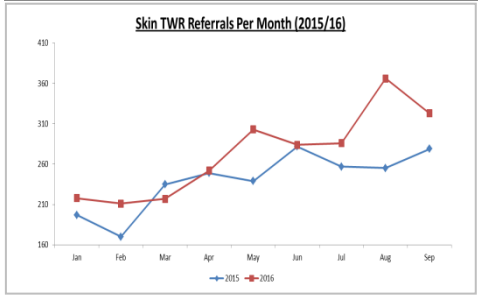
- Skin - 14 day performance is a risk for October and future months due to continued demand above planned activity levels as well as clinical capacity constraints due to consultant vacancies.
- Gynae performance is constrained by capacity shortfalls to meet current levels of demand, for both 14 and 62 day standards.
- Diagnostic constraints - in particular CT-colon, CT reporting and hysteroscopy.
- Admin vacancies within the cancer data team has created administration delays which have prevented the expedition of delays in patient pathways.

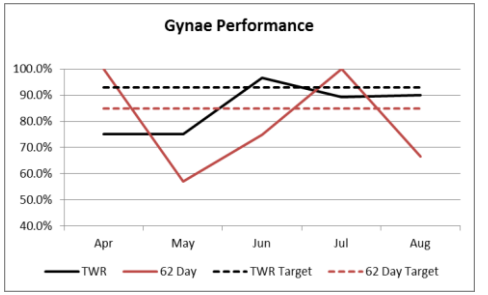



| Monthly Trajectory | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 |
|---|---|---|---|---|---|
| STF Performance Trajectory | 83.2% | 77.5% | 81.6% | 90.2% | 86.6% |
| Performance Actual | 83.2% | 77.5% | 81.6% | 90.2% | 86.6% |
| Meeting STF | ✗ -0.1% | ✗ -4.2% | ✗ -2.2% | ✓ 5.1% | ✓ 1.4% |

# 5. Divisional KPIs Overview 2016/17: September 16 Performance (Page 1 of 2)

St George's University Hospitals NHS
NHS Foundation Trust

## Monthly View

September 2016

| | | | COMMUNITY SERVICES | MEDICINE | SURGERY | WOMEN & CHILDREN | TRUST LEVEL |
|---|---|---|---|---|---|---|---|
| Access Metrics | 18 weeks - admitted waits (division level) | % | 0 | 72.3 | 59.8 | 71.7 | 64.5 |
| | 18 weeks - incomplete waits (division level) | % | 91.7 | 90.6 | 81.7 | 91.6 | 86.7 |
| | 18 weeks – non-admitted waits (division level) | % | 95.6 | 76.2 | 77.5 | 87.6 | 82.8 |
| | A&E waits (4 hours) | % | 100 | 91.3 | 0 | 0 | 92.2 |
| | Cancelled operations re-booked within 28 days (division) | % | 0 | 3.3 | 5.6 | 0 | 3.8 |
| | LAS handover within 15 mins | % | | | | | 54.5 |
| | LAS handover within 30 mins | % | | | | | 96.5 |
| | LAS handover within 60 mins | No. | | | | | 0 |
| | No Trolley Waits in A&E - 12 hours | No. | | | | | 0 |
| | Urgent operations cancelled for the second time | No. | 0 | 0 | 0 | 0 | 0 |

**Note: Cancer performance is reported a month in arrears, thus for August 2016**

August 2016

| | | | COMMUNITY SERVICES | MEDICINE | SURGERY | WOMEN & CHILDREN | TRUST LEVEL |
|---|---|---|---|---|---|---|---|
| Access Metrics | 2 week gp referral to first outpatient (breast symptoms) - (division) | % | | | 93.5 | | 93.5 |
| | 2 week gp referral to first outpatient (cancer) - (division) | % | | | 94.3 | | 94.3 |
| | 31 day second or subsequent treatment (drugs) - (division) | % | | | 100 | | 100 |
| | 31 day second or subsequent treatment (surgery) - (division) | % | | | 100 | | 100 |
| | 31 day standard from diagnosis to first treatment - (division) | % | | | 97.4 | | 97.4 |
| | 62 day urgent gp referral to treatment for all cancers - (division) | % | | | 86.6 | | 86.6 |
| | 62 day urgent gp referral to treatment from screening - (division) | % | | | 96.2 | | 96.2 |

# 5. Divisional KPIs Overview 2016/17: September 16 Performance (Page 2 of 2)

St George's University Hospitals NHS
NHS Foundation Trust

## Monthly View

September 2016

| | | | COMMUNITY SERVICES | MEDICINE | SURGERY | WOMEN & CHILDREN | TRUST LEVEL |
|---|---|---|---|---|---|---|---|
| Outcome Metrics | Average LOS (elective) (division) | Ratio | 0 | 4.1 | 4.6 | 2.8 | 4.3 |
| | Average LOS (non-elective) (division) | Ratio | 9.5 | 4.1 | 5.8 | 2.9 | 4.2 |
| | C-sections (applicable to women & children only) | % | 0 | 0 | 0 | 24.4 | 24.4 |
| | CAS alerts | No. | | | | | 1 |
| | Falls (ward level) | No. | 11 | 76 | 40 | 1 | 128 |
| | FFT Recommended Rate- A&E | % | | | | | 83.1 |
| | FFT Recommended Rate- Inpatient | % | | | | | 94.4 |
| | HSMR | Ratio | | | | | 88.9 |
| | Incidence of c.difficile | No. | 0 | 3 | 0 | 0 | 3 |
| | Incidence of e-coli | No. | 0 | 4 | 0 | 2 | 6 |
| | Incidence of MRSA | No. | 0 | 0 | 0 | 0 | 0 |
| | Maternal deaths | No. | 0 | 0 | 0 | 0 | 0 |
| | Medication errors causing serious harm (division) | No. | 0 | 0 | 0 | 0 | 0 |
| | Mixed sex accomodation | No. | 0 | 0 | 0 | 0 | 0 |
| | MSSA | No. | 0 | 3 | 0 | 1 | 4 |
| | Never events | No. | 0 | 0 | 0 | 0 | 0 |
| | Never events (ward level) | No. | 0 | 0 | 0 | 0 | 0 |
| | Serious incidents (division level) | No. | 1 | 1 | 2 | 0 | 4 |
| | SHMI | Ratio | | | | | 0.9 |
| | Trust acquired pressure ulcers | No. | 0 | 0 | 0 | 0 | 0 |
| | VTE risk assessment (data submitted to unify) | % | | | | | 96.3 |

| | | | COMMUNITY SERVICES | MEDICINE | SURGERY | WOMEN & CHILDREN | TRUST LEVEL |
|---|---|---|---|---|---|---|---|
| Quality Governance Indicators | Friends & family response rate | % | 53.3 | 26.1 | 39.4 | 20.3 | 27.7 |
| | Number of GP Quality Alerts | No. | 0 | 5 | 3 | 3 | 11 |
| | Number of NICE Technology Appraisals | No. | | | | | 7 |
| | Patient satisfaction (friends & family) | % | 87.5 | 86.2 | 92 | 94.1 | 87.9 |
| | Percentage of harm free care | % | 95.1 | 93.6 | 96.5 | 99.1 | 95.4 |
| | Percentage of staff appraisal (medical) - (division) | % | 71.4 | 78.1 | 85.3 | 81.1 | 81.6 |
| | Percentage of staff appraisal (non-medical) - (division) | % | 78.9 | 72.8 | 69.3 | 65.6 | 69 |
| | Sickness/absence rate - (division) | % | 4.9 | 3 | 4.3 | 3.2 | 3.5 |
| | Staff turnover - (division) | % | 20.5 | 17.6 | 17.3 | 19.3 | 18.9 |
| | Voluntary staff turnover - (division) | % | 16.4 | 15.2 | 13.9 | 15.9 | 15.5 |
| | Ward staffing: unfilled duty hours | % | 3.5 | 5.1 | 6.9 | 3.2 | 4.9 |

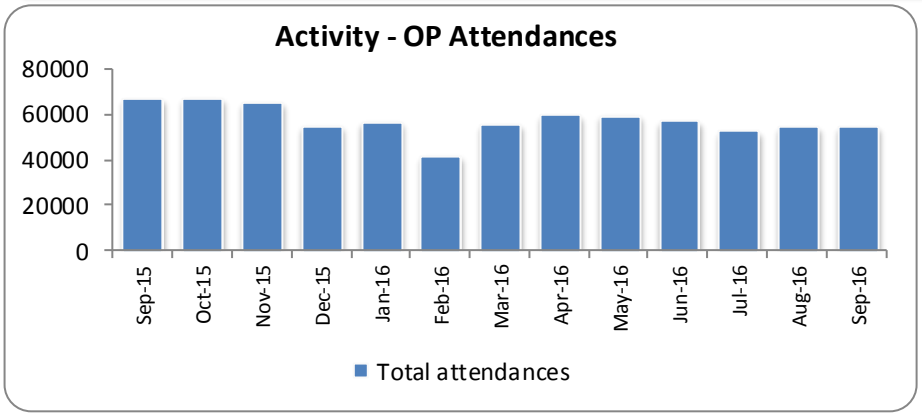
**Key Messages:**

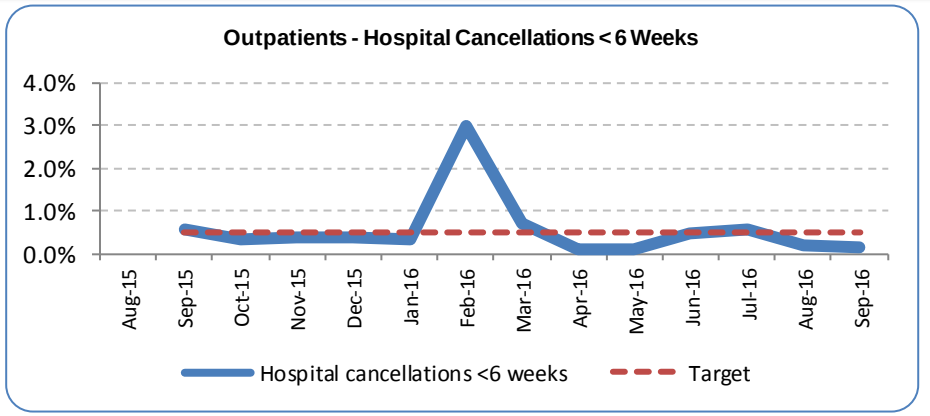
This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components,. Cancer performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of September 54.5% of patients had handover times within 15 minutes and 96.55% within 30 minutes, both of which are not within target. The trust had zero reported 60 minute LAS handover in September.

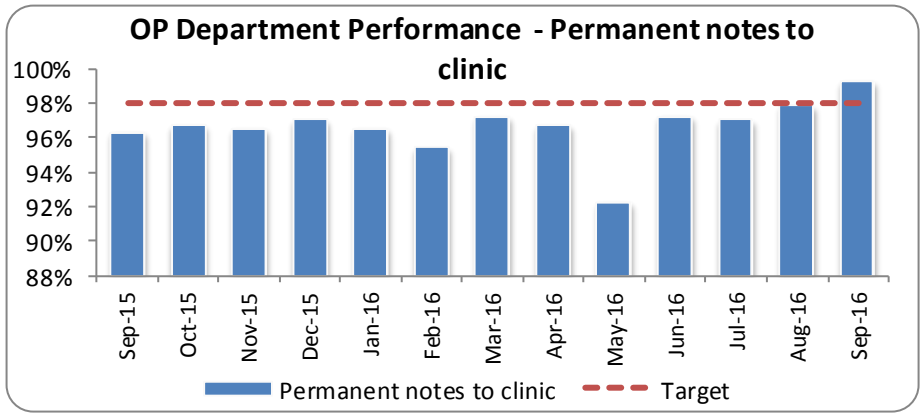
The trust has a zero tolerance policy on avoidable pressure ulcers and has placed significant importance on its prevention. In September the trust had 0 grade 3 pressure ulcer SI's and no Grade 4. All grade 3 and 4 unavoidable pressure ulcers acquired in our care are investigated as serious incidents, and a full investigation and Root Cause Analysis will be produced for each.

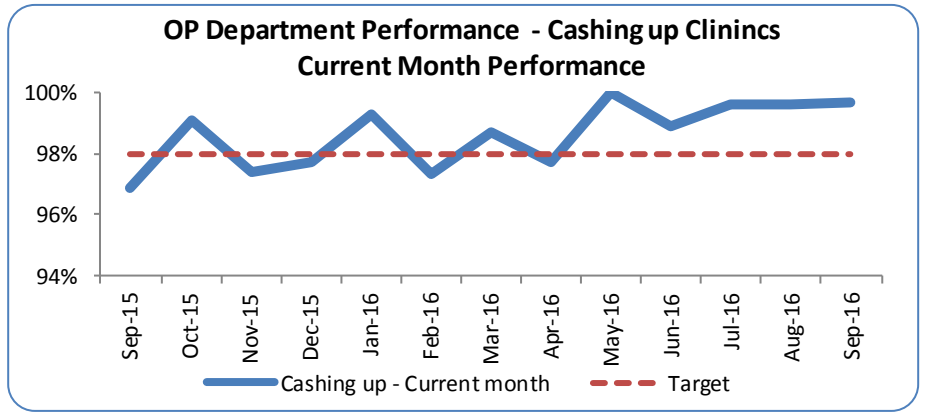
# 6. Corporate Outpatient Services (1 of 2) - Performance Overview

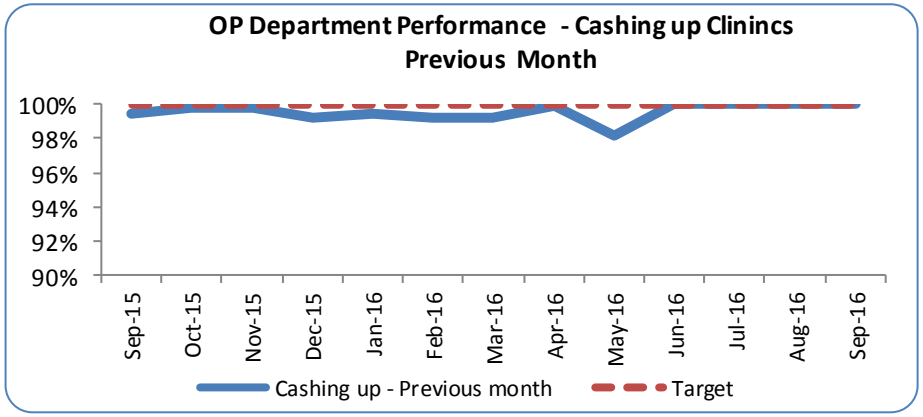
St George's University Hospitals NHS
NHS Foundation Trust

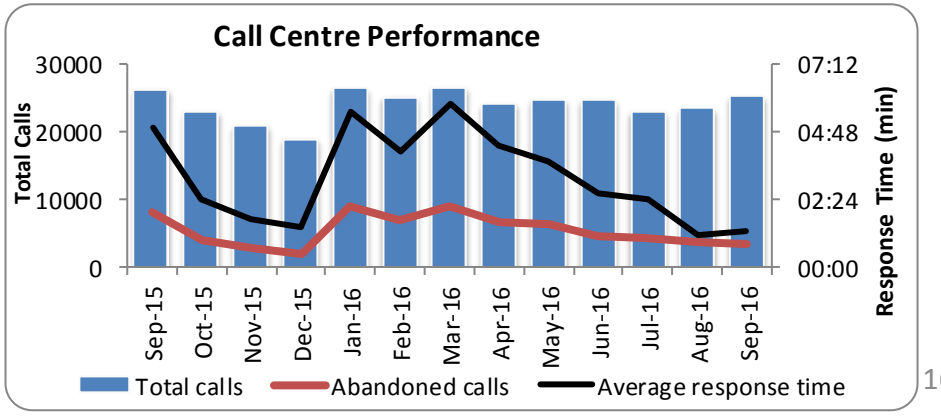


# 6. Corporate Outpatient Services (2 of 2) - Performance Overview

St George's University Hospitals NHS
NHS Foundation Trust

| | | Target | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activity** | Total attendances | N/A | 66271 | 66501 | 64863 | 54618 | 56239 | 41552 | 55261 | 59211 | 59055 | 56519 | 52223 | 54159 | 54143 |
| | Hospital cancellations <6 weeks | <0.5% | 0.54% | 0.32% | 0.36% | 0.37% | 0.35% | 2.97% | 0.69% | 0.11% | 0.08% | 0.48% | 0.54% | 0.17% | 0.15% |
| **OPD performance** | Permanent notes to clinic | >98% | 96.31% | 96.72% | 96.52% | 97.02% | 96.50% | 95.42% | 97.20% | 96.70% | 92.26% | 97.22% | 97.01% | 97.82% | 99.25% |
| | Cashing up - Current month | >98% | 96.90% | 99.10% | 97.40% | 97.70% | 99.30% | 97.30% | 98.70% | 97.70% | 100.00% | 98.90% | 99.60% | 99.60% | 99.70% |
| | Cashing up - Previous month | 100% | 99.40% | 99.80% | 99.75% | 99.20% | 99.40% | 99.20% | 99.20% | 99.90% | 98.20% | 100.00% | 100.00% | 100.00% | 100.00% |
| **Call Centre Performance** | Total calls | N/A | 26357 | 23138 | 21082 | 19093 | 26557 | 25273 | 26674 | 24279 | 24924 | 24881 | 23186 | 23552 | 25372 |
| | Abandoned calls | <25%/<15% | 8253 | 3930 | 2756 | 1953 | 9084 | 6949 | 9055 | 6671 | 6362 | 4542 | 4185 | 3648 | 3405 |
| | Mean call response times | <1 m/<1m30s | 04:59 | 02:24 | 01:43 | 01:24 | 05:30 | 04:06 | 05:49 | 04:20 | 03:45 | 02:37 | 02:26 | 01:10 | 01:18 |

**Key Messages:**

- Activity remains consistent with previous month with 54,143 attendances compared to 54,159 last month. Attendances are 12,128 lower than same period last year.
- Percentage of Hospital cancellations <6 weeks has improved by 0.2% and has achieved the target for a consecutive month.
- Permanent notes to clinic has maintained improvement since February, and has achieved the target in September.
- The level of call activity and the number of abandoned calls significantly improved in August and has been maintained in September. With the number of total calls remaining in line with previous months, the total of abandoned calls and the mean call response time have both achieved the target.

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

# Quality Report

# Sep-2016

*Excellence in specialist and community healthcare*

# 7. Clinical Effectiveness

St George's University Hospitals NHS
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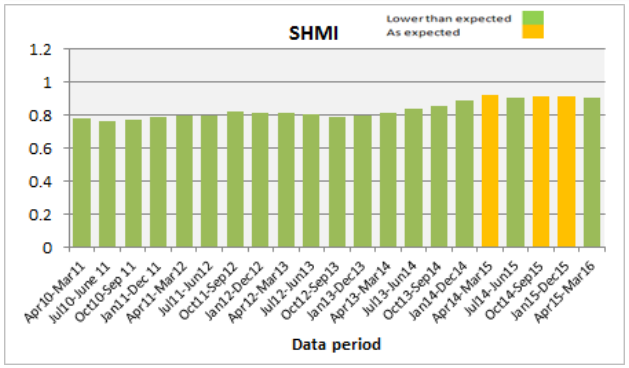
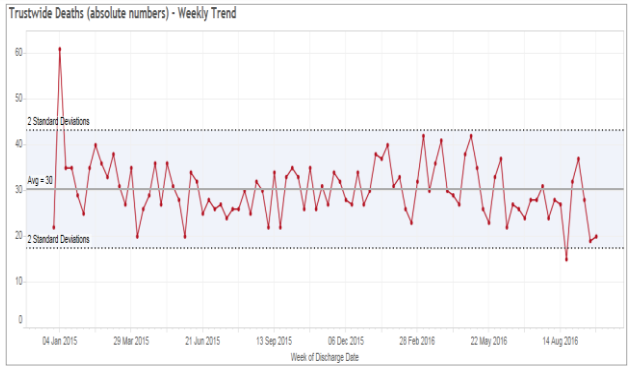
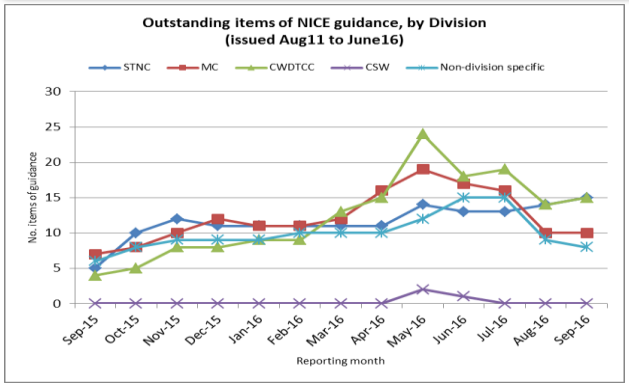


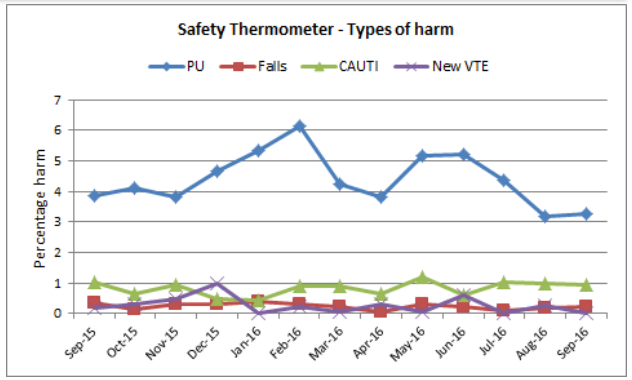





**Items of NICE Guidance with Compliance Issues (June 2010 to June 2016)**

| Division | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|
| STNC (n=12) | 0 | 1 | 2 | 1 | 3 | 2 | 3 |
| M+C (n=19) | 2 | 0 | 2 | 1 | 2 | 5 | 7 |
| CWDTCC (n=15) | 3 | 1 | 0 | 2 | 5 | 2 | 2 |
| CSW (n=0) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-division specific (n=14) | 0 | 2 | 0 | 3 | 1 | 4 | 4 |




**Mortality**

- HSMR remains better than expected: June 15 – May 16 = 88.9 [weekend emergency admissions = 94.4 (as expected); weekday emergency admissions = 86.6 (better than expected)].
- SHMI April 15 – March 16 = 0.90 - lower than expected. One of 16 Trusts in England in this banding.
- Raw mortality within usual limits.
- Dr Foster Imperial Unit Outlier Alert: Coronary Atherosclerosis and other heart disease. Investigation by CCAG underway.

**NICE Guidance**

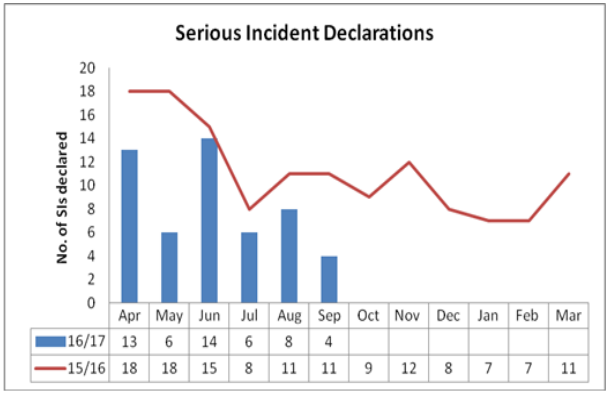
- 60 items of guidance with compliance issues that are with the Divisions for action; either to agree deviation and submit to PSQB or to devise an action plan.
- 48 items of guidance for which there has been no assessment of compliance. These have been escalated to each division for resolution and will be reviewed in October.
- Following comprehensive review by CE team, full reports detailing the above have been provided to divisions to support action and elimination of backlog. The Deputy
- Implementation of NICE guidance to be included in Divisional Performance Reviews.

