Trust Board Meeting

Date and Time: Thursday 9 February 2017, 10:00 – 12:15
Venue: Boardroom H2.7, 2nd Floor, Hunter Wing

STAFF STORY
Tom Howard will present a Staff Story on the Central Booking Service (CBS) and how with the help of Listening Into Action (LIA) the team have improved patient service, staff morale, and developed a much healthier and open staff/management relationship.

Time	Item	Subject	Action	Lead	Format
OPENING ADMINISTRATION					
10:15	**1.1**	**Welcome and Apologies**	-	Chairman	-
	1.2	**Declarations of Interest**	-	All	Oral
	1.3	**Minutes of Meeting held on 05.01.17**	Approve	Chairman	Paper
	1.4	**Action Log and Matters Arising**	Review	All	Paper
	1.5	**Chair & CEO's Report**	Inform	CEO	Oral
PATIENT SAFETY, QUALITY AND PERFORMANCE					
10:30	**2.1**	**Emerging Outpatients Strategy**	Update	MD	Paper
	2.2	**Quality Improvement Plan**	Assure	DQG	Paper
	2.3	**Performance & Quality Report**	Review	COO/MD	Paper
	2.4	**Elective Care Recovery Programme**	Update	ECRPD	Paper
	2.5	**Standard Operating Procedure**	Review	COO	Paper
	2.6	**Report from Quality Committee**	Inform	Chair of Committee	Paper
FINANCE					
11:10	**3.1**	**Month 9 Finance Report**	Assure	CFO	Paper
	3.2	**Report from Finance & Performance Committee**	Inform	Chair of Committee	Oral
WORKFORCE					
11:30	**4.1**	**Workforce Performance Report**	Update	HRAB	Paper
	4.2	**Report from the Workforce and Education Committee**	Inform	Chair of Committee	Oral
	4.3	**Guardian of Safe Working Report (Q3)**	Assure	MD	Paper
GOVERNANCE & RISK					
11:50	**5.1**	**Corporate Risk Report**	Review	DQG	Paper
	5.2	**Report from Audit Committee**	Inform	Chair of Committee	Paper
CLOSING ADMINISTRATION					
12.05	**6.1**	**Questions from the Public**	-	Public	Oral
	6.2	**Summary of Actions**	-	Co Sec	Oral
	6.3	**Any New Risks or Issues**		All	-
	6.4	**Items for Future Meetings** i. Review of Trust's Insurance Arrangements (March 2017) ii. Update on Leadership Development (March 2017) iii. Communications Strategy and Annual Plan (March 2017) iv. Lanesborough Wing, Electrical HV/LV Infrastructure Upgrade (March 2017) v. Flow Update (March 2017) vi. Estates Strategy (April 2017) vii. Update on Outpatients Programme and Business Case (May 2017) viii. Evaluation of Overseas Visitors and Migrant Cost Recovery Pilot (June 2017)		-	-
	6.5	**Any Other Business**	-	Chair	-

		Reflection on Meeting	-	All	Oral
12:15		**Close**			

Resolution to move to closed session

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

Date and Time of Next Meeting: Thursday 9 March 2017, 10:00 – 13:00

Trust Board
Purpose, Membership and Meetings

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

Membership and Those in Attendance		
Members (Voting)	**Designation**	**Abbreviation**
Sir David Henshaw	Chairman	Chairman
Simon Mackenzie	Chief Executive	CEO
Ann Beasley	Non-Executive Director	
Stephen Collier	Non-Executive Director	Name/NED
Jenny Higham	Non-Executive Director (University Rep)	
Gillian Norton	Non-Executive Director	
Sir Norman Williams	Non-Executive Director	
Sarah Wilton	Non-Executive Director	
Avey Bhatia	Chief Nurse	CN
Margaret Pratt	Chief Financial Officer	CFO
Andrew Rhodes	Medical Director	MD
Thomas Saltiel	Associate Non-Executive Director	Name/NED
Executive Team		
Mark Gammage	HR Advisor to the Board	HRAB
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
Diana Lacey	Elective Care (Data Quality) Recovery Programme Director	ECRPD
Iain Lynam	Chief Restructuring Officer	CRO
Paul Moore	Director of Quality Governance	DQG
Larry Murphy	Chief Information Officer	CIO
Divisions		
Alison Benincasa	Divisional Chair, CSD	DC/CSD
Tunde Odutoye	Divisional Chair, SCTN	DC/SCNT
Lisa Pickering	Divisional Chair, MedCard	DC/MedCard
Justin Richards	Divisional Chair, CWDT	DC/CWDT
Secretariat		
Fiona Barr	Corporate Secretary and Head of Corporate Governance	Co Sec

Trust Board Dates 2016-17
Thursday 09.03.17 10:00 – 15:30

St George's University Hospitals NHS
NHS Foundation Trust

Trust Board (Public)
5 January 2017 – From 10:00
H2.7 Boardroom, 2nd Floor, Hunter Wing

Name	Title	Abbreviation
PRESENT		
Sir David Henshaw	Non-Executive Director (Trust Chairman)	Chair
Simon Mackenzie	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Gillian Norton	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Suzanne Banks	Chief Nurse	CN
Margaret Pratt	Chief Financial Officer	CFO
Andy Rhodes	Medical Director	MD
IN ATTENDANCE		
Thomas Saltiel	Associate Non-Executive Director	ANED
Mark Gammage	HR Advisor to the Board	HRAB
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
Iain Lynam	Chief Restructuring Officer	CRO
Paul Moore	Director of Quality Governance	DQG
Larry Murphy	Chief Information Officer	CIO
Alison Benincasa	Divisional Chair, CSD	DC - CSD
Tunde Odutoye	Divisional Chair, Surgery	DC - SNTC
Justin Richards	Divisional Chair, CWDT	DC - CWDT
Lisa Pickering	Divisional Chair, MedCard	DC - MedCard
SECRETARIAT		
Fiona Barr	Interim Corporate Secretary & Head of Corporate Governance	Co Sec

PATIENT STORY

The Chairman invited Mark Westcott to describe his experience of being a patient at St George's. Mr Wescott's concerns centred on a lack of sleep on the wards, very high temperatures, a lack of fresh air, concerns about infection prevention and control but particularly the food that was served during his stay which did not cater for vegan patients and which presented food choices with a high fat and sugar content. Mr Westcott explained that he had made a complaint about his experiences, which had been dealt with helpfully and professionally, though his main concern remained on the food provided in the hospital. On behalf of the Board, the Chair thanked Mr Westcott for sharing his experiences and asked him if he would help the Trust improve the food choices to patients. Mr Westcott agreed and the CN agreed to involve Mr Westcott in a taskforce to help the Trust significantly improve the food it served to its patients and also cater for different needs. Mr Westcott was very happy to accept the invitation.

TB.05.01.17/07	Chief Nurse to involve Mark Westcott in a campaign to improve hospital food and ensure that it caters for patients with different needs.

OPENING ADMINISTRATION

Welcome and Apologies

1.1	The Chairman opened the meeting and welcomed everyone.
1.2	The apologies were as set out above.

Declarations of Interest	
1.3	The Chairman asked for declarations of interest. None were made.
Minutes of Meeting held on 01.12.16	
1.4	These were accepted as a true and accurate record of the meeting held on 01.12.16 save for an amendment to change minute 2.4 from "first collaborative palliative care meeting" to "end of life steering group meeting".
Matters Arising and Action Log	
1.5	The Board received the Action Log and noted that actions TB.03.11.16/02 and TB.03.11.16/05 could be closed subject to their consideration on the agenda.
Chief Executive's Report	
1.6	The CEO confirmed that the Trust had signed contracts with commissioners and submitted its financial plans for the years 2017-19. Both the South West London CCGs' and the NHS England Specialised Services' contracts had been agreed on Payment by Results basis that reduce the income risk to the Trust. Richmond CCG had indicated that it would implement a prior approval process for Procedures of Limited Clinical Effectiveness from January 2017 which the Trust was planning to challenge. The Annual Plan and financial models that would form the basis for income and expenditure budgets in 2017-18 were submitted to NHS Improvement (NHSI) on 23.12.16.
1.7	The Trust received a visit from senior representatives from NHSI between Christmas and New Year who commended the Trust on progress being made since 01.11.16 when the Trust was put into Special Meausures.
1.8	The CEO concluded by advising that Avey Bhatia would joining the Trust as Chief Nurse on 01.02.17 on a one year secondment from Maidstone and Tunbridge Wells NHS Trust replacing Suzanne Banks, Chief Nurse, who leaves at the end of January.
PATIENT SAFETY, QUALITY AND PERFORMANCE	
Trust Quality Improvement Programme Progress Report	
2.1	The DQG presented the Quality Improvement Progress (QIP) report which updated the Board on the Quality Improvement Plan, and provided assurance on progress and a breakdown of the anticipated benefits for each workstream. The actions which were not on track or were at risk of breaching implementation deadlines were reported as exceptions.
2.2	The Quality Improvement Plan was reported to be making good progress; most of the actions were on track or ahead of schedule. Staff on Gwynne Holford ward were praised for their efforts though overall on the QIP, challenges remained with: i. Depivation of Liberty Safeguards (DOLS) compliance ii. Old beds/bed rails which required replacement iii. Duty of candour compliance iv. Apprentice programme not delivering to agreed to timescales v. Some elements of the Estates workstream, particularly fire safety wardens and evidencing the water flushing regime.
2.3	The NEDs welcomed the thoroughness of the plan but questioned if efforts would be better directed in tackling the Care Quality Commission's "must do" actions rather than being so task orientated. They also queried if the delivery appeared "too green". The NEDs were assured that the regulators' concerns would be addressed by good practice

	becoming "business as usual"; the DQG confirmed that good progress was being made.
2.4	The Board thanked the DQG for the update and received the report.
Performance & Quality Report	
2.5	The COO introduced the performance report advising that early indications of the Trust's performance over Christmas was positive and the Trust had fared well, not least due to pre-planning the impact of the Christmas period back in November. There was an increase in the number of operations were cancelled on the day in November – this was attributed to the Trust being put under additional pressures as it had to cope with a local tram derailment (which was handled very expertly) and temperature and ventilation failures. All cancellations were now reviewed every week and preparations had been made for managing occupancy and increased unplanned activity for January – December involving all the Divisions.
2.6	The CN led the Board through the quality metrics noting that mortality remained within normal range though there had been a slight increase in Serious Incidents (SIs) in November. Whilst the safety thermometer metrics were in line with the national position, there was an increase in pressure ulcers in November. These were both old and new pressure ulcers and therefore included both patients who had acquired pressure ulcers whilst at the Trust as well as those admitted from a care home/their own home with a pre-existing pressure ulcer. The Board was advised how the Trust was working with the CCGs to flag these patients to ensure - from a safeguarding perspective – they were followed up. The CN confirmed that, to capture performance more accurately, she was now measuring pressure ulcers/1000 bed days (this related to action TB.03.11.16/02). For the fifth consecutive month, patients had not developed a grade 3 or 4 pressure ulcer whilst at the Trust and performance remained well below the threshold of 19 for 2016-17.
2.7	There had been a year to date reduction in the number of patient falls. Measured per 1000 bed days, the acute service performance in November was 3.69 against national benchmark of 5.6 though the community service performance was slightly above the national average of 9.16 at 8.6.
2.8	In December, a point prevalence audit of all beds and trolleys showed that a large number needed replacement. ***Post Meeting Note:*** *Following the Board meeting, the Executive confirmed an investment in new bed stock in reponse to the findings.*
2.9	The CN reported a rise in CDiff cases: four in December and a year to date total of 26 against an annual threshold of 31 cases. The position was being closely monitored through infection control audits though there was no evidence to suggest inappropriate antibiotic use and all but the latest case had been assessed as "unavoidable". A flu outbreak within the Trust was also being closely monitored.
2.10	She closed by advising that she had commissioned an external review of safeguarding and following, training in Level 3 Safeguarding and Deprivation of Liberty Safeguards (DOLS), there had been an increase in DOLS requests. Complaints increased in November though there was no change in the themes.
2.11	The Board received the report.
Overseas Visitors and Migrant Cost Recovery Pilot	
2.12	The CRO introduced the paper which proposed that the Trust participated in a pilot to recover costs from overseas visitors and migrants who used NHS services but were not entitled to free NHS care. Following recent research by NHSI, a number of trusts which had a high number of such users had been approached to participate in a pilot scheme to recover costs in two clinical areas: maternity and an elective service. Previously

	these costs had been written off.
2.13	The Board was advised that St George's would be one of twenty trusts in the pilot and patient and clinical safety would remain the overriding priority throughout; as now emergency patients would continue to be treated free of charge. Planning had started in October 2016 and the pilot study aimed to provide better understanding of the scale of the issue and how best to recover costs from overseas visitors and migrants. Two forms of identification would be requested from those wishing to use the Trust's services in the pilot scheme.
2.14	The Board approved the Trust's involvement in these pilots and its wider participation in a project into overseas visitors and migrant cost recovery. It agreed to receive an evaluation report in June 2016.
TB.05.01.17/08	Board to receive an evaluation report on the pilot programme to recover costs in two clinical areas (maternity and an elective service) from overseas visitors and migrants who use NHS services but are not entitled to free care. Report to be received in June 2016. LEAD: CRO
FINANCE	
Month 8 Finance Report	
3.1	The CFO presented the Month 8 Finance Report which showed the Trust had an in-month deficit of £3.9m in November 2016 which was £4.4m worse than plan. Included in month were a non-pay overspend, excess pay costs and above plan income though some costs for pay and non pay were unforeseen and outside the control of the Trust. The YTD deficit was £51.6m and the Trust was assuming a year-end deficit forecast of £80.7m which was significantly greater than the £17.2m planned deficit.
3.2	Whilst agency costs had risen since Month 7, more controls were now in place and a change of attitude towards using agency workers was evident. The CFO advised that she would undertake a detailed review of risks and opportunities and report a more detailed position in February. The Finance & Performance Committee later in the month would examine the Trust's financial position closely.
3.3	The Board received the report and noted the current Trust financial position.
Report from Finance & Performance Committee (FPC)	
3.4	As this had been covered in the previous item, the Chair advised he had nothing further to report from the FPC.
Communications Plan to Support Trust's Long-Term Strategy	
3.5	The CEO introduced the paper, explaining that this was a communications strategy to raise awareness and seek buy-in for the Trust's long-term strategy agreed by the Board in December 2016.
3.6	The Board approved the broad approach and planned communications activity and agreed to minor changes in the Clinical Vision and Strategic Priorities, subject to replacing the word "become" with the word "be" in the Strategic Priority on Teaching and Research: ***Teaching and Research:*** *To* ***be*** *a high quality centre for teaching and world-class research, in partnership with St George's, University of London.*
WORKFORCE	

Workforce Performance Report	
4.1	The HRAB presented the Workforce Report which showed that: i. Staff in post had increased and vacancies reduced though there was still more to do to reduce agency usage and spend. The Trust was continuing to recruit in all areas. ii. Turnover rates remain high. iii. Appraisal and mandatory & statutory training (MAST) compliance rates were poor – including by comparison with similar Trusts.
4.2	Measures to exert a greater grip and control on payspend and overall workforce efficiency included: i. Recruiting substantively where possible to reduce agency expenditure. ii. Examining all requests for recruitment to explore ways in which the resource need could be managed differently (eg through business re-engineering or process re-design). iii. Understanding the overall establishment position before the approval to recruit is given as the current establishment is based on out of date information and the new establishment will be informed by the Demand and Capacity Model being developed by the COO. iv. Reviewing the end to end recruitment process to see where improvements can be made. v. Improving the bank staff system and procedures.
4.3	The Board noted the workforce performance report and actions outlined within it but agreed to meet for a half day workshop to better understand the impact on demand and capacity modelling on workforce planning (including job planning).
TB.05.01.17/09A	Organise a half day workshop before the end of January to better understand the Demand and Capacity Model and its implications, particularly on workforce planning. LEAD: Co Sec
4.4	The HRAB also confirmed that there needed to be better and more regular performance management of staff and all staff should be formally appraised at least annually. He advised that he and his team could help by simplifying the appraisal procedures and also providing appraisal training. NED Jenny Higham also asked that appraisal for clinical staff was closely linked to the University where necessary.
4.5	Regarding MAST, the HRAB advised that some of the problems associated with the low levels of compliance could be an incomplete understanding of the level and frequency of training required by different groups of staff. This would be better understood by conducting a training needs analysis to better understand the requirements and so inform the MAST programme. He also noted that there remained some problems with the electronic recording of training which also had to be addressed and resolved.
4.6	The Board received the report but requested a further update at its next meeting.
TB.05.01.17/10	Provide an update on MAST training at the February Board meeting (09.02.17). LEAD: **HRAB**
Leadership Development	
4.7	The Board was advised that the Trust had made insufficient investment in leadership development and capacity in recent years and this had to be addressed to drive positive change within the organisation. Recent reports by the Care Quality Commission and PwC had pointed to weaknesses in leadership and governance though the Trust had been successful in obtaining funding from Health Education England South London (HEESL) which planned to use to invest in clinical leadership.
4.8	The Board supported the approach to leadership development and use of HEESL funding and to a 'roll it forward' beyond March 2017. It also agreed to receive a further, more detailed report at its March 2016 meeting.

TB.05.01.17/11	Present an updated report on leadership development to the March Board meeting (09.03.17). LEAD: **HRAB**
GOVERNANCE AND RISK	
Information & Communications Technology (ICT) Update	
5.1	The CIO presented the paper, advising that it updated on progress made on the stabilisation of the IT infrastructure and the reduction of the risk to the Trust of catastrophic IT infrastructure failure. He noted that significant investment was required in the Trust's IT infrastructure following years of under-investment and the first priority was to ensure that the Trust had a stable IT platform after which there could be a greater focus on more strategic, long term planning for the ICT service.
5.2	The Board agreed to continue to support ICT in continuing with the current programme until completion in March 2017 though agreed that the issues with ICT should be explored at the half day away day.
TB.05.01.17/09B	Explore the current position and future plans and timescales for ICT at the half day workshop to be organised before the end of January. LEAD: Co Sec
5B Corporate Risk Report	
5.3	The DQG presented the Corporate Risk Report (CRR) noting that ICT and data quality risks featured significantly in the CRR and had the highest rating (25 – catastrophic). He also advised that a new risk had been added around the deteriorating patient.
5.4	The Board received the report.
Claims & Insurance – Briefing Paper	
5.5	The DQG presented the paper which set out the Trust's claims profile, nature of current indemnity schemes and premiums payable,and benchmarked the Trust's performance against other London acute trusts. He briefly described the review into the Trust's current insurance arrangements by an insurance expert, advising that he would provide a fuller update once this review had concluded.
5.6	The Board welcomed the paper and looked forward to a further update in March 2016.
TB.05.01.17/12	Present an update report to the March Board meeting (09.03.17) on the Trust's insurance arrangements following the review by an external insurance specialist. LEAD: **DQG**
6 CLOSING ADMINISTRATION	
Questions from Public	
6.1	Before inviting questions from the public, the Chair thanked Suzanne Banks for all her work as CN; she was standing down for personal reasons. Avey Bhatia would be joining the Trust on a one year secondment from Maidstone & Tunbridge Wells NHS Trust from 01.02.17.
6.2	Questions from the public included: i. How lessons were learned and cascaded in the organisation. ii. Concerns about the continued high use of expensive interim resources. iii. The forthcoming staff survey and morale amongst staff. iv. Having clear protocols for cost recovery from overseas visitors and migrants who use NHS services.

Any Other Business	
6.3	As there were no further items of business, the Chair resolved to move to closed session and end the meeting. He asked for reflections on the meeting and all concurred that the patient story had been very illuminating and generally these stories set the scene for the Board. It was requested that there also be staff stories presented and this was agreed.

Date and Time of Next Meeting: Thursday 9 February 2017, 10:00 – 15:30

Trust Board Public - 05.01.17

Action Ref	Theme	Action	Due	Revised Date	Lead	Commentary	Status
TB.03.11.16/03	**Mortality Statistics**	Undertake a deep dive into mortality statistics at the Quality Committee every six months.	QC.29.03.17		MD & CN	This action will be added to the Quality Committee Action Tracker for reporting at the March meeting.	Open
TB.05.01.17/07	**Patient Story**	Chief Nurse to involve Mark Westcott in a campaign to improve hospital food and ensure that it caters for patients with different needs.	TBC		CN	A verbal update will be provided in the meeting.	Open
TB.05.01.17/08	**Overseas Visitors and Migrant Cost Recovery Pilot**	Board to receive an evaluation report on the pilot programme to recover costs in two clinical areas (maternity and an elective service) from overseas visitors and migrants who use NHS services but are not entitled to free care. Report to be received in June 2016.	TB.08.06.17		CRO	Not Yet Due.	Open
TB.05.01.17/10	**Workforce**	Provide an update on MAST training at the February Board meeting (09.02.17).	TB.09.02.17		HRAB	HRAB to provide update as part of the Workforce Report to the Board on 09.02.17.	Proposed for closure
TB.05.01.17/11	**Leadership Development**	Present an updated report on leadership development to the March Board meeting (09.03.17).	TB.09.03.17		HRAB	Not Yet Due.	Open
TB.05.01.17/12	**Claims and Insurance**	Present an update report to the March Board meeting (09.03.17) on the Trust's insurance arrangements following the review by an external insurance specialist.	TB.09.03.17		DQG	Not Yet Due.	Open

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 February 2017	**Agenda No**	**2.1**
Report Title:	Emerging Outpatient Service Strategy		
Lead Director/ Manager:	Professor Andy Rhodes (SRO) - Medical Director; Alison Benincasa - Divisional Chair		
Report Author:	Steve Sewell, Programme Director		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted (select using highlight)		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	This paper outlines: the progress the Outpatient Programme has made since September 2016, the key challenges the programme faces, and the emerging strategic direction. The programme has made progress and delivered a wide range of improvements, contributing circa £2m towards the Trust's 2016-17 cost improvement target and is on target to exceed the £2.1 target for the year. This has been despite several challenges impacting progress. One of the key pieces of work is the development of a target operating model for Outpatient Services, which is now progressing well and has engaged a wide range of stakeholders. Many important strategic themes are emerging and shaping this work: • Target Operating Model centred around teams supporting groups of Clinical Services (Support Hubs) • Organising clinical services around patient pathways • Reducing overall outpatient activity provided in hospital settings • Developing stronger relationships with local providers • All Outpatient Services will operate within the agreed Target Operating Model with improved standard operating processes • The role of Clinical Specialists (Consultants/Nurses/AHPs) will begin to change and provide more; oversight of community/primary care services, education, advice and guidance to GPs, and face to face consultations in community settings. • Automation and efficiency through Technology and digitalisation of processes and patient communications is critical • Reduced operating and administrative cost of Outpatient Services *Note: a definition of Target Operating model is included in section 8.* This redesign, allied to ongoing business process improvements through the Optimise strand and the emerging new Models of Care workstream, is anticipated to deliver annual operational savings rising from £2m in 2017-18 to an estimated 30% of operating costs (~£4m) by full implementation (est 2020).		

Recommendation:	Trust Board is requested to note progress made and provide steer on current priorities and the emerging strategic direction.		
Supports			
Trust Strategic Objective:	• Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. • Refresh the Trust's strategy, to develop a sustainable service model with a clear and consistent message		
CQC Theme:	• Quality of Care • Finance and Use of Resources • Operational Performance • Strategic Change		
Single Oversight Framework Theme:			
Implications			
Risk:	See Section 3. A number of a significant challenges are outlined.		
Legal/Regulatory:	There are no specific legal or regulatory implications in this paper, although it has and will continue to address issues raised by the CQC in its recent report.		
Resources:	Improving Outpatient Services continues to be an important part of overall Trust strategy, with the approach to balance optimising the current system and future fundamental transformation. During 2017/18, it is expected that roughly £2m will be required, excluding IT and Estates cost.		
Previously Considered by:	Transformation Board (19th Jan), Outpatient Strategy Board (25th Jan).	**Date**	
Equality Impact Assessment:	Included within the DIP for current plans, will be part of the Business Case due at Trust Board in May 2017 for future plans.		
Appendices:	N/A		

Outpatient Programme
Board Update 9 February 2017

1.0 Purpose

1.1 The current Outpatient Programme has been in place since June 2016. This document updates progress to date, challenges the programme is experiencing and the emerging strategic direction.

1.2 Outpatient services are critical to the success and sustainability of the Trust. There are around 730,000 outpatient appointments undertaken across the Trust each year and they play an important role in determining the reputation of the Trust. For GPs it is the service area with which they interact with most and for patients it is often the first or only point of contact.

1.3 The Trust Board is asked to note the update and confirm the emerging strategic direction.

2.0 Programme Update

2.1 Over the five months since the last Trust Board update, the programme's key areas of progress include:

- Through widespread Text reminders for appointments and targeted communication campaigns, DNA rates have reduced from 14.2% to around 10%. The result being that 2000 additional patients receive care every month.
- Call Centre performance has continued to improve, with around 80% of calls being answered within 60 seconds although there are weeks when this has peaked at over 90%. The number of abandoned calls has decreased dramatically and around 7000 fewer people abandon calls each month
- More than 4800 redundant clinic templates have now been removed from iClip and some specialities have now submitted new, accurate templates, and updated Directories of Service (DoS) onto E-Referral (Choose and Book). 1400 new templates have been built and the 6 month backlog has been eliminated. This work has, so far, halved the number of Adhoc clinic templates being used, improving our understanding of Trust capacity and reducing process inefficiencies. It will also benefit GPs in reaching E-Referral appointment booking targets and enabling 'right first time' referrals into correct clinics.
- We have agreed with CCGs an expansion of Advice and Guidance services provided by the Trust specialists to GPs.
- Increased the outpatient activity at Nelson Health Centre by over 50% since April 2016.
- Ran a large Service Redesign workshop, with a wide range of participants, from frontline admin and clinical staff, management, patients, governors, GPs and commissioners. 130 people attended the event.
- Clearer operational business rules and governance has reduced the number of clinics cancelled within 6 weeks, reducing the number of Trust initiated cancellations.
- Eliminated incomplete referral entries on the iClip system through training and configuration changes.
- Reduced the footfall in Lanesborough Wing by 15% to meet the CQC target. This was achieved with minimal disruption to patients and GPs and smooth transfer of services

- Moving Community Midwifery and Hypertension (BPU) services out of Knightsbridge Wing in February 17.
- The first of 5 priority specialities are fully enabled for GP to Consultant advice and guidance messaging, adding to the existing 74 consultants already providing GPs with advice and guidance through the Kinesis system.
- Captured and verified the use of clinic rooms right across the Trust; developed a Clinic Utilisation Tool for use to enable better clinic room planning and space management, and reduced costs for additional space for displaced outpatient clinics.
- Developed new approaches including 'virtual clinics' to reduce follow-up appointments. across targeted specialties, with pilots starting in Jan 2017
- Have completed the transfer to 'full booking', as requested by commissioners. All patients now receive a letter with an appointment, soon after receipt of their GP referral

2.2 Progress remains broadly in line with the benefit trajectories set out in the June 2016 Value Proposition. The following table outlines the latest position against these:

Key Programme Benefits	Baseline	Actual	16/17 Target
Monthly DNA Rate	14.2%	**10.1%**	9.0%
Monthly use of Ad hoc Clinics	177	**71**	75
Clinics cancelled in < 6wks	78	**69**	25
Friends and Family Test	88%	**91%**	90.5%
Nelson Health Centre - Monthly OP Activity (November 16 data – as last full month of data)	1085	**1661**	2700
Trust Reputation - GP rating of clinical care as either high or extremely high	61%		75%
Central Booking Centre % calls answered in 1 min	20%	**89%**	95%

To date circa £2m of cost improvements have been confirmed, with the remainder of the £2.1m 2016/17 cost improvement target on track to deliver or exceed target. This has been achieved through improving clinic utilisation and in particular reducing DNA (Did not Attend) rates.

3.0 Key Challenges to Delivery

3.1 The current situation within the Trust impacts heavily on the ability of the programme to deliver its objectives. It's important to recall the main challenges that the programme faces. The main ones are as follows:

- **Maintaining focus on the programme with the scale of the problems across the Trust**
- **Being able to plan and make positive changes to services when Commissioner and STP plans and Trust Strategy are unclear**
- **The state of infrastructure limits operation and available solutions**
- **Organisation Culture**
- **Delays from navigating Corporate Processes**.

3.2 The programme does identify and manage risks, however in some areas it has limited influence to mitigate the impact or likelihood.

4.0 Emerging Strategy (Outpatient Forward View)

4.1 The Outpatient Strategy Board outlined an initial and very outline strategic direction in the summer, which was endorsed by Trust Board. From discussions with stakeholders, in particular at the Future of Outpatients service redesign event in December 2016, and at Outpatient Strategy Board a series of themes have emerged. As the programme redesigns the outpatient model and develops a supporting business case over the coming 3 months, it is important that Trust Board confirms that the emerging strategy is consistent with the overall Trust strategy.

4.2 The programme is aware of the processes to develop Trust-wide Information Technology and Estates strategies. We will maintain close links with all of these over the coming months and ensure the developing programme informs and reflects each of these. Additionally, the programme will work closely with the STP process to ensure that work also reflects the Trust commitment to the delivery of STP outpatient ambitions.

4.3 The emerging strategic themes that Trust Board are asked to endorse, are as follows:

- **Target Operating Model (definition in section 8) centred around teams supporting groups of Clinical Services (Support Hubs)** – Currently, the delivery of services within clinics is fragmented. Administrative and clinical (nursing and doctors) staff are all accountable through different management structures. The result is that processes are inefficient, and there is limited accountability for performance, quality and the financial sustainability of services. One of the strongest themes from engagement activities is the need to develop a team centred approach in clinic areas, across all grades of staff. These teams would enable greater localised responsibility for quality, performance and financial sustainability of services.
- **Reducing overall outpatient activity provided in hospital settings** - There are many services that the trust provides, which in many other parts of the UK are or would be regarded as being best delivered in primary and community based settings.
- **Developing stronger relationships with local providers** – For the Trust to support STP and commissioner plans and improve system sustainability, the Trust will need to build more effective relationships with other local providers and play an active part in the development of integrated services models through collaboration, providing strong local system leadership whilst ensuring a sustainable financial model for services. The Trust will need to play a leadership role in turning STP intentions into clinical and operational policy, innovative and reduced cost services, in particular with two largest funding commissioners (Wandsworth and Merton CCGs)
- **All Outpatient Services will operate within the agreed Target Operating Model** – To ensure that the maximum benefits for the Trust and services, all services will operate consistently within the target operating model, but with flexibility to adapt some elements at service level. There are currently many different Operating Models
- **The role of Clinical Specialists will begin to change** –the role of clinical specialist is beginning to change with an increasing requirement to provide; education, advice and guidance, clinical oversight of some integrated community/primary care services, and increased job plan time in the community. This is driven by new integrated approaches and associated pathways, crucial to the new models of care driving the STP.
- **Organising clinical services around Patient pathways** – most services are structured around professional boundaries, which don't always support the needs of Patients. The

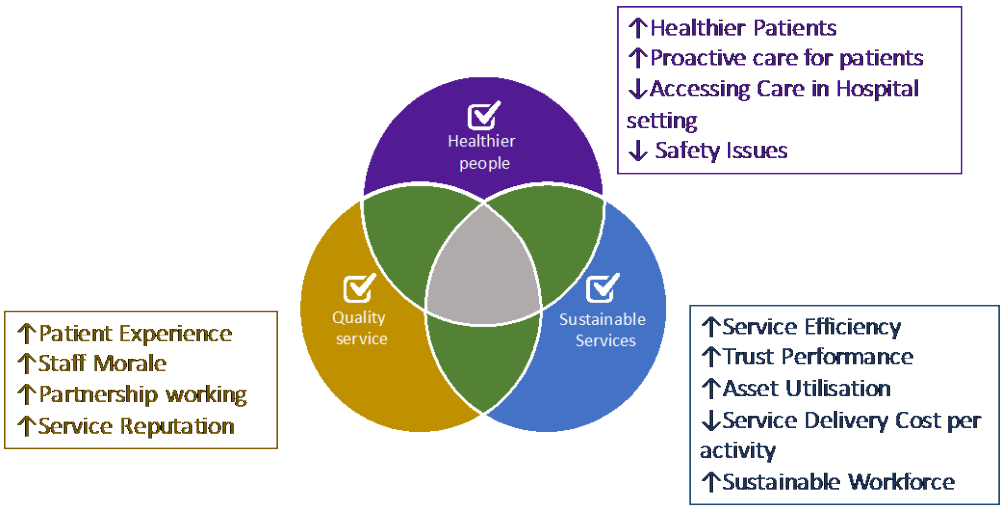
programme is developing support hubs in a manner that is more patient focused, for example, a support hub that draws together and supports patients with Cancer, drawing services from a range of specialities to enable them to work together would a provide a much better patient experience, improve efficiency and be more empathetic to patient needs.

- **Automation and efficiency through Technolgy is critical** – One of the driving forces behind the redesign work is to achieve a fully digital service and to ensure the IT strategy fully supports this. This reflects the NHS Five Year Forward View Digital Technology stream overarching objective of harnessing the information revolution is to make the NHS paperless by 2020. In particular, this will cover NHS Digital Technology key deliverables: Offering digital services for patients and citizens; Offering digital services for professionals**;** Information sharing and transparency.
- **Reduced operating and administrative cost of Outpatient Services**– The approach being taken in the redesign work is to simplify and automate processes, and ensure Trust wide consistency supported by technology. These are the key drivers for the reduction in costs associated with outpatient support services.

5.0 Plans for 2017 into 2018

5.1 The strategic direction that is emerging, outlined in section 4, drives the plans for 2017 and beyond. Over the coming weeks the programme will develop more detailed objectives and plans, supporting the Trust Strategy, emerging STP plans, and Target Operating Model for Outpatients. A Business Case to support the Target Operating Model is expected to be presented to June 2017 Trust Board for approval.

5.2. As with plans for 2016, these plans will focus on creating sustainability through achievement of a number of defined outcomes based on the following triple aim model:



5.3 The Value Proposition, agreed in July 2016, promised a business case around redesigned operating model for outpatient support services. This is due to be presented at Trust Board in early June. This business case will outline the programme for financial year 2017/18. The aim within the business case will be to deliver a range of benefits, including financial benefits (aspirations are around 30% of the cost of the current operating model across the Outpatients Directorate, and Outpatient support activity carried out by the Specialities ~ £4m) from the

redesigned model in the first year, however the full extent of the benefits will be dependent on technology and are likely to take 2 to 3 years.

5.4 Additionally, work to optimise the current outpatient model will continue with the focus over the coming months being:

- Continuing to respond to CQC concerns, reducing footfall and improving the environment in Clinics B and D (Lanesborough Wing)
- Changes to Clinical Service Models in line with STP plans
- Seek to ensure that all outpatient consultations have access to a scanned record of the notes, by fully exploiting the eDM (electronic document management) system.
- Reducing follow-up ratios and overall follow-up appointments through supporting clinical services to develop and implement new approaches that also provide more effective ongoing care
- Improving the quality of and efficient production of patient letters and other patient correspondence
- Stabilising and simplifying the very complex eTriage system and processes
- Significantly increasing the number of referrals from GPs through the E-Referral system (a national CQUIN requirement)
- Increasing the use of Telemedicine across the trust to provide services (a local CQUIN requirement)
- Significantly increasing the scale and breadth of the clinical Advice and Guidance to GPs (a national CQUIN requirement).

5.5 Finally, although STP plans are still in development, the programme will continue to work with commissioners and other providers to develop and implement these plans. It is important the Trust influences and leads the STP agenda and plans to ensure close alignment with Trust objectives. More information regarding these plans will be presented to Trust Board over the coming months.

5.6 The Trust financial situation remains a priority and the programme would be seeking to ensure around £2m of cost efficiencies from year one implementation of the redesigned outpatient model. Additionally, the programme will work closely with Divisions to support the delivery of their cost improvements. Work to outline these for 2017/18 is underway.

5.7 Outpatient services continue to be an important part of the overall Trust strategy, with a balance of optimising the system and more fundamental transformation remaining as the approach. During 2017/18, it is expected that to achieve the ambition outlined above, roughly a £2-2.5m total investment will be required, excluding IT and Estates cost.

6.0 Implications

Risks

6.1 Outlined in section 3 above.

Legal Regulatory

6.2 There are no specific legal or regulatory implications in this paper, although it has and will continue to address issues raised by the CQC in its recent report.

Resources

6.3 Outpatient Services continues to be an important part of the overall Trust strategy, with a balance of optimising the system and more fundamental transformation remaining as the approach. During 2017/18, it is expected that roughly £2-2.5m will be required, excluding IT and Estates cost, to deliver this Programme.

7.0 Recommendation

7.1 The Trust Board receive the update in sections 2 and 3.

7.2 The Trust Board support the emerging strategic direction underpinning current design and planning:

- Target Operating Model centred around teams supporting groups of Clinical Services (Support Hubs)
- Reducing overall outpatient activity provided in hospital settings and reducing overall appointments
- Developing stronger relationships with local providers
- All Outpatient Services will operate within the agreed Target Operating Model
- The role of Clinical Specialists will change to support emerging new models of care
- Organising clinical services around Patient pathways
- Automation and efficiency through Digital Technology is critical
- Reduced administrative and operating costs of Outpatient Services

8.0 Target Operating Model – A Definition

8.1 Target operating model is used throughout this document and for clarity, the following defines what's meant by this term.

8.2 The Target Operating Model will define the administration and management functions of all outpatient clinic-based activity delivered by any Trust specialty at any location the Trust operates from, i.e. the people, processes, organisational structure, information, technology, channels and locations that ensure that the right patient is with the right specialist, in the right place, at the right time, with the right information and that the outcomes of the appointment are acted upon and appropriately communicated. The key functions describing the outpatients service are:

- Referral receipt and clinic allocation
- Booking and communicating appointments
- Preparing information for the patient consultation
- Recording the outcomes of the appointment and ensuring they are acted upon and appropriately communicated (e.g. to patient, referrer)
- Effective monitoring, reporting and cashing up by the Trust.

Author: Steve Sewell, Programme Director
Date: January 2017

Meeting Title:	Trust Board		
Date:	9 February 2017	**Agenda No:**	**2.2**
Report Title:	Quality Improvement Programme: progress report		
Executive Sponsor	Paul Moore - Director of Quality Governance		
Report Authors:	Paul Moore – Director of Quality Governance Anne O' Connor – Quality Improvement Plan Project Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	In this report we provide assurance on the progress of the Quality Improvement Plan, a breakdown of the anticipated benefits for each workstream, and draws to the Board's attention by exception all actions that are not on track or at risk of breaching implementation deadlines. As at 30/01/2017 • 24.5% of actions have completed embedded actions (Blue) (16.8% in December) • 66% of actions are on target (Green) (78.0% in December) • 4.1% are at risk of breaching (Amber) (3.2% in December) • 5.4% have breached target date for implementation (Red) (2% in December) • The Board will note, with concern, that four workstreams have been rated 'red' overall due to the number of overdue actions. The relevant Executive Director is aware; the QIP Board and Quality Committee have been briefed accordingly. An explanation for the slippage is given against each action in the body of this report. • An increasing number of actions have been embedded (blue) particularly within the Estates workstream.		
Recommendation:	The Board of Directors are invited to: 1. note there has been some slippage on planned delivery of the Quality Improvement Plan in January 2017; 2. consider and discuss corrective actions to bring the QIP back on track; and 3. advise on any further action required by the Board.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	All CQC Domains		
Single Oversight Framework Theme:	(i) Quality of Care (ii) Operational Performance (iii) Leadership and Improvement Capability		

Implications			
Potential Risk:	I. Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care; and II. The Trust fails to comply with NHSI enforcement undertakings and the provider licence.		
Legal/Regulatory:	Compliance with: (i) The Health and Social Care Act 2008 (Regulated Activities) Regulations (ii) 2014; (iii) The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015; (iv) Care Quality Commission (Registration) Regulations 2009; and (v) The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission		
Resources:			
Previously Considered by:	Quality Improvement Board	**23/01/17**	
Equality Impact Assessment:	No adverse impact identified.		
Appendices:	Workstream Overview Report for: (i) Personalised Care (ii) Safety Culture (iii) Governance (iv) Human Resources (v) Estates (vi) Operations (vii) Healthcare Informatics (viii) Leadership		

Quality Improvement Programme Update Report: January 2017

1.0 PURPOSE

1.1 The purpose of this paper is the ensure the Board of Directors are up to date on the progress of the Quality Improvement Plan, and to highlight to the Board, by exception, elements of the plan that are not on track or at risk of not meeting target dates for implementation.

2.0 BACKGROUND OR CONTEXT

2.1 The Quality Improvement Plan brings together the actions required to address the CQC compliance concerns identified following inspection in June 2016. The plan takes account of: (i) the Section 29A Warning Notice, served on the Trust in August 2016; (ii) all the 'must do' and should do' recommendations contained within the inspection reports; and (iii) a range of improvement interventions identified locally as quality priorities by the Trust.

2.2 The Quality Improvement Plan forms part of NHS Improvement's enforcement undertakings and, in this regard, the Board is required by November 2017 to: (i) provide NHSI with assurance that it has addressed the 'must do' actions to the CQC's satisfaction; (ii) is no longer considered by CQC to be inadequate in the well-led domain; and (iii) has improved against all domains rated as inadequate or requires improvement when compared to the CQC's inspection findings.

2.3 Following publication of the CQC report, the Quality Improvement Plan expanded and restructured into eight workstreams.

3.0 ANALYSIS

3.1 Although the QIP will continue to provide a 'confirm and challenge' function to support delivery of the RTT plan, it is acknowledged that the RTT Programme has separate plan and governance structure, with its own reporting arrangements to the Board of Directors. This report does not, therefore, provide assurance to the Board on the delivery of the RTT Programme.

3.2 Within the 8 workstreams involved in the QIP there are 318 actions. Of those actions: 66% (n=209) are on track; 24.5% (n=78) have completed embedded actions; 5.4% (n=18) have breached the target date for implementation; and 4.1% (n=13) are identified as at risk of breaching target date for implementation.

3.3 **The Board will note, with concern, that four workstreams have been rated 'red' overall due to the number of overdue actions. The relevant Executive Director is aware; the QIP Board and Quality Committee have been briefed accordingly. An explanation for the slippage is given against each action in the body of this report**.

Personalised Care – Exceptions

3.4 Staffing levels in Paediatrics and Neurorehabilitation (Gwynne Holford Ward) is likely to remain challenging as there does not appear to be many candidates available to fill establish vacancies. Options to address this might include accepting the risk, or consideration of reducing capacity in these areas to optimise staffing ratios and curtail bank/agency expenditure. It was felt appropriate to allow the new Chief Nurse time to consider the issue before taking forward any proposals.

3.5 Beds and bed rails. There has been a decision to purchase 844 electronic low-profiling beds with integrated bed rails at a cost of £1.3m in the current financial year. This will simultaneously improve quality, minimise the risk of falls from height,

improve comfort for patients, minimise moving and handling risk and deliver the requirement of the QIP. However, this action is not likely to be rated green or blue until the beds are delivered.

3.6 Fire wardens. This action is an unnecessary breach of the implementation deadline. Insufficient progress has been made in this area. The Chief Nurse has been briefed.

Safety Culture - Exceptions

3.7 Radiation Safety Committee will now meet on 6th February 2017. This is behind plan.

3.8 The appointment of a Radiation Protection Advisor is underway, but this is not likely to be concluded before 31st March 2017.

3.9 Venous-Thromoembolism prevention is to be incorporated into the suite of Mandatory and Statutory Training provided to clinical staff. This is behind schedule.

3.10 Insufficient compliance with monitoring the temperatures of drug fridges has been detected during the confirm and challenge meetings. Action is being taken by Pharmacy to resolve the problem in those areas identified as not compliant.

3.11 The roll out of the SAFER bundle is in progress, but behind schedule. The Medical Director has been briefed and roll out is being accelerated (for details see p17 action 2.3.1b).

Governance - Exceptions

3.12 Duty of Candour has been delivered for all qualifying incidents in January 2017. This action has changed from 'red' to 'green'.

Human Resources – Exceptions

3.13 The Trust continues to rate as 'red' the action requiring a reduction by 10% or more in bank and agency expenditure. Details are provided in the Finance Report.

3.14 Mandatory and Statutory Training – access to, development of modules and recording of completion are not yet assured. The Director of Human Resources is aware and considering options to strengthen mandatory training as part of the Quality Improvement Plan.

Estates – Exceptions

3.15 Daily flushing of low-use water outlets to minimise the risk of Pseudomonas contamination is not yet assured. Responsibility for flushing and recording is being transferred to the Trust's third-party cleaning provider which should improve availability of assurance going forward.

3.16 Installation of UPS in Richmond Ward. This action is not on track. The installation did not take place during the weekend of 28/29th January as planned, due to unforeseen installation problems. Discussions have taken place with the contractor, and installation is in progresss. A revised completion date of 28th February 2017 or sooner has been agreed.

Warning Notice

3.17 The Trust submitted its response to the Section 29A Warning Notice to the Care Quality Commission on 30/11/2016. CQC have acknowledged receipt of the Notice at a routine engagement meeting between the Trust and local CQC inspectors held on 9 December 2016. **No further instructions have been received at the time of report in respect of the Section 29A actions**.

4.0 IMPLICATIONS

4.1 Potential Risks

At a strategic level, there are two potential risks concerning the delivery of the Quality Improvement Plan:

I. The Trust may expose service users to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care;
II. The Trust may fail to assure the Regulator that: (i) it has addressed the 'must do' actions to the CQC's satisfaction; (ii) is no longer considered by CQC to be inadequate in the well-led domain; and (iii) has improved against all domains rated as inadequate or requires improvement when compared to the CQC's report published in November 2016.

The actions set out in the Quality Improvement Plan are designed to mitigate these risks.

2.2 Legal/Regulatory

Compliance with:

(ii) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;
(iii) The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015;
(iv) Care Quality Commission (Registration) Regulations 2009; and
(v) The Health & Social care Act 2012, the NHS Provider Licence General Condition 7 – Registration with the Care Quality Commission.

5.0 RECOMMENDATION

The Board of Directors are invited to:

a) note there has been some slippage on planned delivery of the Quality Improvement Plan in January 2017;
b) consider and discuss corrective actions to bring the QIP back on track; and
c) advise on any further action required by the Board.

Author(s): **Paul Moore – Director of Quality Governance**
Anne O'Connor – Quality Improvement Plan Project Manager
Date: **01/02/2017**

Appendix 1 Summary of QIP Workstream Ratings:

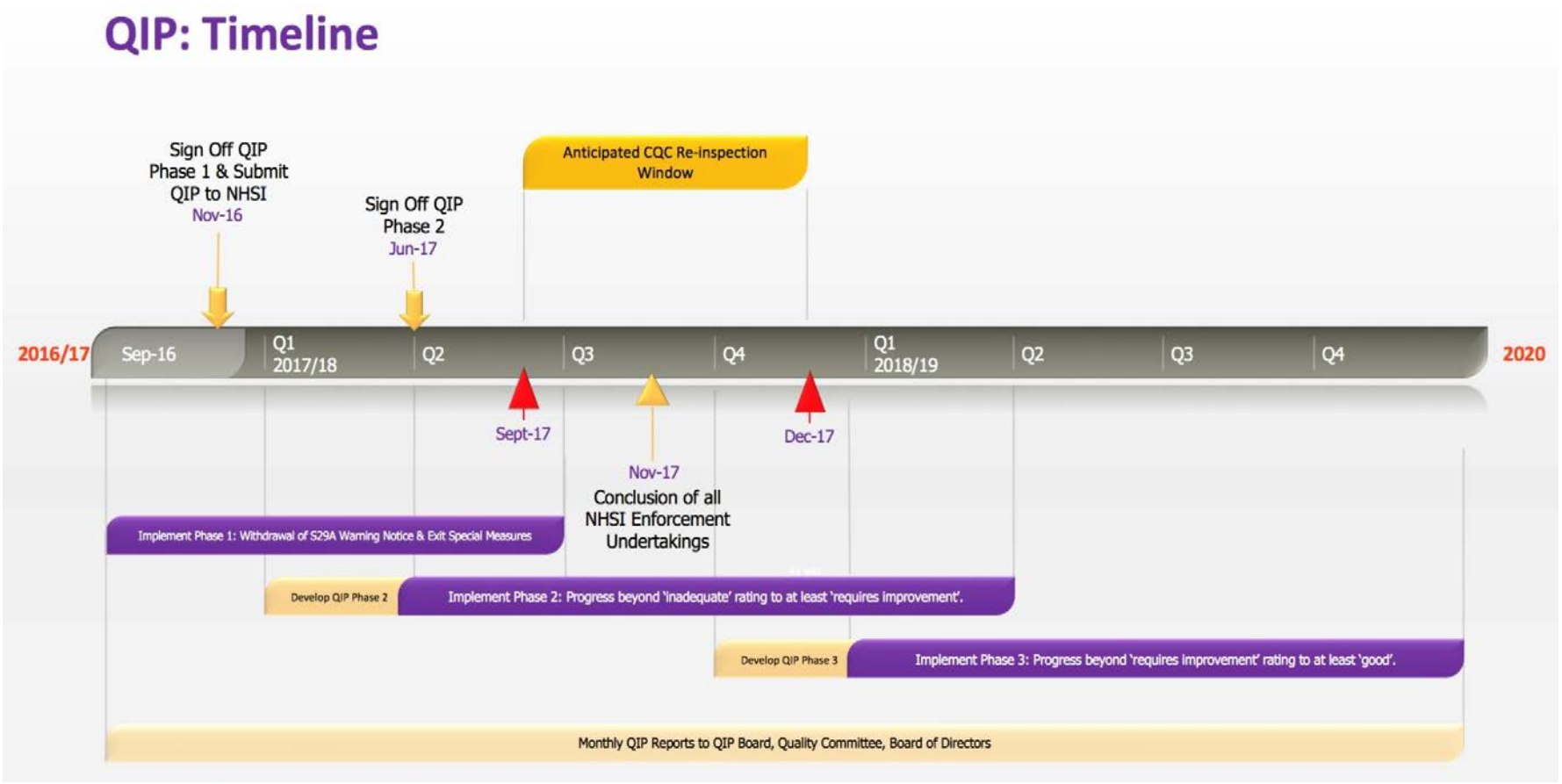
QIP Workstream	Total Actions	B	R	A	G	B/G	Overall Status	Comments
Personalised Care		24	8	3	66			Risks relate to • Staffing levels in Paediatrics, NNU and Gwynne Holford wards. • Ensuring sufficient and appropriate bed stock & bed rails availability. • Fire wardens for each shift in each clinical area
Safety Culture		16	4	5	57			• New Radiation safety committee has not yet met (due to meet 6/02/17) • Medicines management; fridge temperature monitoring, MAST training for VTE • Roll out of SAFER bundle delayed
Governance		9	0	1	19			
Human Resources		6	3	2	12			• Risks relate to reduction in agency staff to no more than 10% of total pay bill, induction of staff into clinical areas and • MAST training
Estates		20	2	1	16			• Water safety management (Pseudomonas) • UPS to Richmond Ward (currently underway)
Operations		2	1	1	29			• OPD: answering telephone within SLA of ≥ 95%
H/C Informatics		0	0	0	6			• The 6 actions remain within time scales thus rated green. • Recognised that this is a significant piece of work for the Trust
Leadership		1	0	0	4			• 5 actions remain within time scales thus rated green. • Recognised that stable leadership is fundamental to implementing improvements within the Trust.
RTT								Evidence presented to RTT Board for assurance. Opportunity to provide challenge at the QIP workstream.
Total		78	18	13	209		318	

Table 1: Summary of BRAG rating by workstream.

Overall workstream BRAG rating

Blue	Workstream completed, embedded and assured in daily practice
Red	≥ 5% actions in workstream have breached target date for implementation
Amber	≥ 20% of actions in workstream are either breached or at risk of breaching target dates
Green	< 20% of actions in workstream are either breached or at risk of breaching target dates
Blue/Green	Blue subject to CQC confirmation.

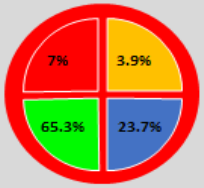
QIP: Timeline



St George's University Hospitals NHS

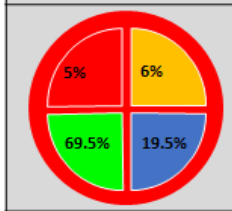
FLASH REPORT JANUARY 2017

PERSONALISED CARE



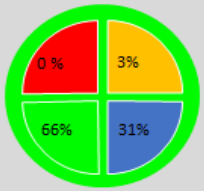
- Substantive recruitment on Gwynne Holford Ward & Paediatrics
- Roll out of MCA / DoLS training and completion
- Availability of Fire Warden on every ward and every shift

SAFETY CULTURE



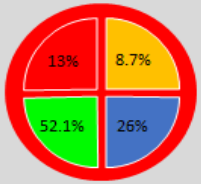
- EWS, HON, SAFE and Deteriorating Patient actions added to the QIP
- Delay to New Radiation Safety committee meeting

GOVERNANCE



- Compliance with Duty of Candour for all qualifying moderate harm incidents

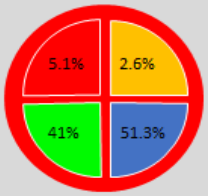
HUMAN RESOURCES



- Effectiveness of bank and agency controls
- MAST

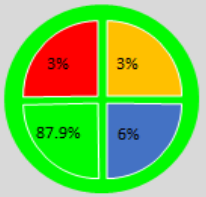
ESTATES

- Relocation of 15% of outpatient services in LW concluded
- Water Safety Management – pseudomonas flushing routine
- Commencement of Theatres Refurbishment Plan
- Ligature / self harm hazards in Paediatrics



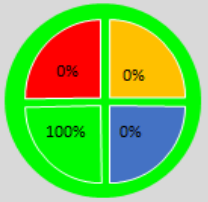
OPERATIONS

- OPD: answering telephone within SLA of ≥ 95% off track



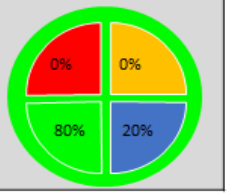
HEALTHCARE INFORMATICS

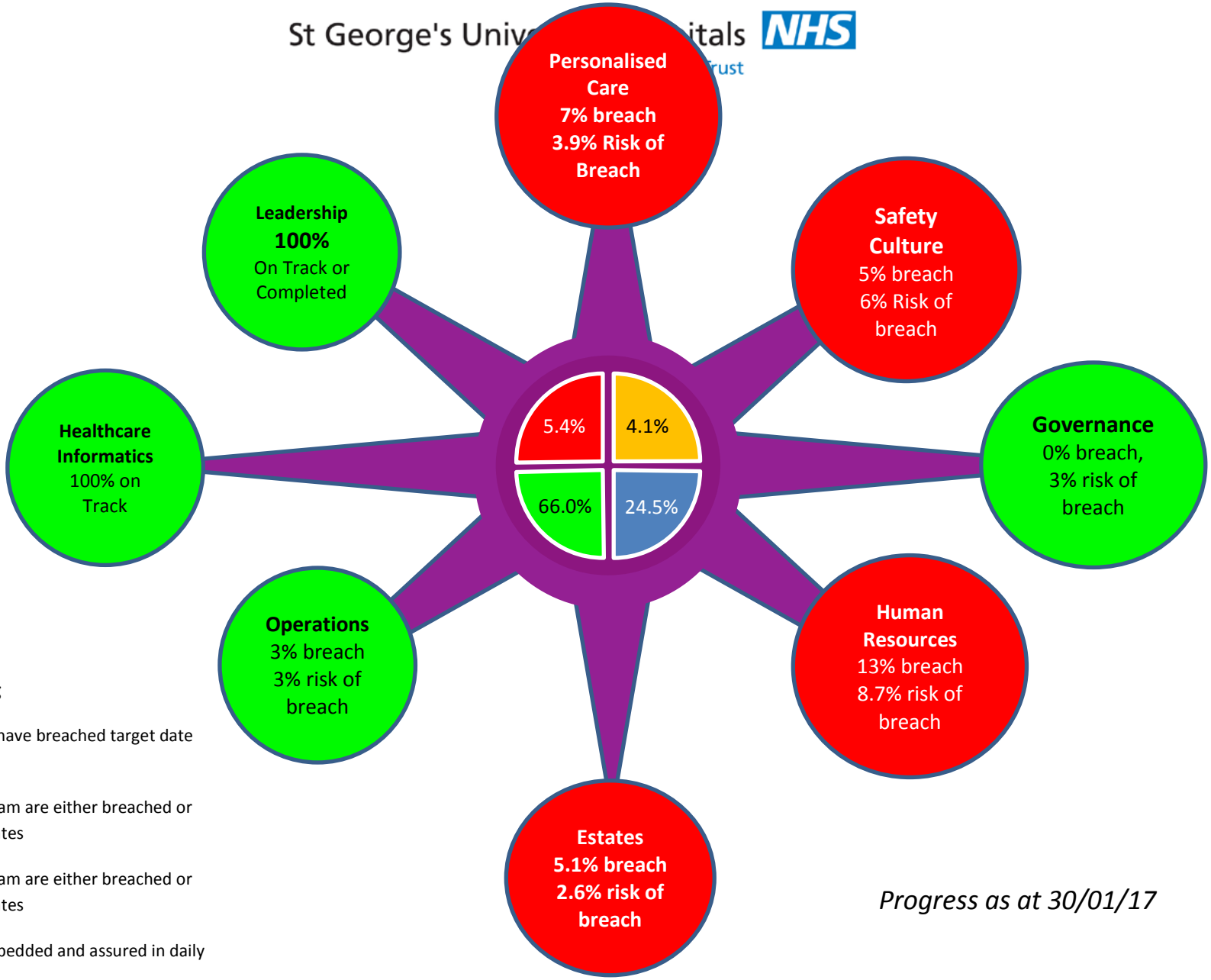
- 6 new actions addition to the QIP
- All actions on track for target dates



LEADERSHIP

- Reduced to 5 key actions on the QIP
- All actions on track
- Recognised that stable leadership is fundamental to implementing improvements within the Trust.





Key to Overall Workstream Rating

- ≥ 5% actions in workstream have breached target date for implementation
- ≥ 20% of actions in workstream are either breached or at risk of breaching target dates
- < 20% of actions in workstream are either breached or at risk of breaching target dates
- Workstream completed, embedded and assured in daily practice

Progress as at 30/01/17

Appendices 1-8: Workstream Overview Reports

1: Personalised Care Workstream Overview report

QIP Work stream Personalised Care		Executive Lead: Title: Chief Nurse Name: Suzanne Banks						
Overall BRAG ≥ 5% actions in workstream have breached target date for implementation	**Reporting Period:** January 2017	Action BRAG rating analysis					Active Actions	Assurance Actions
		B	R	A	G	B/G	77	24
		24	8	3	66		Total Actions in Workstream	
							101	

Key

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

Exception Report: Red / Amber Actions					
Objective/Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**	**Update**
Gwynne Holford 1.2.2a To stabilise the workforce on GH	**30/07/2016**		On-going vacancies for 13 Band 5 posts despite active recruitment campaigns. 10 beds have been closed to help stabilise staffing levels and manage workload and stress levels. Stabilised usage of agency staff, same staff used.	**TBC**	

Gwynne Holford **1.2.9b** Full compliance of the IPC policy and standards	**24/06/2016**		All staff have re-read and signed policy. However results of audit show poor hand hygiene compliance from full MDT (46%) in December. IPC team to carry out further training.	**28/02/17**	
Bed Rails **1.3.1a** Ensure sufficient and appropriate bed stock and bed rails availability	**30/09/2016**		Point prevalence results show 45.3% of detachable bed rails and 98.2% integrated bed rails are fit for purpose. IDDG approved business case for high acuity and bariatric beds only. Findings to be taken to the Risk Committee to decide whether the Trust is willing to accept the level of risk.	**31/03/17**	Verbal update to QC that funding has been approved to replace all the beds and bedrails identified in the point prevalence audit (800 beds approximately). To go to the Feb Board for sign off. Beds to be purchased before 31/03/17.
Bed Rails **1.3.1d** Clarify responsibility for obtaining and fixing bed rails OOH	**30/11/2016**		This issue has still not been resolved. A meeting has been set up between nursing & Estates end of January to resolve.	**28/02/17**	The policy states this is the responsibility of the clinical staff. AO'C brought to the attention of AHP & Nurse lead. Agreed that teaching of nurses will become part of Local ward induction (unless new beds will be all integrated).
1.7.1a **Privacy & Dignity** Review curtains and screens used to screen the beds to ensure they fit correctly.	**31/12/2016**		The main areas that do not meet the standard are the medical wards in St. James wing. In the short term, 500 additional curtains have been rented. Some areas not complying. Paper sent to IDDG requesting funding, verbal approval has been given.	**31/03/17**	Verbal update to QIB that funding has been approved to replace non-compliant curtains and rails. When will purchasing & fitting go ahead

Bed Rails 1.3.2d Establish a falls group	**30/11/2016**		A Band 7 falls lead post is to go to the VCB 24/01/17. The falls group is to be re-established and report to PSQB.	**28/02/17**	Meeting of the falls group arranged for 8/03/17 at 14.30. Falls lead position has been approved by VCB, due to go out to advert.
Paediatrics 1.9.3a Decrease the number of agency staff used on the paediatric units	**31/12/16**		There has been a slight improvement in paediatric nurse recruitment. This is a National problem. Recruitment plan in place to try and recruit to all vacancies. Review of skill mix, introduction of nurse practitioner roles, discharge coordinators to release nursing time. Working with St Helier to look at sustainable plan across the region. Reviewing Band 5 role and looking at Band 6 as development roles.	**TBC**	
Fire Wardens 5.1.6g 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.	**31/07/16**		% total of all shifts covered on each ward ranges from 25%– 100% coverage; insufficient to demonstrate compliance. Fire safety checks are included in the CIN responsibilities. The standard will be that all trained nurses will be receive fire warden training, this will ensure a minimum of 75% nurses are trained. The MAST data will line up with e-Rostering, Note: This has moved from Estates Workstream.	**TBC**	The standard will be that all trained nurses will receive fire warden training, this will ensure a minimum of 75% nurses are trained. The MAST data will line up with e-Rostering, When will this start and anticipated to reach target number?

Gwynne Holford 1.2.1b Strategy: Develop a plan for the provision services within GH ward.	**31/01/2017**		There is a risk the target date will be breached. First strategy has been reviewed by division, for further consultation with the GM & DDNG at the end of January.		As over
1.4.1b MCA/DoIs Audit against compliance with the MCA, DoLs and safeguarding policy	**31/01/2017**		This action is Amber as risk identified that compliance numbers may not significantly improve during Jan-17 if staff unable to be released for training. Results of re-audit will be available w/b 30/01/17	**31/03/17**	Awaiting audit end of Jan
1.9.3b Paediatric Care Decrease the number of agency staff on the neonatal ward	**31/03/17**		Successful bid for 4 nursery nurses to extend their role to degree level, it will not include IV administration as originally included in the bid. This will free up nurses to work in high dependency and NICU. Consideration to be given to closing 8 cots to reduce the number of agency staff. This has significant implications for other areas e.g. obstetrics and areas outside of SGUHT if this was to happen as the Trust is a Level 3 provider unit.	**TBC**	

Personalised Care Recommendations Regarding Delivered and Embedded Actions

	Area	Action (Number then action narrative)	Comments	Evidence
1.	EOLC	1.1.1.b Governance arrangements included within 3 year strategy for EoLC including TOR for Steering group and	Strategy with governance arrangements signed off by EMT 19/12/16	Evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	EOLC	1.1.1c Best practice framework included within implementation plan	Signed off by steering group 28/11/16	

3.	EOLC	1.1.1d KPIs identified and included within implementation plan	Signed off by steering group 28/11/16	
4.	EOLC	1.1.1.e Outcome measures included within implementation plan and divisional action plans	Signed off by steering group 28/11/16	
5.	EOLC	1.1.1.h Identify NED Lead for EOLC	Sarah Wilton identified and agreed as NED	
6.	EOLC	1.1.1i Establish an EOLC steering group to drive and lead implementation of strategy	First meeting held 28/11/16	
7.	EOLC	1.1.2a Clarify contracts and SLA's with Trinity Hospice for community EOLC Nursing	SLA signed and in place	
8.	EOLC	1.1.2b Clarify contracts and SLA's with Trinity Hospice for EOLC Medical cover	SLA signed and in place 01/12/16	
9.	GH	1.2.1e Introduce ward meetings with the leadership team and staff	Taking place on a weekly basis	
10.	GH	1.2.2d To ensure safe staffing levels on Gwynne Holford by utilising the therapies for basic care e.g. washing and dressing.	Process implemented	
11.	GH	1.2.4a To achieve compliance rates ≥ 85% with MAST	Compliance achieved as of 30/11/16. To be monitored on an on-going basis.	
12.	GH	1.2.4b Work with the Pharmacy to deliver medicines management training	All training sessions undertaken and training continues on a rolling basis.	
13.	GH	1.2.7a Review and improve patient record keeping as patients move between floors.	Patients now on one floor.	
14.	GH	1.2.7b Ensure a secure space for storage of clinical records	All notes now stored together in one locked cupboard and accessed by MDT	
15.	GH	1.2.8 Develop a competency assessment and training for all qualified nurses for the management of the deteriorating patient		
16.	GH	1.2.9a Amend MRSA policy to reflect patients receiving rehabilitation		

17.	GH	1.2.9c Undertake regular audits following trust policy.	Monthly 'Saving Lives' audit undertaken. Actions taken to manage poor compliance	
18.	Bedrails	1.3.1b Develop briefing for staff to be delivered on local induction on falls to include bed rail use ensuring safe usage and knowledge of risks.	Briefing on eG October 2016	
19.	Bedrails	1.3.1e Audit bed rail , use and application This should be undertaken bi-annually in both Acute and Community	Ward audits carried out October and November. Point prevalence (as per 1.3.1a) in December.	
20.	Bedrails	1.3.2a Review and update current bed rail policy	Completed and on intranet 30/11/17	
21.	MCA/DoLs/ Safeguarding	1.4.1a Finalise, ratify and re-launch MCA/DoLs policy. Upload onto Policy hub,		
22.	MCA/DoLs/ Safeguarding	1.4.2a Finalise, ratify and re-launch safeguarding policy. Upload onto policy hub		
23.	Pain Management	1.6.5 There is an area to store analgesia within the streaming area of ED triage to prevent delay in administration.		
24.	Paediatrics	1.9.1e Risk assessment carried out on ED and Frederick Hewitt ward. Specification for remedial works out to tender		

2: Safety Culture Workstream Overview report

QIP Work stream Safety Culture		Executive Lead: Title: Medical Director Name: Andrew Rhodes						
Overall BRAG	Reporting Period: January 2017	Action BRAG rating analysis						
		B	R	A	G	B/G	Active Actions	Assurance Actions
							66	16
		16	4	5	57		Total Actions in Workstream	
							82	

Key

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

Exception Report: Red / Amber Actions					
Objective/Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**	**Update**
Radiation Safety 2.2.2a Formation of Radiation Safety Committee that replaces the RCPC and MEC committees	**31/12/2016** (target date extended to 06/02/2017)		First meeting has not yet been held.	**06/02/17**	Verbal confirmation that this meeting is to take place 6/01/17
Radiation Safety 2.2.2b 'Appoint fulltime Band 8c Radiation Protection Advisor (RPA) (as supported by CEO). This position will also act as an Medical Physics Expert (MPE) or develop an alternative approach	**31/12/2016**		Dir of Estates has approved this role. Currently going through process with HR	**31/03/17**	Going through HR currently. Has not been advertised

Medicines Management 2.1.8b VTE/anticoag education to be added to MAST for all clinical staff as well develop bespoke and refresher training.	**31/12/2016**		Awaiting VTE programme to go live on MAST	**31/03/17**	MAST paper to Workforce Committee 31/01/17 with short, medium and long term plans for approval
Medicines Management 2.1.11 Ensure consistent temperature monitoring across all areas.	**31/12/2016**		November - December data shows an improvement with non-compliance moving from 16 to 8. Nelson area continues to be a problem.	**28/02/17**	Email sent to Chris & Wendy for update.
Deteriorating Patient 2.3.1b Embed the improvement of the initial 3 wards from the first wave of the SAFER Bundle roll out (Marnham, Rodney Smith and Heberden)	**12/12/2016**		Missed target date but in the process of rolling out.	**31/01/17**	**Progress this month** • Baseline audit in progress • All elements are being driven through the Perfect week operational meetings with demonstrable improvements seen across Trust • Final push for full engagement for the SAFER workshop on the 7/2/17 **Actions next month** • Establish daily monitoring of SAFER elements-active • Work to develop a ward checklist(JP/MH) • Visit all wards weekly to support progress-JP • Enable all wards to put the teams though a quality improvement training

					session(MH/JP)
Radiation Safety 2.2.2c Identify resources and appoint a fulltime Band 8a Magnetic Resonance Imaging Safety Expert or develop an alternative approach.	**31/01/2016**		Currently going through process with HR	**31/03/17**	
Deteriorating Patient 2.3.4b A training package integrating the training objectives of resus, simulation and critical care is designed and rolled out to all clinical areas and becomes part of the MAST programme for all clinical and HCA staff.	**31/03/2017**		There is a risk of not meeting target date due to issues with uploading and mandating on Totora.	**31/03/17**	As above for MAST
Deteriorating Patient 2.3.4d Agency/Locums are signed off as competent with observation, recognition and escalation	**31/03/2017**		There is a risk of not meeting target date due to issues with uploading and mandating on Totora.	**31/03/17**	As above
Deteriorating Patient 2.3.4f Develop & approve a business case for a critical outreach team	**01/02/2017**		Business case and model will be described , to go to SOG for approval, at risk of not being signed off	**01/02/17**	

Issue to Highlight to QIB	Mitigating Action
1. IT component of the deteriorating patient is encompassed within the HC Informatics workstream, therefore will no longer be included in Safety Culture. 2. 3 of the 5 amber rated actions on the deteriorating patient relate to difficulties with MAST training and uploading onto Totora. This is raised in the HR workstream. 3. WHO observational audits are carried out by the internal theatre staff reporting 95 -100% compliance. To be reviewed at the PSQB.	AO'C to meet SJ for further discussions

Safety Culture Recommendations Regarding Delivered and Embedded Actions

	Area	Action (Number then action narrative)	Comments/Evidence
1.	Medicines Management	2.1.1b Review the fluid storage within ED major incident cupboard to ensure that no fluids are out of date	Evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	Medicines Management	2.1.1c Provide report on monthly basis identifying outliers in compliance to best practice	
3.	Medicines Management	2.1.2 Ensure medical gases are stored, prescribed and audited to meet national standards	
4.	Medicines Management	2.1.3b Remove FP10 prescriptions where services do not use them. Brief leadership/ management teams on correct processes.	
5.	Medicines Management	2.1.3c Amend the medicines management policy to changes in practice, adding to the appendices the SOP and standard template for reconciliation	
6.	Medicines Management	2.1.5 Compliance with administration and recording of wasted drugs in resuscitation room in ED	
7.	Medicines Management	2.1.9c Presentation on antimicrobial stewardship and resistance to all at all divisional governance boards	
8.	Medicines Management	2.1.9d Antimicrobial stewardship champions to be appointed in all care groups	

9.	Medicines Management	2.1.12 Review stock lists and implement optimum stock holding process	
10.	Medicines Management	2.1.13 Achieve compliance with medicines reconciliation	
11.	Medicines Management	2.1.14 Compliance with allergy management	
12.	Medicines Management	2.1.15 Develop and implement patient group directives (PGD's) to enable radiographers to administer medication (contrast media)	
13.	Radiation Safety	2.2.1a Review Ionising Radiations Safety Policy to include the new governance arrangements., key roles and responsibilities	
14.	Radiation Safety	2.2.1c Update current the Ionising Radiation Safety Policy to reflect new committee structure	
15.	Radiation Safety	2.2.1f Strengthen the current policy for reporting radiation incidents and include in as an appendix in both radiation policies	
16.	Radiation Safety	2.2.3a Expand templates for reporting from the subcommittees to the Radiation Safety Committee Create template for reporting from the Radiation Safety Committee to PSQB	

3: Governance Workstream Overview report

QIP Work stream Governance		Executive Lead: Title: Director of Quality Governance Name: Paul Moore						
Overall BRAG	**Reporting Period:** January 2017	**Action BRAG rating analysis**					**Active Actions**	**Assurance Actions**
		B	**R**	**A**	**G**	**B/G**	**20**	**9**
		9	**0**	**1**	**19**		**Total Actions in Workstream**	
							29	

Key

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

Exception Report: Red / Amber Actions					
Objective/Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**	**Update**
3.1.8a Urgently review the mechanism to deliver Duty of Candour. Address gaps and achieve full compliance with Duty of Candour	**30/09/16**		We have commenced monthly reporting of DOC. We are not yet fully compliant for all qualifying moderate. incidents and are reporting this. Anticipated full compliance by the end of January with 100% compliance 10 days end to end completion by end February.	**31/03/17**	Changed from Red to Green: As of the 30th January we are 100% compliant with DOC requirements to notify patients in writing of an incident rated moderate harm or above.