**Safety Thermometer**

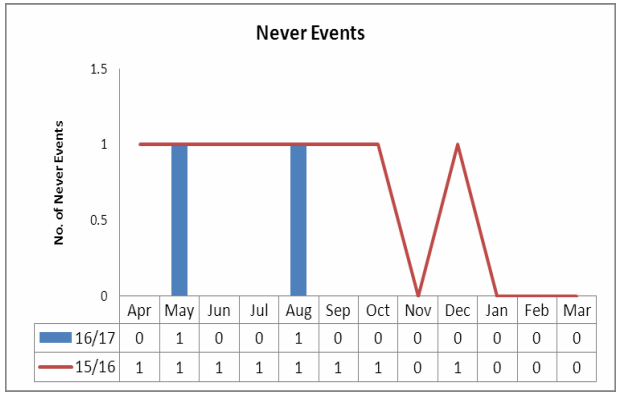
- 95.65% patients received harm free care in September; in line with national (94.07%).
- 62 harms to 56 patients: 51 patients experienced 1 harm, 4 patients experienced 2 harms and 1 patient experienced 3.
- 36 harms (58.1%) were old and cannot be attributed to care delivered by the Trust.

# 8. Patient Safety

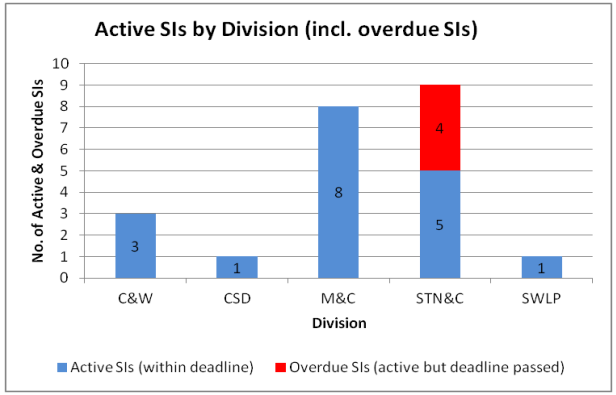
St George's University Hospitals NHS
NHS Foundation Trust

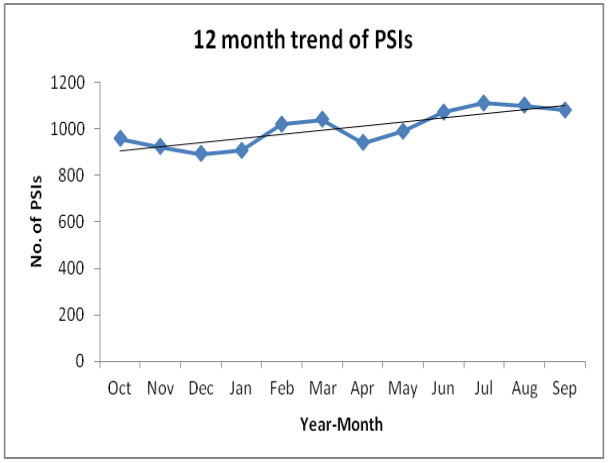


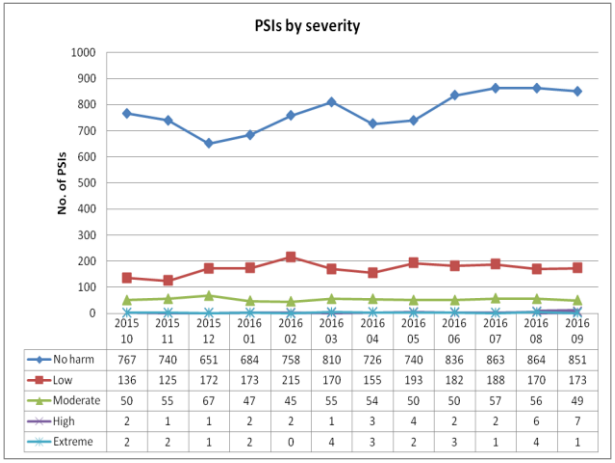

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16/17 | 13 | 6 | 14 | 6 | 8 | 4 | | | | | | |
| 15/16 | 18 | 18 | 15 | 8 | 11 | 11 | 9 | 12 | 8 | 7 | 7 | 11 |



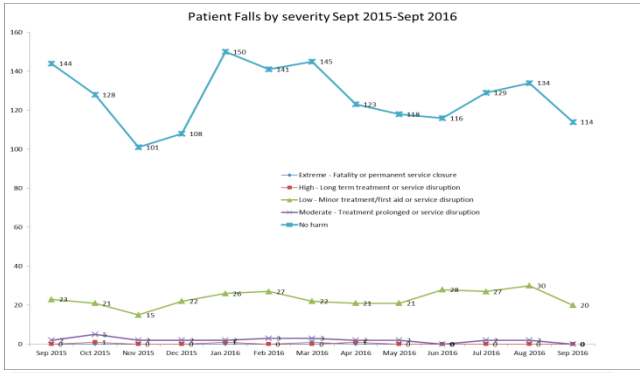

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16/17 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 15/16 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 |




| | 2015 10 | 2015 11 | 2015 12 | 2016 01 | 2016 02 | 2016 03 | 2016 04 | 2016 05 | 2016 06 | 2016 07 | 2016 08 | 2016 09 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No harm | 767 | 740 | 651 | 684 | 758 | 810 | 726 | 740 | 836 | 863 | 864 | 851 |
| Low | 136 | 125 | 172 | 173 | 215 | 170 | 155 | 193 | 182 | 188 | 170 | 173 |
| Moderate | 50 | 55 | 67 | 47 | 45 | 55 | 54 | 50 | 50 | 57 | 56 | 49 |
| High | 2 | 1 | 1 | 2 | 2 | 1 | 3 | 4 | 2 | 2 | 6 | 7 |
| Extreme | 2 | 2 | 1 | 2 | 0 | 4 | 3 | 2 | 3 | 1 | 4 | 1 |




| YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15/16 | 169 | 125 | 143 | 164 | 139 | 169 | 155 | 118 | 132 | 179 | 171 | 171 |
| 16/17 | 147 | 141 | 144 | 158 | 166 | 134 | | | | | | |

**Patient Safety Incidents (PSIs) including Serious Incidents and Never Events**

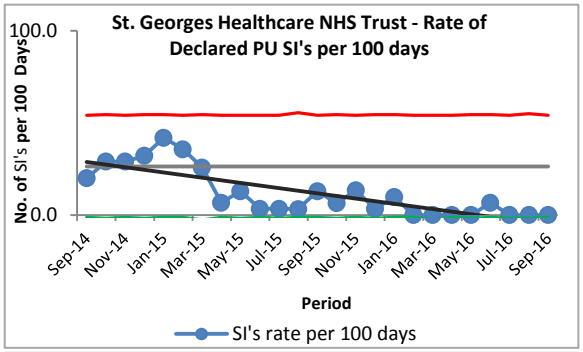
- Reduction in Serious Incidents (SIs) declared Apr–Sep: 51 compared with 81 SIs declared Apr-Sep 15/16, this represents a 37% decrease.
- Four currently overdue SI reports within STN&C Division .
- The trend for the number of PSIs continues to increase showing a positive reporting culture, as does the proportion of incidents moderate or above severity (5.3%).

**Falls**

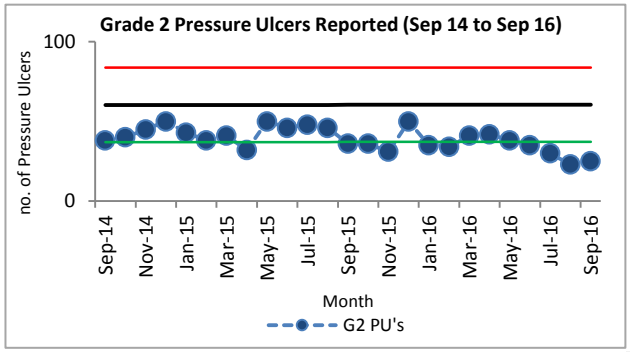
- Number of falls has reduced this month, with no severe/ moderate harm.
- Number of actions underway to support correct use of policy and best practice guidance encompassed within Trust Quality Improvement Plan (QIP)
- Falls audit planned for November

# Patient Safety

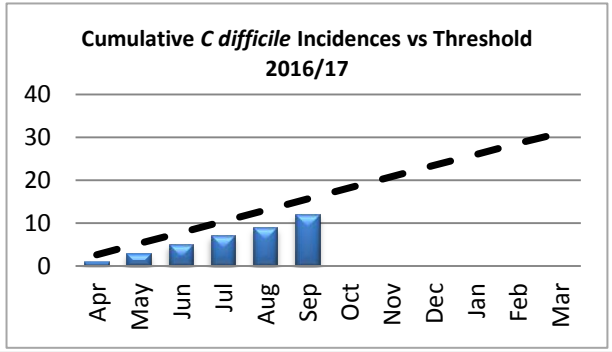
St George's University Hospitals NHS
NHS Foundation Trust




| YTD | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| 16/17 | 0 | 0 | 2 | 0 | 0 | 0 |
| 15/16 | 2 | 4 | 1 | 1 | 1 | 4 |




| YTD | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| 16/17 | 41 | 38 | 35 | 30 | 23 | 25 |
| 15/16 | 32 | 50 | 46 | 48 | 46 | 36 |




| YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16/17 | 1 | 2 | 2 | 2 | 2 | 3 | | | | | | |
| 15/16 | 3 | 3 | 3 | 2 | 2 | 5 | 4 | 0 | 1 | 2 | 3 | 1 |

| VTE Compliance (Target >95%) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
| Unify 2: Data extracted from system on patient discharge via discharge summary or iClip | | | | | | | | | | | |
| 97.10% | 96.80% | 96.50% | 96.60% | 96.70% | 97.04% | 96.45% | 97.59% | 97.60% | 96.90% | 96.74% | 96.3% |

| Safeguarding Training rates (target 85%) | | |
|---|---|---|
| Division | Safeguarding Children * | Safeguarding Adults ^ |
| CWDTCC | 89% | 84% |
| M&C | 89% | 82% |
| STNC | 81% | 86% |
| CSD | 86% | 88% |
| Corp | 100% | 76% |
| **Trust** | **89%** | **83.2%** |

**Infection control**

- C Diff – There were three trust apportioned episodes: cumulative total is 12 = below the trust threshold of 31 for the year. No MRSA cases.

**Pressure Ulcers**

- Grade 2 pressure ulcers have reduced (May 50 – September 36) and no grade 3 or 4 for three consecutive months
- Target to reduce grade 2 pressure ulcers by 10% by March 2016

**VTE**

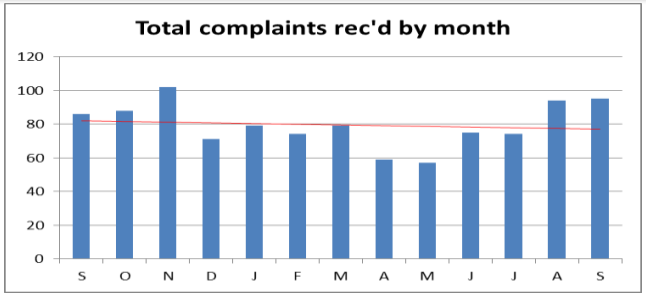
- Electronic records of assessment shows compliance of 96.3%

**Safeguarding Children and Adults & MCA training** * source manual ^ source ARIS

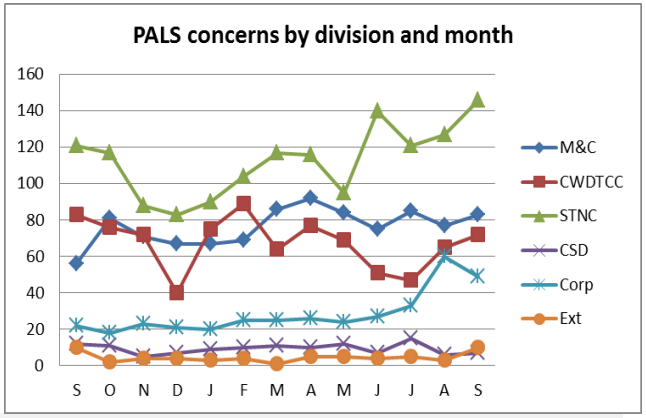
- Safeguarding adults Trust wide is 83.2% which is below target and safeguarding children training Level 3 is 89% which is above target
- Mental Capacity Act (MCA) training rollout commenced with 273 staff trained in three months

# 9. Patient Experience






| YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15/16 | 71 | 73 | 84 | 90 | 79 | 87 | 88 | 101 | 72 | 78 | 75 | 79 |
| 16/17 | 57 | 58 | 75 | 74 | 94 | 95 | | | | | | |




| YTD | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15/16 | 248 | 227 | 294 | 302 | 257 | 304 | 305 | 264 | 222 | 264 | 303 | 308 |
| 16/17 | 330 | 289 | 304 | 306 | 338 | 367 | | | | | | |

## Friends & Family Test

| | Apr | May | Jun | Jul | Aug | Sep | |
|---|---|---|---|---|---|---|---|
| M&C | 97% | 96% | 95% | 97% | 96% | 96% | ⇔ |
| STNC | 94% | 95% | 94% | 97% | 96% | 94% | ⇩ |
| CWDTCC | 90% | 96% | 91% | 93% | 90% | 95% | ⇧ |
| CSD | 93% | 92% | 94% | 92% | 96% | 87% | ⇩ |
| Trust | 94% | 95% | 94% | 95% | 95% | 94% | ⇩ |

| Complaints Performance | % within 25 working days (target 85%) | | % within 25 working days or agreed timescales (Target 100%) | |
|---|---|---|---|---|
| **Division** | **July** | **August** | **July** | **August** |
| CWDTCC | 72% | 29% ▼ | (5) 100% | (5) 64% ▼ |
| M&C | 88% | 68% ▼ | (2) 96% | (8) 100% ▲ |
| STNC | 44% | 63% ▲ | (4) 75% | (4) 75% ◇ |
| CSD | 83% | 100% ▲ | (1) 100% | (0) 100% ◇ |
| Corp | 70% | 75% ▲ | (1) 80% | (3) 100% ▲ |
| **Trust** | **72%** | **65%** ▼ | **(14) 91%** | **(20) 86%** ▼ |

**Complaints & PALS**

- Number of complaints received continues to increase month on month since May 16.
- Top themes are: clinical treatment, communication and appointment delay/ cancellation
- Complaints performance has declined overall in Aug having improved for the second consecutive month in July and remains inconsistent: Exception reports have been requested by the Deputy Chief Nurse from the Senior Nursing Team.
- Staffing problems in the Complaints and Improvements Department remain. As of end of Sept complaints are being sent to divisions within 2 working days as KPI.
- The divisions have committed to achieve targets for complaints received in Sept.
- High number of PALS concerns received in Sept: +9% compared with Aug 16 (338) and +21% when compared with Sept 2015 (304)

**Friends & family test**

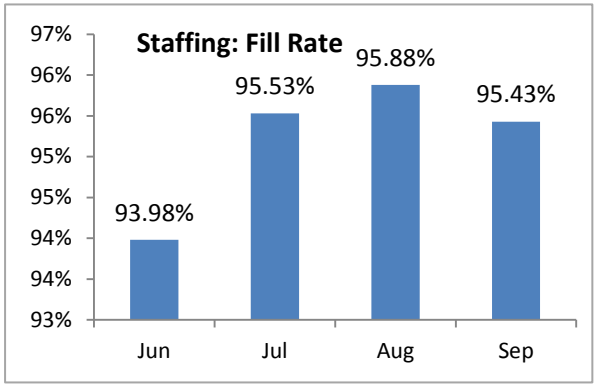
- Our FFT scores (the percentage of people who said they were "Extremely likely" or "Likely" to recommend a service to friends or relatives) are reported by division.
- Trust wide FFT is 94%.

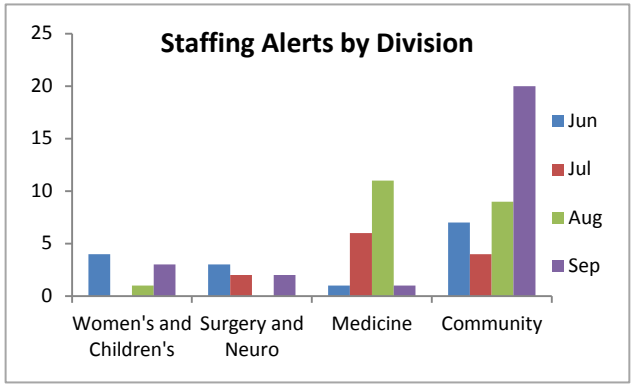
It draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient or relative that would have trouble understanding the standardised survey question. Further breakdowns are available for services and location type.

- Outpatient based services score lower than all other settings in the Trust, while Critical Care and Day case service score higher.

# 10. Workforce






| Care Hours per patient day (CHPPD) | | | | |
|---|---|---|---|---|
| | Jun | Jul | Aug | Sep |
| Number of patients | 23,137 | 21,043 | 20,335 | 23,562 |
| Registered nurse/registered midwife | 9.44 | 10.55 | 10.72 | 9.06 |
| Care staff | 3.24 | 3.74 | 3.75 | 3.11 |
| Overall total | 12.68 | 14.29 | 14.48 | 12.17 |

**Key messages**

- Fill rates for September 2016 are 95.43% in line with Unify return.
- Safe staffing relies on good rostering management so that budgeted posts are filled and deployed effectively and the staff employed are available to work (erostering rosters to be completed 8 weeks in advance to assist in planning staffing). There has been a significant improvement in medicine and surgery divisions. The other two divisions are working to improve.
- Anecdotal evidence suggests that safe staffing audit or datix forms are not being completed consistently. No area should remain on alert / unsafe. A review is being undertaken of the escalation process to ensure the safe staffing policy is utilised effectively.
- Community division have employed a recruitment nurses to assist in reducing vacancies and improving retention .
- From May 2016, all acute trusts with inpatient wards/units began reporting monthly care hours per patient day (CHPPD) data to NHS improvement. Over time this will allow trusts to review the deployment of staff within a speciality and by comparable ward. When looking at this information locally alongside other patient outcome measures, trusts will be able to identify how they can change and flex their staffing establishment to improve outcomes for patients and improve productivity. Guidance on the use of this tool is expected from NHS Improvement to assist the trust in implementation.

# 11. Nursing and Midwifery Heatmap – September 2016

St George's University Hospitals NHS
NHS Foundation Trust

| Division | Ward | Incidence of c.difficile | Incidence of MRSA | Trust acquired pressure ulcers | Percentage of harm free care | Patient satisfaction (friends & family) | Friends & family response rate | Ward staffing: unfilled duty hours | Falls (ward level) | Serious incidents (ward level) | Sickness/ absence rate - ( ward) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| COMMUNITY SERVICES | Mary Seacole | 0.0 | 0.0 | 0.0 | 95.1 | 87.5 | 53.3 | | 5.0 | 0.0 | 4.8 |
| MEDICINE | ALLINGHAM | 1.0 | 0.0 | 0.0 | 96.3 | 68.4 | 32.2 | 3.0 | 10.0 | 0.0 | 1.0 |
| | AMYAND | 1.0 | 0.0 | 0.0 | 84.4 | 95.2 | 38.9 | 2.8 | 3.0 | 0.0 | 4.6 |
| | BELGRAVE | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | 35.6 | 9.0 | 7.0 | 1.0 | 3.1 |
| | BENJAMIN WEIR | 0.0 | 0.0 | 0.0 | 96.7 | 93.8 | 31.1 | 7.1 | 2.0 | 0.0 | 0.6 |
| | BUCKLAND | 1.0 | 0.0 | 0.0 | 100.0 | 100.0 | 54.5 | 8.3 | 1.0 | 0.0 | 4.3 |
| | CAESAR HAWKINS | 0.0 | 0.0 | 0.0 | 87.0 | 100.0 | 31.1 | 3.6 | 8.0 | 0.0 | 1.6 |
| | CARDIAC CARE UNIT | 0.0 | 0.0 | 0.0 | 88.9 | 100.0 | 82.6 | -3.1 | 0.0 | 0.0 | 1.8 |
| | CAROLINE | 0.0 | 0.0 | 0.0 | 100.0 | 91.7 | 54.8 | 9.0 | 4.0 | 0.0 | 1.0 |
| | CHESELDEN | 0.0 | 0.0 | 0.0 | 91.7 | 98.0 | 57.5 | 0.8 | 0.0 | 0.0 | 1.3 |
| | DALBY | 0.0 | 0.0 | 0.0 | 95.8 | 100.0 | 31.3 | 4.1 | 6.0 | 0.0 | 4.5 |
| | EMERGENCY DEPARTMENT | 0.0 | 0.0 | 0.0 | | 83.0 | 24.3 | 12.3 | 0.0 | 0.0 | 2.4 |
| | GORDON SMITH | 0.0 | 0.0 | 0.0 | 100.0 | 90.9 | 19.0 | 8.0 | 4.0 | 0.0 | 2.1 |
| | HEBERDEN | 0.0 | 0.0 | 0.0 | 91.7 | 94.1 | 72.3 | 7.0 | 4.0 | 0.0 | 6.7 |
| | JAMES HOPE | 0.0 | 0.0 | 0.0 | 100.0 | 98.9 | 87.5 | 14.2 | 0.0 | 0.0 | 2.5 |
| | MARNHAM | 0.0 | 0.0 | 0.0 | 90.5 | 92.9 | 47.5 | 4.8 | 4.0 | 0.0 | |
| | MCENTEE | 0.0 | 0.0 | 0.0 | 96.4 | 100.0 | 54.2 | 3.5 | 2.0 | 0.0 | 1.4 |
| | RICHMOND | 0.0 | 0.0 | 0.0 | 90.9 | 90.0 | 20.1 | 3.7 | 13.0 | 0.0 | 5.1 |
| | RODNEY SMITH | 0.0 | 0.0 | 0.0 | 96.4 | 82.4 | 35.4 | 1.1 | 4.0 | 0.0 | 2.0 |
| | RUTH MYLES DAY UNIT | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | 67.6 | 2.1 | 1.0 | 0.0 | 6.7 |
| | TREVOR HOWELL | 0.0 | 0.0 | 0.0 | 93.3 | 88.9 | 33.3 | 1.1 | 2.0 | 0.0 | 6.0 |

# Nursing and Midwifery Heatmap – September

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|---|---|---|---|---|---|---|---|---|---|---|---|
| **SURGERY** | BRODIE NEURO | 0.0 | 0.0 | 0.0 | 100.0 | 92.9 | 12.2 | | 4.0 | 0.0 | 3.3 |
| | CAVELL | 0.0 | 0.0 | 0.0 | 100.0 | 78.3 | 68.9 | 8.7 | 4.0 | 0.0 | 5.7 |
| | FLORENCE NIGHTINGALE | 0.0 | 0.0 | 0.0 | 100.0 | 98.2 | 80.4 | 7.2 | 1.0 | 0.0 | 5.3 |
| | GRAY WARD | 0.0 | 0.0 | 0.0 | 87.5 | 98.7 | 73.5 | 8.1 | 3.0 | 0.0 | 1.8 |
| | GUNNING | 0.0 | 0.0 | 0.0 | 96.2 | 95.3 | 78.6 | 6.8 | 4.0 | 0.0 | 3.9 |
| | GWYN HOLFORD | 0.0 | 0.0 | 0.0 | 100.0 | 100.0 | 73.3 | 6.1 | 5.0 | 0.0 | 7.8 |
| | HOLDSWORTH | 0.0 | 0.0 | 0.0 | 96.0 | 91.4 | 87.5 | 4.6 | 4.0 | 0.0 | 3.6 |
| | KEATE | 0.0 | 0.0 | 0.0 | 90.0 | 92.9 | 34.7 | 7.0 | 3.0 | 1.0 | 7.3 |
| | KENT | 0.0 | 0.0 | 0.0 | 100.0 | 82.4 | 25.3 | 4.1 | 3.0 | 0.0 | 3.8 |
| | MCKISSOCK | 0.0 | 0.0 | 0.0 | 88.2 | 94.9 | 45.9 | 13.5 | 3.0 | 0.0 | 8.4 |
| | THOMAS YOUNG | 0.0 | 0.0 | 0.0 | 95.8 | 62.5 | 42.1 | 4.9 | 4.0 | 0.0 | 3.5 |
| | VERNON | 0.0 | 0.0 | 0.0 | 100.0 | 98.6 | 60.0 | 7.1 | 0.0 | 0.0 | 6.9 |
| | WILLIAM DRUMMOND HASU | 0.0 | 0.0 | 0.0 | 100.0 | 97.2 | 36.7 | 8.6 | 2.0 | 0.0 | 5.4 |
| **WOMEN & CHILDREN** | CARDIOTHORACIC INTENSIV.. | 0.0 | 0.0 | 0.0 | 92.9 | | | 2.7 | 0.0 | 0.0 | 2.5 |
| | CARMEN SUITE | 0.0 | 0.0 | 0.0 | 100.0 | | | -7.1 | 0.0 | 0.0 | 9.2 |
| | CHAMPNEYS | 0.0 | 0.0 | 0.0 | 100.0 | 97.4 | 33.9 | 11.7 | 0.0 | 0.0 | 0.5 |
| | DELIVERY | 0.0 | 0.0 | 0.0 | 100.0 | 95.3 | 9.5 | -4.8 | 0.0 | 0.0 | 4.6 |
| | FREDDIE HEWITT | 0.0 | 0.0 | 0.0 | | 72.0 | 40.0 | 9.0 | 0.0 | 0.0 | 2.9 |
| | GENERAL ICU/HDU | 0.0 | 0.0 | 0.0 | 100.0 | | | 4.2 | 0.0 | 0.0 | 3.5 |
| | GWILLIM | 0.0 | 0.0 | 0.0 | 100.0 | | | 0.1 | 1.0 | 0.0 | 3.0 |
| | JUNGLE | 0.0 | 0.0 | 0.0 | | 100.0 | 85.0 | 2.8 | 0.0 | 0.0 | 3.9 |
| | NEONATAL ICU | 0.0 | 0.0 | 0.0 | 100.0 | | | 6.2 | 0.0 | 0.0 | 4.1 |
| | NEURO ICU | 0.0 | 0.0 | 0.0 | 100.0 | | | 3.4 | 0.0 | 0.0 | 3.5 |
| | NICHOLLS | 0.0 | 0.0 | 0.0 | | 80.0 | 50.0 | 5.7 | 0.0 | 0.0 | 6.0 |
| | PICU | 0.0 | 0.0 | 0.0 | | | | 2.3 | 0.0 | 0.0 | 3.2 |
| | PINCKNEY | 0.0 | 0.0 | 0.0 | | | | 5.9 | 0.0 | 0.0 | 2.1 |

# 12. Heat map acute



**CWDC division**

- Cardiothoracic Intensive Care Unit (CTICU) scored 92.9% in relation to harm free care. This relates to 2 old pressure sores
- Champneys is the only Ward returning FFT, however the ward moved in September and will now be reported as Keate Ward in surgery.