3.1.3b Implement a quality improvement plan to meet CQC domains for safe care where workstreams remain on track	**31/07/17**		Measured against achievement of overall QIP –Estates, HR. Safety Culture & Personalised care Workstreams off track.	**31/07/17**	

Risk/Issue to Highlight to QIB	Mitigating Action	Status
3.1.6a Anticipate a potential risk of SI performance slippage in Medicine and Cardiology due to vacancies.	This is being closely watched and the team supported to ensure it does not become an actual risk.	

Governance Workstream Recommendations Regarding Delivered and Embedded Actions

	Action (Number then action narrative)	Comments	Evidence
1.	3.1.1a Establish and appoint a Director of Quality Governance to lead on governance, risk management and the Quality Improvement Plan	Director of Quality Governance appointed	Evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	3.1.1b Undertake a rapid review of board assurance, risk management arrangements and effectiveness of the Board's assurance committees.	Agreed at the Council of Governors meeting 28/07/16	
3.	3.1.1f Commence a series of 'Good Governance Master classes', delivered by the Director of Quality Governance, to engage and support the Board and divisional teams to improve governance, risk management and compliance	Total of 246 attended training as of October 2016	
4.	3.1.2a Develop and write a paper outlining the requirements for a Freedom to Speak Up Guardian (FTSUG). Appoint FTSUG	Paper to QRC and agreed. FTSUG offered and agreed, Karen Richards Wright	

5.	3.1.5c Reconstruct the Corporate Risk register with clear escalation pathways and processes to the Board	A summary of the proceedings of RMC is incorporated into the corporate risk report received by the board at each formal meeting. This has been the case since Sept 2016.	
6.	3.1.5d Ensure risk registers are handled through Datix Web in order to pass control to managers, speed up recording, and improve monitoring and reporting. Ensure identified risks are included on the divisional Risk register"	All four clinical divisions have now reported Risk Registers through RMC (Sept/Oct 2016).	
7.	3.1.6b Extend current RCA training to include enhanced guidance for panel chairs/members – to include guidance around SMART actions aligned where possible to auditable measures in order to measure effectiveness of action taken.		
8.	3.1.7b Upgrade Datix system to enhance functionality and feedback mechanisms to reporters		
9.	3.1.7c Appoint Datix Administrator to support enhanced training programme for staff around Datix use		

4: HR Workstream Overview report

QIP Work stream HR		Executive Lead: Title: Director of Human Resources Name: Mark Gammage						
Overall BRAG ≥ 5% actions in workstream have breached target date for implementation	**Reporting Period:** January 2017	**Action BRAG rating analysis**					**Active Actions**	**Assurance Actions**
		B	**R**	**A**	**G**	**B/G**	**17**	**6**
		6	**3**	**2**	**12**		**Total Actions in Workstream**	
							23	

Key

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

Exception Report: Red / Amber Actions

Action	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
4.1.2e We will develop and launch a values based recruitment programme for all managerial roles	**31/12/2016**		External company's bids did not meet the requirements of the Trust, awaiting rebids. Anticipated that work will start in February, ready to launch in April 2017	**30/06/17**
4.1.4d Improve the quality of patient care and experience by improving continuity of staffing, brought about by the reduction of agency usage (Reduce to no more than 10% of total pay bill).	**31/03/2017**		New controls and new level of sign off are in place. All nursing and medical agency on the day are to be signed off by exec. Nursing have seen a reduction in agency use with midwifery increasing bank and decreasing agency use. There is a risk of not achieving the % of reduction needed	**TBC**

4.1.8 Ensure all staff are inducted into clinical areas.	**31/12/2016**		There is currently no systematic way of capturing the data on induction at a local level. Currently looking at systems such as Totora or Health Roster.	**31/03/17**
4.1.3c Review and improve staff supervision, training and staff development.	**31/01/2017**		Arrangements for supervision of staff requires further discussion and agreement between HR, CN and MD	**31/03/17**
4.1.4c Completion of a deep dive into the bank and agency staff process.	**30/01/2017**		The initial work on this has now started (draft scoping document produced) and work is expected to take place through January, due to report February 2017.	**31/03/17**

Risk/Issue to Highlight to QIB	**Mitigating Action**	**Status**
Across a number of the QIP workstreams, problems with MAST has been highlighted. These include delays to uploading training materials, approval to include training on the system, uploading face to face (non- electronic) training data to ensure all training numbers and compliance is captured.	Paper on MAST and Appraisal systems to the Workforce Committee end of January.	

Recommendations Regarding Delivered and Embedded Actions

	Action (Number then action narrative)	**Comments/Evidence**
17.	4.1.1a Revise Fit and Proper Person Policy in discussion with, and support from, our Improvement Director	Evidence is retained by the QIP Programme Manager and available on request to the Board.
18.	4.1.1b Audit all current Executive Director and Non-Executive Director personal files and identify gaps with compliance.	
19.	4.1.1c Evidence of licensed accountant on the Board	
20.	4.1.2a Complete review and update of acting up policy and ongoing audit for compliance.	

21.	4.1.2b Board approved Workforce Race Equality Standard in place. Workforce Race Equality Standard presented to and received by the Board	
22.	4.1.2c Action plan for Workforce Race Equality Standard presented to Board	

5: Estates Workstream Overview report

QIP Work stream Estates		Executive Lead: Title: Director of Estates and Facilities Name: Richard Hancock						
Overall BRAG ≥ 5% actions in workstream have breached target date for implementation	**Reporting Period: Jan 2017**	**Action BRAG rating analysis**					**Active Actions**	**Assurance Actions**
		B	**R**	**A**	**G**	**B/G**	**19**	**20**
		20	**2**	**1**	**16**	**0**	**Total Actions in Workstream**	
							39	

Key

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

Exception Report: Red / Amber Actions					
Objective/Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**	**Update**
5.1.11e Daily flushing carried out and documented for pseudomonas	**30/11/16**		Flushing returns for December: 50% KBW 97% LNS 81% STJ A change in process has been introduced from January where Mitie will include flushing and reporting as part of routine cleaning. There will also be a third party enhanced inspection. We await the January figures.	**31/03/17**	Awaiting Jan figures. No further update

5.1.16 Ensure continuous power supply to ventilated patients on Richmond Ward.	**31/12/16**		There was a delay to installing UPS as there was no available space. This has now been resolved and work is expected to complete by end of January	**31/01/17** (extended to 28/02/2017)	The UPS has not been installed as there are additional works to be carried out.
5.1.22b The paediatric ward environment is safe and suitable for treating and caring for children and young people with mental health conditions.	**31/01/17**		RA has been carried out. Ligature points have been removed. Business Case to replace blinds, doors, showers to IDDG for approval. Tender quotes have been received.	**28/02/17**	

Risk/Issue to Highlight to QIB	Mitigating Action	Status
5.1.11e Daily flushing carried out and documented for pseudomonas Part of the 29A Warning notice compliance requirements	Flushing will come under the remit of Mitie from January 2017 as part of routine cleaning. This includes sinks, showers and baths.	

Estates Recommendations Regarding Delivered and Embedded Actions

	Action (Number then action narrative)	Comments	Evidence
1.	5.1.1 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. Cleared Gutters and drains. Vegetation pruning and removal of tree and roots.	Evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	5.1.2 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. Beds have now been removed, the area has been zoned off and secured, this area has been taken out of use.	
3.	5.1.3 Compliance with fixed wiring testing for Buckland Ward and Knightsbridge Wing	Building has decanted of clinical services. Remaining renal OPD and phlebotomy will move end of January	

		and building will be hoarded. Fixed wire testing no longer required for this building.	
4.	5.1.4 Renal ward in Knightsbridge Wing - to be relocated	All renal services relocated as of 31/12/16. .	
5.	5.1.5 Relocate 15% outpatient services in Lanesborough Wing	15/12/16 15% OPD services relocated.	
6.	5.6.1.a 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	
7.	5.1.6.b 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	
8.	5.1.6.c Complete audit and replacing where necessary fire extinguishers to all locations including plant rooms (Lanesborough)	Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016	
9.	5.1.6.d 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	
10.	5.1.6.h 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. Complete 30/09/16.This will become a rolling programme across all clinical areas.	
11.	5.1.6.i Complete fire risk assessments for Lanesborough and verify mitigation plans are in situ and accessible to staff	A requirement for Lanesborough but is being rolled out across the Trust	
12.	5.1.6. k 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 met with Estates and carried out inspection is 31st August 2016	
13.	5.1.7 Relocate staff working in Wandle Annex and demolish this facility.	Staff have been relocated. Building is now demolished.	
14.	5.1.9.b Replace 2 faulty air handling units in St James Wing theatres.	Completed. Air handling units installed.	

15.	5.1.10 Replace ceiling tiles Replace fixed lighting Repair cause of condensation leaks from hot water tank above staff room.	Replaced	
16.	5.1.11. c Replace electronic monitoring (L8 Guard) with paper and department folders until suitable electronic flushing records can be resolved.	Reverted to paper based reporting in October 2016	
17.	5.1.11.d Twice weekly flushing carried out and documented for Legionella	3 months consecutive 100% compliance of known outlets Oct-Dec. This role will now be taken over by Mitie as part of routine cleaning. Includes sinks, showers and baths.	
18.	5.1.13 Replace ripped chairs within patient areas in ED so that they can be thoroughly cleaned.		
19.	5.1.14 Identify the cause of the leaks into ceiling in the Emergency Department and ensure repairs are made.		
20.	5.1.15 Heating system to be fixed within the Mortuary and the carpet to be replaced.		

6: Operations Workstream Overview report

QIP Work stream Operations		Executive Lead: Title: Chief Operating Officer Name: Mark Gordon						
Overall BRAG	Reporting Period: January 2016	Action BRAG rating analysis					Active Actions	Assurance Actions
		B	R	A	G	B/G	31	2
		2	1	1	29	0	Total Actions in Workstream	
							33	

Key

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

Exception Report: Red / Amber Actions

Action	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
6.1.4a **Patient Access** Percentage of telephone calls answered by staff in the outpatient department are within the service level agreement targets of ≥95% Review staffing levels against call frequency to optimise availability of staff to answer calls.	**01/12/16**		Some deterioration in response time to answering calls identified in last call centre performance report. Not sure why this is the case but expected to come back on plan by the end of February but expected to come back on plan by the end of February. Actions have been identified and are currently been worked on.	**28/02/17**
6.1.4c **Patient Access** Review staffing levels against call frequency to optimise availability of staff to answer calls. Review performance at the OPD workstream meeting and identify opportunities for improvement	**28/02/2017**		Although there is significant improvement from 40%-93%, the Trust target of 95% has not yet been met.	

Risk/Issue to Highlight to QIB
Note: removal of neuro rehabilitation service to personalised care workstream and Data management information to Healthcare Informatics workstream.

Operations

Recommendations Regarding Delivered and Embedded Actions

	Area	Action (Number then action narrative)	Comments/Evidence
1.	Equipment requirements	6.2.1a Purchase required number of Ureteroscopes and cystoscopes.	Evidence is retained by the QIP Programme Manager and available on request to the Board.
2.	Health visiting	6.7.2b Robust mechanisms for data collection relating to the 6 to 8 week health visiting reviews are in place.	

7: Healthcare Informatics Workstream Overview report

QIP Work stream Healthcare Informatics		Executive Lead: Title: CIO & SIRO Name: Larry Murphy						
Overall BRAG	**Reporting Period:** January 2017	**Action BRAG rating analysis**						
		B	**R**	**A**	**G**	**B/G**	**Active Actions**	**Assurance Actions**
							6	**0**
		0	**0**	**0**	**6**	**0**	**Total Actions in Workstream**	
							6	

Key

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

Risk/Issue to Highlight to QIB	
Rated green due to working within Target dates. However IT systems and integrity of data is a significant risk for the Trust. The CIO has agreed to further extend the plan to include "improving electronic access for clinical areas across the Trust and roll out of clinical systems programmes e.g. e-prescribing, whiteboards and NEWS" This will be included in the next iteration of the QIP V1.6	Full review currently under way.

8: Leadership Workstream Overview report

QIP Work stream Leadership		Executive Lead: Title: Chief Executive Officer Name: Simon Mackenzie						
Overall BRAG	Reporting Period: January 2017	Action BRAG rating analysis					Active Actions	Assurance Actions
		B	R	A	G	B/G	4	1
		1	0	0	4	0	Total Actions in Workstream	
							5	

Key

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

Risk/Issue to Highlight to QIB	Mitigating Action	Status
Rated green due to working within Target dates, however, a Trust strategy and a stable, substantive leadership team are fundamental for moving the Trust from an inadequate rating to good or outstanding.	Anticipated that Chair will be recruited by February (as per Core Brief Jan 2017) Core Brief Jan 2017) Search for a new Chief Executive, with the post going out to formal advertisement Jan. The process for appointing permanent staff to positions on the executive team will begin thereafter. Focus on Leadership development programme.	January's Core Brief.pdf

Leadership Recommendations Regarding Delivered and Embedded Actions

	Action (Number then action narrative)	Comments	Evidence
1.	8.1.2 Paper and board workshop to confirm vision, clinical vision and priorities	1/12/16	Evidence is retained by the QIP Programme Manager and available on request to the Board.

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St George's University Hospitals NHS
NHS Foundation Trust

Performance Report
For Trust Board

Month 9 – December 2016

Excellence in specialist and community healthcare

excellent / kind / responsible / respectful /

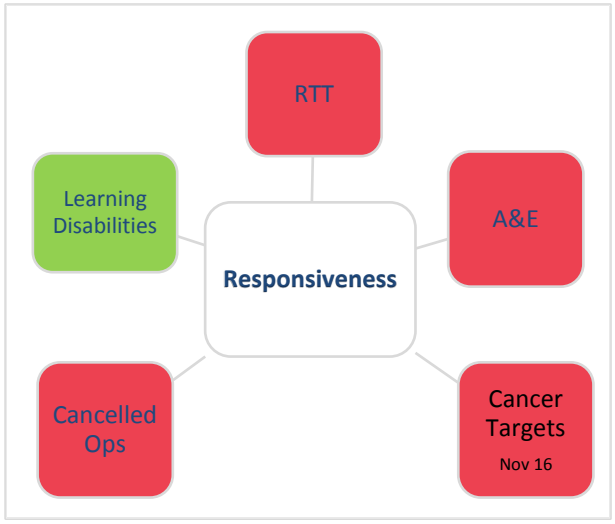
St George's University Hospitals NHS
NHS Foundation Trust

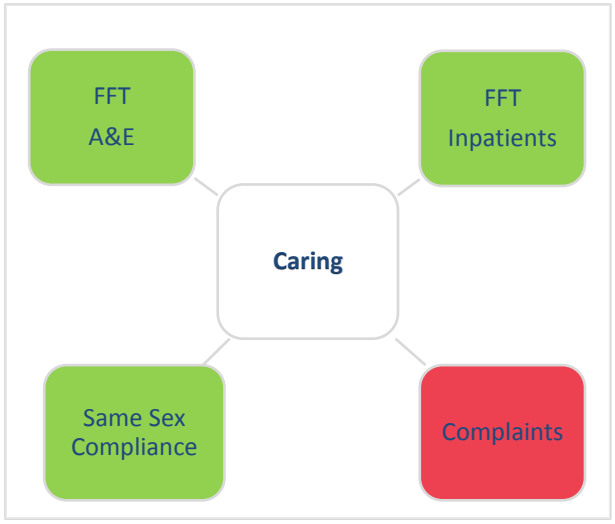
Performance against Frameworks

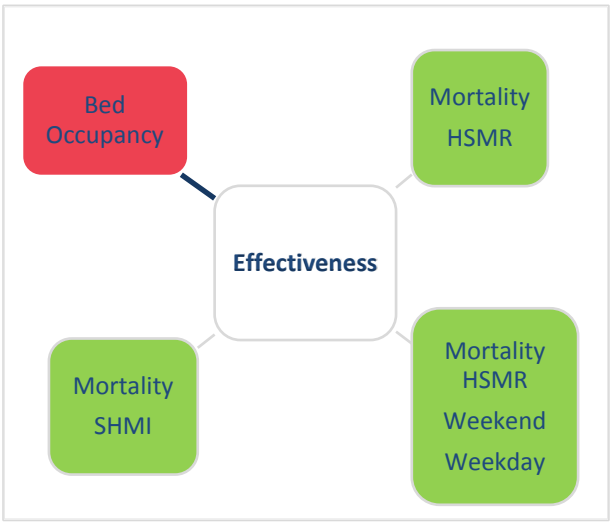
Excellence in specialist and community healthcare

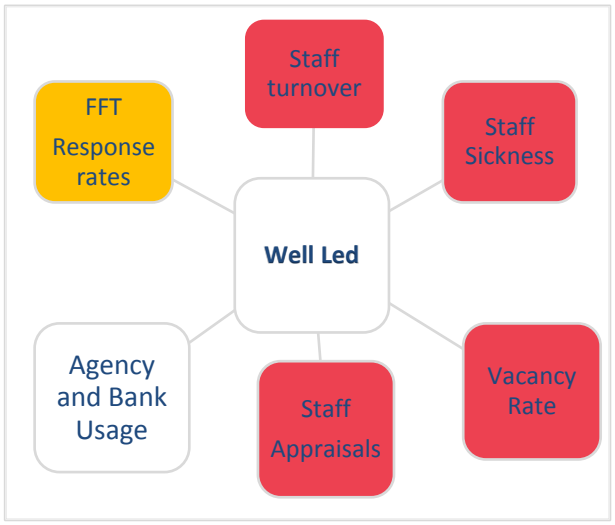
1. Executive Summary - Key Priority Areas December 2016*

St George's University Hospitals NHS
NHS Foundation Trust









The above shows an overview of December 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 November 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: December 2016 Performance (Page 1 of 1)

St George's University Hospitals NHS
NHS Foundation Trust

	Metric	Standard	Weighting	Score	YTD	Nov-16	Dec-16	Movement
ACCESS	Referral to Treatment Incomplete Pathways	92%	1	1		86.30%		
	A&E All Types Monthly Performance	95%	1	1	92.96%	93.50%	89.14%	-4.36%
	Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q2**	**Q3**	**Movement**
	62 Day Standard	85%	1	0	84.36%	88.46%	84.00%	-4.46%
	62 Day Screening Standard	90%			92.90%	94.50%	93.90%	-0.60%
	31 Day Subsequent Drug Standard	98%	1	0	99.70%	100%	99%	-0.90%
	31 Day Subsequent Surgery Standard	94%		0	97.20%	97.70%	96.00%	-1.70%
	31 Day Standard	96%	1	0	97.30%	97.10%	97.00%	-0.10%
	Two Week Wait Standard	93%	1	0	90.50%	93.79%	89.40%	-4.39%
	Breast Symptom Two Week Wait Standard	93%	1		93.80%	94.50%	96.70%	2.20%

	Metric	Standard	Weighting	Score	YTD	Nov-16	Dec-16	Movement
OUTCOMES	Clostridium(C.) Difficile - meeting the C.difficile objective (de minimise of 12 applies)	31	1	0	26	4	4	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		53.2	52.1	-1.1
	Referral Information	50%	1	0		86.8	86.5	-0.3
	Treatment Activity	50%	1	0		71.6	73.7	2.1
	Trust Overall Quality Governance Score					**2**	**3**	1

December 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. Q3 relates to November performance only.

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: December 2016 Performance

St George's University Hospitals NHS
NHS Foundation Trust

RESPONSIVENESS

Metric	Standard	YTD	Nov-16	Dec-16	Movement
Referral to Treatment Incomplete	92%		86.30%		
Referral to Treatment Incomplete 52+ Week Waiters	0		13		
Diagnostic waiting times > 6 Weeks	1%		0.99%	0.98%	-0.012%
A&E All Types Monthly Performance	95%	92.6%	93.5%	89.1%	-4.36%
12 Hour Trolley Waits	0	0	0	0	0.00%
Proportion of patients not treated within 28 days of last minute cancellation	0%	12.64%	9.80%		
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

EFFECTIVENESS

Metric	Standard	YTD	Nov-16	Dec-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		84.1	84.1	0.00
Hospital Standardised Mortality Ratio - Weekday Emergency	100	0	82.4	82.4	0
Hospital Standardised Mortality Ratio - Weekend Emergency	100	0	86.7	86.7	0
Summary Hospital Mortality Indicator (HSCIC)	100	0	0.90	0.88	-0.02
Bed Occupancy - Midnight Count General Beds Only	85%		89.4%	88.2%	-1.2%
LOS - Elective			5.1	4.8	-0.3
LOS - Non-Elective			4.1	4.2	0.10

Metric	Standard	YTD	Oct-16	Nov-16	Movement
62 Day Standard	85%	84.36%	88.60%	80.00%	-8.60%
62 Day Screening Standard	90%	92.90%	96.00%	92.68%	-3.32%
31 Day Subsequent Drug Standard	98%	99.70%	100%	98.04%	-1.96%
31 Day Subsequent Surgery Standard	94%	97.2%	96.0%	96.0%	0.00%
31 Day Standard	96%	97.30%	97.20%	96.89%	-0.31%
Two Week Wait Standard	93%	90.50%	93.20%	85.71%	-7.49%
Breast Symptom Two Week Wait Standard	93%	93.80%	98.90%	94.81%	-4.09%

CARING

Metric	Standard	YTD	Nov-16	Dec-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		97.5%	95.9%	-1.57%
A&E Scores - Friends & Family Recommendation Rate	46		84.40%	82.30%	-2.10%
Number of complaints			92	56	-36
Mixed Sex Accommodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	Nov-16	Dec-16	Movement
Clostridium Difficile - Variance from plan	31	26	4	4	0
MRSA Bacteraemia	0	1	0	0	0
Never Events	0	2	0	0	0
Serious Incidents	0	72	10	4	-6
Percentage of Harm Free Care	95%		95.8%	93.8%	-2.0%
Medication Errors causing serious harm	0	7	2	0	-2
Overdue CAS Alerts	0	1	1	1	0
Maternal Deaths	1	0	0	0	0
VTE Risk Assessment (one monthe in arreas)	95%		96.2%	96.0%	-0.2%

WELL LED

Metric	Standard	YTD	Nov-16	Dec-16	Movement
Inpatient Response Rate Friends & Family	30%		47.6%	29.3%	-18.3%
A&E Response Rate Friends & Family	20%		21.5%	21.6%	0.1%
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%		18.0%	18.0%	0.0%
Trust level sickness rate	3.5%		3.6%	3.6%	0.00%
Total Trust Vacancy Rate	11%		14.4%	15.2%	0.8%
% of staff with annual appraisal - Medical	85%		81.10%	76.00%	-5.1%
% of staff with annual appraisal - non medical	85%		65.10%	64.20%	-0.9%

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.

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St George's University Hospitals NHS
NHS Foundation Trust

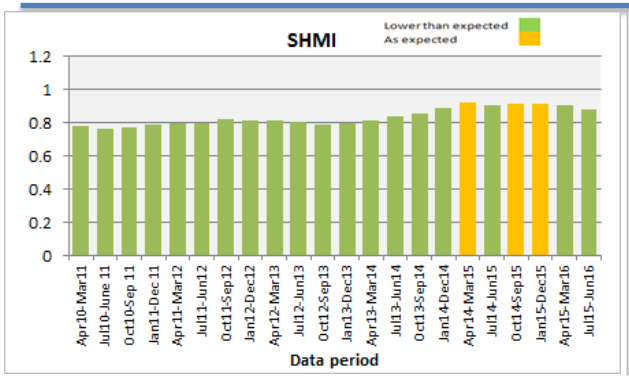
Quality Report

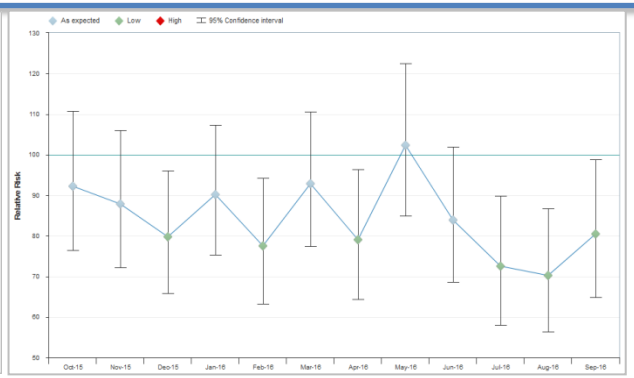
December-2016

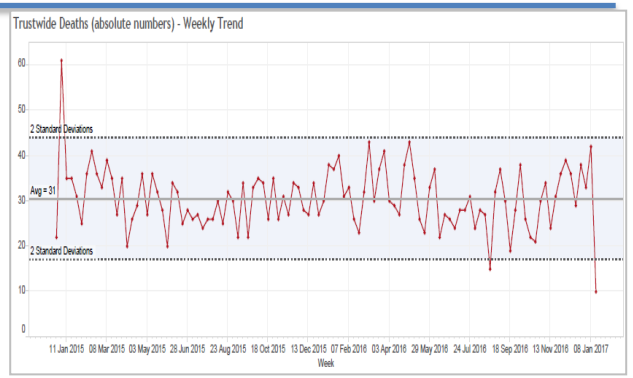
Excellence in specialist and community healthcare

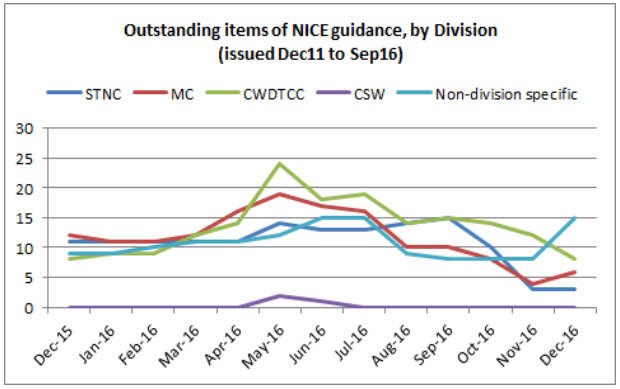
Clinical Effectiveness

St George's University Hospitals NHS
NHS Foundation Trust



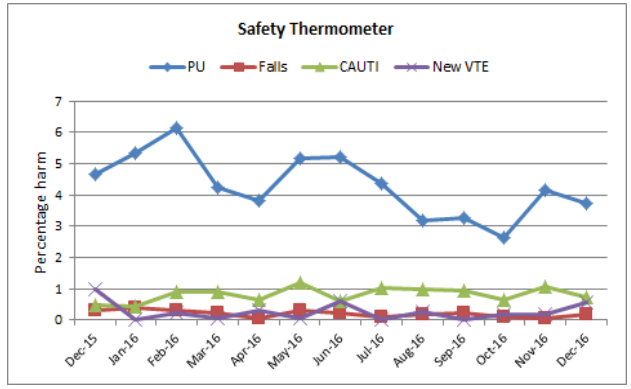






Items of NICE Guidance with Compliance Issues
Jun10 to Sep16, Total n.75

Division	2010	2011	2012	2013	2014	2015	2016
CWDTCC (n=12)	3	0	1	2	2	1	3
M+C (n=22)	2	0	1	1	2	9	7
STNC (n=17)	0	1	2	1	3	2	8
CSW (n=0)	0	0	0	0	0	0	0
Non-division specific (n=24)	0	3	0	3	3	4	11



Mortality

- For Oct 15 – Sep 16 HSMR is better than expected at 84.1 [weekend emergency admissions = 86.7 (better than expected); weekday emergency admissions = 82.4 (better than expected)].
- For the most recent month for which data is available (Sep 16) the HSMR is better than expected at 80.4 [weekend emergency admissions = 73.5 (as expected); weekday emergency admissions = 85.1 (as expected)].
- Latest SHMI July 15 – June 16 = 0.88 – lower than expected. One of 15 Trusts in England in this banding and identified as a repeat outlier.
- Raw mortality within usual limits.
- Key workstreams: Report into outlier alert Coronary Atherosclerosis has been redrafted for CQC. Continuing to participate in National Mortality Case Record Review pilot and local implementation.

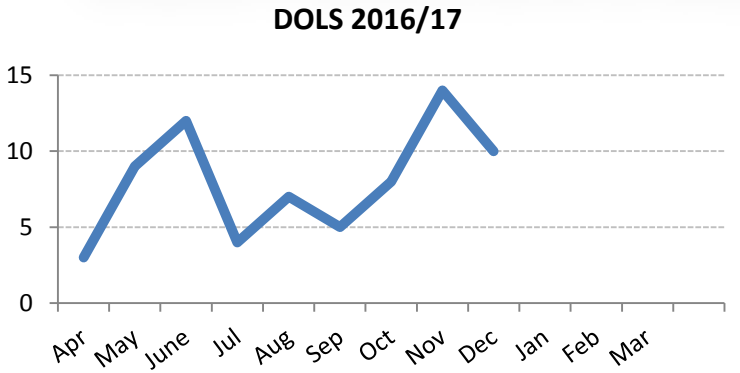
NICE Guidance

- 75 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.
- 32 items of guidance for which there has been no assessment of compliance, down from a peak of 71 in May. These have been escalated to each division for resolution.
- Monthly reports detailing the above are provided to divisions to support action and elimination of backlog.

Safety Thermometer

- 95.07% patients received harm free care in December. This meets our target of 95% and is better than the national average (94.28%).
- 57 harms to 54 patients: 51 patients experienced 1 harm and 3 patient experienced 2 harms.
- 30 harms (52.6%) were old and cannot be attributed to care delivered by the Trust.

Safeguarding Training Compliance – Adults 2016/17									
Lead Director	July	Aug	Sep	Oct	Nov	Dec	2016/2017Target	Forecast April 2017	Date expected to meet standard
SB	84%	83%	84%	83%	85%	86%	85%	G	-



Division	No. of compliant Staff	No. requiring training	Compliant (%)
Children and Women's Diagnostic and Therapy Services Division	602	689	90%
Community Services Division	115	129	89%
Corporate Division	3	3	100%
Medicine and Cardiovascular Division (ED)	185	214	86%
Surgery & Neurosciences Division	26	27	96%
Overall for the Trust	931	1062	89%

Safeguarding Children

Training : Through a manual counting of the training data on ARIS it has become apparent that :

- There are staff on ARIS down to have level 3 - who should not be. These inevitably take up places which inevitably reduces the space available for those who should be trained.
- Staff who should have level 3 not showing on ARIS - but are being trained. This means that the training being done is not fully reflected in the system.
- The safeguarding children Team and MAST are working together to rectify the training needs analysis on Totora.

Serious Case Reviews and Internal Management Reviews: A second practitioner learning even for Child AA is being held on 20th February 2017.

Other:

The review of the safeguarding service provision in the Trust is underway – the review covers adults and children.

Safeguarding Adults

- Continue to monitor safeguarding training via ARIS and MAST steering group. Divisions to take action around low compliance. Steady increase in compliance over last 8 months
- Review procedures following implementation of Care Act – Pan London procedures published Feb 2016 – local guidance completed Spring 2016. E-Learning revised May 16. Additional training given to senior staff Oct 2016 possibly resulting in increase in referrals

DOLS & MCA

DOLS: Since April 2014 and the Supreme Court judgement there has been a significant increase in DOLS activity which is reflected nationwide.. New Law Society Guidance now indicates that a significant number of patients are being understandably deprived of their liberty in their best interests. This is not necessarily a reflection of poor care and treatment. July 15 – fresh legal advice obtained around risk to organisation and patients with regard to non application of DoLs. Revised briefing paper presented for QRC July 2015. MCA/DoLs Guidance produced Sep 16. Working party commenced Sep 16 to address issues of training, guidance, governance, audit. CQC Sec 29 notice issued - training plan in place to address gaps in training. Initial audit completed Oct 16. To re-audit Jan 17

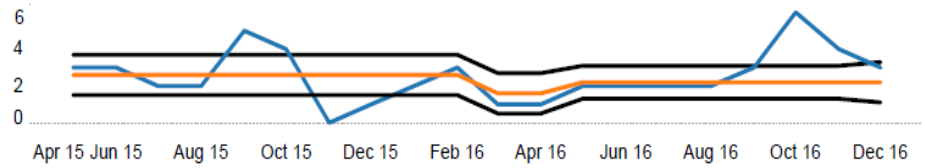
Delivering Safe Care

St George's University Hospitals NHS
NHS Foundation Trust

Average LCL Metric Measure UCL

Incidence of c.difficile
National Target applied for the Trust is 31 reported cases per year

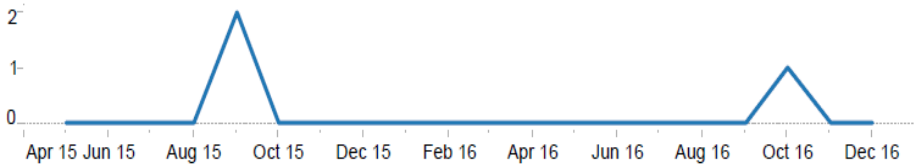
Standard: 31 YTD: 26 Nov 16: 4 Dec 16: 4 Movement: 0



4 reported C-difficile incident reported in December of which 3 cases in Allingham and one case in community . YTD this is a total of 26 cases against a target of 31

Incidence of MRSA
National objective is zero tolerance of avoidable MRSA bacteraemias

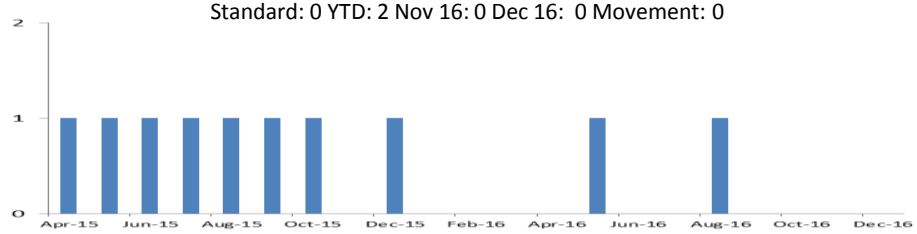
Standard: 0 YTD: 1 Nov 16: 0 Dec 16: 0 Movement: 0



There has been a single episode of Trust-assigned MRSA case YTD 2016/17 (target 0) this occurred in October 2016 more than a year since the previous episode

Never Events
Serious Incidents that are wholly preventable Threshold is 0

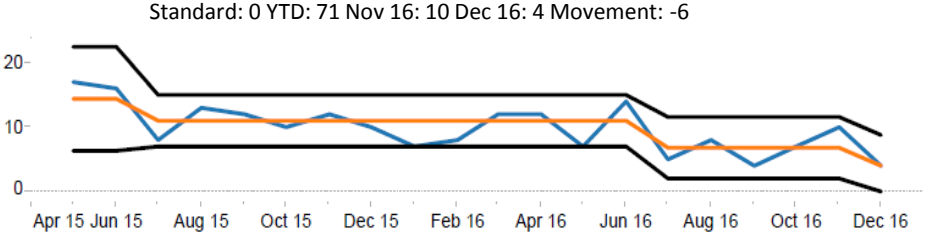
Standard: 0 YTD: 2 Nov 16: 0 Dec 16: 0 Movement: 0



2 Never Events (wrong site surgery) declared between Apr – Dec 2016/17, compared with 8 in Apr-Dec the previous year

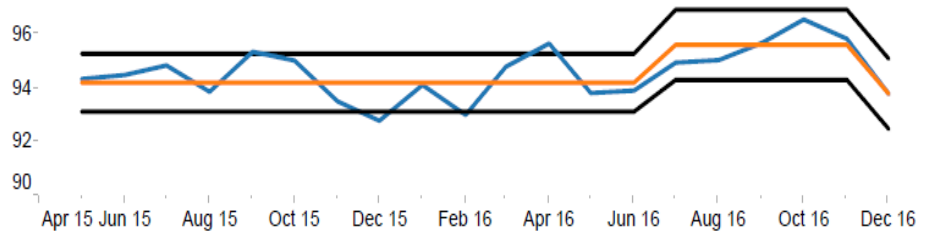
Serious Incidents
Number of serious incidents reported Threshold is zero

Standard: 0 YTD: 71 Nov 16: 10 Dec 16: 4 Movement: -6



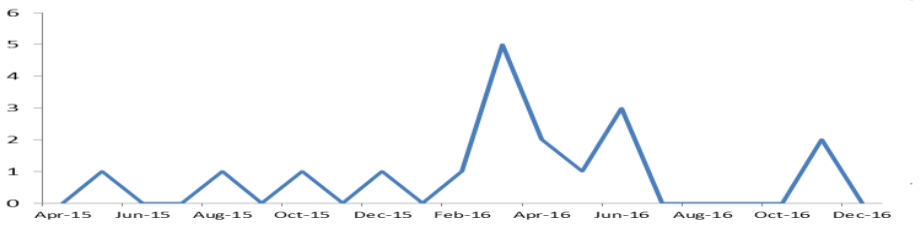
Reduction in Serious Incidents (Sis) declared Apr-Dec 2016/17 which represents a 35% decrease compared to the same period last year.

Percentage of Harm Free Care
Supporting Trusts in their aim to eliminate harm in patients from 4 common conditions; pressure ulcers, falls, UTI & VTE. Threshold is 93%



95.07% patients received harm free care in December. This meets our target of 95% and is better than national average (94.28%)

Medication Errors Causing Serious Harm
Patient safety incidents of type medication error, resulting in severe harm or death reported to the National Reporting and Learning Service (NRLS) by provider. Threshold is 0



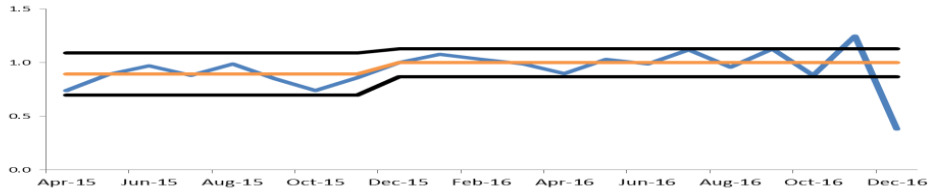
2 cases of medication errors resulting in serious harm were reported in November, zero reported in December

Average LCL Metric Measure UCL

Falls Per 1000 Bed Days

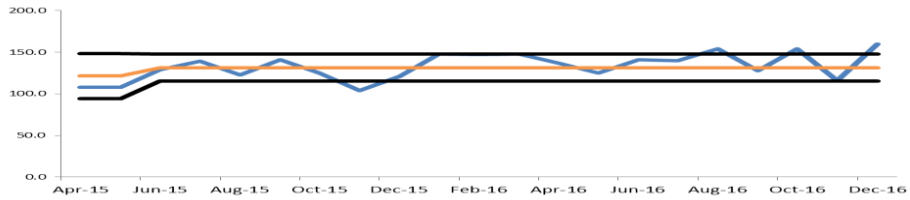
Number of Beds Occupied Per 1000 Bed Days Threshold is 3.1%

Standard: 3.1% YTD: N/A Nov 16: 0.88% Dec 16: 1.25% Movement: ▲0.37%



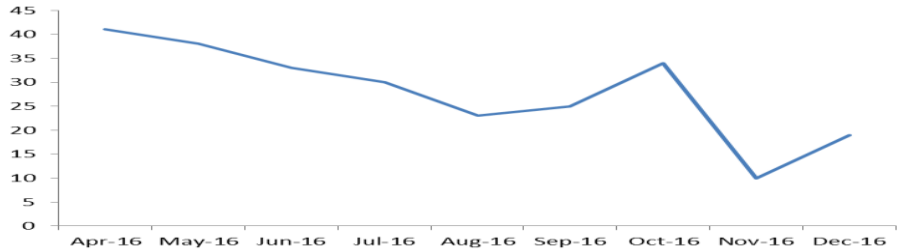
Total Patient Falls

Standard: 0 YTD: 1574 Nov 16: 116 Dec 16: 160 Movement: ▲44



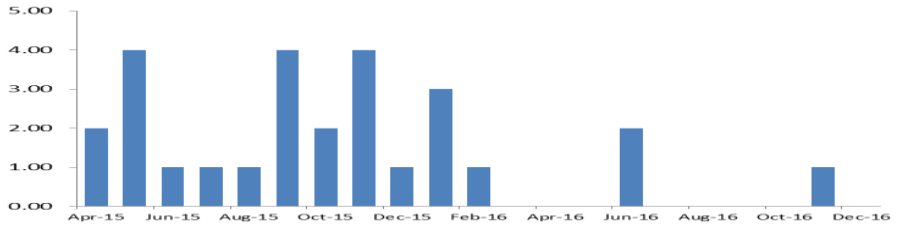
The graph shows an increase in the number of falls reported in the month of December. Total falls for the month is 169 (160 aligned to wards only), of which 146 were reported as no harm, 21 low harm, and 2 moderate harm

Attributable Grade 2 Pressure Ulcers



Avoidable Grade 3 and 4 Pressure Ulcers

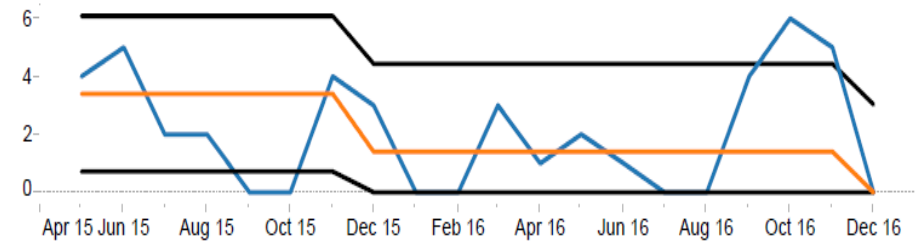
Standard: 0 YTD: 3 Nov 16: 0 Dec 16: 1 Movement: ▲1



1 case reported in December on Dalby Ward. 3 cases YTD against a target of 0.

MSSA Cases

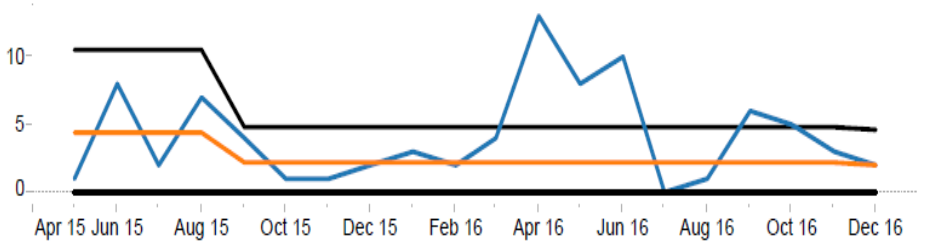
Standard: 0 YTD: 19 Nov 16: 5 Dec 16: 0 Movement: -4



Zero cases for the month of December

Incidence of E-Coli

Standard: 0 YTD: 48 Nov 16: 3 Dec 16: 2 Movement: -2

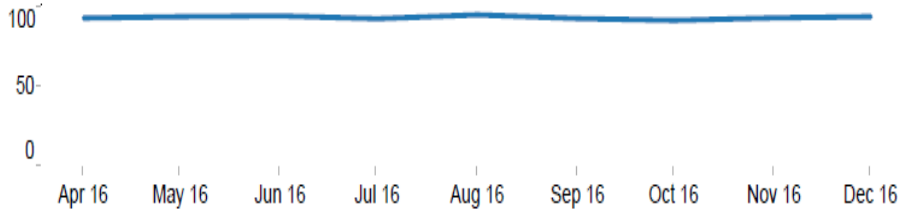


The Trust reported 2 E-coli incidents in the month of December

Metric Measure

Saving Lives Audits - Cleaning and Decontamination

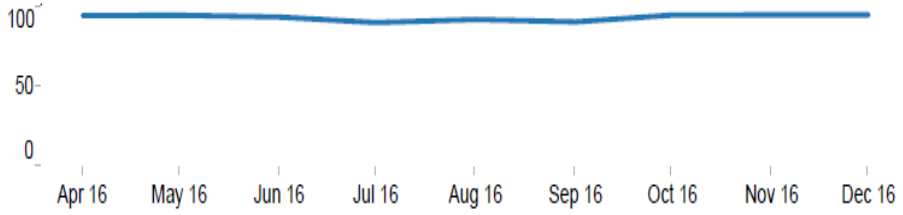
Standard: 100% YTD: N/A Nov 16: 93.25% Dec 16: 94.04% Movement: ▲0.79%



Ensuring that all equipment is correctly cleaned and decontaminated. December reported 94.03% against a target of 100%

Saving Lives Audits - Hand Hygiene

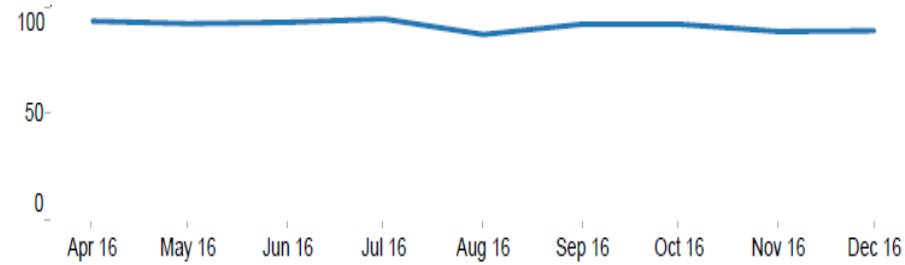
Standard: 95% YTD: N/A Nov 16: 94.37% Dec 16: 94.39% Movement: ▲0.02%



Ensuring that all staff complete the hand hygiene process correctly. December reported 94.39% against a target of 95%

VTE Risk Assessments Completed

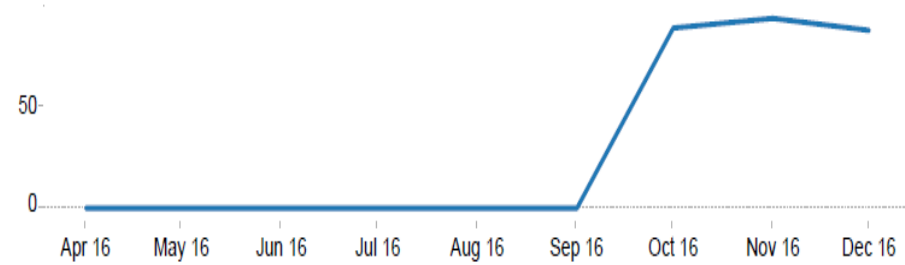
Standard: 95% YTD: N/A Nov 16: 88.74% Dec 16: 89.09% Movement: ▲0.35%



Ensuring that all VTE assessment forms are completed correctly. Performance in December was 89.09% against a target of 95%

Bed Rails Audit

Standard: 95% YTD: N/A Nov 16: 93.14% Dec 16: 87.23% Movement: ▼-5.91%



Please note completion of audit commenced in October 2016. Performance in December was 87.23% against a target of 95%.

Patient Experience

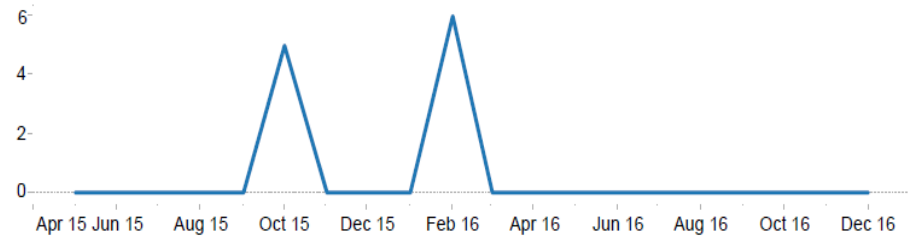
St George's University Hospitals NHS
NHS Foundation Trust

Average LCL Metric Measure UCL

Mixed Sex Accommodation Breaches

Number of occurances of unjustified mixing in relation to sleeping accommodation

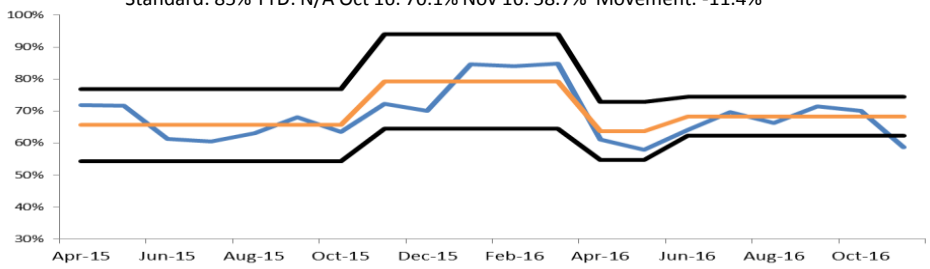
Standard: 0 YTD: 0 Nov 16: 0 Dec 16 0 Movement: 0



Zero cases reported YTD

Complaints responded to within 25 days

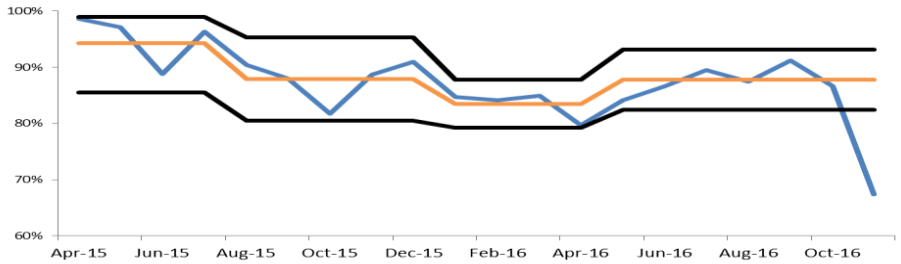
Standard: 85% YTD: N/A Oct 16: 70.1% Nov 16: 58.7% Movement: -11.4%



November performance was 58.6% against a target of 85%. Performance declined across all areas except Community Services. Divisions are being held to account at divisional meetings

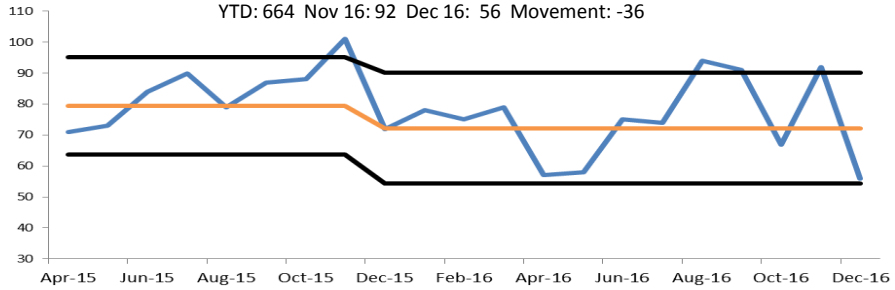
Number of Complaints With Agreed Extensions

Standard: 85% YTD: N/A Oct 16: 86.6% Nov 16: 67.4% Movement: -19.2%



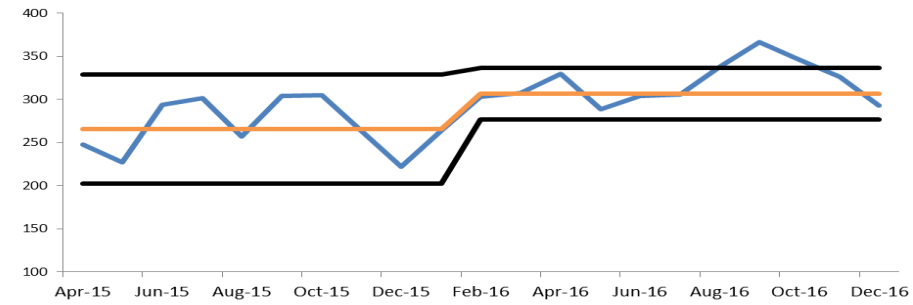
Total number Complaints received by Month

YTD: 664 Nov 16: 92 Dec 16: 56 Movement: -36



Number of complaints received reduced significantly from 92 in November to 56 in December which is not unusual for the festive period. Top themes are; clinical treatment, communication and appointment delay / cancellation

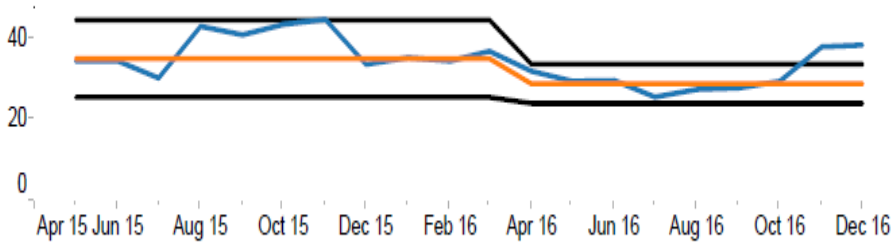
Number of PALS concerns received



Complaints Performance	% within 25 working days (target 85%)				% within 25 working dayes of agreed timescales (target 100%)			
Division	**August**	**September**	**October**	**November**	**August**	**September**	**October**	**November**
CWDTCC	29%	50%	67%	61%	(5) 64%	(9) 85%	(5) 94%	(3) 78%
M&C	68%	84%	64%	54%	(8) 100%	(5) 100%	(5) 100%	(6) 71%
STNC	63%	73%	68%	61%	(4) 75%	(3) 86%	(1) 73%	(8) 89%
CSD	100%	75%	75%	83%	(0) 100%	(1) 100%	(1) 100%	(1) 100%
Corp	75%	57%	88%	40%	(3) 100%	(2) 86%	(1) 100%	(1) 60%
SWLP	N/A	N/A	100%	N/A	N/A	N/A	(0) 100%	N/A
Trust	**65%**	**69%**	**70%**	**59%**	**(20) 86%**	**(20) 91%**	**(13) 90%**	**(19) 79%**

FFT Response Rate

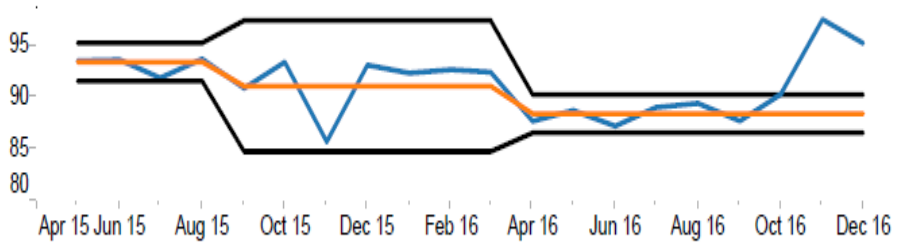
Standard: 20% YTD: N/A Nov 16: 37.87% Dec 16: 38.31% Movement: ▲0.44%



Total response rate for the month of December was 38.31% of which ED; 21.6% and consistent with previous months and IP reporting 29.3% which was a decrease compared with previous month.

FFT Score

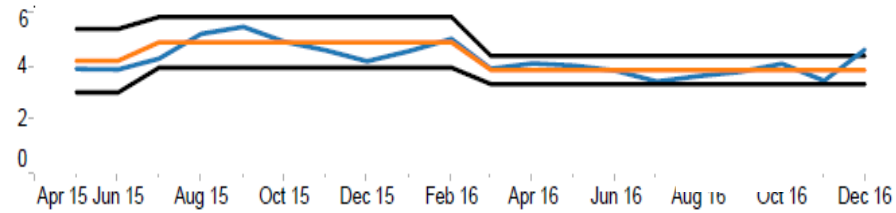
Standard: 90% YTD: N/A Nov 16: 97.45% Dec 16: 95.16% Movement: ▼-2.29%



Total recommendation rate by patients was 95.16% against a target of 90%, this was an increase compared to November. ED reporting 82.30% and IP 95.9%

Sickness/Absence Rate

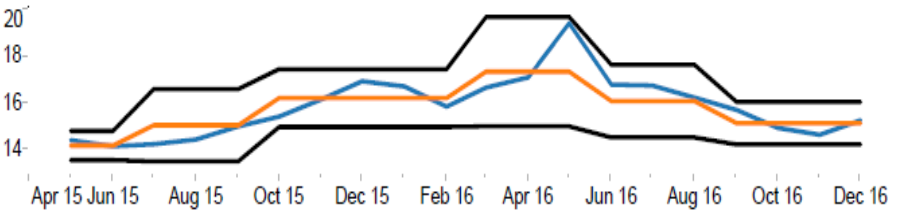
Standard: 3.5% YTD: N/A Nov 16: 3.48% Dec 16: 4.65% Movement: ▲1.17%



The sickness / absence rate has remained consistent since June 2016, however a slight increase was observed in December reporting 4.65% against a target of 3.5%

Vacancy Rate

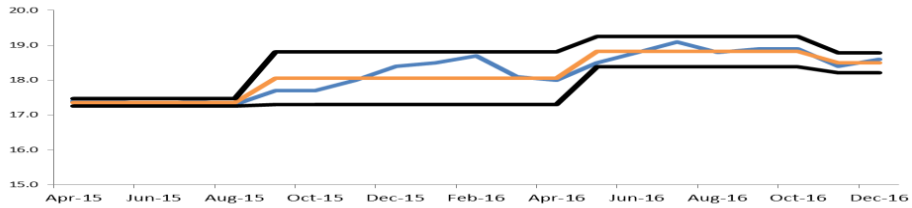
Standard: 11% YTD: N/A Nov 16: 14.67% Dec 16: 15.29% Movement: ▲0.62%



The Trust vacancy rate dipped in November however has seen an increase in December to 16.7%.

Turnover Rate

Standard: 13% YTD: N/A Nov 16: 19.71% Dec 16: 24.94% Movement: ▲5.23%

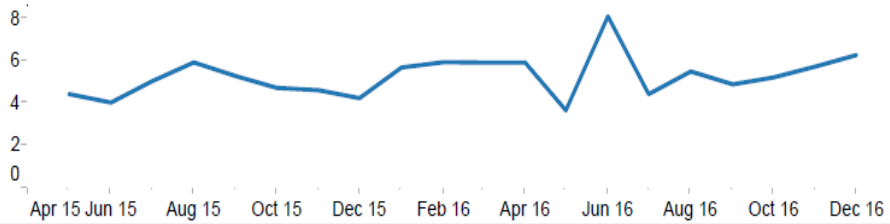


The Trust Turnover rate increased by 5.23% in December reporting 24.94% against a target of 13%

Metric Measure

Ward Staffing Unfilled Duty Hours

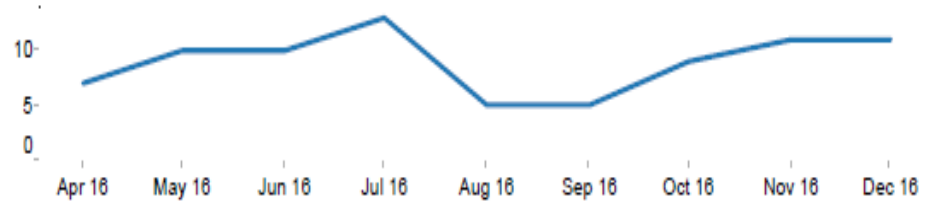
Standard: 10% YTD: N/A Nov 16: 5.71% Dec 16: 6.25% Movement: ▲0.54%



Audit against number of areas that report that they were not safely staffed as detailed in the safe staffing policy. 11 areas reported for December against a target of 0. Areas with lowest rate recorded are; Jungle Ward, Keate Ward and Rodney Smith Med Ward

Safe Staffing Alerts

Standard: 0 YTD: 81 Nov 16: 11 Dec 16: 11 Movement: ▸0



Audit against number of areas that report that they were not safely staffed as detailed in the safe staffing policy. 11 areas reported for December against a target of 0. Alerts reported within Rodney Smith, Neonatal, Holdsmith, Heberden and Gray Ward

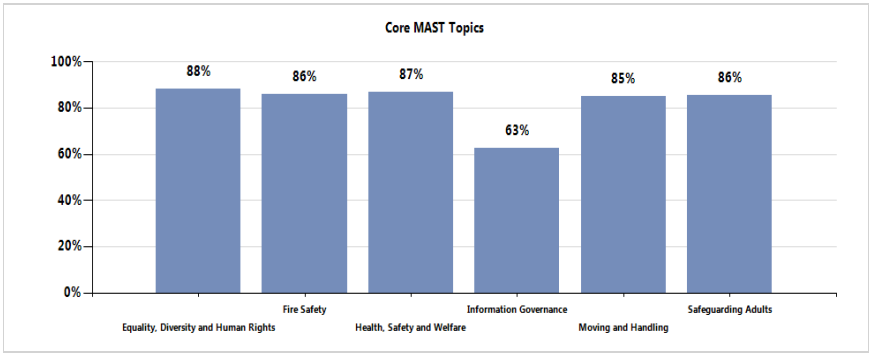
Care Hours per day (CHPPD)

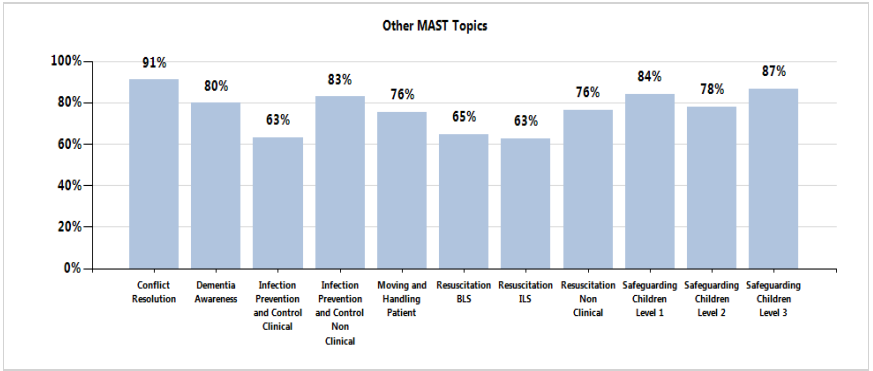
	JULY	AUG	SEPT	OCT	NOV	DEC
Combined care hours per patient day	14.29	14.48	12.17	12.60	13.02	12.87
Registered nurses care hours per patient day	10.55	10.72	9.06	9.45	9.74	9.57
Unregistered nurses care hours per patient day	3.74	3.75	3.11	3.11	3.28	3.30

Safe staffing alerts confirmed

	Medcard	Neuro / Surgical	Women's and Children's	Community
October	2	3	1	9
November	4	3	0	13
December	3	0	4	4

Core Mast Training Compliance





excellent / kind / responsible / respectful /

St George's University Hospitals NHS
NHS Foundation Trust

Performance and Activity

Excellence in specialist and community healthcare

Unplanned Care

Emergency Department – Due to poor performance in early December, four hour performance for the month was under our agreed trajectory and National target. Quarter 3 performance was 91.95%, therefore 0.3% below agreed trajectory. YTD performance is currently 92.53%. ED attendances were 3% higher compared to the same period last year with higher volumes of medical admissions and patient acuity levels. This is evidenced by actual activity for the month of December being 28% above plan. Ambulance arrivals in December has observed up to a 1% increase compared with previous month and YTD average. Bed capacity continues to be the highest cause of 4 hour breaches (18.92%) followed by ED capacity (17.63%) and treatment decisions (16.13%).

Planned Care

18 Weeks RTT –There has been a month on month improvement in the incomplete waiting list with a reduction of 2691 patients waiting compared to August 2016 and a reduction of 18 week backlog of 636 patients.
18 week backlog reduction also seen within the First Outpatient PTL (21.9%) and the admitted PTL (14.8%). Detailed backlog recovery plans are being developed for all specialties.
52 week waiters – Predicted 10 for the month of December. Weekly performance meetings are in place for all specialties focusing on reduction of long waiters and prevention of 52 week breaches.

Activity - Day case activity for December was 23% above plan (treating 552 patients above planned activity).
Specialties above plan include; General Surgery (+4.4%), Gynae (+19%), Plastics (+8%) and Urology (+24%)
Overall, elective Inpatient activity was slightly below plan as part of the winter plan to reduce bed occupancy, but this was offset by the increase in day case and a number of specialties increased activity including Cardiology (+4%), ENT (+15%), Gynae (+37%) and Plastics (+9%).

Diagnostics 6 Week Wait – Diagnostic performance in December fell below national standard and the Trust did not achieve STF Trajectory. In total 151 breaches were reported against a waiting list size of 6906 patients. 68.9% of the 6 week breaches were within Endoscopy, particular Gastroscopy and Cystoscopy.

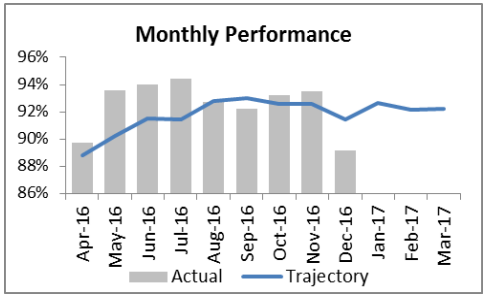
Cancer

Both Two Week Wait and 62 day performance was below standard in the month of November, all other standards achieved.
Two Week Wait Standard – performance was 85.7% against a target of 93%, with a high number of breaches within Skin (70.5% of all breaches). This is a result of capacity pressures due to clinical vacancies. The plan to improve performance in TWR includes increased capacity in Dermatology (Consultants) and 2 added Endoscopy rooms. Performance within Gynae, Head & Neck and Urology all observed performance improvement against the standard.
62 Day Standard – This target has been achieved since July however performance in November was below target, reporting 80% against the National target of 85%. Primarily this was due to an increase in 62 day backlog over October and November within Upper GI and Urology (accounting for 50% of all backlog) which has impacted on performance when patients are treated. However we have taken action to create added capacity for both areas to enable increased treatment capability for cancer treatment.