**Medcard**

- The division has had 3 C.Diff cases reported which are undergoing RCA which will be presented at the Infection Control task force.
- Currently there appears to be no lapses in care identified for these patients.
- The safety thermometer data captures new and old harms for patients within the organisation. For the division the average 93% against a target of 95%, with the national average being 94% for this month. Following a review of the data when looking at the percentage of harm associated with new harms no area flags as red and the divisional percentage increases to 97.25% against a target of 95%. The division will be working with the clinical audit team to review new harms reported to establish if there are any themes in these area.
- The response rate for FFT has improved month on month for the last 3 months with Gordon Smith now being the only area flagging this month. This is new for this area and has been addressed with the ward team due to sickness in the admin team who supported this data capture.
- The division remains below the trust target for sickness and matrons and ward managers meet weekly to review the sickness position to ensure management plans are in place.
- Allingham and Richmond ward our outliers this month with falls. These have been low and no harm falls and the Ward sister and Matrons have been asked to produce and action plan to improve this.
- The division remains concerned about the number of vacancies in particular Caeser Hawkins, Rodney Smith, Allingham, Richmond, Amyand and Gordon Smith and the DDNG will be reviewing vacancies with the HON to move staff to ensure patient safety.

**Surgery**

- The areas where there remain continued improvements in performance are FFT satisfaction, Zero incidences of trust acquired pressure ulcers and Zero incidents of MRSA.
- Areas requiring further support are Gwynne Holford and Gray ward. The challenges on Gwynne are well documented within the QIP, but in summery relate to an offsite service with a 50% vacancy factor and poor environment to support operational working and patient safety. The indicators for Grey although not immediately evident from the scorecard relate to vacancy factor, poor leadership and a recent flurry of complaints relating to care. In addition to this, the longer term challenges around EWS compliance compounded by a recently declared SI relating to lack of escalation of a deteriorating patient. There is an action plan in place and fortnightly meetings with the DDNG to maintain oversight of progress with immediate team.
- Vacancy factor overall is increasing within neurosciences although they are safe at present. They have a number of agency staff working lines which currently provides some continuity of care, although the position is fragile. There needs to be a strategic discussion within the division about continued sub specialisation within neuro, which impacts upon dependency and requires uplifted staffing levels and training to deliver safely. The area where this impacts most significantly are Kent and Brodie where there is a proposal to set up 10 spinal rehab beds at the end of the Neurosurgical ward. The ward establishment cannot support this currently, there will be substantial training requirements as well as the potential to impact upon retention.
- There are 28 red alerts for September 2016 compared to 14 for the previous reporting period and an increase in overall alerts from 18 to 30. However it should be noted that last month's scorecard did not include sickness absence rates and ward staffing unfilled hours.
- Falls for the surgical and neuro directorate have again triggered red indicators when they fall within set target parameters, therefore of the 12 red indicators flagged for falls in September's scorecard, all 12 are incorrect as they are within acceptable limits.
- There is also one red indicator for an SI on Keate ward, this is incorrect and no SI has been declared for the month of September 2016.
- Therefore the correct number of red alerts for September 2016 for the STNC division should have been 15, instead of 28.

# 13. Nursing and Midwifery Heatmap Community – September 2016

St George's University Hospitals NHS
NHS Foundation Trust

| Domain | Indicator | Frequency | 2015/2016 Target | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | July 16 | Aug 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Quarter 2 2015/16 | | | Quarter 3 2015/16 | | | Quarter 4 2015/16 | | | Quarter 1 2016/17 | | | | |
| Patient Safety | SI's REPORTED | Monthly | | 0 | 1 | 4 | 1 | 3 | 1 | 1 | 0 | 0 | 0 | 1 (DIC) | 0 | 0 | 0 |
| Patient Safety | Number of SI's breached | Monthly | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Safety | Grade 3 & 4 Pressure Ulcers | Monthly | 0 | 0 | 1 | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Safety | Grade 4 Pressure Ulcers | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Safety | Number of Fall of No Harm and Low Severity | Monthly | 0 | 12 | 8 | 13 | 10 | 11 | 13 | 10 | 13 | 18 | 6 | 19 | 19 | 11 | 16 |
| Patient Safety | Number of moderate falls | Monthly | 0 | 1 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Patient Safety | Number of major falls | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Safety | Number of falls resulting in death | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Safety | MRSA (cumulative) | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Safety | CDiff (cumulative) | Monthly | 31 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Safety | CAS ALERTS - Number ongoing-received (Trust) | Monthly | 0 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Patient Safety | Number of Quality Alerts | Monthly | | 9 | 11 | 4 | 6 | 7 | 4 | 7 | 5 | 5 | 3 | 3 | 4 | 1 | 1 |
| Safeguarding | % of staff compliant with safeguarding adults training | Monthly | 85% | 84% | 81% | 81% | 77% | 74% | 70.0% | 70.0% | 68.0% | 79% | 82.0% | 84.0% | 85% | 88% | 88% |
| Safeguarding | % of staff compliant with safeguarding children's training | Monthly | Level 1 85% | 82% | 79% | 88% | 89% | 86% | 85% | 89% | 79% | 79% | 80.0% | 81.0% | 80% | 82% | 85% |
| | | | Level 2 85% | 82% | 74% | 66% | 67% | 63% | 83% | 80% | 85% | 92% | 66.0% | 73.0% | 79% | 79% | 75% |
| | | | Level 3 85% | 90.00% | 70% | 85% | 87% | 84% | 84% | 84% | 80% | 80% | 82.0% | 82.0% | 82% | 87% | 87% |
| Patient Outcomes | Mortality SHMI ratio (Trus) | Monthly | <100 | 0.86 | 0.86 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9 | 0.9% | |
| Patient Experience | Active Claims | Monthly | | 3 | 1 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | Not yet available |
| Patient Experience | Number of Complaints received | Monthly | | 5 | 2 | 5 | 5 | 5 | 5 | 4 | 6 | 7 | 1 | 2 | 5 | 6 | 12 |
| Patient Experience | Number of Complaints responded to within 25 days ( reporting 1 month in arrears) | Monthly | 85% | 100% | 100% | 85% | 100% | 100% | 89% | 100.0% | 50% (3) | 71% | 75% | 100% | 100% | 83% | Not yet available |
| Patient Experience | Number of Complaints responded to within 25 days with an agreed extension | Monthly | 95% | 100% | 100% | 92% | 100% | | 78% | 100% | 67% (1) | 50% | 100% | | | 100% | Not yet available |
| Patient Experience | FFT Score | Monthly Mary Seacole A | | 71.0% | 97.3% | 84.2% | 94.4% | 94.4% | 100% | 90% | 95% | 95% | 90.0% | 85.7% | 87.0% | 75% | 100% (9) |
| | | Monthly Mary Seacole B | | 95.40% | 90.90% | 75% | 90% | 94% | | 85% | | | | | | 90% | 100% (7) |
| Patient Outcomes | Catheter related UTI (Trust) | | | 1.32 | 1.50 | 1.03 | 0.67 | 0.96 | 0.47 | 0.46 | 0.90 | 0.90 | 0.65 | 1.22 | 0.63 | 0.52 | 0.97 |
| | Number of new VTE (Trust) | | National 0.005 | 0.08 | 0.24 | 0.17 | 0.30 | 0.48 | 1.01 | 0.00 | 0.23 | 0.08 | 0.33 | 0.08 | 0.63 | 0 | 0.27 |
| Workforce | Number of DBS Request Made | Quarterly | annually | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 206 | 206 in 2015 | | | N/A | N/A |
| Workforce | Sickness Rate - | Monthly | 3.50% | 4.69% | 5.75% | 5.53% | 5.90% | 5.71% | 6.00% | 6.50% | 6.19% | 4.70% | 4.72% Mar16 | 5.67% | 4.89% | 4.5% | 4.51% |
| Workforce | Turnover Rate- | Monthly | 13% | 20.08% | 21.00% | 21.15% | 20.75% | 20.76% | 21.20% | 20.80% | 21.59% | 20.50% | 20.54% Mar16 | 20.3% | 18.74% | 22.1 | 21.1% |
| Workforce | Vacancy Rate- | Monthly | 11% | 12.60% | 13.42% | 12.59% | 15.67% | 18.50% | 19.40% | 18.90% | 18.70% | 19.40% | 19.43% Mar16 | 20.81% Apr 16 | 20.81% | 25.5 | 25.37% |
| Workforce | Appraisal Rates - Medical | Monthly | 85% | 69.57% | 84.00% | 84.00% | 79.41% | 81.26% | 87.10% | 87.10% | 83.87% | 88.90% | 88.89% Mar16 | 92.59% Apr 16 | 79.17% | 70% | 65.22% |
| Workforce | Appraisal Rates - Non-Medical | Monthly | 85% | 75.42% | 76.02% | 68.22% | 64.91% | 62.92% | 62.40% | 63.20% | 63.53% | 63.20% | 63.25% Mar16 | 64.48% Apr 16 | 77.81% | 77% | 76.3% |

# CSD scorecard exception report (August 2016)



- 0 x serious incidents
- Falls : 16 : 5 Mary Seacole Ward (MSW) A / 3 Mary Seacole Ward (MSW B/ 5 patient homes , all low or no harm. Of the 5 in MSWA- this involved the same patient for 3 incidents when the patients NOK mobilised the patient without asking staff for support. Message to Next of Kin that they should ask for support from staff for mobilisation.
- Complaints: All in July closed within 25 w days or extension period.
- Complaints: 12 in August of which 11 are from Offender Health Care.
- Friends Family Test: Both MSW A & B were scored at 100%
- Quality Alerts (MAD: make a difference): 1 in August Community Adult Health Service re: staffing and patient medication changes (closed). Action: follow up with GP to confirm prescription.
- Level 3 child safeguarding (manual count) 123 eligible staff - 110 staff have completed training as per MAST data but this has excluded 10 staff who have completed training but has not been “picked up” on MAST data; therefore: 120 staff have completed mandatory level 3 – equating to 98% and not 89% as per MAST data
- Workforce: Recruitment nurse now started. Priority areas; Community nursing, offender healthcare
- Safe staffing alerts; Reduced. Sit rep daily enables staffing and patient care delivery to be match and optimised.
- Medical appraisal rates: a plan is in place to improve compliance

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO THE TRUST BOARD** *November 2016*

| | |
|---|---|
| **Paper Title:** | Workforce report |
| **Sponsoring Director:** | Karen Charman, Director of Workforce and Organisational Development |
| **Author:** | Rebecca Hurrell, Head of Workforce Information<br>Jacqueline McCullough, Deputy Director of HR |
| **Purpose:** | *To provide a report to the board on performance against key performance indicators* |
| **Action required by the board:** | For information |
| **Document previously considered by:** | Executive Management Team Meeting |

**Executive summary**
*Key points in the report and recommendation to the board*

**1. Key messages**

The workforce report includes:

- The approved re-designed workforce performance report for September 2016

The redesign workforce performance report contains detail of workforce performance against key workforce performance indicators for August 2016. The larger detailed report including benchmarking where available is stilled available to the bi-monthly Workforce and Education Committee

Key points to note are:

- Vacancy rates have fallen by 0.85%
- Sickness absence has risen whilst still below same time last year
- Stability continues to increase
- Bank and Agency spend continues to remain high despite increase staff in post.
- Headcount reductions are starting to take effect however further corporate measures are required to control pay spend.

**Key risks identified:**
*Key workforce risks include:*

- Failure to recruit and retain sufficient staff in relation to annual turnover rates and to safely support future increases in capacity'
- Failure to reduce the unacceptable levels of bullying and harassment reported by staff in the annual staff survey.
- Possible reductions in the overall number of junior doctors available with a possible impact on particular speciality areas.
- Failure to maintain required levels of attendance at core mandatory and statutory training (MAST)

| | |
|---|---|
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | **To develop a highly skilled and engaged workforce championing our values that is able to deliver the trust's vision.** |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | **Are services well led?** |

Commentary on performance in key workforce indicators

Workforce Stability

Vacancy rates have decreased by a further 0.85% with Turnover remaining the same. Whilst both indicators are still above the Trust target we now have two months since we have reversed a previous one year increase on Turnover.

Workforce stability, the percentage of staff who stay more than 12 months, has seen its second. increase after a steady decline of almost 12 months. A small increase this month to 84.08% means that we have now achieved the stability rate of Teaching Hospitals in London (84%).

Temporary Staffing Costs

Temporary staffing costs have fallen by 1.3% as a percentage of WTE however the spend has continued to increase which is reflective of the mix in agency bookings with Nursing spend decreasing and Medical and Dental increasing.

The Trust will breach its Agency cap spend limits for the year during October 2016 and must implement internal controls and limits to return to monthly targets. As part of this the Trust must review all agency usage over 6 months together with a plan to reduce or remove and the same exercise must be completed on high cost agencies.

These plans have been submitted to NHS Improvement and their impact will be added to the Recovery plan forecast.

Staff Training and Support

MAST has increased to 80% returning to levels achieved in June and July. However we are taking action to ensure we are appropriately requesting higher levels Resuscitation and Safeguarding training across the Trust and that subsequently we have sufficient and appropriate levels of training available. Whilst we prepare a longer term solution, short term manual changes and audits will be undertaken to ensure central recording and departmental expectations remain the same and appropriate to patient need. The Board should be assured that currently we believe too high a level of training participation is requested and so we are over training some of our staff however this does limit places on courses for others that need to attend.

Spotlight on Agency

It is essential this month that the Board is aware of the areas of high agency spend both in terms of percentage of total pay and overall spend. Whilst smaller, specialist areas both clinical and non clinical related to turnaround can skew the figures, larger services relying heavily on agency can be regarded as fragile and the Executive Team will be considering alternatives for these services during the rest of the year.

Karen Charman
Director of Workforce and OD
October 2016

excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

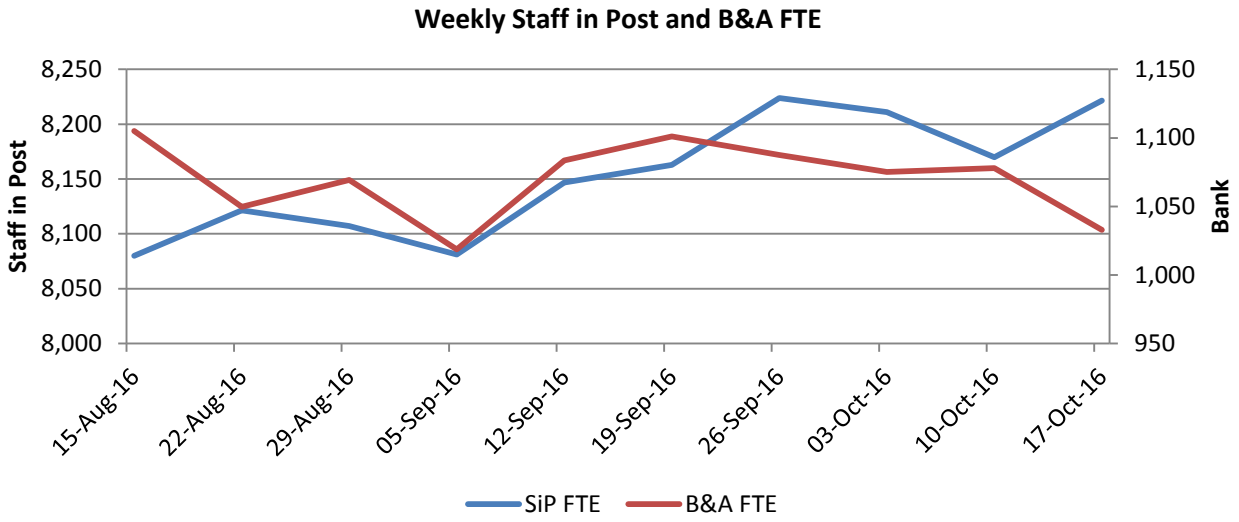
# Workforce Performance Report
to the Trust Board

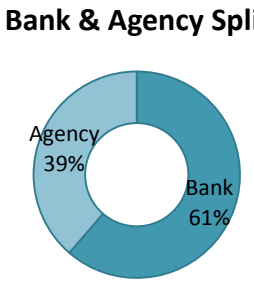
**Month 6 – September 2016**

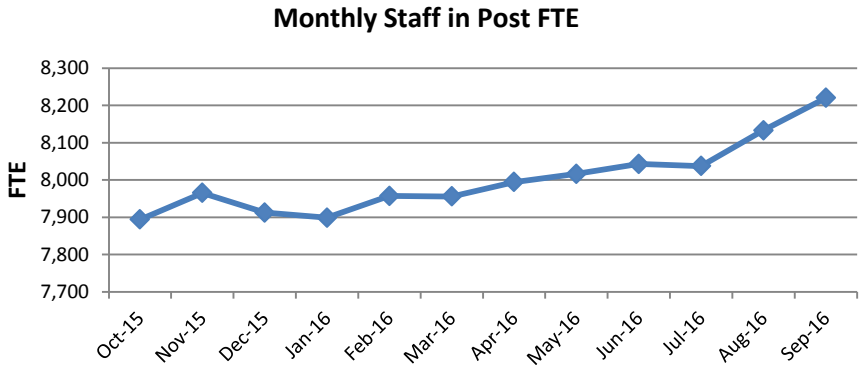

***Excellence in specialist and community healthcare***

# Section 1: Current Staffing Profile and Bank & Agency

The data below displays the current staffing profile of the Trust and key bank & agency data




**COMMENTARY**

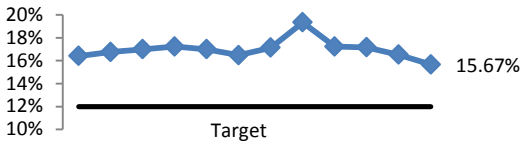
The Trust currently employs 8774 people working a whole time equivalent of 8220 which is 87 FTE higher than August. The growth rate in the directly employed workforce since April 2016 is 2.83%.

This includes 388 FTE from SWL Pathology. Their growth rate since April 2016 is 13.06%.

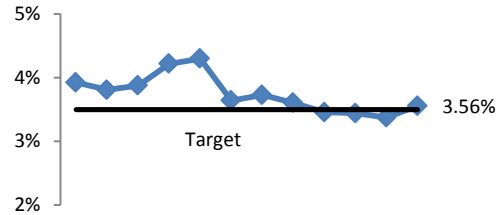
The Trust also employs an additional 486 FTE GP Trainees covering the South London area, which makes the total FTE 8706.

# Section 2: Workforce KPI's

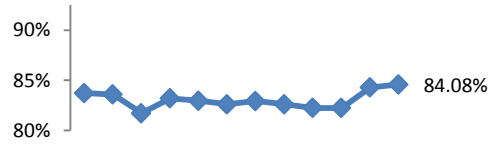
**Vacancy Rate Year Trend**



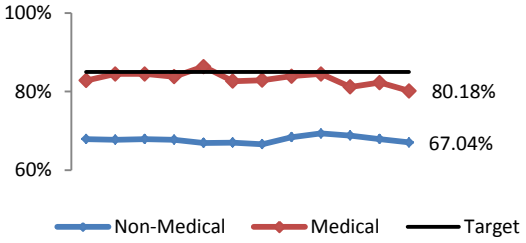

**Sickness Rate Year Trend**



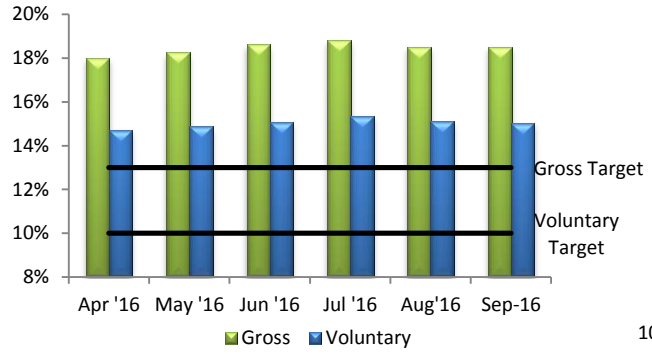

**Stability Rate Year Trend**




**Appraisal Rate Year Trend**



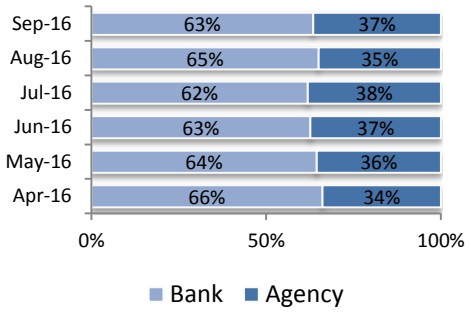

**Turnover YTD**



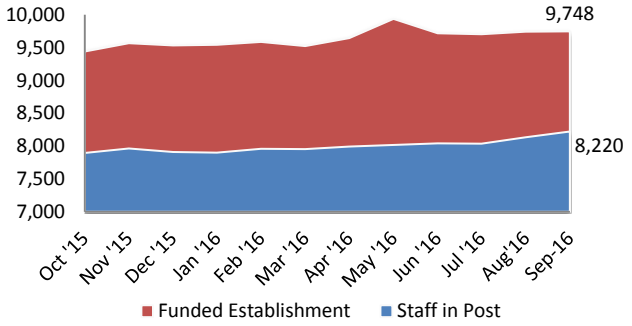

**Key points:**

- Vacancy has fallen by 0.85%
- Sickness has increased by 0.18%
- Turnover has remained the same
- Voluntary turnover has decreased by 0.07%

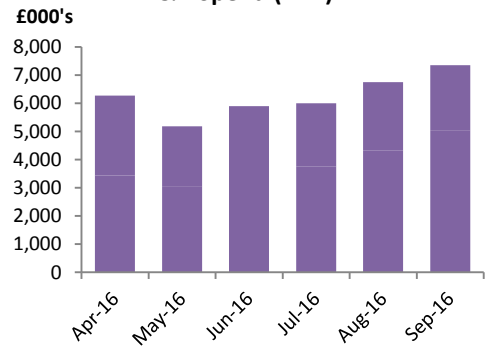
**Bank/Agency Mix**



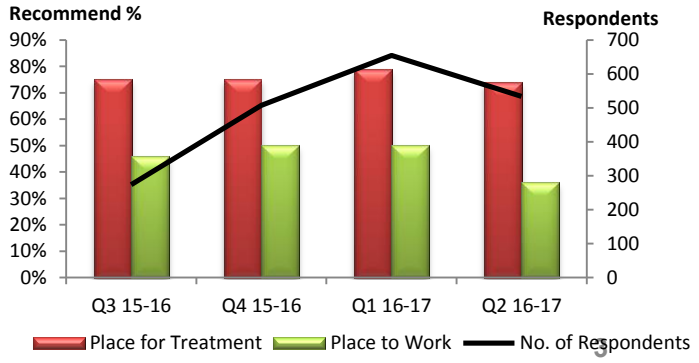

**Trust Establishment & Fill Rate**



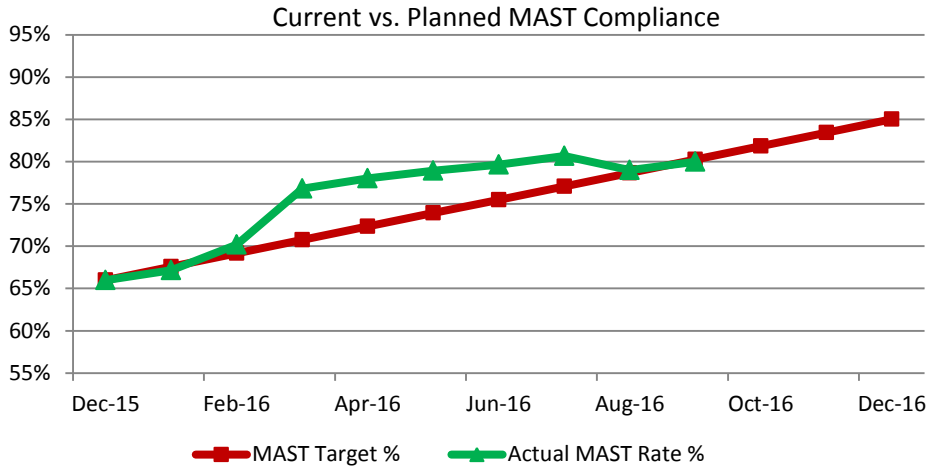

**B&A Spend (YTD)**




**Friends & Family Test**



# Section 3: MAST Compliance



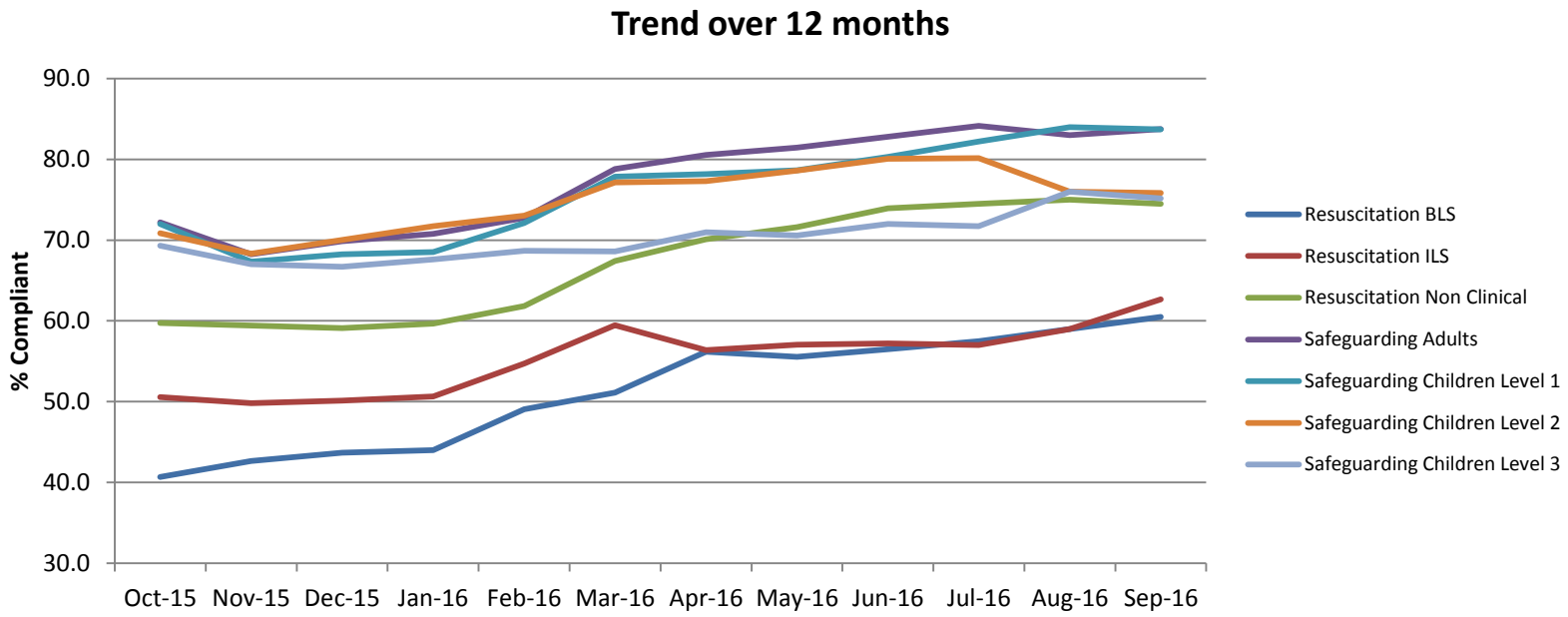

**COMMENTARY**

A programme of working is taking place including:

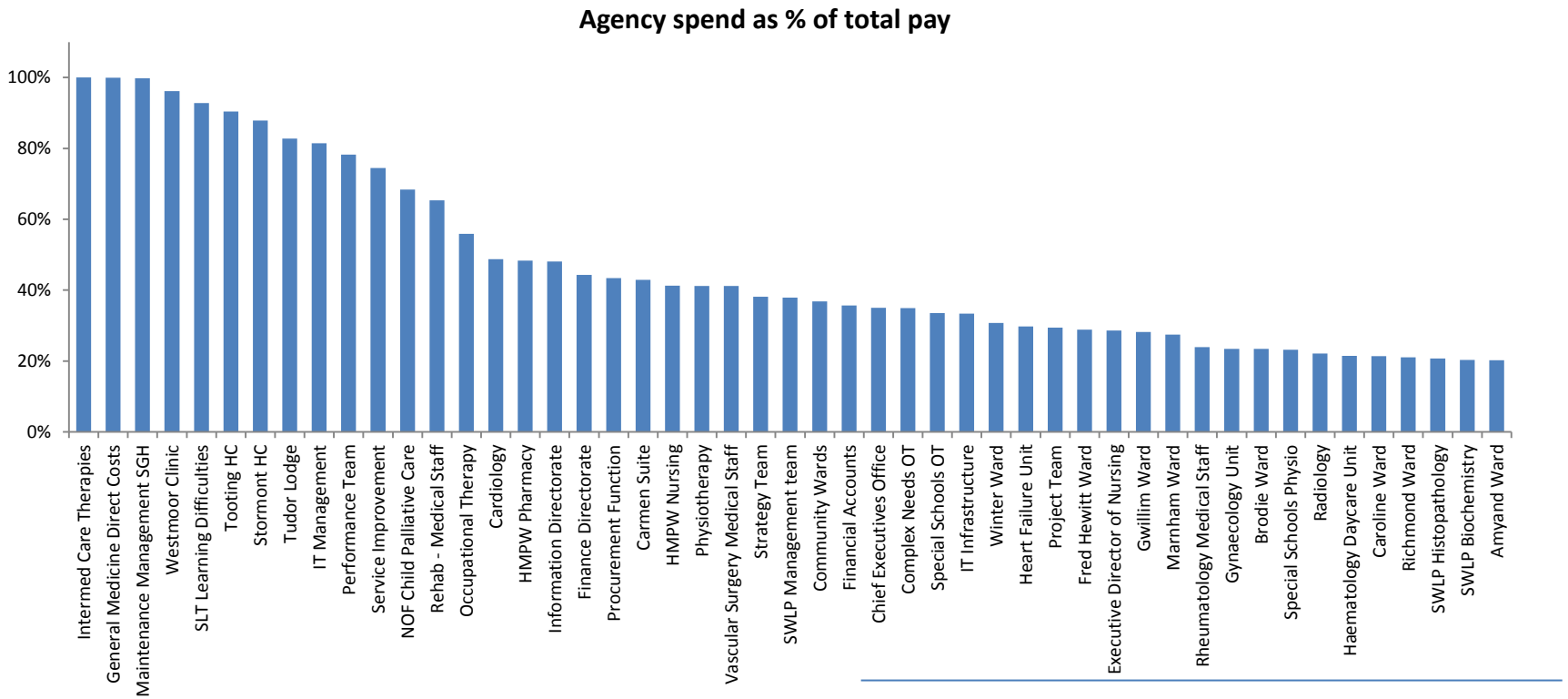
- Changing the method of delivery to on-line testing as far as possible and only training when required
- Reviewing who needs to access the training
- Reviewing the frequency of refresher periods
- Reporting compliance futures for departments so that they are proactive with compliance
- System changes so that accessibility issues are resolved.

Current Issues:

- Fall in compliance rates – largely due to staffing pressures
- Staff unable to access training externally- Software and licencing and IG issue
- Process review between Recruitment/Payroll/Education Department for new starters
- Not enough capacity to provide the training for the needs identified, particularly in resuscitation and safeguarding.



# Section 4: Spotlight on Agency Spend




**Commentary:**
It is essential The Trust Board is informed of areas of the Trust relying on high % of agency cover and also those with the highest spend.

The highest % are reflective of small specialised clinical departments and those with focus on estates and IT turn around. There are 17 ward and clinical areas with agency spend running between 20 and 30% of pay with others such as HMPW running in excess of 40%.

Plans and actions to reduce this spend will be reviewed and revised at the monthly Executive Agency committee

# 5: Interim spend

| Function | Number of interims |
|---|---|
| CEO | 7 |
| IT | 41 |
| Estates | 6 |
| Nursing | 1 |
| Finance | 8 |
| Operations | 7 |
| Transformation (Turnaround) | 19 |
| CQC (Turnaround budget) | 7 |
| Unknown | 1 |
| SWLP | 7 |
| Total # interims | **104** |
| Whole time equivalent | 100 |

**COMMENTARY**

During the month of October, the services of 104 interims were secured equating to 100 WTE.

- This represents 0.1% of the total workforce.

Interim services are secured to provide experience in specialised areas and additional capacity at short notice.

- Of the 104 interims, 37 are covering substantive roles predominantly in the IT function to support the significant challenges of the function
- 67 interims are supporting the delivery of major programmes or projects, specifically in relation to Turnaround: transformation, CQC, IT and Estates

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO THE TRUST BOARD** *November 2016*

| | |
|---|---|
| **Paper Title:** | **Referral to Treatment ( RTT) Access Policy** |
| **Sponsoring Director:** | **Mark Gordon : Chief Operating Officer** |
| **Author:** | Traci Dean - Head of Elective Access<br>Karen Brown – Planned Care Recovery Lead |
| **Purpose:**<br>*The purpose of bringing the report to the board* | *Update of the Trust current Access Policy: revised to incorporate revised national guidance.* |
| **Action required by the board:** | **For decision** |
| **Document previously considered by:** | • National Intensive Support Team for Elective Care<br>• South East CSU :Wandsworth and Merton CCGs<br>• Divisional Management Teams, Operational Managers, Administrative Staff<br>• Executive Management Team 24.10.16 |

**Executive summary**

**1. Key messages**

- This is a revision of the Trust current Access Policy to incorporate the revised national guidance for RTT and is a key component of the Trust RTT recovery programme.
- The policy provides a set of standards for the management of referrals, waiting lists and appointments and admissions to ensure that the Trust maintains clinical priorities and meets statutory responsibilities with regard to the 18 Week Referral to Treatment maximum waiting time for elective patient pathways.
- The principles outlined in this policy support the Trust to deliver the national objectives to reduce waiting times for Outpatient, Diagnostic and Inpatient treatments and improve patient choice.
- The Board considered a draft RTT policy in April 2016 and asked for a final version to be returned to the Board for approval.

**2. Recommendation**

Trust Board are asked to approve the revised policy.

| | |
|---|---|
| **Key risks identified:** | |
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | • **Excellent**<br>• **Responsible**<br>• **Respectful** |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | • **Safe**<br>• **Effective**<br>• **Responsible**<br>• **Care** |

**Equality Impact Assessment (EIA): Has an EIA been carried out? ( No )**
**If yes, please provide a summary of the key findings**

**If no, please explain you reasons for not undertaking an EIA.**

**Appendix A:**

## 1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

| Service/Function/Policy | Directorate / Department | Assessor(s) | New or Existing Service or Policy? | Date of Assessment |
|---|---|---|---|---|
| Referral to Treatment Access Policy | Surgery<br><br>Finance | Wilfred Carneiro<br>Traci Dean<br><br>To be agreed | Update from 2005<br><br>Update from 2011 | 04/11/2010<br><br>To be agreed |

**1.1 Who is responsible for this service / function / policy?**
Chief Operating Officer

**1.2 Describe the purpose of the service / function / policy?** Who is it intended to benefit? What are the intended outcomes?
The purpose of this document is to ensure that patients requiring access to outpatient appointments, diagnostic tests and elective inpatient or day case treatment are managed consistently, according to national frameworks and definitions.

**1.3 Are there any associated objectives?** E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives
Compliance with standards specified within the NHS Operating Framework, and NHS Constitution. To be the provider of choice.

**1.4 What factors contribute or detract from achieving intended outcomes?**
Dissemination and implementation of policy consistently across the organisation; staff training programme; compliance with referral criteria; review of patient appointment and admission letters to ensure that patients clearly understand processes and their responsibilities.

**1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights?**
Details: [see Screening Assessment Guidance]
Positive impact in terms of Human Rights to access healthcare in line with current legislation.

**1.6 If yes, please describe current or planned activities to address the impact.**
Not applicable

**1.7 Is there any scope for new measures which would promote equality?**
Ensuring that patients understand how to access support such as PALS and interpreting services should they require them

**1.8 What are your monitoring arrangements for this policy/service?** Monthly performance reviews at Trust Board, Divisional Management Board and Directorate meetings. Monthly RTT performance and returns made to the DH and commissioners. Monitoring and validation of weekly PTLs by operational managers and administrative staff. Training logs to be kept at departmental level of attendance at RTT and Cerner system sessions, to be reviewed by lead managers.

St George's University Hospitals NHS
NHS Foundation Trust

# Referral to Treatment Access Policy

*The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This Referral to Treatment Access Policy has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it, regardless of their individual differences, and the results are shown in Appendix 1.*

| **Policy Profile** | | | |
|---|---|---|---|
| **Policy Reference:** | *Provided by the Corporate office* | | |
| **Version:** | Version 1.4 | | |
| **Author:** | Traci Dean - Head of Elective Access<br>Karen Brown – Planned Care Recovery Lead | | |
| **Executive sponsor:** | Mark Gordon - Chief Operating Officer | | |
| **Target audience:** | All staff involved in the management of referrals, appointments, waiting lists and admissions | | |
| **Date issued:** | *Date published - completed by Corporate office* | | |
| **Review date:** | *One year from date of issue or earlier if changes in guidance or practice are published* | | |
| **Consultation** | | | |
| **Key individuals and committees consulted during drafting** | Intensive Support Team for Elective Care | **Dates** | March 2016<br>May 2016<br>September 2016 |
| | Divisional Management Teams, Operational Managers, Administrative Staff | **Dates** | March 2016<br>May 2016 |
| | South East CSU :Wandsworth and Merton CCGs | **Dates** | March 2016<br>May 2016 |
| **Approval** | | | |
| **Approval Committee:** | Board | | |
| **Date:** | | | |

| **Document History** | | | |
|---|---|---|---|
| **V1** | **December 2011** | **December 2012** | |
| V1.1 | **December 2015** | | Updated to reflect current RTT guidance |
| V1.2 | **May 2016** | | Updated to reflect national RTT Policy |
| V1.3 | **September 2016** | | Revision of May 2016 |
| V1.4 | **October 2016** | | DNA process to align with national contract |

## Contents

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## Executive Summary

St George's University Hospitals NHS Foundation Trust has a reputation for providing excellent clinical care to local South West London residents as well as the wider national population. This policy describes how the Trust will ensure that access to its clinical services is equitable and fair to all patients in accordance with clinical need.

This policy provides a set of standards for the management of referrals, waiting lists and appointments and admissions to ensure that the Trust maintains clinical priorities and meets statutory responsibilities with regard to the 18 Week Referral to Treatment maximum waiting time for elective patient pathways.

The principles outlined in this policy support the Trust in achieving the national objectives to reduce waiting times for Outpatient, Diagnostic and Inpatient treatments and improve patient choice.

**Access Principles**

- Patients should only be added to the waiting list if there is a real expectation that they will be treated, i.e. they should be willing, able and fit to undergo the planned procedure
- Patients will be treated in order of their clinical need and priority will be given to clinically urgent patients
- Where patients have the same or comparable need they will be treated in chronological order, thereby minimising the time spent on the waiting list and improving the quality of patient experience
- All referral, appointment and waiting time activity must be recorded accurately on the relevant Trust databases (Cerner, Solitan, EPR, E-Triage, etc.)
- Where possible patients will be able to choose/negotiate their appointment or admission date
- The Trust will work to ensure fair and equal access to services for all patients.

All staff involved in the management of referrals, appointments, and waiting lists across all patient-accessible clinical services should demonstrate a sound knowledge of the principles of this policy and full compliance with the accompanying protocols.

This policy was written in consultation with the St George's University Hospitals NHS Foundation Trust RTT Compliance Group, Operational Managers, the Wandsworth Clinical Commissioning Group and NHS Improvement (IMAS).

## 1 Introduction

The length of time a patient needs to wait for hospital treatment is an important quality measure and a visible indicator of the efficiency of clinical services provided by the Trust. This policy describes how St George's University Hospitals NHS Foundation Trust will manage access to its elective services ensuring compliance with the 18 Week waiting time standard and fair, clinically appropriate treatment for all patients.

The arrangements provide clear guidance to all staff involved in the management of patient pathways and specifically the application of 18 Week Referral to Treatment principles. It is vital that these principles are applied for the Trust to achieve the national objectives to reduce waiting times and improve patient choice.

## 2 Purpose

The purpose of this document is to ensure that patients requiring access to outpatient appointments, diagnostic tests and elective inpatient or day case treatment are managed consistently, according to national frameworks and definitions while maintaining the overriding importance of customer care. It is the responsibility of all staff to ensure that internal processes work to support patients in receiving a fair and efficient service.

Every process in the management of patients who are waiting for treatment must be clear and transparent to patients and to partner organisations and must be open to inspection, monitoring and audit. Having in place up to date policies and procedures, robust data collection systems and appropriate continuous staff training is essential to the accuracy of referral and waiting list management and for monitoring key access targets, both internally and externally to commissioners.

The policy will provide a systematic approach to the management of referrals, appointments/admissions and waiting lists within the organisation, from receipt of referral to discharge of care. Assurance will be provided that appointments and admission processes are being managed effectively and equitably through monitoring compliance and regular review, as outlined within the policy.

The policy is intended to:

- ensure that patients receive treatment according to their clinical priority, with urgent cases seen first and routine patients thereafter all treated in chronological order.
- support the continued reduction in waiting times and cancelled operations and the achievement of key access targets by establishing a number of good practice guidelines to assist staff with the effective management of patients requiring outpatient, diagnostic, inpatient and day case treatment.
- ensure that the rules governing the management of 18 Week Referral to Treatment pathways are followed
- provide a practical and easy to follow guide for administrative staff responsible for managing waiting lists. The policy cannot specify all eventualities but aims to give a framework to work within. A common sense approach that maintains the best interest of the patient should be applied to cases that fall outside the policy and advice should be sought from the relevant manager where further clarification is required.

## 3. Scope

This document defines the policy to be followed by all staff at St George's University Hospitals NHS Foundation Trust involved in the management of elective pathways. It defines roles and responsibilities and sets out the parameters for booking and scheduling

and establishes a number of good practice guidelines. The policy determines the framework for managing referral to treatment pathways within 18 weeks and defines the application of 18 week principles of clock starts, stops, pauses and active monitoring.

The policy applies to all elective inpatient, day case and outpatient pathways, including diagnostic and therapy appointments and will be implemented consistently and fairly across the Trust. The Trust will work towards shorter waiting times and improved care pathways for all patients, including those referrals/pathways not subject to performance monitoring.

## 4. Roles and Responsibilities

Whilst responsibility for achieving targets lies with the Clinical Management Board and the Trust Board, it is the responsibility of all members of staff to understand the 18 Week principles and definitions. These must be applied to all aspects of referral and waiting list management and individual pathways.

### 4.1 The Chief Executive

The Trust Board, through the Chief Executive has a corporate responsibility to ensure equitable access to the Trust's clinical services and the management of patients in accordance with the principles described in this policy. The Chief Executive delegates the operational management of the Trust to the Chief Operating Officer.

### 4.2 The Chief Operating Officer

The Chief Operating Officer is responsible for the development, ratification, and implementation and monitoring of this policy through the divisional management structure. The Chief Operating Officer will ensure that this policy is updated in response to changes in national guidance and local arrangements with commissioners.

### 4.3 Divisional Directors Of Operations, Divisional Chairs and Clinical Directors

The Divisional Directors of Operations and Clinical Directors have delegated responsibility for the operational management of clinical services and access to these services.

- The Divisional Directors of Operations and Clinical Directors for each Directorate/Specialty have the responsibility for implementing and ensuring adherence to this policy within their areas.

### 4.4 Hospital Clinicians

- decide which patients require addition to a waiting list and their clinical priority
- ensure that patients added to a waiting list are willing, able and fit to undergo their treatment
- are responsible for the care of all patients on their lists, ensuring that priority is given to clinically urgent patients and thereafter routine cases are seen in strict chronological order within the timescales set out in this policy
- review their waiting list on at least a monthly basis
- ensure that all clinical decisions impacting the patient's pathway are recorded properly and timely communications to other parties involved in the patient's care
- ensure that referrals are reviewed and returned to the Central Booking Service for action within two working days for non-cancer referrals and 24 hours for urgent referrals such as suspected cancers

### 4.5 General/Service Managers

Managers within the Trust are responsible for ensuring that the policy and supporting standards and guidelines are built into local processes and that there is on-going compliance. In support of this they will:

- proactively plan and manage demand, capacity and activity and any backlog to ensure that all patients receive treatment according to clinical priority and within nationally and locally agreed targets
- monitor that all staff in their departments adhere to the Referral to Treatment Access Policy and associated procedures and provide on-going training and compliance assessment with additional training and support for staff who fail to work to the necessary standard
- provide clinicians with details of patients on their waiting list to enable them to clinically manage their patients
- support clinicians understanding and use of RTT coding and clinic outcome forms, advising of any revisions to guidance and implementing change where appropriate

### 4.6 Administrative Teams

Administrative staff are responsible for ensuring that correct administrative processes are followed in accordance with this policy to:

- enable patients to have the maximum opportunity to attend their consultations and admissions in the required time
- ensure that data recorded on the Trust's systems is accurate and timely and that any corrections are made promptly
- escalate to their managers any issues affecting compliance with this policy.

### 4.7 Head of Elective Access

The Head of Elective Access has responsibility for monitoring access arrangements and ensuring compliance with the Trust's Referral to Treatment Access Policy by:

- ensuring a co-ordinated approach to referral, appointment and waiting list management across the Trust
- supporting the Divisional Directors of Operations and Chief Operating Officer in identifying best practice and defining and implementing Trust policy
- working closely with staff across the organisation to ensure that the Referral to Treatment Access Policy guidance and standards are understood and adhered to

### 4.8 General Practitioners (GPs)

GPs are responsible for ensuring that only those patients who are eligible for NHS treatment and who are available to be seen within the timescales stipulated in the policy are referred to the Trust.

### 4.9 Patients

- have a responsibility to make themselves available for treatment within the timescales set out in this document, unless exceptional circumstances or complex clinical issues preclude this.
- must understand the implications of cancelling or failing to attend their agreed consultation or treatment.

### 4.10 Escalation Procedures

If patients are identified as being at risk of becoming a long waiter and no suitable capacity can be found, the problem will be escalated for action.