St George's University Hospitals NHS
NHS Foundation Trust

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

Monthly Actual	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Attendances	13,737	15,067	14,310	14,752	13,814	14,261	14,558	14,025	14,149			
Attendances<4 Hours	12,321	14,105	13,448	13,923	12,811	13,154	13,569	13,114	12,612			
Breaches >4 Hours	1,416	962	862	829	1,003	1,107	989	911	1,537			
Performance Actual	89.7%	93.6%	94.0%	94.4%	92.7%	92.2%	93.2%	93.5%	89.14%			
Performance Trajectory	88.8%	90.2%	91.5%	91.4%	92.8%	93.0%	92.6%	92.6%	91.5%	92.6%	92.1%	92.2%
Meeting STF	✓ 0.9%	✓ 3.4%	✓ 2.5%	✓ 3.0%	✗ 0.0%	✗ -0.7%	✓ 0.6%	✓ 0.9%	✗ -2.3%			



Met STF not National
Not met STF or National
Met STF and National

Quarterly Actual	Q1	Q2	Q3	Q4
Total Attendances	43,114	42,827	42,732	
Attendances<4 Hours	39,874	39,888	39,295	
Breaches >4 Hours	3,240	2,939	3,437	
Performance Actual	92.5%	93.1%	91.95%	
Performance Trajectory	90.2%	92.4%	92.2%	92.3%
Meeting STF	✓ 2.3%	✓ 0.8%	✗ -0.3%	

Remaining Breach Tolerance – Jan-17

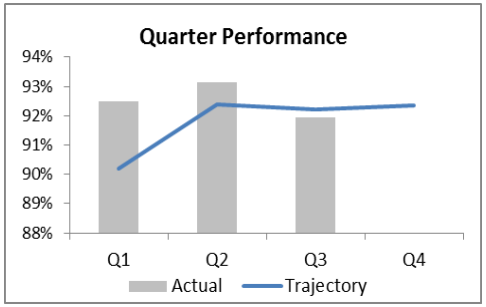
(as of 22/01/2017)

Breach Target Set		
Month	National	SFT
Jan-17	720	1,050
Feb-17	709	1,116

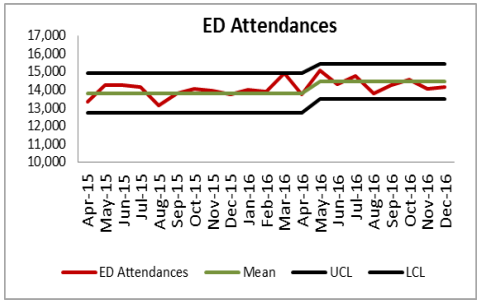
Breaches remaining for Month		
Month	National	SFT
Jan-17	-576	-246
Feb-17	709	1,116

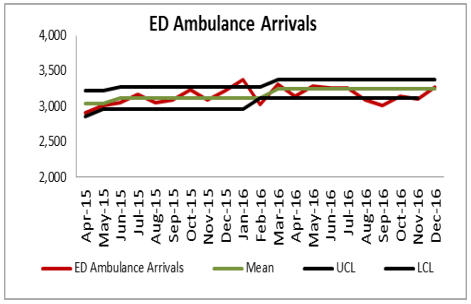
Breaches remaining per day		
Month	National	SFT
Jan-17	0	0
Feb-17	25	39

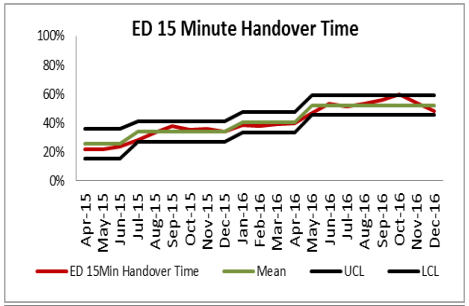
Breach Target Set - Number of breaches set to achieve National and STF
Breaches Remaining for Month - As of w/e how many breaches remain for the month to achieve target
Breaches Remaining per day - Breaches remaining for the month divided by days left to report
Attendances based on projections made as part of STF modelling

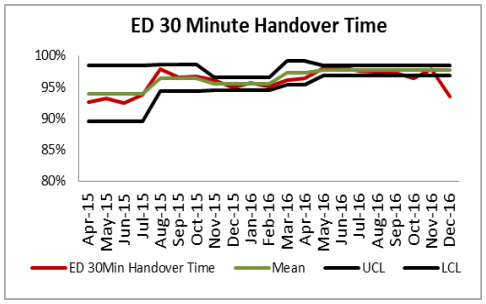


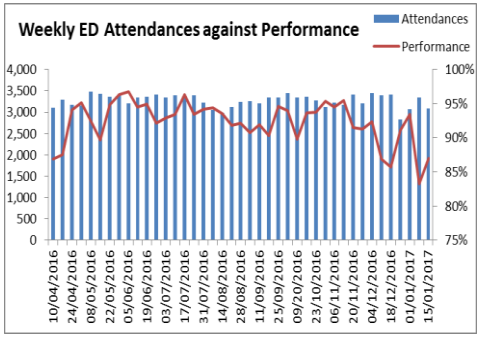
Weekly and Monthly Monitoring

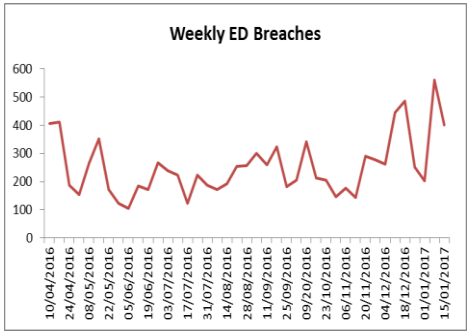


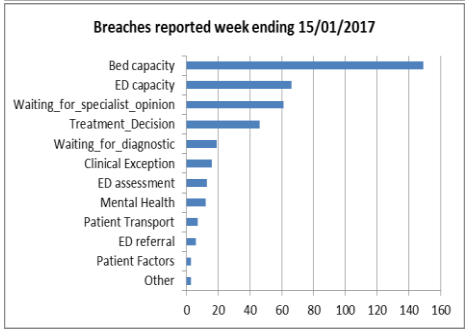


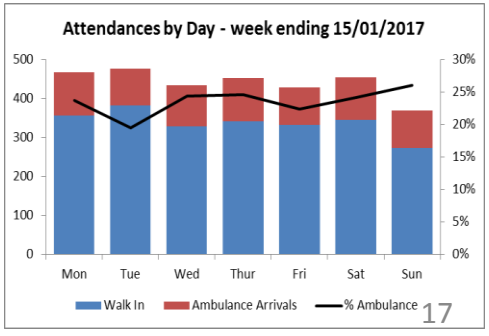












St George's University Hospitals NHS
NHS Foundation Trust

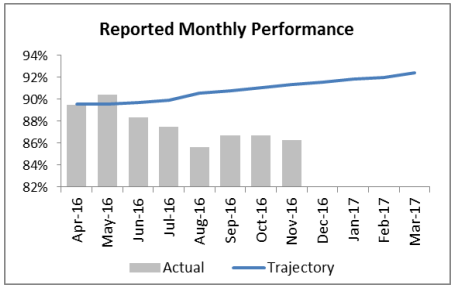
The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

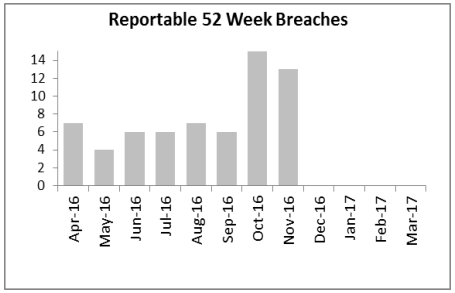
Met STF not National
Not met STF or National
Met STF and National

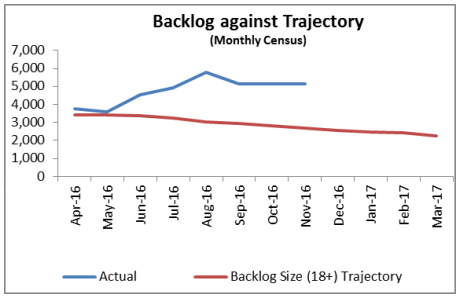
Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Incomplete Waiting List	32,957	32,957	32,618	32,419	31,985	31,721	31,392	30,943	30,504	30,205	29,968	29,765
Total waits < 18 Weeks	29,526	29,526	29,261	29,162	28,956	28,794	28,577	28,274	27,932	27,734	27,558	27,511
Total waits > 18 Week Breaches	3,431	3,431	3,357	3,257	3,029	2,927	2,815	2,669	2,572	2,471	2,410	2,254
Performance Trajectory	89.6%	89.6%	89.7%	90.0%	90.5%	90.8%	91.0%	91.4%	91.6%	91.8%	92.0%	92.4%
Total Incomplete Waiting List	35,626	37,243	38,849	39,573	40,299	38,635	38,594	37,608				
Total waits < 18 Weeks	31,873	33,668	34,309	34,635	34,498	33,487	33,454	32,450				
Total waits > 18 Week Breaches	3,753	3,575	4,540	4,938	5,801	5,148	5,140	5,158				
Performance Actual	89.5%	90.4%	88.3%	87.5%	85.6%	86.7%	86.7%	86.3%				
Meeting STF	✗ -0.1%	✓ 0.8%	✗ -1.4%	✗ -2.4%	✗ -4.9%	✗ -4.1%	✗ -4.4%	✗ -5.1%				

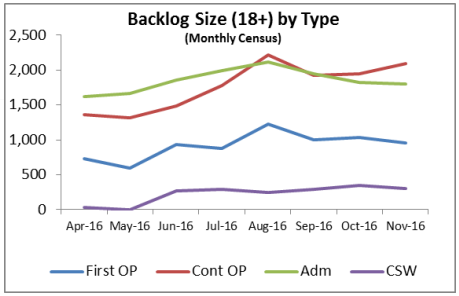
Reportable 52 Week Breaches	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Incomplete Waiting List	7	4	6	6	7	6	15	13				

Reportable 52 Week Breaches - November	Confirmed	Treatment Dec-16	Event Planned Jan-16	Event Planned Feb-16	Need pathway status outcome
OP First	1		1		
OP Continuing	7	1	2	2	2
Admitted	5	2	2	1	
Total	13	3	5	3	2







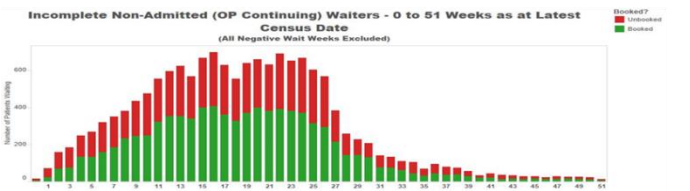


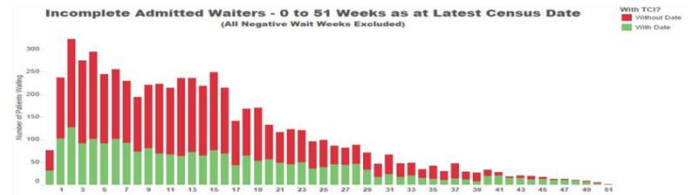
PTL Position (Unvalidated)

Monitoring the weekly PTLs for the number of patients who have been waiting 40+ weeks

PTL: Booked VS Unbooked (Unvalidated)

An overview of the shape of the PTL's broken down by with / without an appointment booked





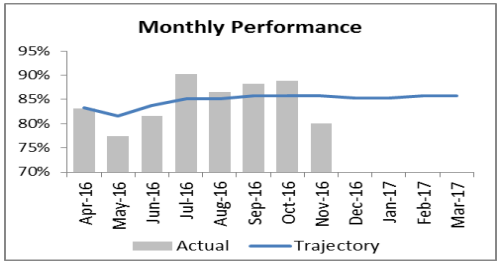
RTT Incomplete Performance by Specialty

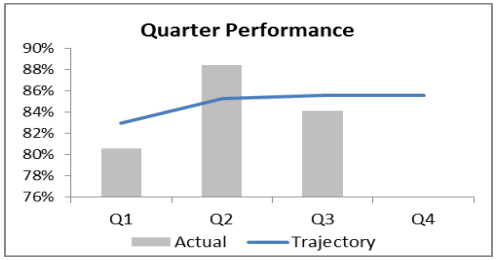
PTL Position - Monthly Census Position (Nov-16)

	OP First						OP Subsequent						IP DC Admitted					
Specialty	Waiting List	18+ backlog	% against target of 92%	Breach Allowance	WL Trend	18+ Trend	Waiting List	18+	% against target of 92%	Breach Allowance	WL Trend	18+ Trend	Waiting List	18+	% against target of 92%	Breach Allowance	WL Trend	18+ Trend
General Surgery	1,393	37	97.3%	111			1,408	378	73.2%	112			844	222	73.7%	67		
Urology	593	19	96.8%	47			465	127	72.7%	37			339	55	83.8%	27		
Trauma & Orthopaedics	2,184	225	89.7%	174			878	457	47.9%	70			325	147	54.8%	26		
Ear, Nose & Throat (ENT)	1,366	107	92.2%	109			690	213	69.1%	55			937	603	35.6%	75		
Oral Surgery	1,784	0	100.0%	142			40	6	85.0%	3			349	121	65.3%	27		
Neurosurgery	566	5	99.1%	45			500	85	83.0%	40			131	20	84.7%	10		
Plastic Surgery	382	8	97.9%	30			331	103	68.9%	26			661	227	65.7%	52		
Cardiothoracic Surgery	41	1	97.6%	3			40	7	82.5%	3			188	40	78.7%	13		
General Medicine	545	50	90.8%	38			223	56	74.9%	17			2	0	100.0%	0		
Gastroenterology	829	51	93.8%	66			517	146	71.8%	41			763	97	87.3%	61		
Cardiology	792	30	96.2%	63			424	47	88.9%	33			641	68	89.4%	51		
Dermatology	1,842	201	89.1%	147			546	99	81.9%	43								
Neurology	626	14	97.8%	50			215	30	86.0%	17			85	3	96.5%	6		
Rheumatology	696	6	99.1%	55			200	26	87.0%	16								
Geriatric Medicine	10	4	60.0%	0			1	0	100.0%	0								
Gynaecology	1,426	17	98.8%	114			1,086	174	84.0%	86			284	105	63.0%	22		
Audiology	588	46	92.2%	47			371	37	90.0%	29								
Clinical Genetics	1,076	10	99.1%	86														
Clinical Haematology	307	15	95.1%	24			118	23	80.5%	9			15	4	73.3%	1		
Diagnostic Imaging							15	11	26.7%	2								
Infectious Diseases	28	0	100.0%	2			21	2	90.5%	1								
Interventional Radiology	9	4	55.6%	0			2	0	100.0%	0			11	1	90.9%	0		
Nephrology	116	0	100.0%	9			106	14	86.8%	8			1	0	100.0%	0		
Paediatric Medicine	1,061	63	94.1%	84			388	18	95.4%	31			23	1	95.7%	1		
Paediatric Surgery	178	5	97.2%	14									117	14	95.4%	9		
Pain Management	378	23	93.9%	30			30	4	86.7%	2			166	57	65.7%	13		
Respiratory Medicine	685	19	97.2%	54			328	40	87.8%	26			12	1	91.7%	0		
Total	19,501	957	95.1%	1,557			8,943	2,103	76.5%	715			5944	1801	69.7%	475		

The Sustainability and Transformation Fund Performance against Trajectory 2016/2017 - 62 Day Standard

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Treatments	60	60	74	74	74	63	70	63	68	68	70	70
Treatments <62 Days	50	49	62	63	63	54	60	54	58	58	60	60
Breaches >62 Days	10	11	12	11	11	9	10	9	10	10	10	10
Performance Trajectory	83.3%	81.7%	83.8%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%	85.3%	85.7%	85.7%
Total Treatments Actual	59.5	71	70.5	71.5	59.5	64	63	70				
Total Treatments within 62 Days Actual	49.5	55	57.5	64.5	51.5	57	56	56				
Total Breaches Actual	10	16	13	7	8	8	7	14				
Performance Actual	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.8%	80.0%				
Meeting STF	✗ -0.1%	✗ -4.2%	✗ -2.2%	✓ 5.1%	✓ 1.4%	✓ 2.6%	✓ 3.1%	✗ -5.7%				





Quarterly Trajectory	Q1	Q2	Q3	Q4
Total Treatments	194	211	201	208
Treatments <62 Days	161	180	172	178
Breaches >62 Days	33	31	29	30
Performance	83.0%	85.3%	85.6%	85.6%

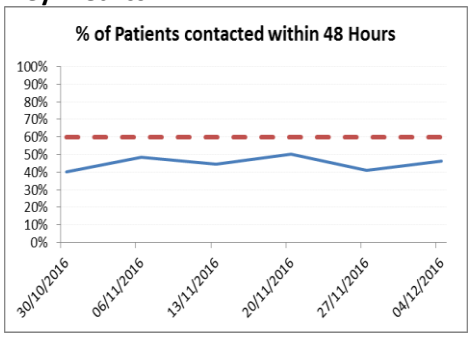
Quarterly Actual	Q1	Q2	Q3	Q4
Total Treatments	201	195	133	
Treatments <62 Days	162	172.5	112	
Breaches >62 Days	39	23	21	
Performance	80.6%	88.5%	84.2%	
Meeting STF	✗ -2.4%	✓ 3.2%	✗ -1.4%	

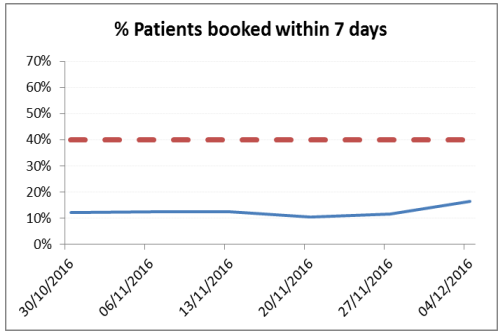
Met STF not National
Not met STF or National
Met STF and National

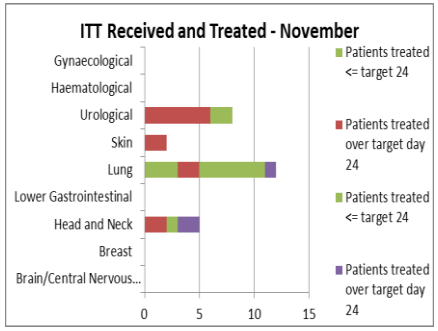
All Cancer Standards Performance Indicators

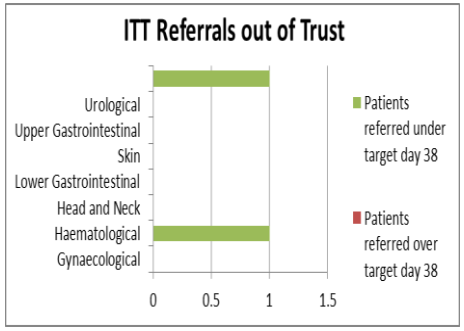
All Cancer Standards	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Trend
14 Day GP Referral (93%)	86.6%	87.3%	90.0%	93.1%	95.1%	94.2%	93.2%	85.7%					
14 Day Breast Symtomatic (93%)	94.8%	95.2%	85.9%	93.8%	94.2%	96.0%	98.9%	94.8%					
31 Day First Treatment (96%)	98.3%	96.3%	98.8%	97.6%	97.4%	96.2%	97.2%	96.9%					
31 Day Subsequent Treatment Surgery(98%)	100.0%	94.7%	96.6%	100.0%	100.0%	93.8%	98.8%	96.0%					
31 Day Subsequent Treatment Drug(98%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%					
62 Day Referral (85%)	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.8%	80.0%					
62 Day Screening (90%)	93.9%	84.8%	94.8%	95.0%	95.8%	92.0%	96.2%	92.7%					
62 Day Consultant Upgrade (85%)	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	92.6%	87.5%					

Key Metrics









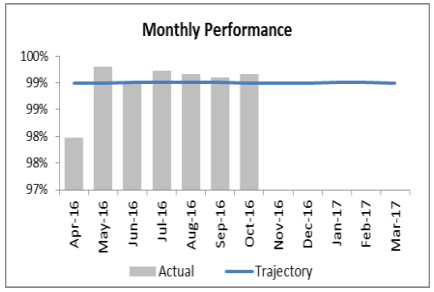
7. Summary of Diagnostic Performance

St George's University Hospitals NHS
NHS Foundation Trust

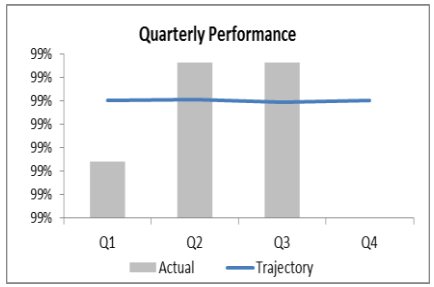
The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total Waits	5,788	5,386	6,046	5,718	5,429	5,750	5,803	5,860	5,776	5,813	5,816	5,802
Total Waits <6 Weeks	5,730	5,332	5,986	5,661	5,375	5,693	5,745	5,801	5,718	5,755	5,758	5,744
Total Waits >6 Weeks	58	54	60	57	54	57	58	59	58	58	58	58
Performance Trajectory	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

Total Waits	7,290	6,588	6,977	6,436	6,085	6,258	6,834	6,878	6,906			
Total Waits <6 Weeks	7,142	6,542	6,908	6,386	6,034	6,202	6,777	6,828	6,755			
Total Waits >6 Weeks	148	46	69	50	51	56	57	50	151			
Performance Trajectory	98.0%	99.3%	99.0%	99.2%	99.2%	99.1%	99.2%	99.3%	97.8%			
Meeting STF	✗ -1.0%	✓ 0.3%	✓ 0.0%	✓ 0.2%	✓ 0.2%	✓ 0.1%	✓ 0.2%	✓ 0.3%	✗ -1.2%			



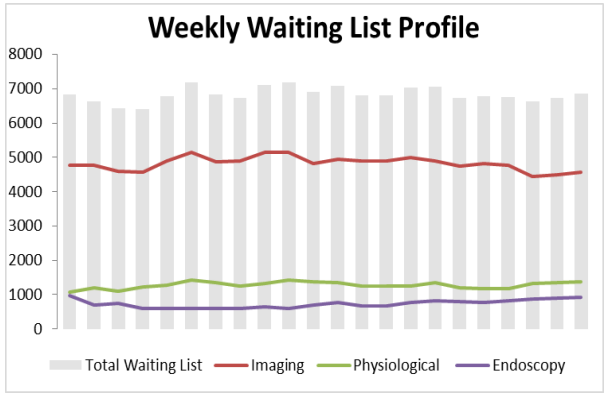
Met STF not National
Not met STF or National
Met STF and National

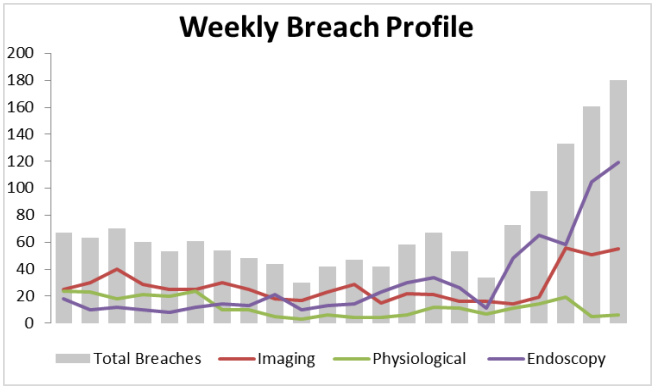


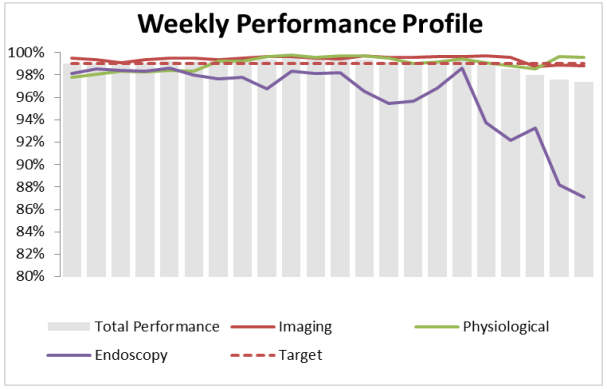
Quarterly Trajectory	Q1	Q2	Q3	Q4
Total Waits	17,220	16,897	17,439	17,431
Total Waits <6 Weeks	17,048	16,729	17,264	17,257
Total Waits >6 Weeks	172	168	175	174
Performance	99.0%	99.0%	99.0%	99.0%

Quarterly Actual	Q1	Q2	Q3	Q4
Total Treatments	20,855	18,779	20,618	
Treatments <62 Days	20,592	18,622	20,360	
Breaches >62 Days	263	157	258	
Performance	98.7%	99.2%	98.7%	
Meeting STF	✗ -0.3%	✓ 0.2%	✗ -0.25%	

Weekly Performance Monitoring up to 15/01/2017

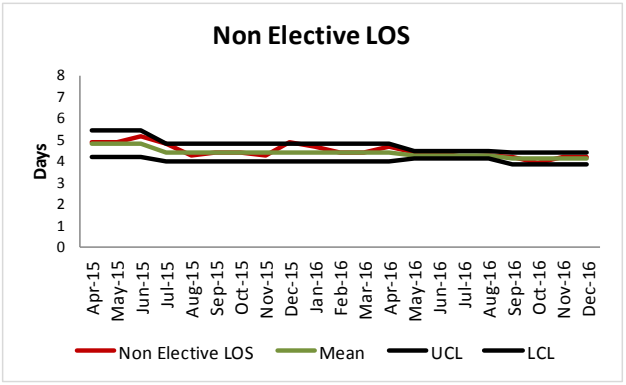


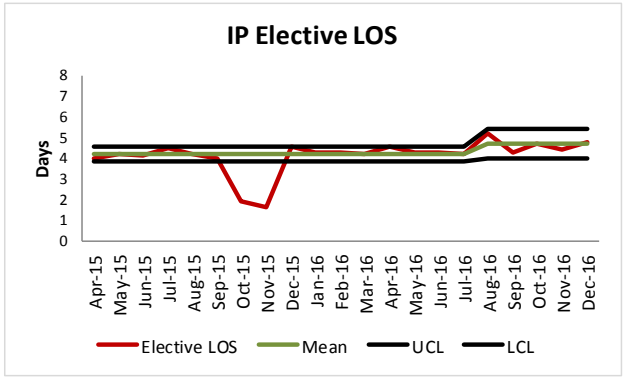




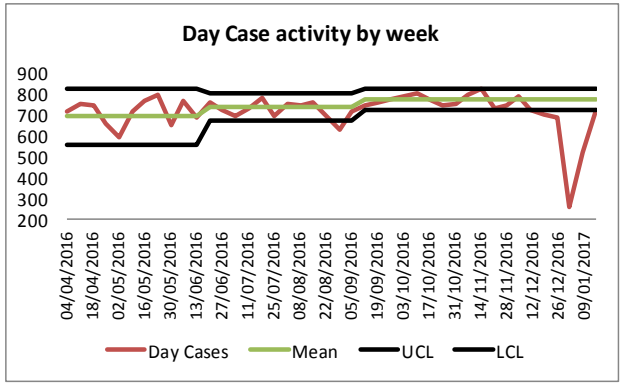
8. Operational Dependencies

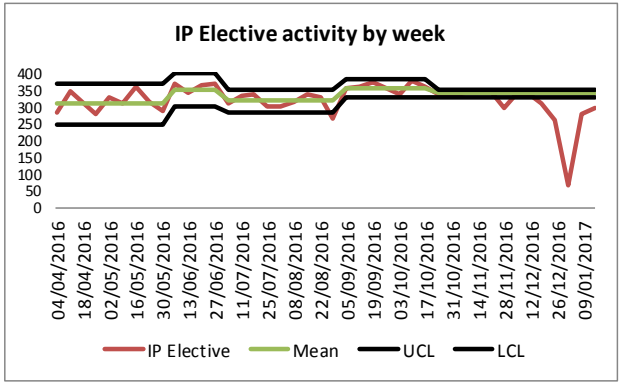
Length of Stay by Month

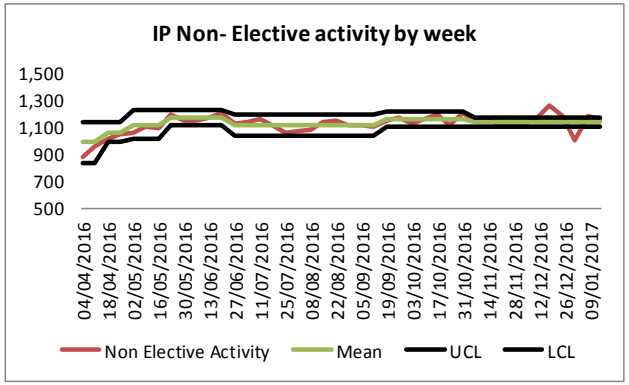




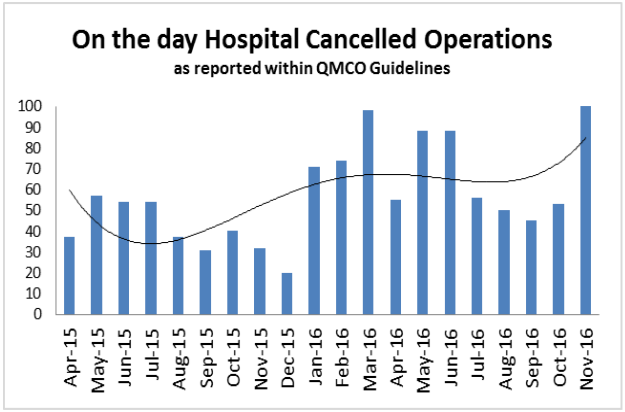
Theatre Productivity by Week

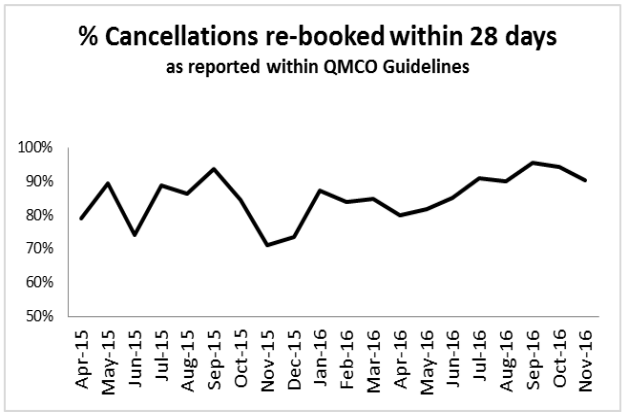


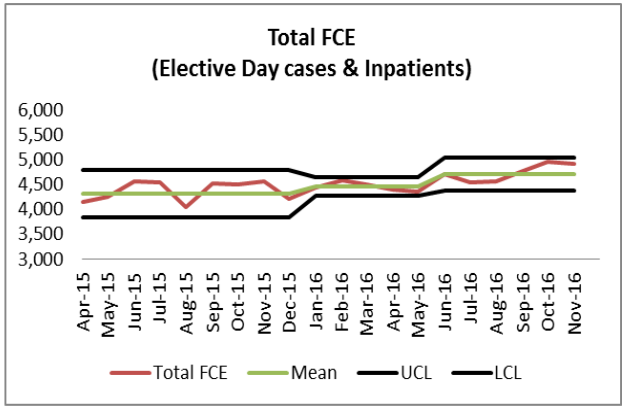




Cancelled Operations

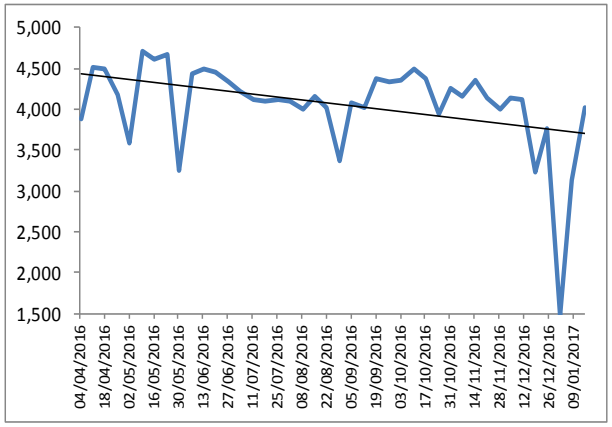


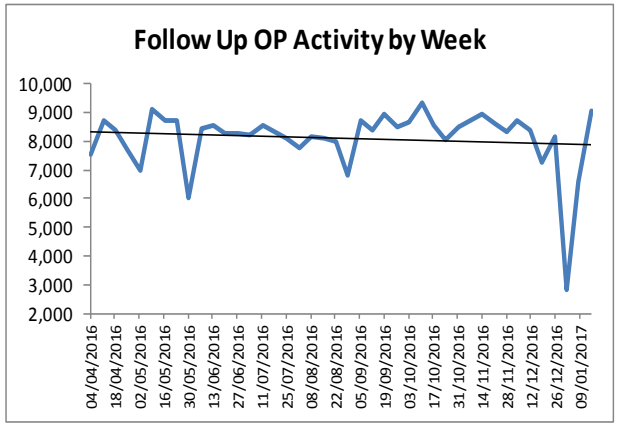


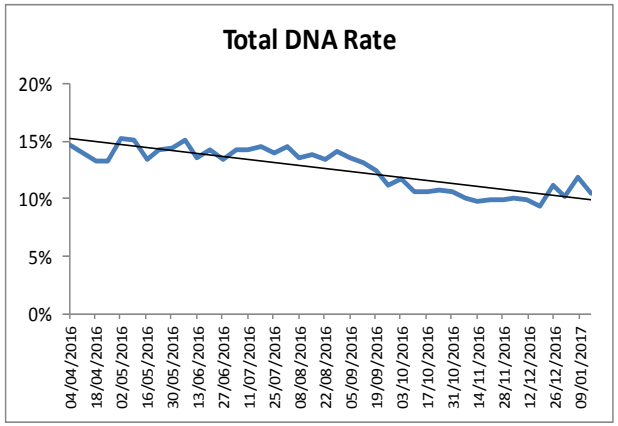


8. Operational Dependencies

Outpatient Activity







St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 February 2017	**Agenda No**	**2.4**
Report Title:	Elective Care Recovery Programme		
Lead Director/ Manager:	Diana Lacey, Director Elective Care Recovery Programme		
Report Author:	Diana Lacey, Director Elective Care Recovery Programme		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Update		
Executive Summary:	This paper gives an update on the implementation of the plan to recover the integrity of elective care data used to administer patient tracking lists (PTL), and deliver the 18 week referral to treatment (RTT), diagnostic and cancer access standards.		
Recommendation:	The Board is asked to note the progress made.		
Supports			
Trust Strategic Objective:	1. Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. 2. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Operational Performance		
Implications			
Risk:	Patients may come to harm as a consequence of waiting in excess of 18 weeks for treatment. A high number of patients waiting will adversely affect Trust performance against the referral to treatment (RTT) standards, and Sustainability and Transformation trajectory with subsequent loss of income. There will be an additional loss of income as the Trust will be fined for non-reporting of the RTT standard. This may affect the reputation of the Trust.		
Legal/Regulatory:	Delivery of the programme will aid the Trust to return to reporting of the referral to treatment (RTT) standard which is a requirement of the NHS Constitution. Delivery of the programme will help to address issues raised in the recent CQC report.		
Resources:	There are no specific resource implications associated with this update.		
Previously Considered by:	Executive Management Team	**Date :**	23rd January 2017
Equality Impact Assessment:	N/A		
Appendices:	Approach to recovery of RTT data quality and performance.		