**Level A: Service Manager**

The Divisional Service Managers are responsible for creating additional capacity as required to ensure that patients are given suitable appointments within the 18 week standard.

If Service Managers are unable to find solutions to capacity problems then on Day 8 this will be escalated to Level B status.

**Level B: General Manager**

The General Manager has 48 hours to resolve the issue. If the issue remains unresolved at this time then the problem is escalated to Level C.

**Level C: Divisional Management Team**

Responsibility for ensuring sufficient clinical capacity is in place for delivery of a successful 18 weeks pathway lies with the Divisional Director of Operations and the Clinical Director. The Divisional Management Team will make the ultimate decision relating to capacity shortfalls which include any that impact upon the Trust's ability to uphold the NHS Constitution.

## 5 18 Week Referral to Treatment Standard

### 5.1 18 Week Referral to Treatment Performance Target

The 18 Week Referral to Treatment (RTT) performance target is concerned with improving patients' experience of the NHS by providing high quality elective care without unnecessary delay. Nationally from December 2008 no patient will wait longer than 18 weeks from GP referral to hospital treatment (NHS Improvement Plan 2004). A small tolerance level is set for those patients who wish to wait longer than 18 weeks or who have complex co-morbidities which preclude them from being treated within the standard. The 18 week pathway does not allow for delays in patient care due to administrative processes or capacity constraints.

It does not replace existing shorter waiting time guarantees such as referral for suspected cancer. The management and reporting of cancer and suspected cancer pathways is separate but runs concurrently with 18 week RTT performance monitoring If a suspected cancer patient subsequently proves to be benign, the cancer pathway ends but the 18 week pathway continues until treatment or discharge.

### 5.2 National Waiting Times Standards

The following national access targets (or operational standards) apply to all patients on an RTT pathway referred to consultant-led services:

- **Incomplete Pathways**: **92%** of all patients waiting to start treatment should have been waiting less than 18 weeks (126 days) from referral. These are also known as `waiting list' waiting times.
- **Diagnostics**: No patient will wait longer than **six weeks** for a diagnostic test or image

- **Audiology Direct Access: 95%** of patients referred to a direct access audiology service (not led by a medical or surgical consultant) should be treated within 18 weeks. Audiology Direct Access waiting times are subject to RTT rules but monitored under separate provision
-

NB. Patients waiting or treated on the 126th day of their 18 week pathway are within the national standard.

### 5.3 18 Week Performance Standards for 2016/17

As set out in the **NHS Standard Contract 2016/17**, providers are expected to achieve all of the Operational Standards and National Quality Requirements. The consequences for failure to achieve these standards are set nationally.

### 5.4 Trust Access Targets

Patients are entitled to receive their first definitive treatment within 18 weeks of referral if it is clinically appropriate to do so.

Individual specialties may operate a degree of flexibility when setting internal targets for first attendance and admission, subject to availability of capacity and pathway requirements, however the combined waiting time, including any diagnostic tests, should not exceed the 18 week maximum target unless it is necessary on clinical grounds.

Separate arrangements apply for urgent referrals and these will be offered a first attendance within four weeks of the referral being received. Urgent referrals for suspected cancer will be seen within 14 days of referral.

### 5.5 18 Week Referral to Treatment Terminology and Definitions

**Terminology**

| Term | Brief Description |
|---|---|
| RTT | Referral to Treatment |
| RTT Status | The stage at which the patient is at along the 18 week pathway |
| Clock Start | Waiting time starts |
| Clock Stop | Waiting time stops |
| Incomplete Pathway | On-going RTT waiting list, patients not yet treated |
| Active monitoring / watchful waiting | Clinical decision is made to monitor the patient's condition without clinical intervention or diagnostic procedures |
| First Definitive Treatment | First intervention intended to manage a patient's disease, condition or injury and avoid further intervention |
| Non-Admitted Pathway | Care provided in an outpatient setting |
| Admitted Pathway | Care provided as a day case or inpatient |

## 18 Week Status Definitions

| | | |
|---|---|---|
| **Clock Starts** | An 18-week clock starts when any care professional or service makes a referral to: | A consultant led service, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner |
| | Choose and Book | A patient converts their unique booking reference number (UBRN) |
| | Self-Referrals | An 18-week clock also starts upon a self-referral by a patient to the above services, where these pathways have been agreed locally by commissioners and providers and once the referral is ratified by a care professional |
| **Clock Starts** | Upon completion of an 18-week referral to treatment period, a new 18-week clock only starts: | When a patient becomes fit and ready for the second of a consultant-led bilateral procedure |
| | | Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan |
| | | Upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral |
| | | When a decision to treat is made following a period of active monitoring. |
| | | When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock |

| | | |
|---|---|---|
| **Clock Stops** | Clock stops when first definitive treatment is given via: | Consultant led service |
| | | Interface service |
| | | Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions |
| | | A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list. |

| | | |
|---|---|---|
| **Clock Stops** | Clock stops for 'non-treatment' when: | It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care |
| | | A clinical decision is made to start a period of active monitoring |
| | | A clinical decision is made not to treat |
| | | A patient DNA's their first appointment following the initial referral that started their 18 week clock, provided that the provider can demonstrate that the appointment was clearly communicated to the patient. |
| | | A patient DNA's any other appointment and is subsequently discharged back to the care of their GP, provided that: |
| | | i) the provider can demonstrate that the appointment was clearly communicated to the patient; |
| | | ii) discharging the patient is not contrary to their best clinical interests; |
| | | iii) discharging the patient is carried out according to local, publicly available, policies on DNA's. |

| | | |
|---|---|---|
| | | iv) These local policies are clearly defined and specifically protect the clinical interests of vulnerable patients (e.g. children) and are agreed with clinicians, commissioners, patients and other relevant stakeholders |

Patients may continue to have on-going treatment for the same chronic condition for many years. The 18 week pathway only applies to the time immediately following referral from a GP to the first definitive treatment, or from any new clock being started later in a patient's pathway for a significantly different treatment.

## 6 Key Principles

- Patients should not be referred for secondary care services unless they are ready, able and willing to commence treatment within a maximum of 18 weeks.
- All patients must be booked in order of clinical need, with urgent and suspected cancer cases taking priority, followed by routine patients scheduled by chronological waiting time.
- Offers of appointments and admission should be agreed with the patient and be reasonable. All dates offered must be within a timeframe to enable the patient to be treated within 18 weeks of referral.
- The scheduling of routine patients must be managed via 18 Week Referral to Treatment PTLs (Priority Treatment Listings) to the agreed maximum internal waiting times for each stage of the pathway along a pathway which is within 18 weeks.
- Written and verbal communications with patients should be clear and concise, outlining the possible consequences of failing to attend without prior notification, periods of patient unavailability or patient-initiated cancellations.
- Patient letters should be generated from the Trust's Cerner Patient Administration System for each event affecting a patient's waiting time to provide consistency and an audit trail of all communications sent. Copies of all patient letters should be sent to the GP or referring clinician
- All patients should receive written guidance to consult their GP if their condition worsens whilst on the waiting list. The instructions must be embedded in Cerner generated letters or other equivalent correspondence. Contact details for the relevant service must also be included. Routine long waiting patients may have their appointment or admission date expedited if there is concern that their clinical condition has changed.
- Any change in the patient's treatment status should be recorded on the Trust's information systems within 24 hours
- Patients may not be discharged and returned to the referrer due to non-attendance, cancellations or non-availability without prior agreement by the lead clinician. Urgent cases must be escalated immediately to the relevant operational manager to ensure the clinician takes the appropriate action to contact the patient to discuss the need for treatment.
- The accuracy of referral and waiting list information held on the Trust's information systems is the responsibility of all staff involved in the management and recording of pathways.

# 7 Outpatients: Non-Admitted Pathways

The guidance within the Outpatient section of this policy document is specific to the management of 18 week Referral to Treatment pathways. Detailed instructions relating to the process rules for recording referrals, administering the outpatient waiting list and booking appointments can be found in the Corporate Outpatient Service's standard operating procedures.

## 7.1 Management of Referrals

Referrals made to the Trust must be legible, follow agreed referral protocols and provide appropriate detail to register and appoint the patient. All referrals must contain sufficient clinical information (including clinically relevant imaging/diagnostic results) for the healthcare professional to make an initial decision about the patient's condition or treatment.

The Trust will make repeated attempts to request any missing information whilst progressing the booking of an appointment. Where the above criterion is not met within a maximum period of twenty one days, the Trust will escalate concerns to the referring commissioner.

### 7.1.1 GP Referrals

Referrals should only be made to the Trust if the patient is willing and able to be treated within the national standards, if this is not the case the referral should not be sent until such time as the patient is available.

The Trust supports the full utilisation of electronic referrals via the e-Referral system, ensuring its Directory of Services is up to date and the appropriate level of capacity is published to make sure that patients have choice of access to services at a convenient date and time.

The Trust is working with local Primary Care Trusts to promote the use of e-Referral however access times and administrative standards are applicable to both paper and electronic referral routes. Operational managers must ensure that e-Referral polling ranges are set to make sufficient capacity available within a waiting time appropriate to the service and consistent with an 18 week pathway.

Letters will be opened and stamped with the date of receipt. All referrals received will be registered on Cerner within 24 hours. Where referrals start a new 18 week pathway, as is the case for GP and Dental referrals, the date of receipt will constitute the clock start. The 18 week pathway for patients referred via the e-Referral service will commence from the date the Unique Booking Reference Number (UBRN) is converted into an appointment by the patient.

### 7.1.2 Tertiary Referrals

- **On-going pathway, referral for treatment at St George's**

Patients will often be referred to St George's from other secondary care providers. These types of referrals are called Tertiary referrals. Pathways that include more than one provider may have an 18 week clock that started prior to referral into the Trust. The clock start date for the existing pathway must be provided by the referring organisation. Tertiary referrals into St George's University Hospitals NHS Foundation Trust from another secondary care provider must include an agreed minimum data set for the purposes of establishing the patient's RTT status and the point along the 18 week pathway. The

prescribed format is the Inter Provider Transfer Minimum Data Set proforma (IPTMDS) and these must be forwarded to the 18 Week Team for verification and entry onto the Cerner system within one working day of receipt.

Details of the referring organisation and clinician for tertiary referrals must be entered into the "Pathway ID Issuer" and "Referring Clinician" fields on the Cerner LC1 Outpatient Referral Conversation screen to enable the correct RTT status and waiting time to be determined. Should the Pathway ID Issuer or Referring Clinician not be available from the drop down menus, the information must be recorded in the free text comments field. Capturing this detail is extremely important, particularly where an IPTMDS proforma is not supplied.

- **New pathway, referral for treatment at St George's**

Occasionally tertiary referrals to St George's are made from other providers for a new condition or a significantly different intervention, for example for surgery after outpatient treatment has not been successful. In these cases a new 18 week monitoring period starts from the date the referral is received in the Trust.

- **Referral for diagnostics or second opinion (not treatment)**

As St George's is a specialist tertiary centre many providers refer their patients for advanced diagnostics or second opinion only, with the intention that the patient will be returned to the referring organisation for treatment. Responsibility for the pathway does not transfer to the Trust and remains with the referring clinician and provider. The resulting interim phase at St George's is added to the overall waiting time by the referring provider. These patients are not included within the Trust's 18 week performance returns but are subject to the six week maximum diagnostic waiting time.

### 7.1.3 Internal Referrals (St George's consultant to St George's consultant)

Consultant to consultant referrals for patients with the same underlying condition will be included on the same 18 week pathway, with the waiting time continuing from the original referral.

Consultant to consultant referrals for a separate (different) condition will start a new Referral to Treatment pathway with a new 18 week clock. If the patient has not been treated for the original referral/condition then the waiting time for the first pathway will run concurrently until the patient is treated or discharged by the original consultant. Details of the referring clinician and originating specialty for all consultant to consultant referrals must be entered in the appropriate Cerner fields in the LC1 Outpatient Referral Conversation. This enables the 18 Week Team to link the activity pathway and validate the patient's RTT status and waiting time.

### 7.1.4 Private Patients

Private patients are excluded from 18 week referral to treatment monitoring. If a patient is found to require private treatment then the Private Patients team must be informed.

Patients may transfer from private patient status to NHS care on the receipt of a clinical referral. The 18 week clock will start on the date the referral was received and the patient may join the pathway at the appropriate point, however no advantage can be gained over patients whose complete pathways have been under NHS management.

### 7.1.5 Overseas Visitors

A patient must be registered with a GP and have been resident in this country for a minimum of 12 months to be eligible for NHS care. If a patient cannot confirm whether they have lived legally in the UK for 12 months then the Overseas Visitors team must be informed. Patients will be considered to be on an 18 week pathway until such time as eligibility is determined.

### 7.1.6 Military Veterans

From 1st January 2008, all veterans should receive priority access to NHS secondary care for any conditions which are likely to be related to their service, subject to the clinical needs of all patients (HSG(97)31). Veterans are ex-service personnel who have served at least one day in the UK armed forces and sustained injuries during that service. Priority should not be given for unrelated conditions.

GPs are required to complete the relevant documentation and state clearly in referrals that the patient is a military veteran and requires priority treatment for a condition that in their clinical opinion may be related to their military service. On receipt of such requests Trust administrative staff must highlight the status of the patient to the relevant clinician and to the service manager for appropriate recording, prioritisation and action.

### 7.1.7 Prioritisation of Referrals

Referrals will be scanned onto the electronic patient record, electronic document management and/or E-triage systems by the Central Booking Service or other referral staff within one working day of registration. It is the responsibility of individual specialties to ensure routine referrals are rejected or accepted and prioritised by consultants or their representatives within two working days, with clear directions regarding booking and scheduling. Separate arrangements apply for urgent referrals and these must be triaged and returned to the Central Booking Service within 24 hours.

## 7.2 Booking Appointments

All appointments must be booked according to the principles specified within this policy, irrespective of location or service.

### 7.2.1 Appointment Offers

The Central Booking Service and other staff responsible for arranging appointments will agree a first attendance date with the patient within the specified target, ensuring that patients are seen in the correct clinic by the correct clinician. Routine patients should be offered appointments in chronological RTT wait order to ensure equity of access.

Patients will be contacted by telephone to negotiate their appointment. If they are not contactable to agree a date then a fixed appointment will be booked and a letter sent to confirm this. Patients who are unable to attend a fixed appointment retain the option to contact the central booking service and arrange an appointment at a date that is more convenient to them.

### 7.2.2 Patient Availability

The overriding principle is that patients are able to choose to delay their treatment for any length of time. However, in some cases if a patient chooses to delay for a period of three months or more it may be necessary for the patient's consultant and GP to discuss the best clinical course of action which may include discharge.

### 7.2.3 Reasonable Offers

Reasonable offers of appointments will be offered to the patient with a minimum of three weeks' notice and two choices of dates. Patients may be offered earlier dates with less than two weeks' notice if these are the first available, however if accepted they are considered to be reasonable and are subject to the same management criteria. If the patient declines a short notice offer it will not have any adverse effect on the management of their pathway.

Patients who cancel their agreed appointment on the third occasion will, following a clinical review and subject to the consultant's agreement, be removed from the waiting list and discharged back to the care of the GP.

### 7.2.4 Recording Appointments

All offers of appointments should be recorded on the Cerner system using the agreed processes and workflows. Appointments must be linked to the appropriate referral that has already been registered on the Cerner system. Staff must not create duplicate referrals as this causes reporting errors and miscalculation of waiting times.

Corporate outpatient staff will ensure that clinic utilisation is maximised and will escalate potential capacity issues as soon as they are identified to the relevant service manager.

Patients will be sent a confirmation letter regarding their booked appointment. The letter will be clear and informative and should include a point of contact and telephone number to call with any queries and also specify arrangements for cancelling or rearranging appointments. The letter must explain clearly the consequences should the patient cancel or fail to attend the appointment at the agreed time. It must also provide guidance to contact their GP for advice or potential escalation should their condition deteriorate prior to attendance.

## 7.3. Cancelled Appointments

The 18 week referral to treatment pathway is unaffected by cancellations of appointments by either the patient or the hospital or via e-Referrals and the waiting time is not automatically reset or adjusted. Therefore it is imperative that appointment cancellations for whatever reason are managed strictly and in a timely manner.

Pathways will continue unless an appropriate RTT clock stop code denoting a decision not to treat is recorded against the cancelled appointment. Should the unavailability or actions of a patient result in discharge back to the GP or referring clinician, the 18 week pathway will end. A new RTT pathway will start if the patient is re-referred.

### 7.3.1. Appointments Cancelled by the Patient including those via e-Referral

Patients giving prior notification that they will not be attending an agreed appointment are classified as patient cancellations and cannot be recorded as a `Did Not Attend', irrespective of whether the cancellation was made on the day of the appointment and the notice minimal.

Where a patient gives prior notice of non-attendance of an agreed appointment they should be rebooked straight away or informed that they must make contact within two weeks to reschedule. The Trust will attempt to make contact with the patient by letter asking them to call and reschedule their appointment. If the patient does not book another appointment within this timeframe, a clinical review of the case by the accepting clinician will take place and they may be returned to the care of their GP or referrer. Both the

patient and GP will be notified by letter of this action. Any clinical information not yet passed to the patient or recommendations for on-going management should be included in the correspondence.

New appointments cancelled by the patient must be rescheduled and a further appointment offered within a period of eight weeks. Should the patient be unable to accept a second choice of appointment within this timeframe they may, following a clinical review and with the consultant's agreement, be removed from the appointment list and discharged back to the care of their referring GP.

If the hospital is not able to identify an appointment within eight weeks then the next available appointment will be offered and this must be escalated to the relevant Specialty Manager in line with the escalation process.

Appointments made via e-Referral that are not required must be cancelled within Cerner as well as the e-Referral system along with the associated open e-Referral request.

### 7.3.2 Appointments Cancelled by the Hospital

Hospital cancellations should be avoided wherever possible and cover arrangements put in place to minimise disruption and inconvenience to patients. Where this is unavoidable and appointments are cancelled by the hospital, patients should be rebooked at the point of cancellation as close to the original date as possible and within two weeks of the date of the cancelled appointment. It is the Trust's responsibility to make contact with the patient to rearrange the appointment.

Trust policy stipulates that a minimum of six weeks prior notice of clinic cancellations must be given by clinicians and a cancellation proforma must be completed. Clinicians are encouraged to provide as much notice as possible when requesting a clinic cancellation, as the greater the notice given the fewer patients will be inconvenienced by having a re-scheduled appointment. Authorisation must be obtained from the General Manager/Divisional Director of Operations for the relevant specialty for clinic cancellations under six weeks.

## 7.4 Patients Who Fail to Attend (Did Not Attends – DNA's)

The Trust operates a `DNA discharge' policy for routine adult new and follow-up patients. The Trust sends a text reminder message to all patients where a mobile number contact is provided at , seven days and then two days before the appointment to reduce the number of patients not attending. Patients failing to attend without giving prior notification will, subject to clinical review/approval, be discharged back to the care of the GP or referring clinician Exceptions to the DNA discharge rule must be agreed with the relevant service and include: clinically urgent cases as advised by the clinician; suspected cancers; vulnerable patients (including dementia); paediatrics; and all conditions where discharge would be clinically inappropriate.

A DNA-discharge letter will be sent to the patient and GP advising them of this decision. Any clinical information not yet passed to the patient or recommendations for on-going management should be included in the correspondence.

### 7.4.1 New Appointment DNA's

Failure to attend a first outpatient appointment will result in both the referral and the DNA being `nullified' for 18 week monitoring purposes. In practical terms, both the referral and the DNA are excluded from reporting. However should the patient be allowed to reschedule, a new RTT pathway will start afresh from the date the patient agrees a new appointment (the booking date).

### 7.4.2 Follow-up Appointment DNA's

Patients who DNA a subsequent appointment after attending for the first time will not affect their pathway waiting time. The 18 week clock continues to run until the patient receives their first definitive treatment or a decision is made to discharge the episode.

### 7.4.3. Safeguarding Children – Non-Attendance

A child should only be discharged from clinic after non-attendance if it is considered by the lead clinician that they no longer require the service or if a more acceptable service can be provided elsewhere. If it is likely that a child's medical care may be compromised by non-attendance or it may be a pointer to wider concerns about the child's welfare, the clinician should be proactive in arranging another appointment and help to facilitate attendance. If it is not possible to engage a family and by non-attendance a family is not meeting the needs of the child, the child's safeguarding procedures should be instigated.

## 7.5 Appointment Outcomes

Clinicians are responsible for completing an `Attendance Outcome Form' for all patients by the end of each clinic. This records the status along the 18 week pathway and details of procedures performed for coding and charging purposes, and if another appointment is required. A decision whether or not to offer a follow-up appointment for patients who have failed to attend should be made by the consultant.

It is imperative for the monitoring of patient pathways that all attendances are cashed up with the correct Referral to Treatment status code. This will signify patient's stage of treatment and identifies whether the 18 week clock continues, stops or a new pathway begins.

Attendance and 18 week status codes must be recorded accurately on Cerner by clinic staff at the end of each clinic or within one working day as decisions regarding the patient's on-going care will be actioned from this information. Patients referred back to their GP should have their registration closed at this stage using the correct Cerner process.

Where clinics are held off-site in a community setting, services should utilise generic nhs.net email accounts to facilitate the transfer of outcome forms to corporate outpatient service staff. This will enable cashing up within the specified one working day timeframe.

### 7.5.1 Active Monitoring

If the patient has not yet received treatment but instead requires a period of watchful waiting followed by further review at a follow-up appointment, this should be recorded as `active monitoring' and the 18 week pathway will stop. If the patient subsequently needs to be sent for investigations or admitted, a new 18 week pathway period will commence.

Patients not requiring further monitoring or follow-up should be discharged back to the care of the GP or referring clinician.

### 7.5.2 Thinking Time

On occasion a patient may be given a choice of treatment options and request time to consider the preferred alternative. Where a patient is given thinking time this is usually limited to a maximum of two weeks but may be extended at the discretion of the consultant responsible for the patient's care. This must be documented in clinical correspondence.

Where the patient requires longer to consider the options and to see how their condition progresses, this should be agreed between clinician and patient. This must be documented in the patient record and on the outcome form. A clock stop will then be applied for a period of `patient initiated active monitoring'. When the patient and clinician agree that treatment is the best option, for example via a telephone call or attendance at a follow-up clinic, a new 18 week pathway will start.

### 7.5.3 Patients Referred for Outpatient Diagnostics

The term `Diagnostics' is used to describe a test or procedure to identify a person's disease or condition and enables a medical diagnosis to be made. Diagnostics are an integral part of the 18 week Referral to Treatment pathway and cover imaging, endoscopy, pathology and elements of physiological measurement. Pathways can include both a diagnostic test and therapeutic treatment, however pathways may stop at the diagnostic phase if it is decided that further investigation or treatment is not required. Direct Access requests from a GP will not start an 18 week pathway; neither will referrals via national screening programmes. Separate arrangements exist under the 18 weeks rules for monitoring direct access referrals to Audiology and treatment for 95% of these patients within the maximum 18 week target is required.

All diagnostics, including Direct Access referrals, must be carried out within a DH target of six weeks from request. The 18 week Referral to Treatment standard includes time required for the diagnostic phase, therefore tests and follow-up appointments to review results must be scheduled to avoid unnecessary delays.

### 7.5.4 Patients to be Added to the Inpatient or Day Case Waiting List

It is extremely important that if the decision is made to add a patient to the inpatient or day case waiting list for a diagnostic or treatment procedure, the admission card is completed and forwarded to the relevant Patient Pathway Co-ordinator within 24 hours of the decision to admit and recorded on the system. Any unnecessary delays in receipt and recording of the waiting list entry will impact on the ability of the Trust to treat the patient within 18 weeks.

### 7.5.5 Procedures Requiring CCG Authorisation

Where the decision is made that a specific procedure or device is required that is excluded from the Contract Schedule, prior authorisation to treat must be obtained from the patient's Clinical Commissioning Group (CCG). The General Manager or Service Manager for the specialty will request permission to proceed via an Individual Funding Request to the relevant CCG. The Trust may treat a small number of specified procedures without having to request prior approval providing that patients meet certain criteria. Equally, for a small number of treatments (mainly cosmetic) it is the GP that seeks approval from the CCG and patients present to the Trust with an approval letter. These procedures are listed in the South West London CCGs' Effective Commissioning Initiative Procedures Protocol.

In the event of urgent clinical need or risk to patient safety, CCGs should grant retrospective approval.

The clock start date remains the date the referral was received in the Trust or the UBRN was converted and the 18 week pathway continues to run. In order to manage these patients within the 18 week target, decisions on these cases must be communicated by the CCG to the Trust within two weeks. If no decision has been received in this time the issue will be referred to the Trust's Assistant Director of Finance – Resources, for escalation and resolution.

### 7.5.6 Outgoing Inter-Provider Transfers

Where the outcome of an attendance is the clinical decision to refer a patient onwards from St George's for treatment at an alternative provider, the local RTT outcome code of `06: Transfer to Another Trust' should be applied and the pathway will continue with the receiving provider.

Patients referred onwards from St George's for elective treatment or care at another provider must have an Inter Provider Treatment Minimum Data Set proforma (IPTMDS) forwarded to the receiving trust at the point of the referral. This identifies the patient's 18 week pathway status and waiting time. Until such time as an electronic system for the transfer of this information can be implemented, the Trust's 18 Week Team should be contacted for advice by the secretary of the referring clinician.

### 7.5.7 Removal from the Outpatient Waiting List

Patients whose outpatient episode is to be closed must be discharged from the Cerner system using the correct workflow.

A new GP referral must be received for a patient with an existing condition if a request for further consultation is made after the original referral has been discharged (the exception being late responses to outpatient PB1 letters within 14 days of the expired deadline).

## 8 Inpatient and Day Case Waiting Lists: Admitted Pathways

The administration of inpatient and day case waiting lists must be consistent, easily understood, patient focused and responsive to clinical decision making. The date on the waiting list will be the date the decision to treat was agreed with the patient, usually at an outpatient attendance. Children up to the age of 16 should be managed on a separate waiting list to adults. Patients who no longer need treatment should be removed from waiting lists.

The 18 week clock stops on the date of admission for treatment, when a clinical decision is made that treatment is not required or a patient declines treatment. An inpatient or day case admission for diagnostics will not stop the 18 week pathway unless treatment is carried out as part of the admission or it is agreed at the time that no further investigations or treatment are required.

### 8.1 Adding Patients to the Elective Waiting List

The decision to add a patient to the waiting list will be made by the consultant after discussion and agreement with the patient. Patients should not be added to the waiting list unless they are fit, ready and available for procedure/surgery and there is a serious expectation of treatment. A request for admission should not be made to reserve a place in the queue `in case' the patient needs surgery or if the intended procedure is not currently available within the Trust or funded by commissioners.

At the time of the decision to admit patients will be given a letter explaining that they will be added to the Trust's waiting list and that within one week they will receive written confirmation this has happened. The letter will contain details of whom to contact should this not arrive. Every patient will receive written confirmation of their addition to the waiting list and the agreed admission date and time. This notification will include guidance to contact their GP should the patient's condition deteriorate while on the waiting list. Routine

long waiting patients may have their TCI date expedited if there is concern that their clinical condition has changed.

### 8.1.1 Additions to the Waiting List Following Clinic Attendance

Patients who require elective admission will be identified by the relevant outcome on the Clinic Outcome sheet and completion of the administrative To Come In (TCI) card. Additions to the waiting list must be linked to the appropriate referral that has already been registered on the Cerner system.

The electronic order will be placed on Cerner using the agreed functionality and workflows within one working day of the date of the decision to admit. Suitable arrangements for adding patients to the waiting list within this timeframe must be made for patients attending satellite clinics.

### 8.1.2 Tertiary Additions to the Waiting List

Tertiary additions to the elective waiting list received from another secondary care provider must be accompanied by an agreed minimum data set for the purposes of establishing the patient's RTT status and point along the 18 week pathway. The prescribed format is the Inter Provider Transfer Minimum Data Set proforma (IPTMDS) and these must be forwarded to the 18 Week Team for verification and entry onto the Cerner system.

Details of the referring organisation and clinician for tertiary waiting list additions must be entered into the "Pathway ID Issuer" and "Referring Clinician" fields on the Cerner LC1 Inpatient Waiting List Conversation screen to enable the correct RTT status and waiting time to be determined. Should the Pathway ID Issuer or Referring Clinician not be available from the drop down menus, the information must be recorded in the free text comments field. This is extremely important, particularly where an IPTMDS proforma is not received. The provision of IPTMDS proformas will be subject to performance monitoring by the Trust, however the absence of a proforma will not delay the patient's treatment.

## 8.2 Pre-operative Assessment

Following a decision to treat, patients are generally referred for pre-operative assessment. Wherever possible, pre-assessment appointments should be agreed with the patient and confirmed by letter explaining the importance of attending and that failure to do so without prior notification may result in postponement of the procedure or removal from the waiting list.

### 8.2.1 Pre-Operative Assessment DNAs

All patients who fail to attend their Pre-Operative assessment should be contacted by telephone to establish the reason for the failed attendance and a further appointment booked. In all cases the Pre-Operative assessment service will inform the Patient Pathway Co-ordinator of the non-attendance. Discharge of the patient back to the care of the GP may be appropriate after clinical review if the patient declines treatment. Should the patient fail to attend a second time this must be escalated by the Pre –Operative service to the lead clinician for liaison and follow-up with the patient's GP.

### 8.2.2 Pre-Operative Assessment Outcomes

Where patients are passed fit for surgery, a local RTT outcome code 13 should be used to denote readiness to proceed and that the pathway continues. Patients who are assessed as unfit at nurse-led pre-assessment should be recorded against an RTT outcome code of 14 and referred back to the consultant for a decision to be made regarding the appropriate clinical management.

It is the responsibility of the consultant to advise the patient and GP of the outcome of assessment and decide on the further management of the patient's condition. If it is apparent that the patient will not become medically fit for the proposed treatment without active intervention, stabilisation and monitoring within primary care, the patient should be discharged back to the GP.

When the patient becomes fit for surgery the GP practice may contact the Patient Pathway Co-ordinator or the Consultant's secretary to arrange for the patient to start a new pathway at the most clinically appropriate stage. In these circumstances the 18 week pathway will commence from the date the GP contacted the Trust. Should the GP contact the Trust more than six months after the patient was discharged, a new referral may be required.

### 8.3 Admission Offer (TCI Date)

Selecting patients for admission entails balancing the needs and priorities of the patient and Commissioners against available resources of theatre time and staffed beds. To ensure equity of access, patients will be selected from the waiting list for admission according to clinical priority and thereafter by order of 18 week waiting time.

#### 8.3.1 Patient Availability

Patients should be available for admission booked with reasonable notice within 18 weeks of referral. Every effort will be made to agree an admission date by week 15 of the pathway. If the hospital is not able to offer admission for treatment within the maximum 18 weeks waiting time, the next available date will be offered. However this will result in a breach of the waiting times guarantee and these patients will form part of the RTT 8% tolerance within the national target.

Under the NHS Constitution patients have the right to access services within maximum waiting times or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible and where the patient requests it. Should a patient invoke their Constitutional right to treatment by an alternative provider it is the responsibility of the relevant General Manager or Specialty Manager to co-ordinate the Trust's internal process, identify the availability of treatment options and respond to the patient.

#### 8.3.2 Reasonable Offers of Admission

All offers of admission will be agreed with the patient. Reasonable offers of admission will give a minimum of three weeks' notice and a choice of two dates, both within a timeframe to enable treatment within 18 weeks of referral. Patients may be offered earlier dates with less than three weeks' notice, if accepted these are deemed to be reasonable offers. If the patient declines a short notice offer, this will not have an adverse effect on the management of their pathway.

Patients will be sent a confirmation letter regarding their booked pre-operative assessment and admission date. The letter will be clear and informative and should include a point of contact and telephone number to call with any queries, specifying the process for cancelling or rearranging admission dates. The letter must explain clearly the consequences should the patient cancel or fail to attend at the agreed time.

#### 8.3.3 Patients Not Contactable by Telephone

Routine patients who cannot be contacted by telephone to agree a reasonable admission date will be sent a fourteen day response letter. Details of patients who fail to call back

within this period will be referred to the consultant in charge of their treatment for a clinical review of their suitability for discharge. Only where is it is clinically safe to discharge patients without treatment should the waiting list entry be cancelled and the patient discharged back to the care of the GP or referring clinician. The patient and GP and, if relevant, the referring clinician, will be notified by letter of the discharge.

In cases where the patient fails to make contact with the Trust to agree an admission date and it is not clinically appropriate to discharge the patient, the consultant should make arrangements to review the circumstances with the patient or their GP.

Flexibility exists to reinstate patients who do not contact the Trust within the specified limit and a common sense, patient-centred approach should be applied where extenuating circumstances are known. Patients contacting the Trust up to fourteen days after the original deadline for response should be added back to the list using the original pathway start date. Patients who contact the Trust more than 14 days after the deadline for response should not be reinstated and may following a clinical review and with the consultant's agreement, be removed from the waiting list and discharged back to the care of their referring GP.

### 8.4 Patients Not Clinically Fit for Admission Whilst on the Waiting List

Patients who are not clinically fit to undergo treatment should not be added to the waiting list. Patients already on the waiting list who become unfit for treatment due to anything other than a short-term minor condition should be removed from the active waiting list for suitable management until they are ready for surgery. RTT pathway waiting times cannot be adjusted for periods of social or medical unavailability and the 18 week clock continues to run.

The clinician will decide whether it is optimal to actively monitor the patient under watchful waiting within outpatients or to return the patient to primary care. The RTT local clock stop code 8 will be recorded against the waiting list cancellation and a new monitoring period will start when the patient is assessed and agreed as being fit to proceed.

If the patient is returned to primary care at such time as the patient becomes fit for surgery the GP practice may contact the Patient Pathway Co-ordinator or the Consultant's secretary to arrange for the patient to start a new pathway at the most clinically appropriate stage. In these circumstances the 18 week pathway will commence from the date the GP contacted the Trust. Should the GP contact the Trust more than six months after the patient was discharged, a new referral will be required.

#### 8.4.1 New Information Received Regarding the Health of a Long Waiting Patient on an Inpatient or Day Case Waiting List

Patients who are on an elective inpatient or day case waiting list that have been identified as clinically non-urgent should be dated in chronological order. All patients added to the waiting list should receive a letter confirming the decision to admit and this should include guidance to consult their GP if their condition deteriorates whilst waiting for treatment. Routine long waiting patients may have their TCI date expedited if there is concern that their condition has changed.

The process for this is as follows:

- If a patient or GP contacts the PPC/secretary to raise concerns about deterioration in the patient's health while awaiting their surgical procedure, this should be highlighted to the relevant consultant within 48 hours with any available

information, e.g. letter from the GP, notes from the phone call and the patient's medical notes. If the consultant is away for a period of time, another consultant or appropriately senior registrar may review the information

- The consultant should inform the PPC/secretary if this changes the patient's clinical priority and an earlier admission date is necessary. Should the consultant identify that the need for treatment is now urgent, the PPC/secretary should offer the patient an urgent TCI date and update the patient's status to urgent on Cerner.
- If the consultant does not feel this information alters the clinical priority of the patient, the PPC/secretary should note the consultant's decision and continue to date patients according to the agreed booking plan. They should also advise the patient or GP of the consultant or senior registrar's decision.

### 8.5 Patients Choosing to Delay Admission

From 1st October 2015 RTT pathways may no longer be paused for patients on an inpatient or day case waiting list who choose to delay treatment due to unavailability and are subsequently unable to accept reasonable offers of admission. The Cerner suspension functionality may continue to be used to capture periods of unavailability but this will be for administrative purposes only and will not affect the patient's monitored waiting time.

Patients who are unavailable for admission for more than three months despite having been given adequate notice and a choice of dates will be subject to a clinical review and following this may be discharged back to the care of their GP or referring clinician if it is agreed as being in the best interest of the patient. When the patient is available the GP practice or patient may contact the Patient Pathway Co-ordinator or the consultant's secretary to arrange for the patient to start a new pathway at the most clinically appropriate stage.

A new 18 week pathway will commence from the date the GP or patient contacts the Trust. Should this be six months or more after the patient was discharged, a new referral will be required.

### 8.6 Admission Dates Cancelled by the Hospital

Patients whose procedure is cancelled by the hospital for non-clinical reasons prior to admission should be offered an alternative date at the time of the cancellation and this must be within the 18 week target. The alternative date should be booked at the patient's earliest convenience and as close to the original date as possible. Patients whose treatment has been cancelled once by the hospital must not be cancelled a second time.

#### 8.6.1 28 Day Readmission Guarantee

The Trust takes every reasonable precaution to avoid cancelling a patient's treatment on the day of admission or surgery and it is the expectation this should not happen. The Trust escalation process must be followed if this is identified as likely.

On occasions where a cancellation on the day for non-clinical reasons does occur, national guidance stipulates patients must be rebooked a new date for their procedure within 28 days of the cancellation or within the maximum 18 week RTT wait, whichever is sooner. A new TCI date should be agreed with the patient within seven days of the cancellation. Patients may choose not to be readmitted within 28 days, in such cases a period of unavailability will be recorded on Cerner with the reasons entered in the comments field for audit purposes. This will not affect the patients 18 week clock.

If the Trust is unable to offer a date for readmission within 28 days the patient must be offered alternative available dates, however the patient should also be given the option of treatment at a provider of their choice.

### 8.7 Admission Dates Cancelled by the Patient

Patients who cancel an agreed pre-operative assessment or admission date booked with reasonable notice are given the opportunity to change their pre-operative assessment or admission date. During this time, the pathway will continue to run.

Cancellations by the patient do not affect the 18 week waiting time and the clock continues to run unless treatment is given. Patients who agree an appointment date and then cancel this on three or more occasions may, following a clinical review and with the consultant's agreement, be removed from the waiting list and discharged back to the care of their referring GP.

### 8.8 Patients Who Do Not Attend (DNA)

The Trust operates a one DNA discharge policy for routine adult patients. Patients who fail to attend for pre-operative assessment or elective admission without giving prior notification may, following a clinical review and with the consultant's agreement, be removed from the waiting list and discharged back to the care of the GP or referring clinician. Exceptions to the one DNA discharge rule include: clinically urgent cases (as advised by the patient's consultant); suspected cancers and patients on a cancer pathway; vulnerable patients; paediatrics; and conditions where discharge would be clinically inappropriate.

A DNA-discharge letter will be sent to the patient and GP advising them of this decision. Any clinical information not yet passed to the patient or recommendations for on-going management should be included in the correspondence.

Failure to attend for pre-assessment or admission will in itself not stop an 18 week pathway. The 18 week clock continues to run with the accrued waiting time until the date the patient is removed from the waiting list and is discharged back to the care of their GP, or alternatively, the patient is rescheduled and the clock stops on treatment.

### 8.9 Elective Admission

The 18 week RTT period stops on admission for treatment and the pathway is deemed to have ended. The exceptions to this rule are if the admission is for a purely diagnostic procedure and the patient requires a subsequent admission for the treatment phase or alternatively if the procedure does not take place for any reason but is still required.

### 8.10 Planned Waiting List

Patients on a planned sequence of treatment pathway must not be included on the planned waiting list unless there are specific clinical reasons why the procedure cannot be undertaken until a specified period of time has elapsed. Patients waiting for planned admissions such as check cystoscopies, removal of metalwork and periodic reviews (surveillance) are outside of the scope of RTT monitoring and are not included within the 18 weeks maximum waiting times standard. These patients are not waiting for an initial RTT treatment, but for a planned continuation of treatment already received. Age or growth related procedures are also considered to be planned as is a series of pain relieving injections.

Although planned procedures are not counted as being part of the waiting list for 18 week purposes, the same waiting list management rules should apply if a patient cancels or DNA's an admission date.

It is the responsibility of Patient Pathway Co-ordinators to ensure that the entry onto Cerner specifies the date the patient's planned treatment is required. Patients on a planned pathway take first choice of capacity to ensure they are allocated an admission date for the scheduled month or timescale. Oversight of the planned list is the responsibility of the Divisional Management team via an agreed weekly PTL meeting.

# 9 Training

An appropriate continuous training programme should support all levels of staff on an on-going basis, with special regard given to newly recruited staff.

Training in the definitions and principles of the 18 Week Referral to Treatment measurement will be available to all staff involved in the implementation of this policy. This will ensure accurate and timely data collection and enable pro-active management of patient pathways.

A formal training programme will be developed for validation staff with competency tests to assess knowledge. Written guidance will be available, including local scenarios for conditions or pathways found to be most problematic

Staff will be trained to a standard level via a generic training package; however this will be tailored to individual requirements where appropriate. Refresher training will be provided as required. New changes in processes will be managed by ad hoc training.

All staff involved with patient contact, e.g. reception staff, patient pathway co-ordinators, will receive training in customer care.

All staff involved in the management of electronic systems used to support the outpatient and elective admission function will be given adequate training that is fit for purpose and enables them to utilise those systems to an acceptable standard. This includes Cerner, EPR, E-Triage, Tiara, and e-Referrals.

The above training will be undertaken as part of induction in the first instance and reviewed on an annual basis. A continuous staff training programme will be implemented and adherence to the policy will be included within the administrative staff appraisal process.

# 10 Monitoring Compliance

## 10.1 Process for Monitoring Compliance

The Trust will undertake regular planned audits and spot checks on the systems defined and outlined in this policy. This may be in the form of locally performed audits specific to individual departments or specialties or audits undertaken by the Internal Audit team. GP involvement will be requested where this will provide helpful external scrutiny of services and compliance. The Trust also expects to be audited by external auditors appointed to replace the Audit Commission and by other Department of Health bodies in line with national programmes.

Training logs will be kept at departmental level of attendance at RTT and Cerner system sessions, to be reviewed by lead managers.

### 10.2 Compliance Reporting

In addition, compliance with and effectiveness of the Referral to Treatment Access Policy and related operational procedures will be monitored and regular reports made to:

- The Trust Board
- Divisional Management Boards
- Directorate Monthly Performance Reviews
- General Managers' RTT Compliance Meeting
- Monthly RTT Performance Returns made to the DH and Commissioners

Compliance with the policy will be monitored on a weekly basis via the Trust's outpatient first appointment and Continuing OP PTLs, the inpatient and day case waiting list PTL, and the RTT Admitted PTL Dashboard.

Under no circumstances should any member of Trust staff feel pressurised to misrepresent, misreport or otherwise falsify waiting times for an individual patient or performance at a corporate level. Should such circumstances arise, the individual must escalate the issue to their line manager or lead clinician. Should this not be possible, staff can raise concerns in confidence with the Trust secretary or a non-executive director. Alternatively, concerns may be raised by clicking the whistle blowing link on the intranet home page.

This policy shall be reviewed at least annually, or earlier as changes in guidance or practice are implemented.

### 10.3 Standards/Key Performance Indicators

In addition to local standards outlined in the policy and operational procedures, the Trust will also adhere to the national access targets for 18 Weeks, Cancer and other relevant indicators.

Additional audit reports developed by the Information Team will monitor and review compliance with the policy in relation to multiple cancellations and DNAs, unactioned RTT outcomes, triage delays and elapsed time from Decision to Admit to addition to the WL.

## 11 Case Studies

**Case Study 1**

Mr S visited his GP on 3 January complaining of bladder problems. The GP suspected prostatism and recommended that Mr Smith see a consultant. On 5 January, Mr S booked an appointment through the NHS e-Referral Service to see a urology consultant at his local NHS Trust for 15 January.

In this scenario, as the referral is being made to a consultant-led service, Mr S's waiting time clock started when the Trust received the referral, in this case, when Mr S converted his NHS e-Referral UBRN on 5 January.

If Mr S had rung The Appointments Line (TAL) to find that there were no appointments at his chosen provider, the clock would start on the date that TAL electronically sent the booking request to the provider.

**Case Study 2**

Mrs J visited her GP on 17 March complaining of back pain. The GP recommended that Mrs J sees a physiotherapist. Mrs J is seen by the physiotherapist at her local Trust on 3 April.

In this scenario, the referral is a direct access referral into a non-consultant-led service and therefore no waiting time clock is started.

Mrs J found that the physiotherapy helped her symptoms. However, some months or years later she found that her condition was deteriorating and her physiotherapist decided to refer her to an orthopaedic consultant for a specialist opinion.

In this case a waiting time clock would start when the provider received the referral from the physiotherapist to the consultant-led orthopaedic service

**Case Study 3**

Mr B visited his GP on 4 August complaining of difficulties hearing. Mr B's GP decided to refer him to a non-consultant-led audiology service for hearing tests with a view to potentially needing a hearing aid.

In this scenario, no waiting time clock starts, as the GP has made a direct access referral into a non-consultant-led service, although a direct access audiology RTT clock should start.

**Case Study 4**

Mr K has already been referred to a consultant-led orthopaedic service for a hip condition, for which a waiting time clock has been started. At an outpatient appointment, the orthopaedic service identify angina and decide to refer the patient to a cardiologist for further investigation.

Referrals do not have to come from primary care for a waiting time clock to start. In this instance, a consultant has identified a separate condition that requires the specialist opinion of another consultant. Therefore, subject to local commissioning rules on non-urgent new conditions, a new, separate waiting time clock should start from the date that the provider receives the referral. The original waiting time clock is unaffected

**Case Study 5**

Mr R presents at his GP complaining of a change in bowel habit. The GP refers Mr R to the hospital service for a colonoscopy. Depending on the results of the colonoscopy Mr R will either be discharged back to primary care or will receive treatment under the care of secondary care consultant.

In this scenario, the colonoscopy is accessed under a straight to test arrangement, such that, once the referral has been reviewed by the consultant the patient is booked to have a colonoscopy without the need for an outpatient appointment. A waiting time clock will start with the GP referral for a colonoscopy.

**Case Study 6**

Mr B is referred to a consultant ophthalmologist and books an appointment (converts his UBRN) though the NHS e-Referral System on 1 March (clock start). After seeing the consultant as an outpatient it is agreed that he would benefit from operations on both eyes to remove cataracts. He is admitted for a day case procedure on his left eye to remove a cataract on 28 March (clock stop). After a short period of recovery, Mr B contacts the hospital on 15 April to arrange a time for the operation on his right eye to be performed (new clock start). The procedure is undertaken on 10 May (clock stop).

**Case Study 7**

Some time ago, Mrs B was referred by her GP to a consultant physician who prescribed a course of medication and provided the GP with a treatment plan for management of her condition in primary care. Recently, Mrs B's condition had worsened and her GP felt it necessary to refer her back to the consultant for further opinion.

In this instance, a waiting time clock should start on the date that the provider receives Mrs B's referral (i.e. either when Mrs B converts her UBRN via the NHS e-Referral System, or when the provider receives the referral letter from the GP).

**Case Study 8**

A child in a family at risk of familial breast cancer is referred to the genetics service for possible pre-symptomatic testing. It is not appropriate to proceed until the child is old enough to consider for themselves the implications of having a genetic test as there is no risk until they are adult. (Clock stops as active monitoring (or alternatively as a no treatment required stop)). A new clock will start at the point it becomes appropriate for the service to see the patient (or where a new referral is made by the patient's GP if the patient had been discharged back to the care of their GP).

**Case Study 9**

Mr F is referred to an orthopaedic consultant by his GP. The consultant decides that a hip replacement operation may be the best course of action. Mr F however wishes to wait to see how he continues to cope with his condition before going down the route of surgery and his waiting time clock is stopped as active monitoring (patient initiated). A year later, at a follow up outpatient appointment, Mr F is finding his condition harder to cope with, and after discussion with the consultant agrees to undergo surgery.

A new waiting time clock therefore starts on the date that the decision to treat was made at the follow up outpatient appointment

**Case Study 10**

Mr D is seen by the cardiologist and given a diagnosis of an aortic aneurysm. Mr D and the consultant discuss the possibility of surgery, but it is agreed that at this stage it is too small for surgery. The patient is therefore put on a period of active monitoring. During this time regular ultrasound tests will be carried out to measure the size of the aneurysm and life style changes (weight, exercise) are addressed to minimise the risk of rupture to the patient (which would then result in emergency surgery). As the risk of death from surgery is higher than the risk of death from a rupture, not all aneurysms

result in surgery and this patient may be monitored and then perhaps discharged back to the GP, or if the aneurysm increases in size then surgery will be required.

**Case Study 11**
Mrs R is referred to general medicine with undefined respiratory disease. The consultant has no clear plan of treatment and wants to monitor the patient before any intervention. There are two options, to discharge back to the GP for monitoring (clock stop) or to start a period of active monitoring, with the patient having a follow up appointment in three months, but to contact the hospital before if her condition deteriorates.