Elective Care Recovery Programme Report
Trust Board
9 February 2017

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Trust Board with an update on the establishment and delivery of the Elective Care Recovery Programme (ECRP).

2.0 BACKGROUND

2.1 Following identification of a number of performance and data quality issues by the national Referral to Treatment (RTT) Intensive Support Team (IST), St George's University Hospitals NHS Trust commissioned a comprehensive review of their systems and processes that manage patients on the elective care pathway. The review conducted by MBI identified multiple operational process and technology issues at every stage of the elective care pathway that posed significant risks to the quality of care and safety of patients.

2.2 Specifically, the Trust has a high number of 'open' patient records on its Patient Administration Systems (PAS) dating back to at 2014 and possibly earlier. The Trust cannot say with certainty that these patients have been treated or are at the correct stage of their care pathway and it is probable that patients may have been harmed due to their extended wait. The Trust Board took the decision to suspend national reporting of RTT performance in July 2016.

2.3 The scale and complexity of the resolution to the issues is great. The Elective Care Recovery Programme has been established to rectify the issues and return St George's to national reporting of the RTT standard.

2.4 The Recovery Programme has three areas of focus; validating and correcting historic patient records, assessing patients with excessive waits for clinical harm and expediting their treatment, and ensuring data capture is accurate, complete and timely in future (see Appendix 1)

3.0 UPDATE

3.1 The Recovery Programme is now established with a detailed programme of work, and executive leads identified for each work stream. The programme Board, chaired by the programme Director meets fortnightly, with attendance from local commissioners, specialised commissioners and regulators.

3.2 The process for the review of patients who may have been harmed by a long wait is established. The process is overseen by the Clinical Harm Review Group chaired by Dr Nicola Payne (Deputy Medical Director, NHS England London Region). Patients included in the review include all patients who have waited more than 52 weeks for treatment, and others identified at risk through DATIX, GP and primary care alerts. In the 82 cases reviewed no harm had occurred in 73 of the cases, and in 9 cases low harm had occurred.

3.3 Validation and correction of historic patient records is planned to take place in three phases. Approval has been given by NHS Improvement for the Trust to contract with an external supplier to undertake the first phase; this is the validation and correction of the records of those patients who are most at risk of clinical harm due to a long wait to be seen. It is expected that the validation and correction process will begin at the beginning of February and will take 5 months to complete.

3.4 Commissioners have committed to partially reinvest fines levied as a consequence of non-reporting national RTT performance data, (Information Breach Notice penalties) and will contribute two thirds of the costs incurred by this contract in 2016/17. In addition local commissioners have committed to reinvest Information Breach Notice penalties in 2017/18 in a combination of RTT validation and transformation schemes to be agreed with the Trust.

3.5 At the request of NHS Improvement the Trust is considering the feasibility of undertaking the second phase of validation and correction 'in house' rather than contract with an external supplier. The Outline Business Case is being developed for presentation to the Elective Care Recovery Board in mid-February; the preferred solution will require the support and agreement of the Strategic Oversight Group (SOG).

3.6 One of the sources of information if the patient record is inaccurate or incomplete is letters. The backlog of letters waiting more than ten days (approximately 8,800 at the end of November) is expected to be eliminated by the end of February to prevent an unnecessary delay in the validation and correction process.

3.7 The current process of month end validation to ensure accuracy of performance reporting has ceased and the validation effort focussed on ensuring accuracy of the Patient Tracking Lists (PTL) and a move to using the PTL for the management of waiting lists.

3.8 The validation team has been expanded and is focussed on validating and correcting the records of patients as the patient is referred into the Trust (specifically to ensure that the clock start is accurate), and when the patient is added to the admitted patient PTL. In addition each week the validation team will validate the records of the longest waiting patients enabling clinical and operational teams to ensure that all long wait patients have a date for treatment.

3.9 The initial focus will be on all patients waiting more than 48 weeks but will reduce to 44 and 40 weeks as patients are treated.

3.10 Weekly reporting will focus on the number of patients on the 48 week plus list who have been booked, and the number of patients on the 48 week plus list that have received treatment in the previous week and been removed from the list.

3.11 A PTL for diagnostic patients will be in place in April 2017.

4.0 NEXT STEPS

4.1 Award contract to external supplier for technical validation and establish operation and contract management processes

4.2 Secure SOG approval for preferred approach to Phase 2 of the validation and correction process.

4.3 Focus on treating long wait patients by clinical teams and Divisions.

4.4 Complete the training needs assessment for the all staff with administrative responsibility for the elective patient pathway.

5.0 RETURN TO REPORTING

5.1 Until the approach to phase 2 of the validation process is agreed and commissioned it will not be possible to forecast when the Trust will be in a position to consider a return to national reporting of RTT performance data.

5.2 Other NHS Trusts who have had similar issues with data quality have found the recovery to be a lengthy process taking in excess of eighteen months. Given their experience and what we already know about the volume of records to be corrected St Georges will most likely return to reporting in 2018/19.

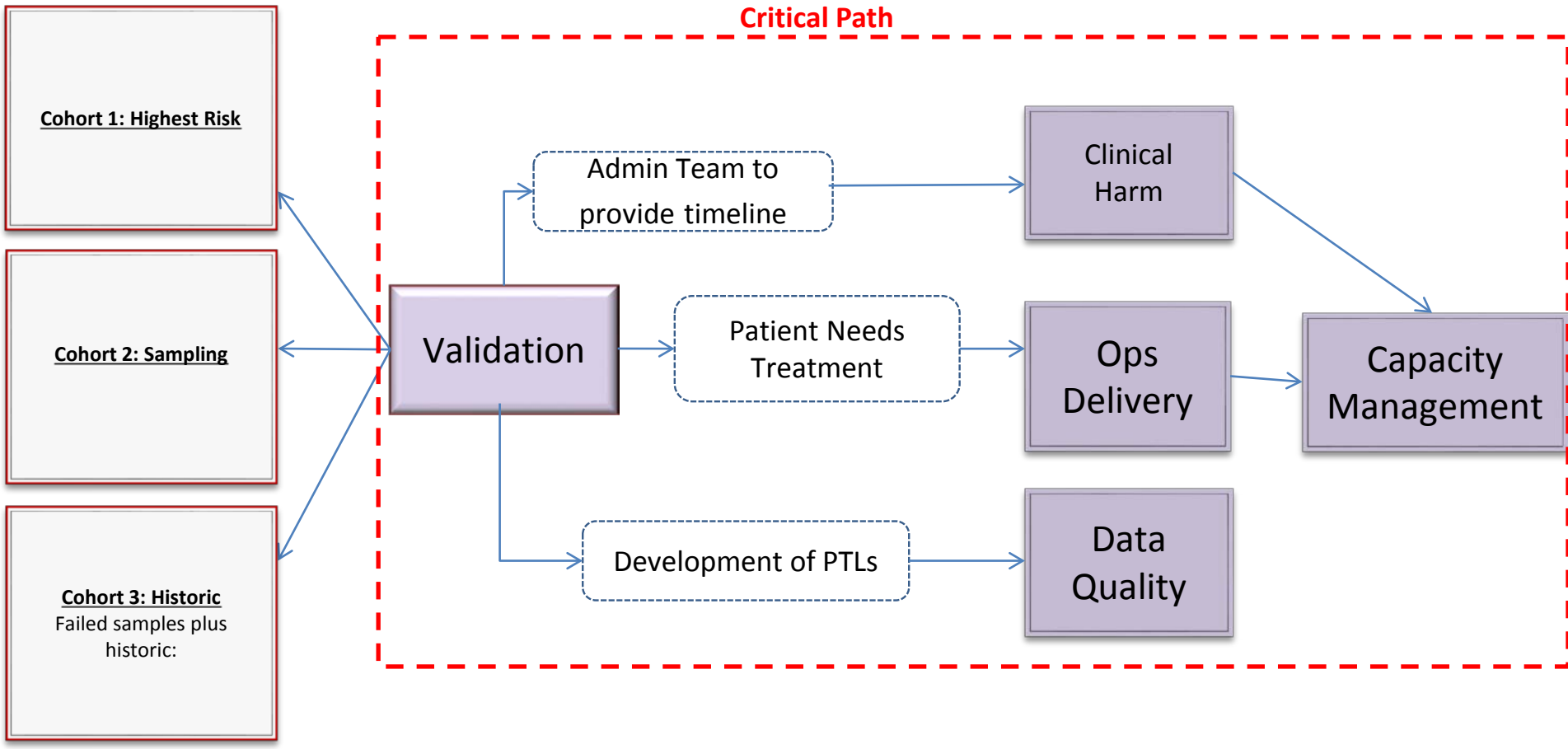
6.0 RECOMMENDATION

6.1 The Trust Board is asked to note progress being made.

Author: **Diana Lacey, Director Elective Care Recovery Programme**
Date: **1st February 2017**

Appendix 1

Approach to recovery of RTT data integrity and performance



St George's University Hospitals NHS
NHS Foundation Trust

Standard Operating Procedure

Operations Centre

Contents

Appendices

1.0 Introduction

The purpose of this document is to provide guidance to Trust staff helping to ensure the Trust provides a pro-active response to increasing capacity pressures both within the Emergency Department and in the organisation as a whole. This will ensure there is organisational flow at the beginning and end of the patient's pathway. The objective of this Standard Operating Procedure (SOP) is to ensure there is clarity about how site / beds are managed at St. George's Hospital and provide clarity around roles and responsibilities both within the site management team and divisions.

The standard operating procedures (SOP) have been formulated to ensure patient safety, to support the patient experience and to enhance the patient pathway (emergency & elective). The SOP has been designed so that it can be quickly implemented and the impact of actions taken can be quickly realised. The actions are expected to ensure that flow is sustained for emergency patients within the Emergency Department by releasing bed capacity to maintain patient flow allowing patients access to the "Right place at the right time" whilst also ensuring patients who are being admitted electively are done so in a timely manner, again into the correct clinical area at the right time.

The purpose of this document is to provide a proactive hospital escalation plan to ensure consistent and appropriate actions are taken, in all Divisions, to optimise the management of patient flow at all times by creating sufficient bed capacity to meet patient demand. This will be achieved by ensuring defined actions are taken in times of escalation.

2.0 Aim

The aim is to ensure maintenance of a high quality, comprehensive service for patients, balancing elective and emergency work to ensure the Trust meets all of its performance targets (4hour standard, RTT, infection control, mixed-sex etc.).

Divisional Chairs and Directors of Operations are responsible for bed utilisation on a day to day basis for specialities within their Divisions. It is expected that the Divisions will work together, ensuring their staff carry out appropriate actions, enabling all patients to be cared for safely, in a timely manner, ensuring Trust objectives in all areas are successfully achieved.

The decision to close beds as part of an agreed long term strategy remains with the Divisional Director of Operations for the Division. The Head of Operations will be charged with the responsibility of ensuring that patient flow is not compromised during the closure of the beds.

Short term closures of beds during anticipated dips in activity, i.e. Christmas and Easter will form part of the agreed relevant corporate plans. The Site Manager will implement these closures through discussion with the On-Call General Manager and the On-Call Director. Re-opening of these areas will again be negotiated via the same method.

The Clinical Site Management Team operates with the delegated authority from the Chief Nurse & Director of Delivery and Improvement in order to utilise the Trust bed stock in order to achieve safe patient placement.

The opening of escalation beds out-of-hours must have been agreed as a plan in core hours with the Divisional representatives. If no plan is in place it will be agreed between the HoN (ops), GM on Call and Director on Call. The HoN (ops) will then take on the accountability for safely staffing such areas until the earliest opportunity for these areas to be handed to the relevant Division. It is the

responsibility of each Division to supply accurate planned activity data for each area including highlighting potential threats to target patients if activity is cancelled.

Decisions to open escalation beds will be taken as early in the day as possible to ensure that the environment is adequately prepared, safely staffed and appropriate patients identified for transfer.

3.0 Workload Forecasts

The Surge Capacity Management Plan defines the Hospital's bed capacity into four categories. Business as usual is defined within Green & Amber status. The surge capacity score is calculated with the matrix in Appendix 1.

The site team will provide an update at 8am outlining divisional bed requirements for the next 24 hours. This will be split per speciality to take account of all requirements (elective, emergency, ITU stepdowns, inter-hospital transfers) Divisions will be expected to keep within their bed stock and to proactively drive discharges to support the creation of the right level of capacity at the right time. Additionally, all divisions are expected to participate in all communications, engaging and working collaboratively with each other and the site management team.

Once an escalation status category has been defined and declared by the Clinical Site Manager, the appropriate staff are in a position to act on that information promptly within a defined timescale that will correct and move the Trust back to a level of capacity which will be sufficient to meet the predicted demand on inpatient beds against agreed bed stock capacity.

Information on corrective actions will be reported via a Trust Capacity Meeting. This meeting will be called by the Clinical Site Manager as defined by the surge capacity score and attendance by the designated Divisional Managers/Clinicians is mandatory.

4.0 Capacity Meetings (Terms of Reference see Appendix 2)

These meetings provide a forum where the Trusts capacity can be reviewed. These meeting will occur in the Operations Centre (in hours at 10am, 1pm and 4pm) or by conference call (out of hours at midday). The required frequency and attendance may change depending on the pressures being experienced at that time. The Head of Nursing (Operations) or Head of Operations will chair all meetings where status is green/amber/red. The Chief Nurse / Director of Ops or the Director On-Call (or nominated other) will be responsible for chairing meetings where the black surge capacity plan is being followed.

Communication of the Trusts Capacity Status will be communicated through the Trust Intranet and also Trust Capacity Update reports emailed, by the CSM, within one hour after the capacity meeting.

If there are unforeseen circumstances, meaning a representative cannot attend, please contact bleep 6007 or email apologies to bedmanagers@stgeorges.nhs.uk

Required Staff During Core Hours

Green/Amber	Red	Black
Head of Nursing – Operations* (Chair) Administrator. Representative from each division. ED Nurse-in-Charge. ITU Representative. OCM (at 4pm only).	Attendance as for 'Green / Amber plus: • HoN + Head of Operations (Chair) • On-Call Manager. • DDO (or deputy) from each division. • On Call consultant from pressured division. • Transport Manager. • HoN AMU/A&E (or deputy).	A Clinical Operational Meeting will be held within 30mins of black status being declared. The meeting will follow the Surge Capacity Plan format.

**There will be a pre-meet between the HoN (Ops) with all bed managers 20mins before each Trust Capacity Meeting. The bed managers will then not be expected to attend the Capacity Meeting.*

Required Staff Outside of Core Hours

A daily conference call (Details in appendix 3) will be held at midday on weekend and bank holidays. The format will be as per usual daily format. Depending on pressures being experienced further conference calls can be arranged as agreed on the call. It may also be necessary to invite additional members of on call staff (e.g infection control consultant, transport manager etc) as needed. If requested to do so it is expected that any on call member of staff will endeavour to do so.

Green/Amber/Red	Black
Director On Call General Manager On Call – Acute General Manager On Call - Community Head of Nursing – Operations	The Surge Capacity plan will be followed.

5.0 ROLES AND RESPONSIBILITIES

The actions required at each stage of escalation are detailed in the Trust Surge Capacity Management Plan and provided a framework from which each member of staff can base their actions. There are a number of action cards that detail the response from staff members at particular levels of 'surge' (Appendix 4)

Surge Capacity Status	Actions to be taken
Score : 13 – 26 = **Surge Capacity – Green**	• **BUSINESS AS USUAL – GREEN ACTIONCARD** • Maintain knowledge of the Trust's bed position for the next 24 hours and the status of the Emergency Department. • CMS (https://nww.pathways.nhs.uk) is updated two hourly. • Communication in and out of CSM Team as usual inc. Escalation Mtgs • Utilise the Surge Capacity Management Matrix (Appendix 1) to establish pressure points in organisation. • Clinical Site Management Report to be circulated by 11:00 hrs. • Outliers information collated and passed on before 08:30hrs to facilitate timely medical review • Clinical Ward Rounds to be conducted and patient transport booked to agreed routine schedules • Maintain flow for GP referrals direct to the Rapid Assessment Area/AAA and the RATs process • Ensure timely assessment and treatment of patients throughout the ED pathway via ED Escalation Policy • Fully utilise the Trust wide Discharge Lounge and ambulance discharge crews as appropriate and Social Services • Hospitals expecting patients to be repatriated to them to be contacted before midday ad conversation documented on repatriation website (https://nww.ihtl.nhs.uk/stg). Escalation of concerns as per repatriation SOP.
Score: 27 – 39 = **Surge Capacity - Amber**	• **COMMENCE AMBER ALERT ACTIONCARD** • As for Surge Capacity Green and in addition: • Emphasis on **early decision making** medical and nursing review of patients **from all 4 divisions** to facilitate all possible discharges on a timely basis and appropriate access of **Community Services.** • Review of **Staffing Plan** resources available and pressures by care group • Staff to highlight and escalate system delays for resolution to HoN CSM team and identify **investigations and diagnostics** which if expedited will lead to discharge on a timely basis and expedite these actions. • Ensure robust triage, **smooth ambulance handover** and **RATs process** appropriate patient re-direction in ED. • Escalate all delays and **patient repatriations** to Dir. Ops level. • **Focus** on pharmacy TTOs, patient transport, domestic and portering services to ensure priority is given to patient transfer and discharge, and the relative priority of requests after agreeing priority with HoN CSM team • Book **patient transport** "confirmed, ready"
Score: 40– 52 = **Surge Capacity –**	• **COMMENCE RED ALERT ACTIONCARD –CAPACITY ESCALATION LIST** • Notify, via switchboard, **Capacity Escalation** List to ensure consideration of professional issues, via text alerts

Red	• Instigate Surge Capacity meeting as assessed appropriate. • Request support as appropriate from the DDNGs • Request additional support from CSU/CCGs re: GP input into UCC, MIU • Ensure **all patients reviewed**, if necessary by 2nd ward round, by Snr medical staff • Consider **re-distribution of clinical and medical staff** if appropriate, utilising senior medical leadership as required. Consider cancellation of study leave. • Review all elective lists Consider capacity projection for EL workload and activating **private sector protocol.** • Agree with LAS the need for an **ALO to be based in ED** • Comsider the use all **safe escalation areas** in St. George's Hospital. • Ensure **Escalation Process for all DTOC & non-DTOC patients** is being utilised. • **Scheduled maintenance (PPM)** to be reviewed – consider rescheduling • Review and prioritise planned and elective admissions for the next two days including **Critical Care pressures**. Any decisions to cancel made using the **Proforma for Reviewing Elective Activity**
Score: 53 – 65 = **Surge Capacity – Black**	• **COMMENCE BLACK ALERT ACTIONCARD** • As for Surge Capacity Red and in addition: • Alert **communications** (Via Text / Email)& public relations managers to consider any communication requirements • Chief Nurse and Director of Operations or Director on call to **escalate to CSU On Call** (pager SWL1) immediately on declaring Black • Contact CSU to request via primary commissioning that **GPs to be encouraged to avoid admission of patients** with chronic diseases by managing them at home, and to delay sending any patients who are not in serious danger. Risk management to be formally notified at point of BLACK and potential reduction in discharge thresholds agreed. • Actively pursue **discharge of patients** able to be discharged/transferred • Consider as set out in **Proforma for Reviewing Elective Activity** cancellation of all electives except 'Clinically critical ' (who must receive care within 24 hours) or complex agreed by medical referee. Inform theatres not to call new cases until approved by CSM team. • Instigate prompt senior medical and nursing review of all patients and **consider lowering of the threshold for discharge** where possible. • Review 36 hours **staffing** and cancel study leave where appropriate (DDNGs to support decision) • Director on call requests LAS to put in place **360^{o} Redirection** as per LAS flow chart • Consider declaring formal corporate Business Continuity.

Notification of Escalation Following Trust Capacity Meetings

- The Internal Escalation Status will be determined and communicated by the CSM following each Trust Capacity Meeting as well as at any time that the CSM determines that that the situation is deviating from expected.
- The Internal Trust Escalation Status (i.e. Green, Amber, Red, Black) will be displayed in the Operations Centre and also on the front page of the Trust Intranet. This will be kept up to date by the Operations Centre Staff.
- The Trust Status Update Report will be completed by the HoN/CSM and e-mailed via the bedmanagers@stgeorges.nhs.uk email account. This will occur within one hour of the Trust Capacity Meeting completing and follow the template in Appendix 5.
- The following groups will receive the Status report:
    - Executive Directors
    - Clinical Directors
    - Divisional Directors of Operations
    - Divisional Directors of Nursing
    - Heads of Nursing and Matrons
    - General Managers

      It is expected that this is cascaded by line managers to any other interested party within the organisation.
- Where the overall Trust Status is deemed to be red or black a text message will be sent to the above staff detailing this and the timing of the next appointment. (Appendix 6)

6.0 External Reporting Arrangements

The HoN/CSM will ensure the following reporting:

- CMS is updated by the Site Management Team every two hours and is viewable by LAS and the CSU. The reports are due:
    - ED - 2 hourly, 24/7,
    - Beds - 4 hourly, 8am to 10pm

  CMS status will be reported on the Trust Capacity Updates as per RAGB rating.
- Winter Daily SITREP (by 11am Mon – Fri) (via UNIFY)
- SLCSU/NHSE Daily SITREP (by 11am Mon – Fri)
- Daily ECIP Return (by 4pm Mon – Fri) (via UNIFY)

7.0 Elective Activity

The Trust has a number of strands in its elective workload planning:

- The 18 week activity plan does not allow for a reduction in elective activity in winter. The approach is therefore to increase capacity, using other NHS providers and the private sector.
- Appropriate work is transferred to the day surgery unit.
- Gynaecology, surgery and paediatrics agree to utilise beds more flexibly across their areas.
- A weekly theatre planning meeting ensures lists are fully utilised and free lists are handed back to be used by other specialties 4 weeks before the date of the list.
- The heaviest elective days are Monday, Tuesday and Thursday. Cavell Ward is a seven day per week short stay surgical ward. Whilst it is open over the weekend it is anticipated that as many beds remain vacant as possible to allow for the elective lists on Monday morning.
- At times where it is considered prudent to rationalise elective work due to the emergency demands on the Trust there is a procedure to follow. Once complete a copy of the proforma for reviewing elective activity must be submitted to the Operations Centre.

Formal Reviewing of Elective Activity

During times of Black status or extreme operational difficulty/capacity challenges decisions will need to be taken to cancel scheduled elective activity for a period of time to enable the site and its services to resolve a significant deficit of available bed capacity. However, no patient should wait more than 52 weeks for an elective procedure.

It is important that such decisions are considered carefully taking into account the needs of all patients and the trust's requirements. Such decisions must be taken by appropriate senior clinicians.

The process must be open, transparent and fair. Decisions made must result in actions taken.

The proforma in appendix 7 is to be used on occasions where, due to operational pressures, planned elective work is to be cancelled.

8.0 Escalation Areas

At times where Trust Surge Capacity Status is green or amber there should be no escalation areas in use, unless as part of the Divisional Director of Operations plan for activity.

At times where the Trust Surge Capacity Status is red it may require the use of escalation areas in order to ensure patient safety as well as experience is kept at the level expected.

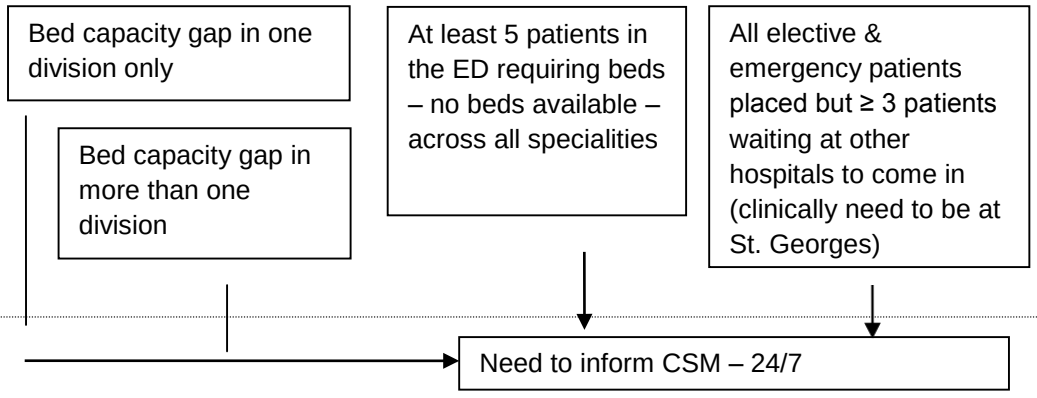
The process to open escalation areas is detailed in the Surge Capacity Management Plan:

Objective – The overriding principle is that patient safety will not be compromised.

The Trust is required to achieve the following:

1. ED quality indicators including the 4 hour standard.
2. 18 weeks access target for elective patients.
3. Cancer access targets.
4. Eliminate mixed-sex accommodation breaches.
5. Manage infection control issues / outbreaks safely

Systems



ED Consultant

Clinical Site team

CSM discusses with Dep. Dir. Ops/ DDO / DDN (Escalation meetings) – in hours.
CSM/HoN discusses with GM on-call out of hours.

Systems

At Surge Capacity Management – Red Level

- Ensure that all actions at Surge Green and Surge Amber have been implemented
- Ensure that any funded beds identified for outlying have been utilised by the speciality experiencing greatest pressure.
- Escalation areas will be opened in the following order: Inform all clinicians of operational status.

  a. Champneys – to be used in consultation with Surgical Management Team.
  b. AAA – to be used in consultation with the Medical Management Team, for appropriate medical patients, ensuring balancing future anticipated ambulatory requirement.
  c. Neuro day Unit – Max. 4 patients – neuro or surgical patients
  d. Endoscopy – Max 4 patients. – Level1, EDD<24 hrs, minimal care needs, non-confused and mobile.
  e. Corporate Business Continuity Plan activation

	The above bed numbers may need to be reviewed dependent on escalating demand.
GM on-call **(out of hours) – Decision maker**	Head of Operations or HoN/CSM team to discuss with GM on-call re.decision → Will advise CSM if a decision to override ring fencing is permitted and how for how long and number of patients.
Director on-call	Discussed by GM on-call

Escalation areas detailed previously are all subject to risk assessments, carried out on an annual basis. Copies of which are held in the Operations Centre.

Additional to this a checklist (Appendix 8) detailing actions taken to open an escalation area safely must be completed and submitted to the Operations Centre prior to an escalation area being used. This is to be completed by an appropriate nurse from within the Division utilising the area. A copy of this is to be kept in the Operations Centre (location to be determined).

Identification of Suitable Patients for Escalation Areas

The overriding principle in the identification of patients for escalation areas is that the patients care needs must be able to be safely met in the area they are being placed.

The CSM must ensure that the appropriate medical and nursing input from the different areas has been sought (as per checklist) in order to authorise patients to be outlied.

It is universally accepted that patients who fulfil the following criteria are never suitable for outlying:

Medically or psychiatrically unstable

Dementia or confusion of unknown cause

Learning disabilities

A requirement for infusion of blood products or chemotherapy

It is expected that if escalation areas are expected to be opened this is done by the latest time 8pm.

9.0 Community Services Escalation Response to Surge Pressure Management

Community Services Division provides St. George's Healthcare with a number of key community based and non-acute services.

The key ones which link to St. George's Hospital capacity are reflected in the pressure surge matrix (Appendix 9). The corresponding responses by those services is below:

Please note that all services with numbers are not expected to close with increased capacity – up to Pressure Score 4 Red is normally expected to be managed within existing resources. Work around supporting winter capacity will ensure safe coverage and therefore to avoid Levels 4 and 5 Red and Black currently being developed led by AD)

Daily capacity plans to be submitted to the Operations Centre by 12pm.

All services have local Business continuity plans which are available on the intranet.

Appendix 1 - Capacity Management Score Matrix

Acute Services

	M&C			CWTD			SNCT		
Surge Capacity Score	**ED Escalation Policy**	**Medicine (beds)**	**Cardiac (beds & electives)**	**Adult ICU**	**Paeds (inc. PICU)**	**Gynae (beds)**	**Neuro**	**Surgery (beds)**	**Surge Capacity Score**
1	Green	BAU	BAU	CRITCON 0	BAU	BAU	+2	-5	**1**
2	Yellow	1 in, 1 out DTA wait >1hr	0 IHT delays 2 CCU beds	CRITCON 1	1 in, 1 out DTA wait <1hr	1 in, 1 out Discharges later	-1	-10	**2**
3	Amber	0 beds now Discharges later DTA wait >2hrs	Elective and IHT work placed No other capacity 2 CCU beds	CRITCON 2	0 beds now Discharges later DTA wait >2hrs	-3 Discharges later	-4	-20	**3**
4	Red	0 beds now Discharges later DTA wait >4hrs	<3 IHT delay 0 beds now Discharges later 1 CCU bed	CRITCON 3	0 beds now Discharges later DTA wait >4hrs	-4 Discharges later	-8	-30	**4**
5	Black	0 beds now No discharges later DTA wait >4hrs	>4 IHT delay 0 beds now or later 0 CCU beds	CRITCON 4	0 beds bow No discharges later DTA wait >4hrs	-4 No discharges	-12	-50	**4**
Surge Capacity Score	**ED Escalation Policy**	**Medicine (beds)**	**Cardiac (beds & electives)**	**Adult ICU**	**Paeds (inc. PICU)**	**Gynae (beds)**	**Neuro**	**Surgery (beds)**	**Surge Capacity Score**
	M&C			**CWTD**			**SNCT**		

	Community					
Surge Capacity Score	**Community Nursing**	**Community Virtual Wards**	**Intermediate Care**	**MIU @ QMH**	**Night Service (20pts/list)**	**Surge Capacity Score**
1	250	200	<50	2 ENP 8 until 8	5	**1**
2	275-288	201-210	51-55	1 ENP 8 until 8 1 ENP part shift	6	**2**
3	288-299	211-215	56-60	1 ENP 8 until 8	7	**3**
4	300	216-220	61-70	1 ENP part shift	8	**4**
5	301	221+	71+	No Staff	9+	**5**
Surge Capacity Score	**Community Nursing**	**Community Virtual Wards**	**Intermediate Care**	**MIU @ QMH**	**Night Service (20pts/list)**	**Surge Capacity Score**
	Community					

Appendix 2
Terms of Reference – Trust Daily Capacity Meetings

Aims
The Trust Daily Capacity Meetings exist to ensure there is sufficient capacity to ensure patients are cared for in an appropriate environment. This meeting will ensure, real time, proactive management of issues surrounding patient flow, patient safety and quality of care associated with this. Intelligence will be provided to allow for the most appropriate decision making and planning possible.

Constitution

Membership

The membership of the meeting will comprise of:

Core hours:

- Head of Operations or Head of Nursing - Operations - Chair
- GM or HoN representation from each Division
- On Call General Manager
- Nurse-in-Charge for ED
- Critical Care Bleep Holder
- Intermediate Care Nurse
- Patient Flow and Discharge Manager
- Infection Control Nurse

Daytime (weekends and Bank Holidays)

- Head of Nursing – Operations or Advanced Nurse Practitioner - Chair
- General Manager On Call (Acute)
- General Manager On Call (Community)
- Director On Call

Night time (every day)

- Head of Nursing – Operations or Advanced Nurse Practitioner – Chair
- General Manager On Call (Acute)

Other staff members may be asked to attend when the group is discussing issues pertinent to their services

Attendance will be recorded; members are required to appoint appropriate deputies to attend on their behalf if they cannot attend.

Quorum

The quorum for meetings will be the Chair and a representative from each Division (core hours). All other times the quorum would be the Chair and either the General Manager or Director on call for acute services.

Frequency of Meetings

Assuming that the Trust Surge Capacity Plan has not been enacted the group will meet at the following times:

Daytime (weekdays)

- Midday
- 16:00hrs

Daytime (weekends)

- Midday

Night time (every day)

- 22:00hrs

Duties and Responsibilities

Purpose
The group will have intelligence presented to it that

- outlines the predicted operational capacity within the Trust for all services for next 24 hours,
- challenges plans in place to ensure sufficiently robust and
- escalation of issues that cannot be resolved.

Standard agenda items:

- Status of last 24 hours, 08:00-08:00 (to include performance figures and contributory factors for performance)
- Predicted emergency admissions for next 24 hours
- Actual elective admissions (inc. detail of any cancellations)
- Predicted discharges per ward
- Capacity gap per Division
- Achieved early morning discharges
- Outlying patients
- Repatriations
- Infection Control issues
- Mixed sex breaches
- Nurse staffing
- Other staffing issues

Duties and Responsibilities

The group will be responsible ensuring appropriate plans are agreed, communicated and actioned to provide a safe environment for patients to be cared for in.

The group will be responsible for escalating to more senior management or external agencies situations where this level of care cannot be achieved in order to resolve the situation. This may include instigation of other Trust capacity management procedures.

Accountability

The group is established as a permanent clinical operational group and is therefore accountable to the Chief Nurse and Executive Director of Delivery and Improvement

Authority

The group, assuming quorum, is authorised to undertake any activity within its terms of reference and associated policies.

Reporting

The Chair of the group will circulate an update to Trust management after each meeting, drawing attention to any issues that may impact on patient flow.

Monitoring Effectiveness

In order to support the continual improvement of governance standards, sub-committees if the Trust Board and executive committees are required to annually:

- Complete a self assessment of the effectiveness of the committee
- Review the terms of reference for the committee
- Reaffirm the purpose and objectives of the committee

Appendix 3

Conference Call

Out of hours the conference call will be held at midday. Further calls can be arranged using these details.

Internal contact numbers to be provided.

Amber	• Ensure all patients are assigned to a physician within 1 hour of arrival. • Review staffing for next 24 hours. • Board round review of all patients in ED • No fixed commitments whilst on shop floor • Reallocate medical staff to area of demand and review skill mix • Ensure investigations are 'front loaded to help reduce delays in decisions later

Red	**Ensure all Amber actions are initiated, then ensure the following:** • Re-assess all clinical areas with ED matron (or NiC if OOH). • Request specialist teams to assist in ED. • Ensure boardrounds are completed two hourly. • Request all available ED consultants and other ED staff to be present on shop floor where this would be helpful. • Consider cancelling all study/SPA/training time to support ED. • Ensure clinical decisions are made with 120 minutes, escalating any concerns.

Black	**Ensure all Red actions are initiated, then ensure the following:** • All clinical staff to undertake clinical duties. • All study/SPA/training time to be cancelled (if not already done so) to support ED. • Where delays in offloading patients from ambulances is occurring to ensure these patients are still assessed. • Request all available ED consultants and other ED staff to be present on shop floor where this would be helpful. • Liaise with the NiC and Site Team regarding the possibility of cohorting patients in an alternative area to create capacity in Majors. • Ensure clinical decisions are made with 120 minutes, escalating any concerns

Amber	• Ensure all inpatients are reviewed by relevant medical teams and that all patients have a management plan and that board rounds have been occurring as planned. • Assist the discharge coordinators in the identification, discharge and coordination of transport requests. Acting as point of contact for service managers and matrons for escalation on flow issues. • Coordination of ancillary services. • Proactively identify issues within area, providing support and advice to ward staff or liaising with matrons for specific areas of concern. • Ensuring all outliers have been identified and appropriate medical cover is in place. • Review staffing for next 24 hours. Liaising with CD/DDN/HoN. • Attend all escalation meetings in the Site Management Office.
Red	**Ensure all Amber actions are initiated, then ensure the following:** • Ensure all inpatients have been reviewed by a senior member of the medical team and urgent discharges initiated. • Request Clinical Director to nominate doctor to go to patient departure lounge to write TTOs if required. • Ensure GP referrals are being accepted by registrar or consultant and only those deemed urgent and correct patient postcodes accepted. • Arrange staff (other than porters) to be able to take patients direct to departure lounge if necessary, ensuring patient care isn't compromised. • Facilitate discharges and timely turnaround of empty beds. • Discuss with CD and DDN possibility of reviewing clinical staff not based in clinical areas that could be redeployed to provide support. • If staffing adequate create a transfer team to enable rapid movement of patients between ED/AMU/Wards. • Ensure all board rounds are completed • Consider cancelling all study/SPA/training time to support Wards. • Discuss and consider the impact of the cancellation of some non-urgent elective patients.
Black	**Ensure all Red actions are initiated, then ensure the following:** • Inform all consultants and senior nurses that Trust is on black alert. • Conduct ward rounds to identify potential discharges and escalate issues as required. • Liaise with the Medicine DDN to ensure all senior and specialist nurses are released to support for ward work. • Ensure all study/SPA/training is cancelled where possible to support Wards. • Enact plans surrounding balancing emergency and elective workload – in conjunction with the Director responsible that day.

Amber	• Business as usual. That is reviews all inpatients awaiting assessment and undergoing planned interventions. • Prioritise patients who can be discharges that day. • Attend MDT meetings and board rounds to highlight potential discharges. • Work with discharge coordinators to identify patients for rehabilitation and those suitable for community beds (such as Nightingale House, QMH or Ronald Gibson House) or community referral.

Red	**Ensure all Amber actions are initiated, then ensure the following:** • Communicate with fellow team members to ensure they are aware of current Trust status. • Check all potential and actual discharges to escalate once discharged from therapy. • Review staffing for next 24 hours. • Consider cancelling all study/training time to support Wards. • Ensure attendance at ward board rounds. • Liaise with own wards to try to expedite earlier discharge with inside or outside resource. • Teams to share caseloads to focus on the urgent discharge and priority cases.

Black	**Ensure all Red actions are initiated, then ensure the following:** • Support nursing staff to identify alternative forms of trsansport (private ambulance, taxi) to discharge patients • Head of therapies to attend escalation meetings throughout day. • Ensure all study/training is cancelled where possible to support Wards.

Amber	• Ensuring an accurate bed state is maintained at all times. • Ensure that an accurate record of all potential and actual discharges is maintained for all areas, escalating any known unresolvable delays to Matron for the area. • Supporting ward staff in identifying all those patients who can move to Departure Lounge and do so in a timely manner. • Attend any planned board rounds or other directorate meetings as required. • Ensure beds vacated are turned around in a timely manner (<30 mins). • Escalate any absence of ward rounds/delays to Site Manager. • Maintain an overview of ED, escalating any unresolvable delays to the Site Manager. • Coordinate (with Divisional Representative) review of elective activity. • Ensure all hospitals have been contacted with regards repatriations. • If required request portering supervisor to mobilise additional support for patient transfers. • Ensure Trust capacity spreadsheet is updated prior to every escalation meeting.
Red	**Ensure all Amber actions are initiated, then ensure the following:** • Communicate with fellow team members to ensure they are aware of current Trust status. • Ensure all actual/potential escalation areas have patients identified for them. • Check all potential and actual discharges, escalating any unresolvable issues to Matron and Site Manager. • Ensure attendance at ward board rounds. • Coordinate (with Divisional Representative) review of elective activity – with a view to likely cancelations.
Black	**Ensure all Red actions are initiated, then ensure the following:** • Ensure continuous validation of available beds. • Ensure escalation of difficulties being experienced with patient flow. • Ensure escalation of any detriment to patient care to appropriate senior staff.

Amber	• Escalate to Divisional representatives • Maintain patient safety as priority. • Chair meeings to review status of all inpatient areas (escalation meetings) • Initiate additional resoiurces as required such as portering and additional nursing cover. • Liaise with community managers to ensure maximum discharges and use of community beds. • Support the areas most under pressure to provide a visible presence. • Escalate potential breach situation to Divisional Teams/General Manager on call if cannot be resolved in timely manner. • Agree contingency actions aimed at reducing escalation level – consider the possibility of opening additional beds • Ensure these actions are completed in each Division • Ensuring appropriate reporting is completed in a timely manner (both internal and externally to Trust).
Red	**Ensure all Amber actions are initiated, then ensure the following:** • Liaise directly with General Managers, DDOs, COO as well as on call Director and General Manager with regards Trust escalation status. • Initiate additional escalation meetings if deemed necessary after discussions with above. • Ensure bed managers have accurate and timely information so as to guide decision making. • Be clear as to where block s to flow are and escalate to appropriate staff to assist in relieving these. Escalating when such actions have not been successful. • Liaise with LAS (DDO) as required.
Black	**Ensure all Red actions are initiated, then ensure the following:** • Consider need to call in additional Site Team support. • Provide data and attend escalation meetings. • Agree and implement contingency actions aimed at reducing escalation level. • To be guided by Director (or deputy). • Ensure ongoing appropriate reporting.

Appendix 5 – Trust Capacity Update

St George's University Hospitals NHS
NHS Foundation Trust

Text Messages (Morning, Daytime Surge, Morning Meeting Alert)

Goodmorning.

Yesterday (01/01/1991)

ED Attendance:
Breaches (unvalidated):
Breaches (Since Midnight):
DTAs awaiting bed:
First 12hr breach:

Medicine
Emergency Admits:
Elective Admits:
Discharges:

Surgery
Emergency Admits:
Elective Admits:
Discharges:

Cardiac
Emergency Admits:
Elective Admits:
Discharges:

This Morning

Medicine

Available beds
AMU –
Wards –
Capacity gap this a.m –

Surgery
Available beds
Wards –
Capacity gap this a.m –

Cardiac
Available beds
CCU –
Wards –
Capacity gap this a.m –

Unfunded Beds Opened -

Staffing

Dear All,

Following the_____capacity meeting there remains a significant capacity gap:

Medicine –

Surgery –

Cardiac –

Neuro –

Paeds –

The next escalation meeting is at _____in the Operations Centre to discuss capacity plans for the remainder of the day and overnight.

Please ensure representation.

Dear All,

Following this evenings capacity meeting there remains a significant capacity gap:

Medicine –

Surgery –

Cardiac –

Neuro –

Paeds –

There will be an escalation meeting at 08:30 tomorrow in the Operation Centre to discuss capacity plans for the day

Please ensure representation.

A

Review of Elective Work
(as per Surge Capacity Management Plan)

Membership

Medical Director/ Chief Nurse and Director of Operations/AMD for Clinical Governance (Chair)	
Divisional Chair Medicine	
Divisional Chair Surgery	
Divisional Chair Women's and Children's	
Head of Operations representation	
Clinical Director/ED consultant rep	

Information to be available for this meeting (collated and presented by Head of Operations)

The following information will be available to the group - demand and capacity for that day and the next 24 hours:

Predicted Medical Admissions		Actual:		
Predicted Surgery Admissions		Actual:		
Predicted Paediatric Admissions		Actual:		
Escalation beds currently utilised	Med: Cardiac:	Surgery: Gynae:		
Electives planned: Endoscopy lists planned:	Medical: Cardiac:	Surgical: Gynae:	Neuro: Stroke:	
Non-Clinical Hospital Cancellations	Medical: Cardiac:	Surgical: Gynae:	Neuro: Stroke:	
Inter-hospital transfers in:	Medical: Cardiac:	Surgical:	Neuro: Stroke	
Repatriations:	Medical: Cardiac:	Surgical: Stroke:	Neuro:	
Discharges:	Medical: Snr. Health: Cardiac:	Surgical: Gynae:	Paeds: Neuro:	
Critical care beds available	Gen.	H'worth.	Neuro.	Cardiac
Critical care transfers out	Gen.	H'worth.	Neuro.	Cardiac
Critical care transfers in	Gen.	H'worth.	Neuro.	Cardiac
Medical Outliers in surgery:				
Surgical Outliers on Medical Wards:				
Champneys Outliers:				

Current Emergency Activity Situation

ED Attendance:	
Emergency Access Breaches:	

ED 4 Hour Target (%)	ED: %	Total: % YTD %

Options

Transfer elective activity off-site i.e. Parkside (see Surgery Private Sector Proforma)

Patient & Speciality	Consequence	Other services impacted

Cancel elective patients

Patient & Speciality	Consequence	Other services impacted

Cancel out patient activity

Patient & Speciality	Consequence	Other services impacted

Decisions

Summary of Decisions

Signed: _____

Date: _____

Appendix 7

Actions Required to Open an Escalation Area Safely

	Actions Required to open an Escalation Area safely:	Person responsible	Comments	Completed
Nursing Staff	1. A response Nurse will be used when available. 2. A bank Nurse will be employed but replaced with a permanent member of staff from within the division.	Site Manager & Matron		
Medical staff	Clearly outline the Medical / Surgical team responsible for the patients placed in escalations beds.	Head of Nursing		
Therapy staff	1. Physio 2. OT Clinical Site Manager to inform Ops Manager, In-patient Therapies	Ops Manager, In-patient Therapies		
Patients	**Medicine:** The AMU consultant will help identify patients on the AMU who are suitable for transfer. Patients will be identified who are medically fit or with an expected date of discharge (DTOC list) **Surgery:** Matrons will assist with identifying patients. **Neuro:** Registrar will identify patients.	Head of Nursing		
Setting up the Ward	Clean / domestic staff informed (MITIE) Check beds table's lockers and chairs are in place.	Head of Nursing		

	Actions Required to open an Escalation Area safely:	Person responsible	Comments	Completed
	Check oxygen and suction. Check with infection control			
IT	Helpdesk (X3456) or IT oncall (SG3456) are informed of ward beds opening and will make any iClip changes Notify network engineers. PACS	Site Manager		
Telecoms	Inform switchboard & ensure telephones are working. The phones have answer machine messages on them so these need to be erased and phones to ring as usual.	Site Manager		
Communication	Information updated at escalation meetings & electronic updates / reports. General communication within adjoining ward that escalations beds are open GM oncall and Director oncall informed	GM Site Services		
Facilities: **Cleaning**	Cleaning. Ensure regular service is instated if needed. Ensure clean curtains are hung Check shower curtains.	Head of Nursing		

	Actions Required to open an Escalation Area safely:	Person responsible	Comments	Completed
Catering **Linen** **Patientline**				
Estates	Ensure nurse call alarm system is working. Check macerator is working. Ensure the Detectors on the ward continued to be tested.	Head of Nursing		
Security/Fire	Inform security officer is aware. Inform Fire Officer and ensure all safety checks are completed - equipment and fire sensors are working. Check Fire escape.	Site Manager		
Stores	Arrange for delivery of stores. Include kitchen stores and stationary as well as medical nursing.	Head of Nursing		
Pharmacy	Inform pharmacy. Check drug fridge.	Head of Nursing		

	Actions Required to open an Escalation Area safely:	Person responsible	Comments	Completed
	Check Pod lockers.			
Other	Check Resus trolley including location.	Head of Nursing		

A copy of this form must be submitted to the Operations Centre prior to use of escalation area.

Appendix 8 - Community Services Division Escalation Response Matrix to Surge Pressure Management

	GREEN/1	AMBER/2	RED/3	BLACK/4
COMMUNITY NURSING	Step down escalation when green for 48 hours	Business as usual capacity can be covered within existing establishments. Review caseloads, increase staffing and reallocate resources to cover high areas of activity	Implement next day deliveries for community nursing equipment	As red
COMMUNITY WARD	Step down escalation when green for 48 hours		Liaise with A and E and prepare to support with ANP for A+E Turn around or wards for Early Supported Discharge patients	As red
Intermediate Care ADMIN.	• Inform care coordinators and IC team leaders • Email OP MT and PA's and escalation rota members	• Inform care coordinators and IC team leaders • Email OP MT and PA's and escalation rota members	• Inform care coordinators and IC team leaders • Email OP MT and PA's and escalation rota members	Inform care coordinators and IC team leaders Email OP MT and PA's and escalation rota members
Intermediate Care BLEEP HOLDER/ MANAGER ON CALL	Identify any delayed discharges from dom and bed based service and escalate	Business as usual capacity can be covered within existing establishments. Review caseloads, increase staffing and reallocate resources to cover high areas of activity	As amber + • Staff up domiciliary service as required • Ensure RG beds in use • Identify any delayed discharges from domiciliary and bed based service and escalate/expedite	As red
OPNR MT PA's	Business As usual	Business As usual	• Email bed state to OP MT, Community nursing, IP, CNRT, PCTT therapy CTLs Jane Attrill alert nominated attendee on rota for next day to ensure attendance at 10:00hrs escalation meeting	As red
OPNR MANAGERS	Monitor capacity and	As green	• Ensure staff attendance	As red

	GREEN/1	AMBER/2	RED/3	BLACK/4
	throughput		at SGH 10;00hrs escalation • Ensure teams following escalation guidance	
Minor Injuries Unit	Business As us**ual**	Reduce service at time and advise patients of waits / alternatives	• Close service at times and advise of redirection to other services •	Close service until staffing is available
QMH Mary Seacole Ward (MATRON /NIC)	Identify any delayed discharges and report to head of nursing	As green	As amber + • Identify any discharges that can be accelerated with Bryson Whyte, Intermediate care, ESD, CNRT and/or outpatient follow up and plan discharge • identify any delays awaiting NHS funded long term care and liaise with commissioners re interim placement • accelerate assessment for patients waiting for assessment if any neuro beds empty	As Red
Night Service	Business as usual	Business as usual capacity can be covered within existing est. Review caseloads, increase staffing and reallocate resources to cover high areas of activity	Review caseloads maintain increased staffing and reduce non-essential care that can wait 1 days	Stop all non-essential care (i.e. Continence ass,) Priority care only (Diabetics, EOLC etc) Divert staff from non-essential services to assist where appropriate
Primary Care Therapy Team	Step down escalation when green for 48 hours	As green	Support ICS if required	As red

REPORT TO THE BOARD FROM: Quality Committee

COMMITTEE CHAIR: Sir Norman Williams

DATE OF COMMITTEE MEETING: 25.01.17

1.0 MATTERS FOR THE BOARD'S ATTENTION

1.1 The Committee was advised that the Trust is not fully compliant with the delivery of Duty of Candour. However the Committee members were very clear that in all cases the Trust must be honest and open with the patient and where relevant family members.

1.2 The Committee received the Safe Staffing report but asked for further work to be done to understand the care hours per day measurements and how these measurements should be used to evaluate staffing in clinical areas.

1.3 The level of compliance with the World Health Organisation checklist remained low especially in areas external to theatres and was prioritised for further action.

1.4 The Committee noted a significant deterioration in the implementation of the Quality Improvement Plan (QIP) as key dates were not being met. The Chief Executive confirmed that the fully delivery of the QIP was a very high priority for the Trust and would be seeking full engagement and support from the Managers involved to ensure that all actions were delivered.

1.5 The Committee received an action plan on complaints handling as the number of complaints received by the Trust continues to rise. The management explained that a route and branch review of the complaints function was necessary to bring about significant improvements in the complaints handling process and would report further.

1.6 The Committee received an oral report from Peter Riley concerning the increase in C. Diff cases and was assured that only two cases were, after appropriate investigation, considered to be due to cross infection.

2.0 ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

2.1 The Committee also received reports on:

I. Quality Dashboard
II. Briefing on Regulation 28 relating to transfer of care
III. Report from Water Safety Management Committee
IV. Quality Report and Quality Account

2.2 The Committee reviewed the two risks allocated from the Board Assurance Framework with the Exec leads for the risks. These risks are Quality Governance and Estates and Facilities

2.3 The Committee also reviewed its Terms of Reference and membership which would be commended to the Board in due course.

3.0 RECOMMENDATION

3.1 To receive the update from the QC.25.01.17 for information and assurance.

Fiona Barr, Interim Corporate Secretary and Head of Corporate Governance
01.02.2017

St George's University Hospitals NHS
NHS Foundation Trust

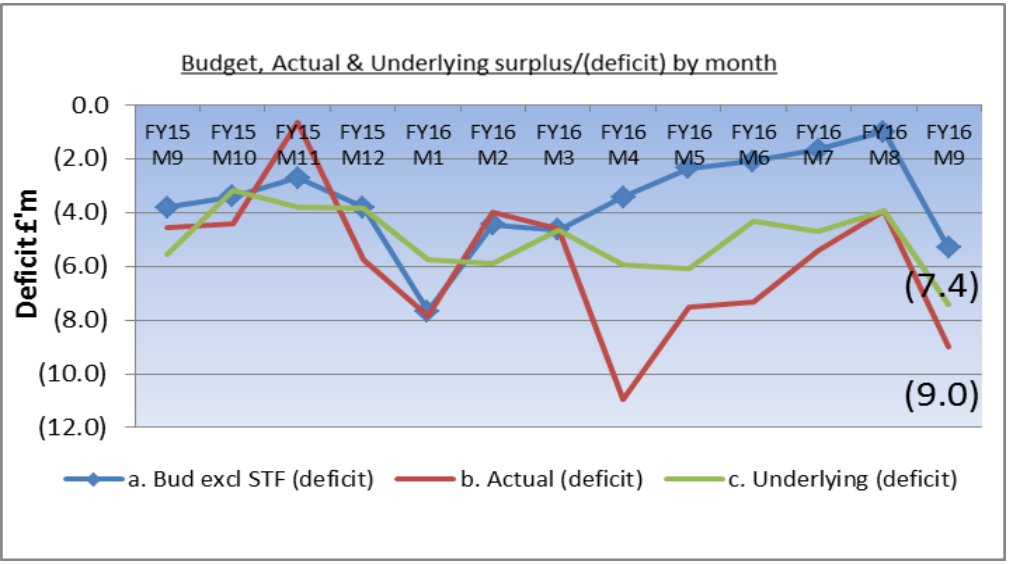
Meeting Title:	**TRUST BOARD**		
Date:	9 February 2017	**Agenda No**	**3.1**
Report Title:	Summary Finance Report- Month 09 2016/17		
Lead Director/ Manager:	Margaret Pratt, Chief Financial Officer		
Report Author:	Michael Armour, Reporting Accountant		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The Trust has reported an in-month deficit of £9.0m in December which is £5.2m worse than plan. Included in month is a Non Pay variance (£3.7m), excess pay costs of £1.5m and below plan Income (£0.5m). £0.7m of Pay, £0.8m Non Pay and £0.6m of income challenge is unforeseen and outside of the control of the Trust. The YTD deficit is £60.6m.		
Recommendation:	The Trust Board is asked to note the current Trust financial position.		
Supports			
Trust Strategic Objective:	Deliver our Transformation Plan enabling the Trust to meet its operational and financial targets		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 6**: Failing to Deliver the Financial Plan		
Legal/Regulatory:			
Resources:			
Previously Considered by:	Executive Management Team Finance & Performance Committee	**Date**	23.01.17 25.01.17
Equality Impact Assessment:	N/A		
Appendices:	Summary Finance Report Month 9		

Summary Finance Report
Month 09 2016/17

Trust Board 9th February 2017

1. Financial Performance for the month December 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	650.2	51.0	50.9	(0.2)	485.6	481.9	(3.7)
STF Income	17.6	1.5	0.0	(1.5)	13.2	0.0	(13.2)
Other Income	112.5	9.4	10.6	1.1	84.7	89.9	5.2
Overall Income	**780.3**	**61.9**	**61.4**	**(0.5)**	**583.5**	**571.8**	**(11.7)**
Pay	(486.5)	(40.7)	(42.3)	(1.5)	(364.3)	(372.0)	(7.7)
Non Pay	(275.9)	(22.1)	(25.8)	(3.7)	(212.3)	(234.2)	(21.8)
Overall Expenditure	(762.4)	(62.9)	(68.1)	(5.2)	(576.6)	(606.1)	(29.5)
EBITDA	17.9	(0.9)	(6.7)	(5.7)	6.9	(34.3)	(41.2)
Financing costs	(35.1)	(2.9)	(2.3)	0.6	(26.3)	(26.3)	0.0
Surplus/(deficit)	**(17.2)**	**(3.8)**	**(9.0)**	**(5.2)**	**(19.4)**	**(60.6)**	**(41.2)**
Memo: Below the Line Items	0.0	0.0	(2.1)	(2.1)	0.0	(11.1)	(11.1)



Commentary

- An in-month deficit of £9.0m is reported in December which is £5.2m worse than plan. The YTD deficit is £60.6m.
- **Below the line** (slide 5) - £11.1m 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. The increase in month is caused by £0.5m of prior period increments and increase in Bad debt provision (£0.8m).
- **SLA income (not STF)** (slides 6-9) - £0.2m shortfall in month and £3.7m shortfall YTD. Increasing challenges, offset by better Elective and Outpatient income have led to a net shortfall. In the YTD, Business Case slippage in Neurosurgery (£3.4m YTD) and the impact of the RTT non-reporting (£1.5m) have had an effect.
- **STF Income –** There is an annual budget of £17.6m that the Trust is not expecting to receive this financial year.
- **Pay** (slides 10-12) - £1.5m overspent in month, and £7.7m YTD, as a result of unbudgeted interim staff spend and divisional vacancies covered by bank & agency. The deterioration from M08 is as a result of increased consultant cost, catch up in prior period agency invoices and recognition of prior period increments across all staff groups. Underlying pay has improved in M09 (see slide 11a) although this includes Christmas so further trend analysis will be required in future months.
- **Non pay** (slide 13) – £3.7m away from budget in month and £21.8m YTD, £17.4m (to date) of which is a consequence of non delivery of Trust CIP plans. £4.0m YTD can be attributed to drugs cost to deliver additional Commercial Pharmacy income.
- **The M9 underlying position (excl. STF)** is a deficit of £7.4m (£4.0m in M8). c£3m of change is owing to a fall in working days and rise in annual leave for Christmas.

2a. Analysis of cash movement M09 YTD

Source and application of funds - cash movement analysis:
M09 YTD and forecast vs Plan

	Actual vs Plan YTD			Based on forecast £80.7m deficit			
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*	*Plan Year £m*	*Forecast Outturn £m*	*Forecast VAR £m*	Notes based on forecast £80.7m deficit
Opening cash 01.04.16	7.4	7.4		*7.4*	*7.4*		
Income and expenditure deficit	-21.7	-60.6	***-38.9***	*-17.2*	*-85.5*	***-68.3***	
Depreciation	18.5	18.2	***-0.3***	*25.0*	*25.0*	***0.0***	
Interest payable	3.8	3.8	***0.0***	*5.1*	*5.8*	***0.7***	
PDC dividend	4.7	3.9	***-0.7***	*6.3*	*5.3*	***-1.0***	
Other non-cash items	-0.1	0.1	***0.3***	*-0.2*	*4.9*	***5.0***	
Operating deficit	**5.2**	**-34.4**	*-39.7*	**19.0**	**-44.6**	*-63.6*	
Change in stock	0.0	-1.8	***-1.9***	*0.6*	*0.6*	***0.0***	
Change in debtors	-1.3	-31.5	*-30.2*	*2.0*	*-12.0*	***-14.0***	does not assume debt targets met
Change in creditors	1.5	39.4	***38.0***	*-5.5*	*8.3*	***13.8***	
Net change in working capital	0.2	6.1	***5.9***	-2.9	-3.1	**-0.2**	
Capital spend (excl leases)	-27.7	-17.1	***10.6***	*-33.4*	*-26.6*	***6.8***	The capital cash spend forecast is reduced to £26.6m - comprising an expenditure underspend of £2m and an increase in capital creditors of £4.75m against the baseline budget excluding emergecy capital As previously reported this means no additional borrowing would be required to finance capital expenditure in year.
Interest paid	-3.6	-3.4	***0.2***	*-5.1*	*-5.6*	*-0.5*	
PDC dividend paid	-3.1	-3.1	***0.0***	*-6.3*	*-5.3*	***1.0***	
Other	-6.2	-5.5	***0.7***	*-8.0*	*-7.8*	***0.2***	
Investing activities	-40.6	-29.2	***11.4***	*-52.7*	*-45.3*	***7.4***	
WCF/ISF borrowing	31.0	57.1	***26.2***	*32.5*	*89.0*	***56.6***	The borrowing forecast excludes emergency (unapproved) capital funding as the capital cash forecast is to under spend the baseline budget. Therefore all the additional borrowing is to finance the higher deficit. The borrowing forecast is £2m lower than last month due to the cash underspend forecast for the capital programme.
Closing cash 31.10.13 / 31.03.17	3.2	7.0	*3.8*	3.2	3.5	***0.3***	

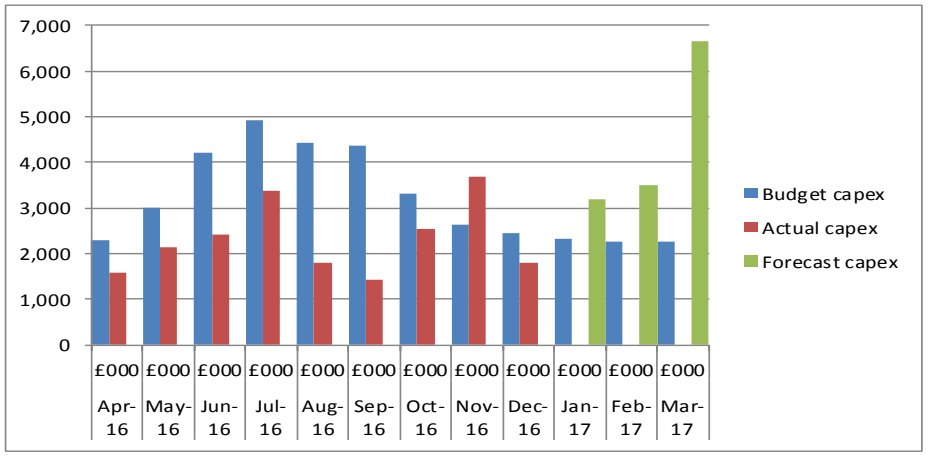
M01- M09 YTD cash movement
The better performance on working capital (+£5.9m) and cash under spend (+£10.6m) on the capital programme offset some of the adverse cash impact of the higher operating deficit (-£39.7m) and helped the Trust to restrict the increase in borrowing necessary to finance the higher revenue deficit to £26.2m.

M09 YTD cash movement

- Within the I&E deficit of £60.6.m YTD, depreciation (£18.2m) 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 £34.4m.
- The operating variance from plan of £39.7m in cash is directly attributable to the I&E deficit. Members will recall that the NHSI plan and Internal trust plan are phased differently (see slide 13)
- The Trust has been able to offset the worsening operating deficit with better performance on working capital (+£5.9m) (slide 19) and cash under spend on capital (+£10.6m) enabling the Trust to contain the increase in borrowing necessary to finance the higher I&E deficit to £26.2m.

2b. Capital programme M09

Capital prog. 2016/17 - budget & actual expenditure per month



CAPITAL BUDGET & EXPENDITURE - BY SPEND CATEGORY

Row Labels	**2016/17 Budget Total**	16/17 Actual YTD	16/17 YTD variance	***Forecast outturn £000***	**Forecast variance £000**
Infra Renewal -EPC	**9,389**	4,677	4,711	***7,634***	**1,754**
Infra Renewal	**7,491**	1,403	3,972	***5,011***	**2,480**
IMT	**4,972**	4,285	-650	***7,421***	**-2,448**
Med Eqpt	**4,613**	1,687	1,253	***3,115***	**1,499**
Major Projs	**8,901**	8,116	-224	***10,313***	**-1,412**
Other	**349**	203	61	***203***	**145**
SWL PATH	**385**	383	-67	***403***	**-19**
Grand Total	**36,099**	20,754	9,055	***34,100***	**1,999**

- Capital expenditure in December was £1.8m and year to date expenditure is £20.7m, an underspend of £9.1m. The table above shows the YTD under spend relates mainly to the energy performance contract (EPC) (£4.7m – down £1.1 on M08) for which the programme slipped earlier in the year and infrastructure renewal (£3.9m) which includes the scheme to replace the stand-by generators. Expenditure on the EPC is accelerating.
- The trust is currently forecasting £2.8m of expenditure this year on CQC related schemes including Renal re-location and the demolition programme against the emergency capital bid which is yet to be approved by NHSI however in overall terms the capital programme is significantly underspent
- The updated forecast outturn for capital expenditure is £34.1m – an underspend of £2m against revised budget.
- The forecast *cash* underspend for capital is £6.75m comprising the expenditure underspend and £4.75m increase in capital creditors.

Meeting Title:	Trust Board		
Date:	9 February 2017	**Agenda No**	**4.1**
Report Title:	Workforce Information Report		
Lead Director/ Manager:	Mark Gammage, HR Advisor to the Board		
Report Author:	Sion Pennant-Williams, Workforce Intelligence Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Update		
Executive Summary:	This report provides workforce information for December 2016. Staff in post and bank and agency usage have fallen, whilst funded establishment has increased. Turnover remains high and has increased since November. Appraisal and MAST rates are still very poor and are a particular area of focus with managers. Over the year sickness and vacancy have fallen, and stability has increased. Data from recruitment shows that their new system has reduced the average time to hire. Comparisons between St George's KPI targets and those from other London Teaching Trusts have prompted discussion that we should review our targets to bring them in line and these will be discussed at the March Workforce Committee		
Recommendation:	The Board is asked to note the workforce performance report and actions outlined within it.		
Supports			
Trust Strategic Objective:	All Trust objectives		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Financial efficiency and operational performance		
Implications			
Risk:	Failure to achieve financial and other targets and manage within agreed control totals.		
Legal/Regulatory:	Failure to meet NHSI control total.		
Resources:	n/a		
Previously Considered by:	Workforce and Education Committee	**Date**	31.01.17
Equality Impact Assessment:	n/a		
Appendices:	Appendix 1 - Workforce Information slides		

Workforce Information report
Trust Board
9 February 2017

1.0 PURPOSE

1.1 To provide workforce information for the Trust Board outlining trends and explaining changes in staffing composition to support decision-making and Board assurance.

2.0 CONTEXT

2.1 There are potential inaccuracies in the vacancy data due to a discord between the Finance establishment and the establishment recorded on the Electronic Staff Record (ESR) system. Finance need to ensure that the base establishment on ESR is correct, and that any changes to establishment are entered onto ESR at the same time that they are entered onto the General Ledger.

2.2 It has been raised that bank and agency usage reported by Workforce differs from that reported on by Finance. Workforce are required to run reports on bank and agency usage on a weekly basis using the Healthroster and HiCom systems due to weekly agency cap reporting to NHSi. Finance run monthly reports from Healthroster but not from HiCom. This results in a discrepancy in reporting on usage as Finance would capture any shifts added retrospectively, but none that were recorded on HiCom. Workforce and Finance are working together to try and reconcile reporting on bank and agency usage.

3.0 ANALYSIS

3.1 The staff in post in December has shown a reduction of 68 FTE, however the vacancy rate has risen by 0.86% due to an increase in funded establishment. This increase was caused by bank and agency budget for porters being moved into the funded establishment to give a more accurate reflection of funded FTE. There are still issues with the reconciliation between funded establishment on the Finance system and that on ESR which could affect the accuracy of the reported vacancy rate. Finance are working to reduce this discrepancy.

3.2 There has been a sharp reduction of nearly 200 FTE in bank and agency usage - this was in the Christmas week and so whilst some reduction is expected, due to annual leave commitments, Christmas can also be a time of high bank and agency usage

3.3 Turnover has increased since last month and at 15% it remains far higher than the target of 10%. Stability has also fallen by 0.26%.

3.4 Appraisal rates have continued to fall. The target is now to increase this rate beyond our target of 85% and reach as close to 100% as we can by the end of the financial year.

3.5 MAST compliance is still poor and being reviewed by the training team. A paper is being prepared for the January workforce committee to explain what action is being taken and how this is being addressed.

3.6 Over the year vacancy and sickness have both fallen by 1.08% and 0.62% respectively, and stability has increased by 1.67%. However turnover, both gross and voluntary, has increased by 0.4%.

3.7 Recruitment data shows current volumes of vacancies and volumes over the past 6 months. The Trac recruitment system has only been in place for 12 months and reporting on it has only happened in the last few months, so it is not yet possible to view trends to see how

volumes have increased or decreased, though with the current recruitment restrictions volumes are expected to reduce. Since Trac implementation the average time to hire[1] has reduced from 18 weeks to 10 weeks from point of offer. The average time to shortlist and time between conditional and unconditional offer is over the Recruitment targets, therefore the recruitment team are working closely with managers to chase progress and encourage them to set key milestones at the onset of any recruitment campaigns. Regular reports are run and monitored by the recruitment manager and highlight areas of continuous improvement.

3.8 Employee relations cases show a higher proportion of disciplinary cases than grievance and harassment cases. This will be reported on in greater detail at the end of the financial year.

3.9 Comparisons with other London Teaching Trusts show that St George's performs worse than others on all KPIs except for voluntary turnover. None of the other Trusts are meeting their targets on turnover, appraisals, or MAST. Our targets will be revised at the end of the financial year with the proposal to align with other Trusts.

4.0 IMPLICATIONS

Risks

4.1 The risks on staff engagement feature in the Trust's risk register alongside failure of leadership. Similarly, the risks to meeting the Trust's financial control total whilst also providing safe and effective care to patients form the primary focus for the Trust.

5.0 ACTIONS

5.1 Proposed KPIs to be agreed for key metrics for 2017/18.

6.0 RECOMMENDATION

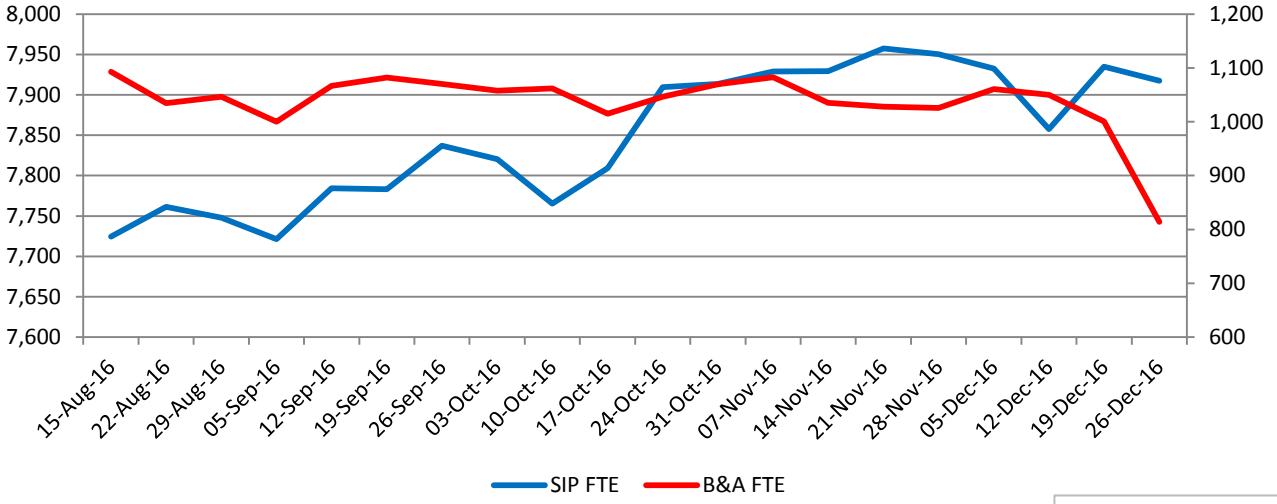
6.1 The Board is asked to note the workforce performance report and actions outlined within it.