**Case Study 12**
Mrs B is referred by her GP to an orthopaedic consultant. The consultant undertakes a number of diagnostic tests which indicate that the patient requires surgery. However as the patient also has angina they are referred for a cardiac opinion to assess their fitness for surgery. The cardiac opinion comes back 4 weeks later that the patient is fit for surgery. Surgery takes place three weeks later.

In this scenario the use of active monitoring may not be appropriate, as the referral for cardiac opinion indicates that clinical interventions or diagnostic procedures may be appropriate at that stage. Therefore, Mrs B's clock should stop when the patient is admitted for surgery. The clock carries on ticking while the cardiac opinion is being obtained.

## 12. Associated Documents

This document provides a broad outline of the Trust's policy for managing 18 week pathways. More detailed guidance and definitions can be found within the following Department of Health publications:

"Referral to treatment consultant-led waiting times - Rules Suite": Department of Health, October 2015

"Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care" – NHS England October 2015

"Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: Frequently asked questions" – NHS England October 2015

"National Direct Access Audiology Clock Rules" – Department of Health, April 2011

"Frequently Asked Questions: Direct Access Audiology Referral to Treatment Data Collection" – Department of Health, April 2011

"The NHS Constitution for England": Department of Health July 2015

"NHS Constitution Waiting Times FAQ - The NHS e-Referral Service and Waiting Times" NHS e-Referral Service Programme Team February 2015

"Implementation of the right to access services in the maximum waiting times: guidance to strategic health authorities, primary care trusts and providers": Department of Health, March 2010

"Diagnostics waiting times and activity - Guidance on completing the diagnostic waiting times & activity" monthly data collection" - Department of Health, Updated: 11 March 2015

Diagnostics FAQs: Frequently Asked Questions on completing the "Diagnostic Waiting Times & Activity" monthly data collection

NHS Choices: Information for Patients: Your Rights in the NHS
http://www.nhs.uk/choiceinthenhs/rightsandpledges/waitingtimes/pages/guide%20to%20waiting%20times.aspx

The policy should be read in conjunction with the following operational guides and documents accessed via the Trust's intranet:

Intranet 18 Weeks Homepage

Information Governance Policy

Private Patients Policy

Overseas Visitors Policy

Health Records Policy

Confidentiality Code of Conduct

Safeguarding Children

Whistle Blowing Policy

## 13 References

The NHS Improvement Plan: Putting people at the heart of public services. Department of Health, June 2004
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084476

The Revision to the Operating Framework for the NHS in England 2010/11 (June 2010)
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_116856

2014/15 South West London Effective Commissioning Initiative
http://www.wandsworthccg.nhs.uk/newsAndPublications/Publications/Documents/Effective_Commissioning_Initiative%202014-2015.pdf

## 14 APPENDIX A

St George's Healthcare NHS
NHS Trust

# 1. EQUALITY IMPACT ASSESSMENT FORM – INITIAL SCREENING

| Service/Function/Policy | Directorate / Department | Assessor(s) | New or Existing Service or Policy? | Date of Assessment |
|---|---|---|---|---|
| Referral to Treatment Access Policy | Surgery<br><br>Finance | Wilfred Carneiro<br>Traci Dean<br><br>To be agreed | Update from 2005<br><br>Update from 2011 | 04/11/2010<br><br>To be agreed |

**1.1 Who is responsible for this service / function / policy?**
Chief Operating Officer

**1.2 Describe the purpose of the service / function / policy?** Who is it intended to benefit? What are the intended outcomes?
The purpose of this document is to ensure that patients requiring access to outpatient appointments, diagnostic tests and elective inpatient or day case treatment are managed consistently, according to national frameworks and definitions.

**1.3 Are there any associated objectives?** E.g. National Service Frameworks, National Targets, Legislation , Trust strategic objectives
Compliance with standards specified within the NHS Operating Framework, and NHS Constitution. To be the provider of choice.

**1.4 What factors contribute or detract from achieving intended outcomes?**
Dissemination and implementation of policy consistently across the organisation; staff training programme; compliance with referral criteria; review of patient appointment and admission letters to ensure that patients clearly understand processes and their responsibilities.

**1.5 Does the service / policy / function / have a positive or negative impact in terms of race, disability, gender, sexual orientation, age, religion or belief and Human Rights?**
Details: [see Screening Assessment Guidance]
Positive impact in terms of Human Rights to access healthcare in line with current legislation.

**1.6 If yes, please describe current or planned activities to address the impact.**
Not applicable

**1.7 Is there any scope for new measures which would promote equality?**
Ensuring that patients understand how to access support such as PALS and interpreting services should they require them

**1.8 What are your monitoring arrangements for this policy/service?** Monthly performance reviews at Trust Board, Divisional Management Board and Directorate meetings. Monthly RTT performance and returns made to the DH and commissioners. Monitoring and validation of weekly PTLs by operational managers and administrative staff. Training logs to be kept at departmental level of attendance at RTT and Cerner system sessions, to be reviewed by lead managers.

| Checklist for the Approval of the Referral to Treatment Access Policy | | | |
|---|---|---|---|
| | **Title of document being reviewed:** | **Yes/No/ Unsure** | **Comments** |
| **1** | **Title** | | |
| | Is the title clear and unambiguous? | Yes | |
| | Is it clear whether the main document is a policy rather than guidelines or procedures? | Yes | |
| **2** | **Rationale** | | |
| | Are reasons for development of the document stated? | Yes | |
| **3** | **Development Process** | | |
| | Are people involved in the development identified? | Yes | |
| | Is there evidence of consultation with stakeholders and users? | Yes | |
| **4** | **Content** | | |
| | Are the objectives and aims defined? | Yes | |
| | Is target population as mentioned in Scope clear? | Yes | |
| | Are the intended outcomes described? | Yes | |
| | Are the statements clear and unambiguous? | Yes | |
| **5** | **Evidence Base** | | |
| | Is the type of evidence required to support the document identified explicitly? | Yes | |
| | Are the references cited in full? | Yes | |
| | Are all supporting documents referenced? | Yes | |
| **6** | **Consultation** | | |
| | Where appropriate, e.g. HR Policies, has the Partnership Forum been consulted on the document? | N/A | |
| | Where appropriate, have Community Services been consulted on the document? | Yes | Primary Care via Commissioners |
| | If relevant, does the policy meet all the prescribed NHSLA standards applicable? | N/A | |
| **7** | **Prescribed format** | | |
| | Has the table of control information been completed on the front cover of the Policy? | Yes | |
| | Has an Equality Impact Assessment been completed? Is the EIA is an appendix to this policy? | Yes | |
| | Has the Policy Checklist been completed and attached to the back of the policy? | Yes | |
| **8** | **Dissemination and Implementation** | | |
| | Does the plan include the necessary training and support to ensure compliance? | Yes | |
| | Is there a plan to review or audit compliance with the document? | Yes | |
| **9** | **Review Date** | | |
| | Is the frequency of review identified? | Yes | |
| **10** | **Overall Responsibility for the Document** | | |
| | Is it clear who will be responsible for co-coordinating the dissemination, implementation and review of the document? | Yes | |

**Approval by the Policy Approval Group:** Date: (TBC)

St George's University Hospitals NHS
NHS Foundation Trust

**Name and date of meeting:**

**TRUST BOARD**
**3 November 2016**

**Document Title:**

**Summary Finance Report- Month 06 2016/17**

**Action for the Trust Board:**

Note the current Trust financial position and forecast projection.

**Summary:**

The Trust has reported an in-month deficit of £7.3m in September which is £6.7m worse than plan. Included in month is a Non Pay overspend (£3.4m), excess pay costs of £2.0m and below plan SLA Income (£2.6m; mainly attributable to the STF (£1.5m) and RTT non-reporting penalty (£2.0m)). £1.0m of Pay and £2.0m of Income in –month is cost unforeseen and outside of the control of the Trust.

The Year to date deficit is £42.2m and the forecast outturn submitted to NHSI at M06 is £55.5m. These values are £26.4m and £38.3m worse than plan respectively.

**Author and Date:**

Margaret Pratt
Chief Finance Officer

**Contact details:**

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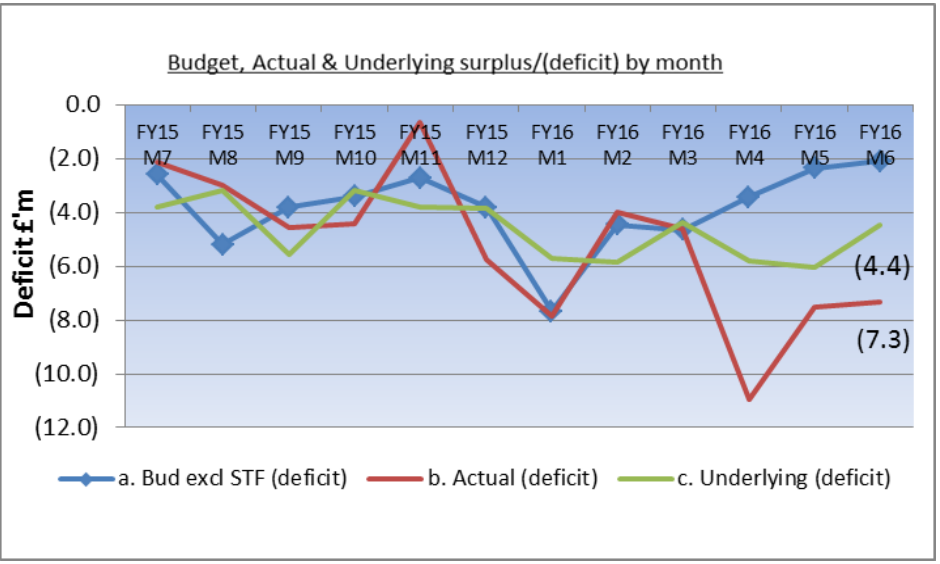
# Summary Finance Report
# Month 06 2016/17

## Trust Board 3 November 2016

# Contents

# 1. Financial Position for the month September 2016

| Income & Expenditure | Annual Budget £'m | Current Month Budget £'m | Current Month Actual £'m | Current Month Variance £m | Year to Date (YTD) Budget £'m | Year to Date (YTD) Actual £'m | Year to Date (YTD) Variance £m |
|---|---|---|---|---|---|---|---|
| SLA Income | 650.0 | 55.3 | 54.2 | (1.1) | 323.9 | 320.2 | (3.7) |
| STF Income | 17.6 | 1.5 | 0.0 | (1.5) | 8.8 | 0.0 | (8.8) |
| Other Income | 111.9 | 9.6 | 10.9 | 1.3 | 56.2 | 58.9 | 2.7 |
| **Overall Income** | **779.5** | **66.4** | **65.1** | **(1.3)** | **388.9** | **379.1** | **(9.9)** |
| Pay | (488.0) | (40.6) | (42.7) | (2.0) | (242.8) | (247.0) | (4.2) |
| Non Pay | (273.7) | (23.4) | (26.9) | (3.4) | (144.4) | (156.8) | (12.4) |
| **Overall Expenditure** | (761.6) | (64.1) | (69.5) | (5.5) | (387.3) | (403.8) | (16.5) |
| EBITDA | 17.9 | 2.3 | (4.4) | (6.8) | 1.7 | (24.7) | (26.4) |
| Financing costs | (35.1) | (2.9) | (2.9) | 0.1 | (17.5) | (17.5) | 0.0 |
| **Surplus/(deficit)** | **(17.2)** | **(0.6)** | **(7.3)** | **(6.7)** | **(15.9)** | **(42.2)** | **(26.4)** |
| Memo: Below the Line Items | 0.0 | 0.0 | (3.0) | (3.0) | 0.0 | (9.0) | (9.0) |




## Commentary

- An in-month deficit of £7.3m is reported in September which is £6.7m worse than plan. Included is a Non Pay overspend (£3.4m), excess pay costs of £2.0m and below plan SLA Income (£2.6m; mainly attributable to the STF (£1.5m) and a penalty for not reporting RTT since June (£2.0m, included in the SLA Income line)). £1.0m Pay and £2.0m of Income is 'Below the line' in month. The YTD deficit is £42.2m.
- **Forecast Outturn** remains a deficit of £55.5m subject to further validation of risk.
- **Below the line** - £9.0m of cost year to date relate to items outside the Trust's initial plan regarding unforeseen, one off costs associated with areas such as the rectification of Estates & IT infrastructure, additional senior management support, lost income from the Junior Doctors' strike, Prior Year agency cost and the RTT penalty.
- **SLA income (not STF)** - £1.1m shortfall in month and £3.7m YTD. Business Case slippage in Neurosurgery (£2.5m YTD) and the impact of the RTT non-reporting penalty (£2.0m YTD) have impacted here. A dialogue with commissioners has commenced asking for reinvestment to support RTT recording and delivery.
- **STF Income –** The cumulative under recovery of £8.8m arises as the Trust has missed its control total. The trend is forecasted to continue to year end.
- **Pay** - £2.0m overspent in month, and £4.2m YTD, as a result of spend on unbudgeted interim staff and (in month) the position has moved considerably as a result of the catch up of agency cost owing to shifts not going through staff bank. Internal control will be strengthened on agency booking and expenditure recognition.
- **Non pay**– £3.4m excess cost in month and £12.4m YTD, £9.2m (to date) of which is a consequence of non delivery of Trust CIP plans. The majority of the £9.2m will need to be cascaded to divisions for October reporting.
- **POST REPORTING NOTE:** Approximately £0.5m of invoices related to purchase orders will need to be recognised in M7 that were not fully understood at the time of finalising M6.
- **The M6 underlying position (excl. STF)** is a deficit of £4.4m (£6.0m in M5). The M6 improvement is owing to additional working days supporting Elective & Outpatient activity (£0.7m), Emergency Income (£0.6m), Outpatient efficiency (£0.2m) and Electives in BMT and Cardiology (£0.2m). The deterioration since 15/16 is owing to higher: pay award & pension cost; spend on interims; soft FM costs; and costs of reactive maintenance.

# 2. Analysis of cash movement M06 YTD

**Source and application of funds - cash movement analysis:**
**M06 YTD and forecast vs Plan**

| | Actual vs Plan YTD | | | Based on forecast £55.5m deficit | | | |
|---|---|---|---|---|---|---|---|
| | Plan YTD £m | Actual YTD £m | *Actual YTD VAR £m* | *Plan Year £m* | *Forecast Outturn £m* | *Forecast VAR £m* | Notes based on forecast £55.5m deficit |
| Opening cash 01.04.16 | 7.4 | 7.4 | | *7.4* | *7.4* | | |
| Income and expenditure deficit | -18.7 | -42.2 | ***-23.6*** | *-17.2* | *-55.5* | ***-38.3*** | |
| Depreciation | 12.2 | 12.2 | ***0.0*** | *25.0* | *25.0* | ***0.0*** | |
| Interest payable | 2.5 | 2.3 | ***-0.2*** | *5.1* | *5.8* | ***0.7*** | |
| PDC dividend | 3.1 | 3.1 | ***0.0*** | *6.3* | *5.3* | ***-1.0*** | |
| Other non-cash items | -0.1 | -0.1 | ***0.0*** | *-0.2* | *-0.2* | ***0.0*** | |
| Operating deficit | **-0.9** | **-24.7** | ***-23.8*** | **19.0** | **-19.6** | ***-38.6*** | |
| Change in stock | -0.2 | -0.9 | ***-0.6*** | *0.6* | *0.6* | ***0.0*** | |
| Change in debtors | -1.8 | -17.6 | ***-15.8*** | *2.0* | *-8.2* | ***-10.2*** | does not assume debt targets met |
| Change in creditors | 3.5 | 35.8 | ***32.3*** | *-5.5* | *4.5* | ***10.0*** | |
| Net change in working capital | 1.4 | 17.3 | ***15.9*** | -2.9 | -3.1 | **-0.2** | |
| Capital spend (excl leases) | -20.5 | -11.5 | ***9.1*** | *-33.4* | *-72.5* | ***-39.1*** | includes emergency capital expenditure in full. *The capex forecast will be revised at the same time as the I&E forecast so that the forecast borrowing requirement takes into account both variables.* |
| Interest paid | -2.5 | -2.3 | ***0.2*** | *-5.1* | *-5.6* | ***-0.5*** | |
| PDC dividend paid | -3.1 | -3.1 | ***0.0*** | *-6.3* | *-5.3* | ***1.0*** | |
| Other | -4.2 | -3.6 | ***0.7*** | *-8.0* | *-8.0* | ***0.0*** | |
| Investing activities | -30.4 | -20.4 | ***9.9*** | *-52.7* | *-91.3* | ***-38.6*** | |
| WCF/ISF borrowing | 25.6 | 29.0 | ***3.4*** | *32.5* | *109.9* | ***77.4*** | includes emergency (unapproved) capital funding and additional borrowing to finance higher deficit but excludes requested £20m cash headroom. *Subject to change re: I&E reforecast & capex reforecast.* |
| Closing cash 31.07.16 | 3.2 | 8.6 | ***5.4*** | 3.2 | 3.2 | ***0.0*** | |

## Commentary

### M06 YTD cash movement

- Of the I&E deficit of £42.2.m YTD, depreciation (£12.2m) does not impact cash. The accruals for PDC dividend and interest payable are added back for presentational purposes and the amounts paid for these expenses shown lower down. This generates a YTD cash operating deficit of £24.7m.
- The operating variance from plan of £23.8m in cash is directly attributable to the I&E deficit. Members will recall that the NHSI plan and Internal trust plan are phased differently
- The Trust has been able to offset the worsening operating deficit with better performance on working capital (+£15.9m) and cash under spend on capital (+£9.1m) delivering a combined cash and borrowing position ahead of plan. However, the trust deferred a supplier payment run from late September and this partly explains the favourable creditors variance.

### Forecast outturn

- The forecast operating cash deficit of £19.6m results from a forecast deficit of £55.5m offset by depreciation of £25m.
- The total forecast borrowing requirement for the year would be £109.9m, £77.4m higher than plan. This includes the emergency capital request of £39.1m and the £38.3m needed to finance the higher operating deficit. NB this borrowing total does not yet include the £20m cash headroom requested.
- The borrowing requirement will be updated when the I&E and capex reforecasts are completed.

# 3. M6 Forecast

- There has been regular dialogue with NHS Improvement over the last month regarding the year end forecast which has been completed each month since Q1 reporting.
- The Trust is being held to account against its initial gross plan of a £34.8m deficit (£17.2m minus £17.6m STF), which includes full achievement of the £42.7m CIP programme.
- A forecast of £55.5m deficit was submitted to NHSI at month 6 as a place hold, which was submitted with a note stating the forecast was very likely to change due to not having sufficient time to validate risks and take through appropriate governance for external reporting (NHSI submission 'appendix 2b').
- A straight-line forecast of the month 6 position leads to an £84.5m deficit by year end.
- Divisions, and the transformation team, have been working on recovery actions to improve the Trusts current run rate, and address the significant deficit position each month.

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO TRUST BOARD** ***November 2016***

| | |
|---|---|
| **Paper Title:** | Corporate Risk Report |
| **Sponsoring Director:** | Paul Moore, Director of Quality Governance |
| **Author:** | Paul Moore, Director of Quality Governance |
| **Purpose:** | To highlight key risks and provide assurance regarding their management. |
| **Action required by the committee:** | The board are asked to:<br>(i) work through each decision point highlighted in this report;<br>(ii) consider, challenge and confirm the correct strategy has been adopted to treat reportable risk;<br>(iii) consider any alternative approaches to treating intractable risks to which the assessment suggests the Trust is over-exposed;<br>(iv) where required validate new significant risks identified since the last meeting and approve their admission to the Corporate Risk Register where agreed;<br>(v) seek assurance that reportable risk is under sufficient control; and<br>(iv) to make decisions where necessary that allow risk to be managed in accordance with the Board's risk appetite. |
| **Document Previously Considered by:** | Risk Management Committee on 14.10.16 |

**Executive summary**

Core operational risk exposure has been grouped under the following risk areas:

- **Timely Access to Clinical Services/Patient Harm**
- **Insufficient Resilience/Unstable Critical IT/Estates Infrastructure**
- **Unsustainable Financial Position**
- **Inadequate Governance/Reputation Loss**

**Risks**

The Trust's overall level of exposure to core operational risk is extreme.

| | |
|---|---|
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | All |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | All CQC Fundamental standards & regulations |

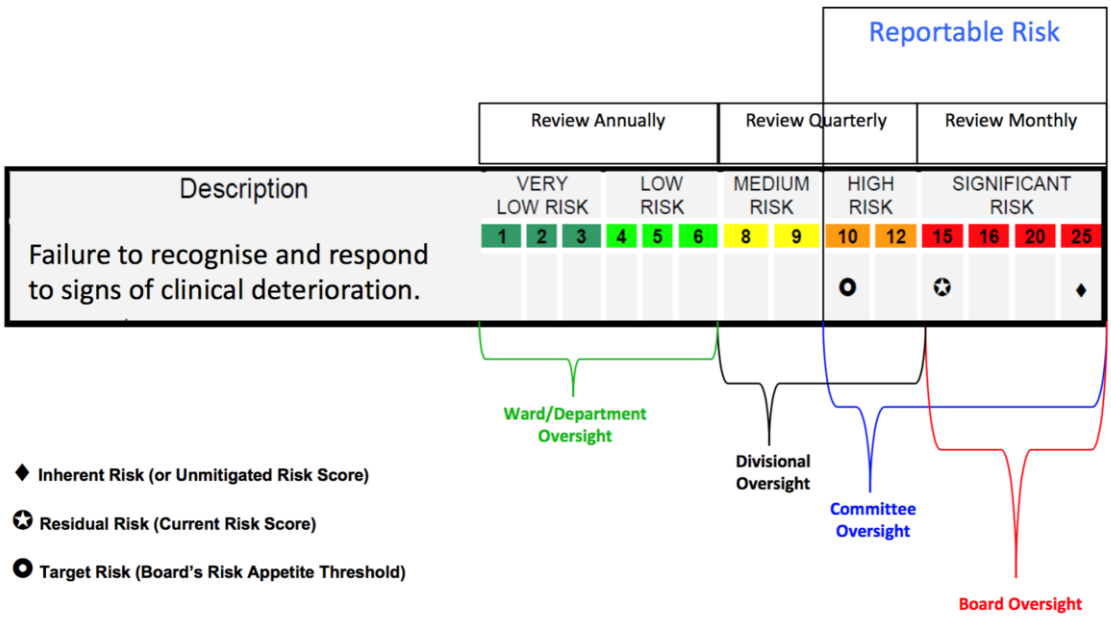
**Equality Impact Assessment (EIA): Has an EIA been carried out? Yes**
**If yes, please provide a summary of the key findings**

# Contents

## Risk Grading Matrix

| SEVERITY MARKERS | | LIKELIHOOD MARKERS* | | |
|---|---|---|---|---|
| 5 | Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence | 5 | Very Likely | No effective control; or ≥1 in 5 chance within 12 months |
| 4 | Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more CSUs; Extended service closure | 4 | Somewhat Likely | Weak control; or ≥1 in 10 chance within 12 months |
| 3 | Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more CSUs; Service closure | 3 | Possible | Limited effective control; or ≥1 in 100 chance within 12 months |
| 2 | Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction | 2 | Unlikely | Good control; or ≥1 in 1000 chance within 12 months |
| 1 | No harm; 0 - £50K loss; or No disruption – service continues without impact | 1 | Extremely Unlikely | Very good control; or < 1 in 1000 chance (or less) within 12 months |

## Risk Escalation Arrangements (illustrated)



**Briefing**

1. The Corporate Risk Register (CRR) has been kept under review with input from the Executive during October 2016. The CRR continues to be rebuilt and reassessed accordingly. This work remains ongoing at time of report. This follows: (i) a simplification and rationalisation of the arrangements for risk management and escalation; (ii) consideration and acceptance by the Board in August of a range of proposals to enhance governance and risk; and (iii) a decision to accelerate the migration of risk registers at divisional and corporate levels into a single electronic database within Datix. Training is being rolled out to support and assist risk register gatekeepers at divisional and corporate levels. This will allow efficient analysis, better oversight and enhanced risk escalation arrangements. Until this work is concluded, caution is advised when interpreting the CRR. The CRR may change as further analysis, challenge and development of the risk profile progresses.

   The full CRR is available in the reading room for reference.

## On The Radar

**Core Operational Risk**

2. The understanding of corporate risk is evolving rapidly as the Executive identify and address uncertainty ahead. A range of significant/extreme operational risks have been identified and are currently being mitigated. These risks could have a direct bearing on requirements within NHSI's Risk Assessment Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective. Figure 1 illustrates using a driver diagram the primary cause, effect and potential impact of core operational risks currently on the CRR. The Board remains exposed to extreme risk in the following areas:

   - **Timely Access to Clinical Services/Patient Harm**
   - **Insufficient Resilience/Unstable Critical IT/Estates Infrastructure**
   - **Unsustainable Financial Position**
   - **Inadequate Governance/Reputation Loss**

3. In due course, once divisional risk registers have been examined more closely, the Corporate Risk Register will reflect risks rated 15 or more after verification and authorisation from the Risk Management Committee.

**Core Strategic Risk**

4. The Board's strategic risks have been assessed and incorporated into the Board Assurance Framework (BAF). This was reviewed by the Board on 6th October 2016. The strategic risk vectors identified for inclusion in the BAF are as follows (in no particular order):

   - **Corporate strategy not aligned to commissioning intentions or anticipated regulatory changes** (i.e. the Trust, CCGs or regulators are moving in different directions - one of the causes might be that commissioning intentions are not known to the Trust, or a lack of clarity regarding corporate strategy, other potential causes might include conflict, competition or poor stakeholder relations)
   - **Exposure to local and specialist commissioner affordability** (this is currently subject to further review)
   - **Loss of influence within and across the local health economy** (one of the potential causes might be inadequate stakeholder relationships)
   - **Addressing demand for care** (on the assumption that demand for services will continue to grow and supply-side resources continue to be stretched)
   - **Future supply, recruitment and retention of the workforce** (thereby affecting staffing levels, quality, safety and operational compliance)
   - **Failure to retain critical community contracts** (one of the causes might be poor

quality/performance/outcomes, or inadequate stakeholder relationships)
- **Expanding deficit and non-delivery of the financial plan** (to incorporate the combined effects of income volatility, liquidity and CIP delivery)
- **Poor or insufficient quality governance** (i.e. poor standards of care, unintended consequences of CIP, poor risk management, non-compliance with CQC)
- **Insufficient performance against contracts and KPIs** (to incorporate applicable KPIs in the NHS Outcomes Framework)
- **Poor service user experience** (inadequate user satisfaction with services for example, this has subsequently been incorporated with the quality governance vector)
- **Failure to deliver the estate improvement or backlog maintenance**
- **Prolonged and unrecoverable critical IT system down time.**

**Proceedings of the Risk Management Committee**

5. The Risk Management Committee met on 14 October 2016 to review the corporate risk register and to review in more details reportable risk in: (i) Children's, Women's, Diagnostic and Therapeutic Division, (ii) Community Services Division; (iii) Estates and Facilities function and (iv) Human Resources function.

   An interim risk appetite was advanced for consideration, and approved for circulation, pending an opportunity for the Board to review at later date. Interim Risk Appetite Statement attached as appendix 2.

**Decision Points**

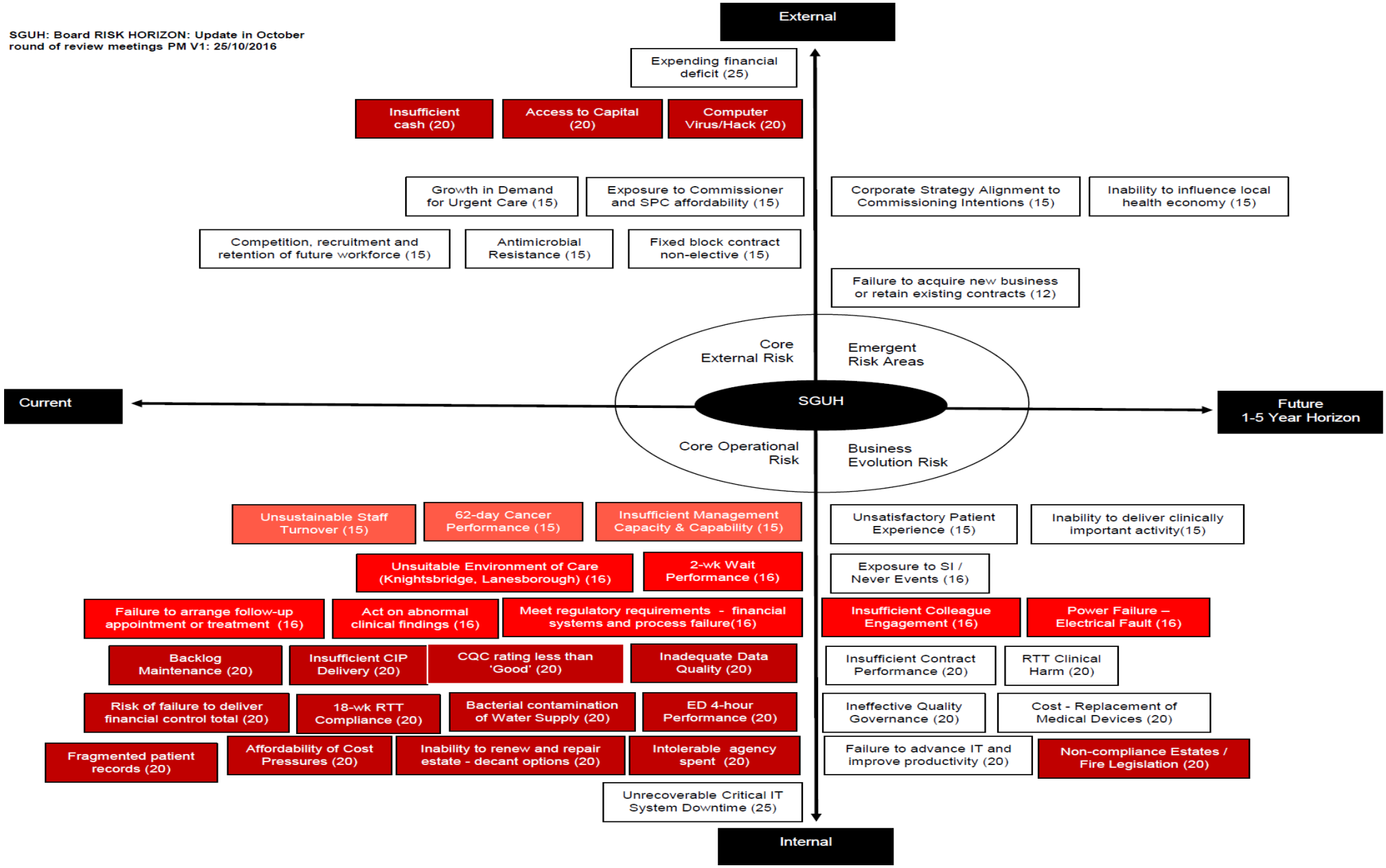
(a) The Board are invited to satisfy itself that the current level of risk exposure is tolerable or acceptable and also satisfy themselves that the risk is under sufficient control;
(b) The Board are invited to consider and advise on any further mitigating action required to achieve control; and
(c) To consider whether any modification is needed to the Board's risk appetite in light of current risk exposure and act accordingly

**Paul Moore**
**Director of Quality Governance**
**October 2016**

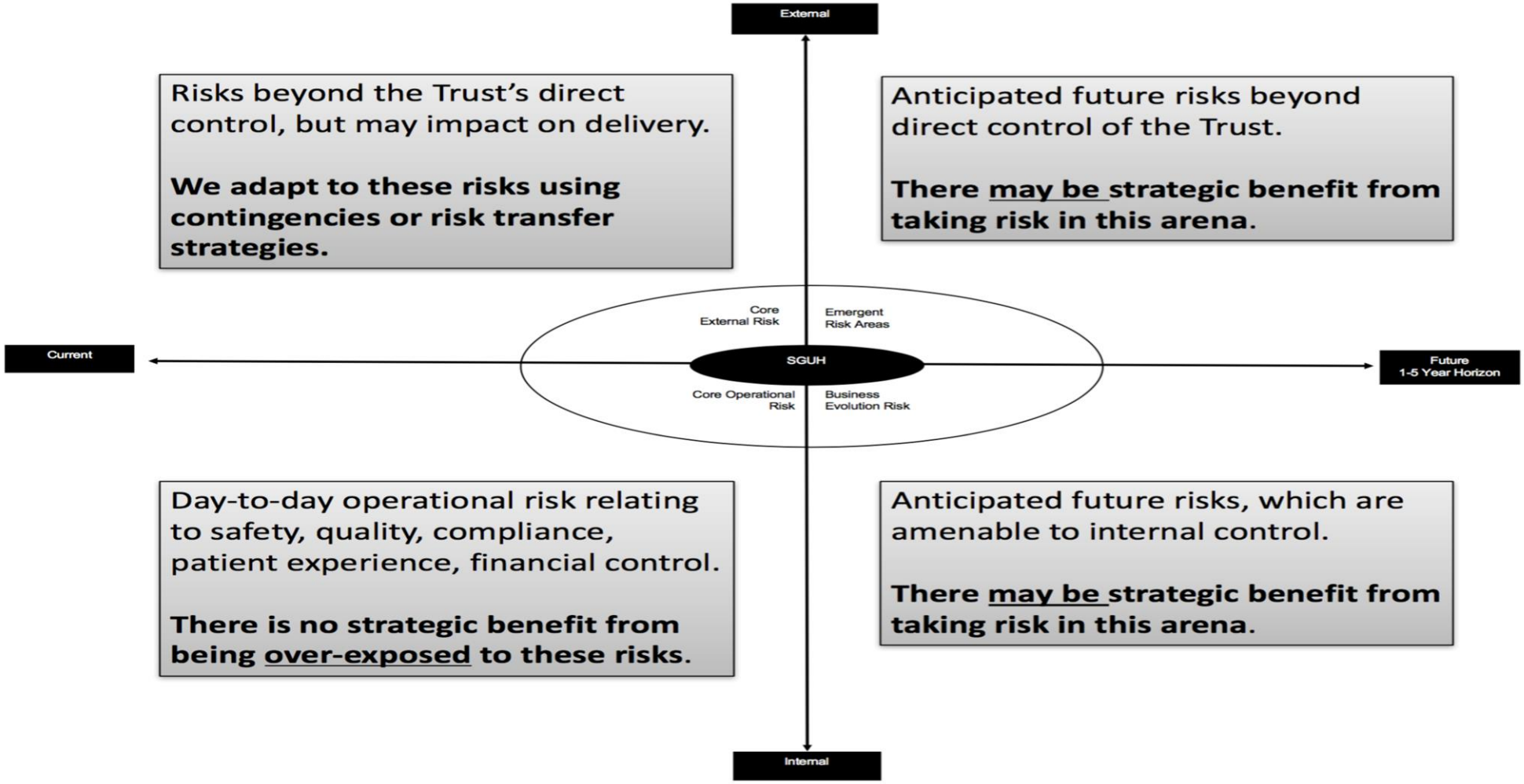
**Figure 1: Core Operational Risk Drivers – OCT 2016**

| PRIMARY CAUSE | RATING | IN MONTH CHANGES | EFFECT | POTENTIAL IMPACT 16/17 |
|---|---|---|---|---|
| Increasing 18-Week RTT backlog with potential for clinical harm | 20 | ⇔ | Timely Access to Clinical Services / Patient Harm | Continuity of Clinical Services<br><br>Material Breach of Licence Conditions<br><br>Integrity of CQC Certificate of Registration |
| Below target 2-week wait performance | 16 | ⇔ | | |
| Below target 62-day cancer performance | 15 | ↑ | | |
| Failure to arrange follow-up appointments or treatments (where clinically required) | 16 | ⇔ | | |
| Below target ED 4-hour performance | 20 | ⇔ | | |
| Unsuitable environment of care (Renal Unit, Lanesborough OPD) – risk of premises closure, prosecution, fire | 16 | ⇔ | Insufficient Resilience / Unstable critical IT and Estates Infrastructure | |
| Potential unplanned closure of premises / non-compliance with estates or Fire legislation | 20 | ⇔ | | |
| Bacterial contamination of water supply (Legionella, Pseudomonas) | 20 | ⇔ | | |
| Inability to address backlog maintenance requirements | 20 | ⇔ | | |
| IT storage: unrecoverable IT system downtime (affecting critical clinical, web and email systems) | 25 | ⇔ | | |
| Vulnerability to computer virus or attack | 20 | ⇔ | | |
| Inability to renew and repair clinical areas due to high bed occupancy and no decant options | 20 | ⇔ | | |
| Power failure – electrical fault | 16 | ⇔ | | |
| Insufficient CIP delivery in 2016/17 | 20 | ⇔ | Unsustainable Financial Position in 2016/17 and beyond | |
| Insufficient cash to meet payment demand | 20 | ⇔ | | |
| Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressures | 20 | ⇔ | | |
| Inability to control agency staffing and associated staffing costs | 20 | ↑ | | |
| Risk of failure to deliver the financial control total | 20 | ⇔ | | |
| Inability to meet regulatory requirements due to financial system and process failure | 16 | ⇔ | | |
| CQC rating less than 'Good' – insufficient safety, effectiveness, caring, responsiveness or not well-led | 20 | ⇔ | Inadequate Governance / Reputation Loss | |
| Failure to recognise, communicate and act on abnormal clinical findings | 16 | ⇔ | | |
| Ongoing exposure to high numbers of serious incidents and never events | 16 | ⇔ | | |
| Fragmented electronic and manual patient records | 20 | ⇔ | | |
| Unsustainable levels of staff turnover | 15 | ⇔ | | |
| Insufficient management capacity or capability to deliver turnaround programme | 15 | ⇔ | | |
| Failure to secure colleague engagement | 16 | ⇔ | | |
| Inadequate data quality, completeness or consistency | 20 | ⇔ | | |
| ↑ = Risk Increase; ↓ = Risk reduced; ⇔ = No change from previous report to Board | | | | |

## Figure 2: Emergent Risk Horizon Scan – OCT 2016



**Appendix 1: Interpreting the Risk Horizon**



**Appendix 2: Interim Risk Appetite Statement**

St George's University Hospitals NHS
NHS Foundation Trust

## Interim Risk Appetite Statement

St. George's University Hospital NHS Foundation Trust will not expose patients to risks that they have not been properly informed of and have agreed to take.

In an emergency, the Trust will act where necessary to save life but in doing so it will take the minimum amount of risk needed. All reasonably foreseeable hazards to personal and patient safety will be identified, managed and kept as low as reasonably practicable.

The Trust will endeavour to innovate, improve performance and maximise opportunity which may involve the need to take risks. Any risk needed to be taken, that may subsequently expose the Trust to extreme risk, shall be considered and approved by the Executive and authorised by the Board of Directors before the Trust is exposed.

## How to interpret the Board's risk appetite in practice

**Patient Safety -** The Trust will not take risks which could result in harm to patients, visitors or staff, unless the risk is a risk arising out of care or treatment options and the patient has been fully informed and given their consent.

**Achieving Strategic Objectives -** Achieving strategic objectives is challenging and involves balancing a range of competing priorities. It may be necessary to take a risk - such as developing innovative models of care, reducing the cost of care, experimental clinical treatments, changes to information systems or the estate. If the risk is extreme, because it is high impact and high likelihood, staff must seek approval from the Executive before the risk is taken

**Finance -** Managing finances is extremely challenging and will involve risk. Therefore will not make financial decision which expose people to the risk of harm, unless there is acceptable mitigation in place. However, the Trust may need to save large sums of money by working differently and to do so will require consideration of risk. Any risk which is needed to achieve financial objectives shall be evaluated and if the risk is extreme, it shall only be taken after approval of the Executive

**Compliance -** The Trust is required to comply with a large amount of regulations, standards and targets. The Trust will not take risks which compromise compliance with the law, regulations, standards or targets unless effective mitigation is in place. If a risk needs to be taken and may expose the Trust to extreme risk of non-compliance, prior approval shall be required from the Executive

Signed

Prof Simon Mackenzie
Chief Executive

St George's University Hospitals NHS
NHS Foundation Trust

**REPORT TO TRUST BOARD** ***November 2016***

| | |
|---|---|
| **Paper Title:** | Quarterly report: Serious Incidents (SIs) incorporating:<br>1. Overview of SIs declared year to date including Never Events<br>2. Current performance status against timescales for SI investigation reports<br>3. Trust-wide learning from SIs |
| **Sponsoring Director:** | Paul Moore, Director of Quality Governance |
| **Author:** | Sal Maughan, Head of Governance<br>Jenny Miles, Risk Manager |
| **Purpose:** | To update the Board upon the current SI profile compared with activity from the previous year and to highlight key learning points and actions taken. |
| **Action required by the committee:** | To note the report |
| **Document previously considered by:** | Patient Safety and Quality Board |

**Executive summary**
Key messages:

This report provides an overview, year to date, of the Serious Incidents (SIs) that have been declared by the Trust, including a summary assessment of Trust wide learning.

- During April – September 2016/17 there have been 51 SIs declared compared with 81 during the same period in 2015/16 – this represents a reduction of 37%.
- During the reporting period there have been 2 Never Events declared compared with 6 during the same period last year. The 2 declared in 2016/17 both relate to Wrong Site Surgery.

**Risks**
There is currently a related risk on the Corporate Risk Register:
*'On-going exposure to high numbers of serious incidents and never events'*
Risk score C4 x L4 = 16.

| | |
|---|---|
| **Related Corporate Objective:**<br>*Reference to corporate objective that this paper refers to.* | All |
| **Related CQC Standard:**<br>*Reference to CQC standard that this paper refers to.* | All CQC Fundamental standards & regulations |

**Equality Impact Assessment (EIA): Has an EIA been carried out? Yes**
**If yes, please provide a summary of the key findings**

## 1. SIs declared including Active SIs by Division

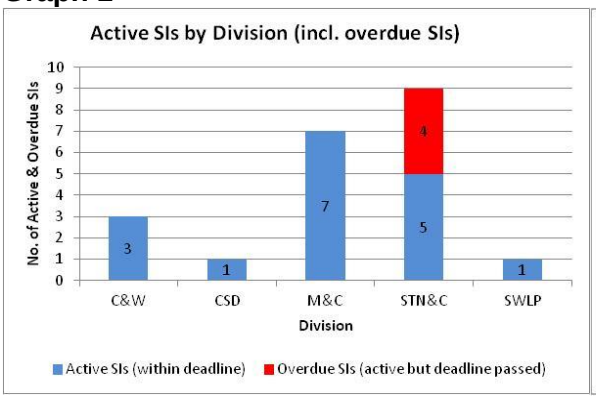
An overview of SIs declared by division (2016/17 YTD) is provided at Table 1:

**Table 1**

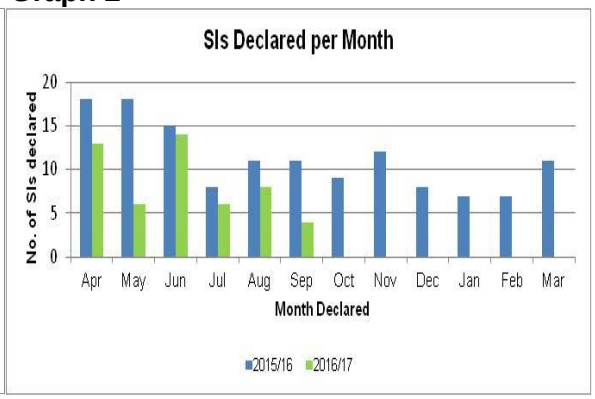
| | Apr | May | Jun | Jul | Aug | Sep | **Total** |
|---|---|---|---|---|---|---|---|
| C&W | 4 | 1 | 3 | 3 | 3 | | **14** |
| Corporate | 1 | | 3 | | | | **4** |
| CSD | | 1 | | | | 1 | **2** |
| M&C | 5 | 2 | 5 | 1 | 4 | 1 | **18** |
| M&C/C&W | | 1 | | | | | **1** |
| STN&C | 2 | 1 | 3 | 1 | 1 | 2 | **10** |
| SWLP | 1 | | | 1 | | | **2** |
| **TOTAL** | | | | | | | **51** |

Graph 1 displays the number of active SIs per division, including overdue SIs. At the time of producing this report, there are 21 active SIs, of which 4 are overdue. For each of the 4 overdue reports, the investigation has been completed and final reports are currently undergoing final quality assurance checks before final sign off and submission to commissioners. Graph 2 compares the number of SIs declared each month during 2015/16 and 2016/17.

**Graph 1**




**Graph 2**




## 2. Never Events declared in 2016/17

Between April and September 2016, there have been two never events[1] declared, both of these relate to Wrong Site Surgery.

The first case related to a paediatric dental case whereby an incorrect tooth was removed as part of a multiple tooth extraction. The tooth was immediately re-implanted successfully.

The second case related to the excision of a sublingual gland from the left side, rather than the right as it was considered this was clinically indicated. The patient was not required to undergo further surgery as the right sided mass resolved spontaneously.

[1] Never Events are a sub-category of serious incidents that are considered preventable due to there being strong national systemic protective barriers available to prevent occurrence. There is a prescribed list of Never Events i.e. retained foreign object post-surgery. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened for that incident to be categorised as a Never Event.

## 3. 2016/17 Year-to-date - Categories of SIs declared

| Type & Categories of Declared Serious Incident 2016/17 | | Apr | May | Jun | Jul | Aug | Sep | Total |
|---|---|---|---|---|---|---|---|---|
| Clinical Assessment / Diagnosis | Failure to follow up | 2 | 2 | | | | 2 | 6 |
| | Mis-diagnosis | 1 | | | 1 | 1 | | 3 |
| | Failure to commence treatment | | | 1 | | | | 1 |
| | Failure to act on adverse image results | | | 1 | | | | 1 |
| | Delay to act on adverse test results | | | | 1 | | | 1 |
| | Delay to Imaging | | | | | 1 | | 1 |
| | Delayed diagnosis | 2 | | | | | | 2 |
| Labour/ Maternity | Unexpected admission to NNU | 1 | | | | 1 | | 2 |
| | PPH (Contributed) | | | 1 | | | | 1 |
| | Placental Abruption | | | 1 | | | | 1 |
| | Retained swab | | | | 1 | | | 1 |
| | Neonatal Death | | | | | 1 | | 1 |
| | Delay in treatment | 1 | | | | | | 1 |
| Treatment/ Procedure | Delay in administration of immunoglobulin | 1 | | | | | | 1 |
| | H&S Needle Stick Injury | 1 | | | | | | 1 |
| | Lost Specimen | | 1 | | | | | 1 |
| | Delay in treatment | 2 | | | | | | 2 |
| | Unavailability of medical device | | | 1 | | | | 1 |
| | Wrong Site Surgery | | 1 | | | 1 | | 2 |
| Trust IT system | RTT Data Quality | | | 1 | | | | 1 |
| Medication | Medication omission | 1 | | 1 | | | | 2 |
| | Wrong Dose | | 1 | 1 | | | | 2 |
| Falls | Patient fall | 1 | | 1 | | 1 | 1 | 4 |
| Pressure Ulcer | Pressure Ulcer - Grade 3 | | | 2 | | | | 2 |
| Unexpected death | Unexpected death | | | 1 | 2 | 1 | | 4 |
| | Death in Custody | | 1 | | 1 | | 1 | 3 |
| Hospital Equipment | IT Downtime | | | 1 | | | | 1 |
| | Ventilation (Service Suspension) | | | 1 | | | | 1 |
| Infection Control | C difficile | | | | | 1 | | 1 |
| Total | | 13 | 6 | 14 | 6 | 8 | 4 | 51 |

## 4. Trust wide learning from SI reports completed in Quarter 2 2016/17

Following completion of the root cause analysis investigation the final SI report is written which includes a SMART action plan to address all points of learning. All reports are then considered in order to identify any Trust wide learning for dissemination throughout

organisation via various newsletter and events. Each individual action plan and the Trust wide learning are reported in detail to the Trust's Patient Safety and Quality Board.

During quarter two there were 32 SI reports completed and as a result of analysis of learning points identified, the following are current areas of focus for the Trust:

- Early warning scores (EWS) and recognition of deteriorating patients
- Team working
- Safer surgery checklist use
- Reviewing arrangements for trialing medical devices in theatre
- Better control over the booking of follow up appointments
- Improved record keeping.