[1] 'Time to hire' is the time between vacancy authorisation stage and the unconditional offer being made

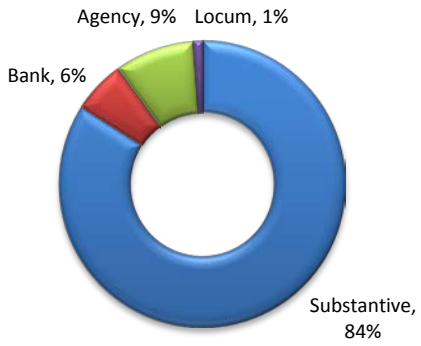
Section 1: Current Staffing Profile and Bank & Agency

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

Weekly Staff in Post and B&A FTE

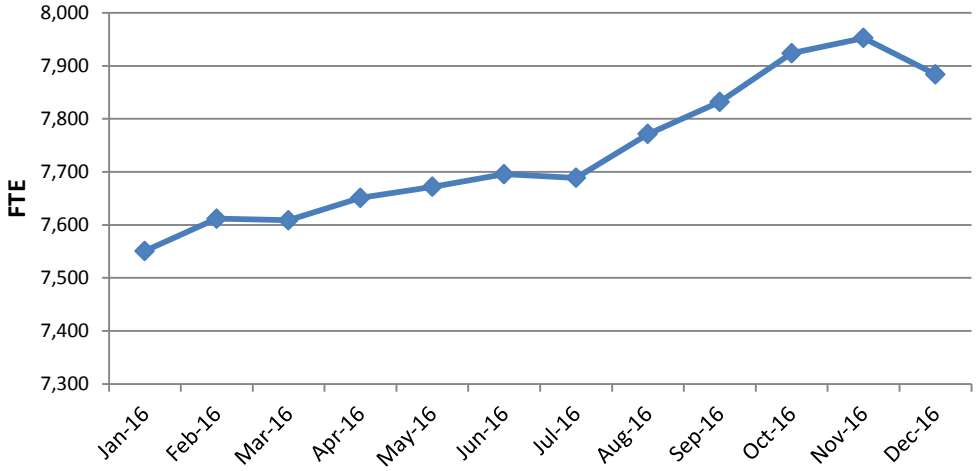


Monthly split (by costs)*



* Does not include SWLP or Central costs

Monthly Staff in Post FTE



COMMENTARY

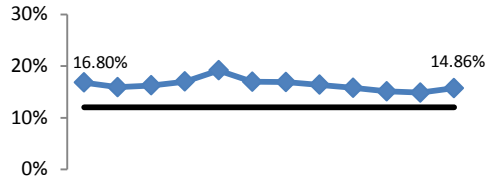
The Trust currently employs a headcount of 8,425 people, working a whole time equivalent of 7,884 which is 68 FTE lower than November. The directly employed workforce FTE in April 2016 was 7,651, so the growth rate is 3.05%.

The Trust also hosts 428 FTE from SWL Pathology and an additional 482 FTE GP Trainees covering the South London area, which makes the total FTE 8,794.

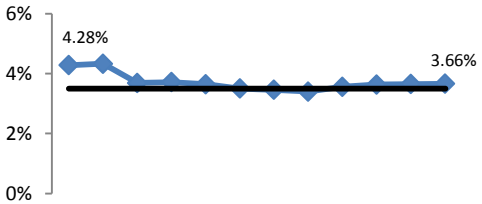
The figures in this report reflect the core St George's workforce, and do not include SWL Pathology or the GP trainees.

Section 2: Workforce KPIs

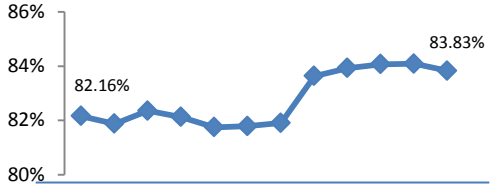
Vacancy Rate Year Trend



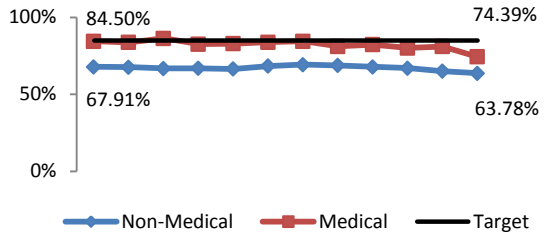
Sickness Rate Year Trend



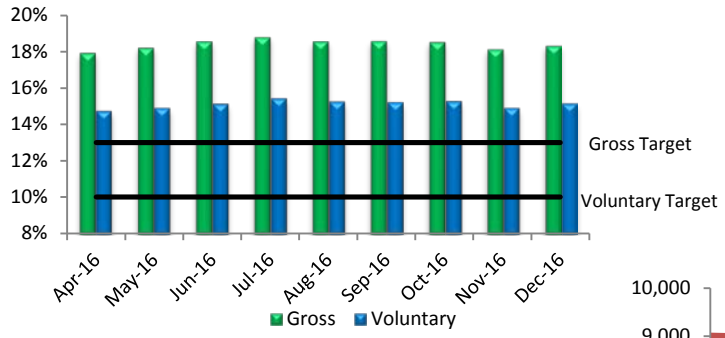
Stability Year Trend



Appraisal Rate Year Trend

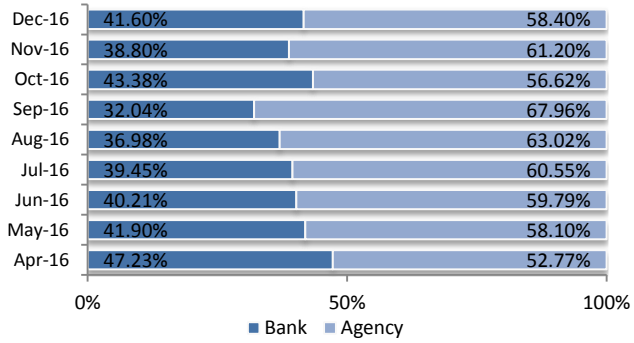


Turnover YTD

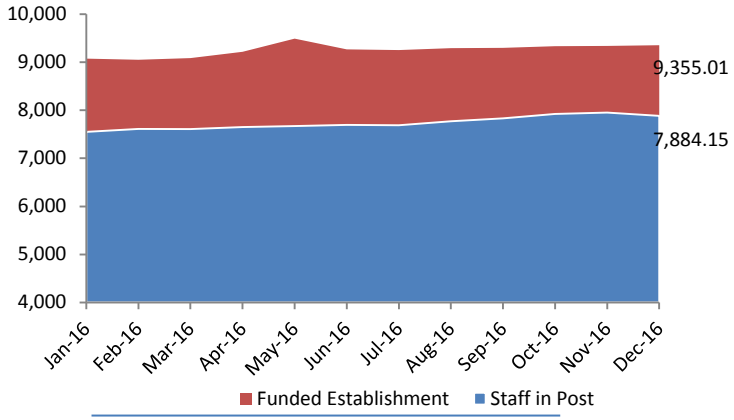


Key Points:		
KPI	Change over the year	Change since last month
Vacancy	-1.08%	0.86%
Sickness	-0.62%	0.01%
Stability	1.67%	-0.26%
Gross Turnover	0.40%	0.20%
Voluntary Turnover	0.41%	0.25%

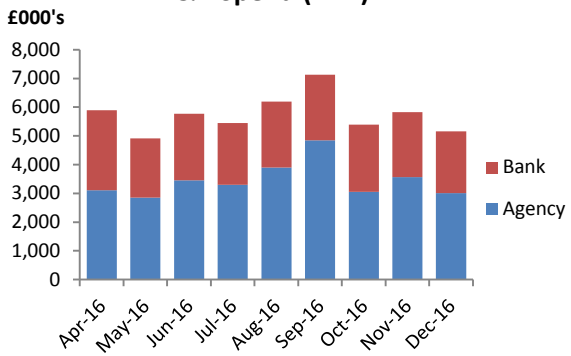
Bank/Agency Mix*



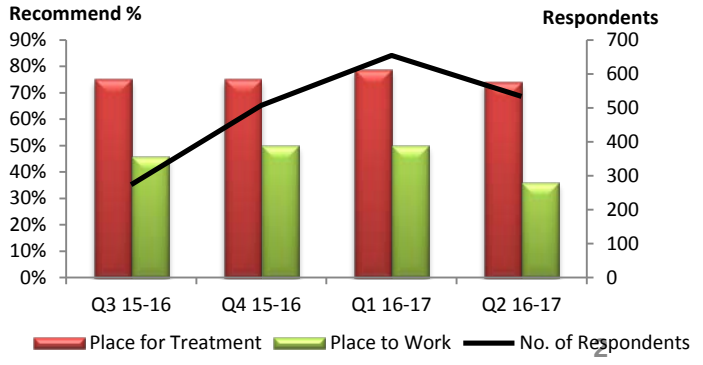
Trust Establishment & Fill Rate



B&A Spend (YTD)*

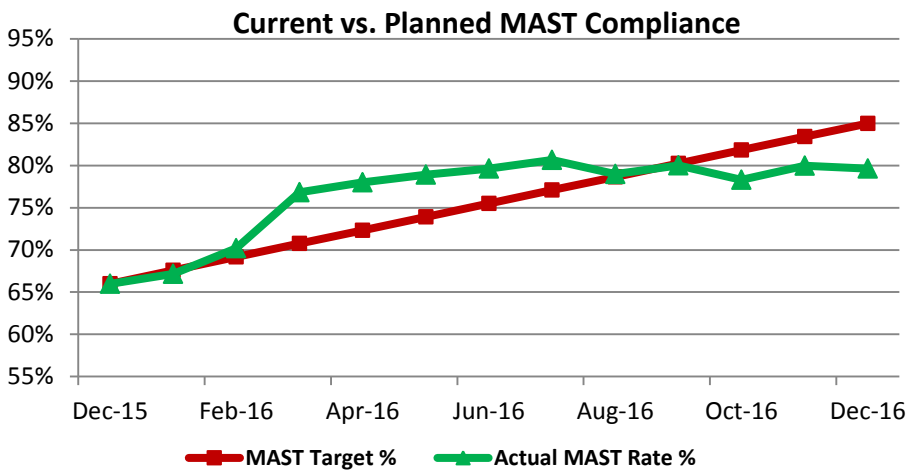


Friends & Family Test



* Does not include SWLP or Central costs

Section 3: MAST Compliance



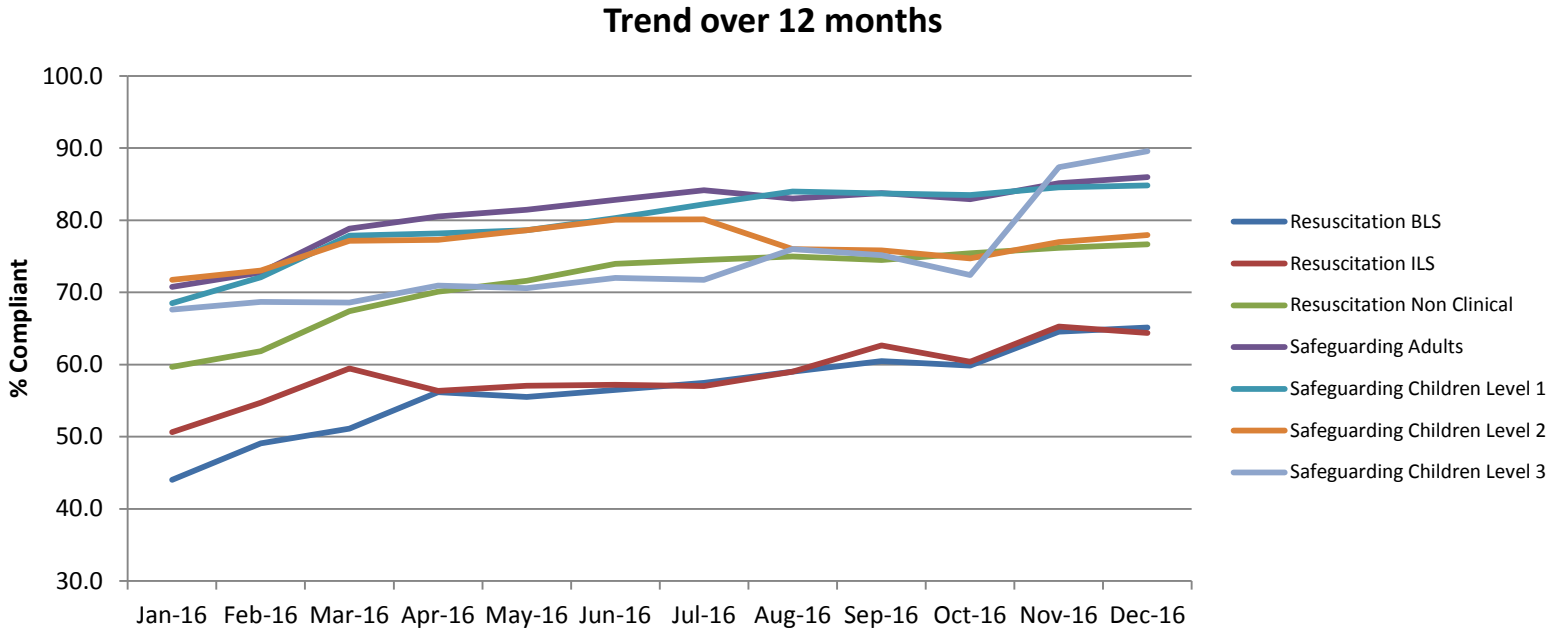
COMMENTARY

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.

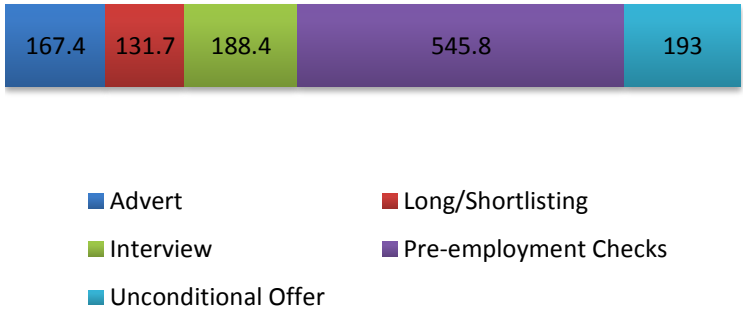
Current Issues:

- 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.
- There is currently a disconnect between actual training completed and the training being reported – this is an issue which is being focussed on.



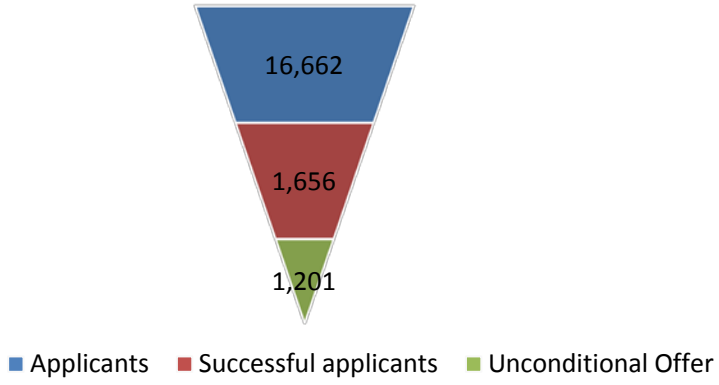
Section 4: Recruitment Pipeline

Current Pipeline (FTE)

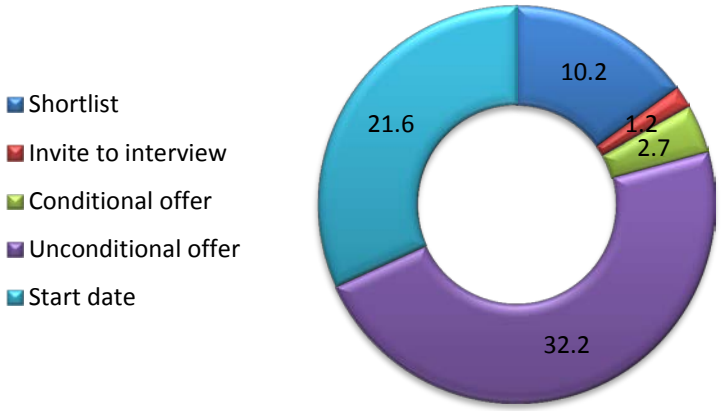


* Data is a snapshot from the end of December

Recruitment volumes (over 6 months)



Average days taken for key stages in Recruitment Process (over 6 months)



Shortlist – days that Recruiting Managers take to shortlist
Invite to interview – days between shortlisting being received from Recruiting Manager to interview invites being sent out
Conditional offer – days between interview outcome paperwork received to formal conditional offer
Unconditional offer – days between conditional offer and unconditional offer
Start date – days between unconditional offer and confirmed start date.

NB: Reporting from the Trac system is relatively new to the Trust and so the figures are intended as a guide only at this stage as they may not be wholly accurate. St George's representatives will be attending training on Trac reporting in January to further their understanding on the data being produce and increase confidence in the figures.

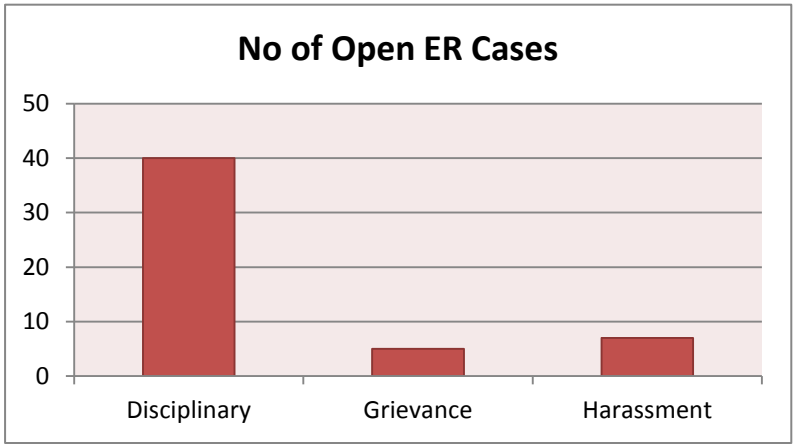
Section 5: Other

KPI benchmarking:

Trust	Vacancy	Sickness	Voluntary Turnover	Appraisal	MAST
St George's	12%	3.50%	10%	85%	85%
King's College Hospital	5-8%	3%	10%	90%	80%
Guy's & St Thomas'	9%	3%	11%	95%	95%
Barts Health	12%	3%	14%	n/a	90%
Imperial College Healthcare	10%	3.10%	10%	95%	90%
University College London Hospitals	7.30%	n/a	13.5%	95%	95%
Chelsea & Westminster	11%	3%	n/a	85%	90%

- Vacancy targets differ but we are at the top end
- Our sickness target is higher than other Trusts
- We have a lower voluntary turnover target than 3 of the other Trusts
- Our appraisal and MAST targets are comparatively low

Employee Relations:



- Further analysis at the end of the financial year will go into more detail and report on cases by ethnicity and age.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 February 2017	**Agenda No**	**4.3**
Report Title:	Guardian of Safe Working Report		
Lead Director/ Manager:	Professor Andrew Rhodes, Medical Director		
Report Author:	Dr Sunil Dasan, Guardian of Safe Working		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	This paper summarises progress in providing assurance that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016. As of 17/01/2016: • 115 Exception episodes have been reported • 4 work schedule reviews have been requested • 1 fine has been levied This report was considered by the Workforce and Education Committee on 31.01.17.		
Recommendation:	The Trust Board is asked to receive and note the Guardian of Safe Working's report and act to prevent any further working time breaches.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	Failure to ensure doctors are safely rostered and enabled to work hours that are safe risks patient safety and the safety of the doctor. Failure to ensure doctors are safely rostered and enabled to work hours that are safe risks overtime payments and fines being levied		
Legal/Regulatory:	Compliance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016		
Resources:	Funding for overtime payments, fines and service changes arising from work schedule reviews Additional PA allocation in consultant job plans for time taken to personalise work schedules, resolve exception reports and perform work schedule reviews Administrative support for the role of guardian		
Previously Considered by:	Workforce and Education Committee	**Date**	31.01.17
Equality Impact Assessment:	N/A		
Appendices:	None		

Guardian of Safe Working Report
Trust Board, 9 February 2017

1.0 PURPOSE

1.1 This paper provides assurance to the Board on the progress being made to ensure that doctors' working hours are safe and to highlight all fines and work schedule reviews relating to safe working hours.

1.2 This report also includes information on all rota gaps on all shifts

2.0 BACKGROUND

2.1 The Guardian of Safe Working is a senior appointment made jointly by the Trust and junior doctors, who ensures that issues of compliance with safe working hours are addressed by the doctor and/or Trust and provides assurance to the Board that doctors' working hours are safe.

2.2 As the Trust is the Lead Employer Organisation for General Practice training across South London the Guardian will receive reports for all of the doctors under its employment from Guardians in host organisations.

2.3 The Guardian reports to the Board through the Workforce and Education Committee of the Board, as follows:

i. The Workforce and Education Committee will receive a *Guardian of Safe Working Report* no less than once per quarter on all work schedule reviews relating to safe working hours. This report will also include data on all rota gaps on all shifts. The report will also be provided to the Local Negotiating Committees (LNC).
ii. A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps will be included in a statement in the Trust's Quality Account, which must be signed off by the Trust chief executive. This report will also be provided to the LNC. This annual report will also be presented to the Board.
iii. Where the Guardian has escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, for decision and action, and where these have not been addressed at departmental level and the issue remains unresolved, the Guardian will submit an exceptional report to the next meeting of the Board.
iv. The Board is responsible for providing annual reports to external bodies, including Health Education South London, Care Quality Commission, General Medical Council and General Dental Council. This will be done through the Medical Director supported by the Guardian.

2.4 There may be circumstances where the Guardian identifies that certain posts have issues that cannot be remedied locally, and require a system-wide solution. Where such issues are identified, the Guardian will inform the Board. The Board will raise the system-wide issue with partner organisations (e.g. Health Education England, NHS England, NHS Improvement) to find a solution. This will be done through the Medical Director supported by the Guardian.

2.5 The Guardian is accountable to the Board. Where there are concerns regarding the performance of the Guardian, the BMA or other recognised trade union, or the Junior Doctors Forum will raise those concerns with the Trust Medical Director. These concerns can be escalated to the senior independent director on the Board where they are not properly addressed or resolved. The Senior Independent director is a Non-executive director appointed by the Board to whom concerns regarding the performance of the Guardian of safe

working hours can be escalated where they are not properly resolved through the usual channels.

3.0 ANALYSIS

3.1 115 exception episodes have been reported in the period 5 October 2016 – 17 January 2017 by the 50 trainees (8 ST3+ O&G and 42 Foundation Year 1 trainees) on the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016.

3.2 These have highlighted FY1 doctors working shifts exceeding the maximum permitted 13 hours within General Surgery & Acute Medicine and doctors regularly working hours in excess of their work schedules in these and other specialties - Trauma & Orthopaedics and Senior Health.

3.3 Work schedule reviews have been formally requested in four specialties (listed above) and a fine has been levied in response to a Foundation Year 1 doctor working in excess of 72 hours over a 7 day period in General Surgery in December 2016. Further fines may be levied in the near future in Acute Medicine and Senior Health if urgent action is not taken to ensure working hours remain below an average of 48 hours per week during the course of the current rota cycle.

3.4 The summary of all exceptions was reported to the Workforce and Education Committee on 31.01.17.

3.5 Data on all rota gaps on all shifts is not currently available and a new monitoring process will be required to collect this data. The Workforce and Education Committee received a list of current vacancies.

4.0 IMPLICATIONS

Risks

4.1 Doctors have exceeded safe working limits in General Surgery and Acute Medicine which risks patient safety and the safety of doctors. This may continue (with the risk of future fines) if service or organisational changes are not made to reduce doctors shift lengths.

4.2 Doctors are regularly working outside of work schedules in General Surgery, Acute Medicine, Trauma & Orthopaedics and Senior Health. Time off in lieu and/or overtime payments will be required unless service changes are made to reduce doctors working hours. Of particular concern are the additional hours being worked in Acute Medicine and Senior Health - urgent action is required to prevent fines being levied in the forthcoming weeks due to breaches of the 48 hour average working week limit.

Legal Regulatory

4.3 Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016

Resources

4.4 Funding for overtime payments represents a cost pressure. Following work schedule reviews, additional staff may be required to bring doctors working hours into safe limits and to bring their hours into line with their work schedules. If actual working hours cannot be brought into line with work schedules, then basic pay for staff may need to increase. This represents a further cost pressure. Lastly, fines may be levied if unsafe working practices continue.

4.5 Educational supervisors previously had 0.25 PA allocated in their job plans per trainee. Personalising work schedules, resolving exception reports and performing work schedule reviews are additional tasks for educational and clinical supervisors which will need further consideration in their job plan reviews. Currently approximately 50% of exception reports have breached the seven day timescale for resolution by supervisors.

4.6 Administrative support for the role of Guardian is currently being considered.

5.0 NEXT STEPS

5.1 To receive the outcomes of the four ongoing work schedule reviews.

5.2 To commence data collection on rota gaps for all shifts and to present data in next quarterly report.

6.0 RECOMMENDATION

6.1 The Board is asked to note this report and consider the costs associated with overtime payments and fines and the potential future costs and service changes associated with the outcomes of the work schedule reviews

6.2 The Board is asked to consider the issue of rota gaps due to medical vacancies and strategies to address these ahead of the Guardian's next report to the Workforce and Education Committee.

6.3 The Board is asked to consider the additional activities for educational and clinical supervisors and the impact on the current round of consultant job planning.

Author: **Dr Sunil Dasan**
Date: **19/01/2017**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 February 2017	**Agenda No**	**5.1**
Report Title:	Significant Risk Profile		
Lead Director/ Manager:	Paul Moore		
Report Author:	Paul Moore		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	1) This paper highlights the core operational risks – known as the Corporate Risk Register. These risks can be grouped under 4 risk areas as: • Timely Access to Clinical Services/Patient Harm • Insufficient Resilience/Unstable Critical IT/Estates Infrastructure • Unsustainable Financial Position • Inadequate Governance/Reputation Loss 2) The Board is receiving an updated emergent risk horizon scan. This illustrates our current understanding of internal and external risk, alongside current and future risks. 3) The Board is receiving a full extract of all risks rated 15 or more on Datix. This is to ensure that there is full visibility of extreme risks; to consider the extent to which these risks are reflected in the Corporate Risk Register; to challenge the residual risk scores assigned by divisions; and to consider the degree to which the risk can be accepted.		
Recommendation:	The Board are invited to consider the CRR and: • Satisfy itself that the current level of risk exposure is tolerable or acceptable and that the Board are content with the level of control achieved over those risks; • Where the Board are not satisfied, to agree further actions required to bring the risks under prudent controls; and • Consider the extent to which the Board's appetite for taking risks is adopted or if changes are needed to achieve prudent control.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Safe / Well-led.		
Single Oversight Framework Theme:	Quality of Care (safe, effective, caring, responsive). Leadership and Improvement Capability (well-led).		
Implications			
Risk:	These risks could have a direct bearing on requirements within NHSI's Single Oversight Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective.		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		

Resources:	There are no specific resource implications		
Previously Considered by:	Risk Management Committee	**Date**	11.01.2017
Equality Impact Assessment:	N/A		
Appendices:	A. Risk Grading Matrix / Risk Escalation Arrangements (illustrated) B. Table 1: Core Operational Risk Drivers – Dec 2016 C. Figure 2: Emergent Risk Horizon Scan – Dec 2016 D. Figure 3: Interpreting the Risk Horizon E. Table 2: Extreme Risks for review Full Corporate Risk Register is available in the reading room for reference		

Corporate Risk Report
Trust Board
Thursday 9 February 2017

1.0 PURPOSE

1.1 To highlight key risks and provide assurance regarding their management.

2.0 BACKGROUND OR CONTEXT

2.1 The Corporate Risk Register (CRR) has been kept under review with input from the Executive during January 2017

2.2 The CRR continues to be developed and reassessed accordingly. It is anticipated that review will be continuous in order to ensure the profile of risk presented to the Committee is relevant and always up to date.

2.3 Training continues to be 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.

2.4 It is anticipated that the CRR will evolve as further analysis, challenge and development of the risk profile progresses; and our understanding of uncertainty facing the Committee's strategy emerges.

3.0 ISSUE

Core Operational Risk

3.1 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 Single Oversight 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

Core Strategic Risk

3.2 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 currently identified within 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**.

The BAF remains subject to review by the Board's committees. The company Secretary leads on the BAF

Emergent Risk Horizon

3.3 The Trust has further developed its understanding of emergent risks and the following risks were added to the horizon scan:

- Potential impact arising from a total loss or significant reduction of the education and training levy;
- Factors that may impede the provision of out of hospital care and 7-day services;
- The potential for industrial action on a scale that might disrupt normal operations;
- The potential workforce implications arising from those eligible for retirement in next 3-5 years; and
- Ageing workforce profile

Review of extreme risks

3.4 Having completed the first full cycle of divisional risk register reviews by the Risk Management Committee, it was agreed to commence formal reporting of all risks rated 15 or more in accordance with the conventions agreed at the Board in July 2016.

Data is extracted from Datix as the central repository for all risks. At time of writing this report (January 2017), there are a total of 41 extreme risks contained within the Divisional/Directorate risk registers at the time of report; 40 of which are either standalone risks or mapped to one or more risks in the Corporate Risk Register.

Therefore, 98% of extreme risks have either directly or indirectly been reported to the Board of Directors at each formal meeting since September 2016. The risk which has not yet been mapped and formally escalated, is:

- 'CSD796 Potential loss of income due to bidding for newly tendered services being unsuccessful' features in the Emergent Risk Horizon under the heading of' Failure to acquire new business or retain existing contract'

Full list of risk discussed at RMC can be found at appendix E

Proceedings of the Risk Management Committee

3.5 The Risk Management Committee met on 11th January 2017 to review the corporate risk register and to review in more detail reportable risk in: (i) Surgery, Trauma, Neurosciences & Cancer Division, (ii) Corporate Nursing and (iii) Governance Support Unit.

The members felt there continues to be a significant improvement in the quality of risk registers and the discussion about their mitigation and options for further adaptation.

- The risk of 'CSD796 Potential loss of income due to bidding for newly tendered services being unsuccessful', included into the Community Services risk register, is to be subjected to more scrutiny before being added to the Corporate Risk Register
- H&S inspection The Health and Safety Executive visited site on Wednesday 11th January 2017. The purpose of the visit was to review Water safety and Theatre ventilation in selected areas. The visit was planned in relation to the CQC report of 2016. No enforcement action or written advice has been issued as a result of the visit and no further visits are currently planned. Verbal advice was provided by the inspector as detailed in the main body of the report

4.0 IMPLICATIONS

Legal Regulatory

4.1 Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence

Resources

4.2 There are no specific resource implications, except where indicated on a specific risk basis and are subject to decision elsewhere.

5.0 DECISION POINTS

The Board to consider:

(i) Is the Board satisfied that it has sufficient visibility of material risk exposures?
(ii) Is the Board satisfied that the control frameworks for mitigating those material risks are sufficiently understood and complied with by management?

6.0 RECOMMENDATION

The Board are invited to consider the CRR and:

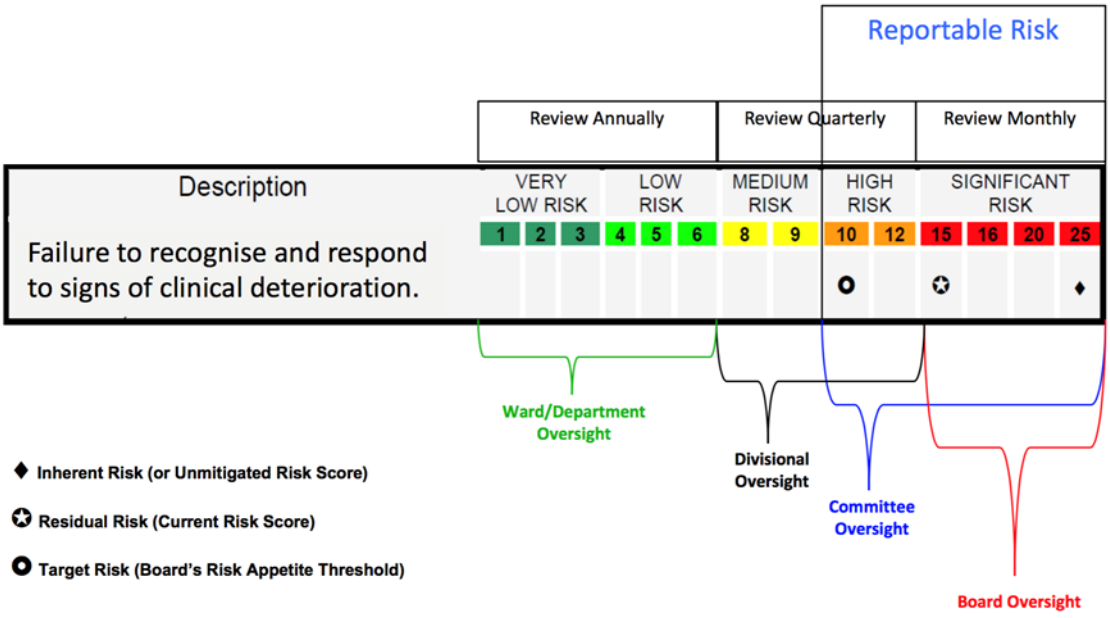
- To satisfy itself that the current level of risk exposure is tolerable or acceptable and that the Board are content with the level of control achieved over those risks;
- Where the Board are not satisfied, to agree further actions required to bring the risks under prudent controls; and
- To consider the extent to which the Board's appetite for taking risks is adopted or if changes are needed to achieve prudent control.

APPENDIX [A]

[Guidance: 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

[Guidance: Risk Escalation Arrangement (illustrated)]



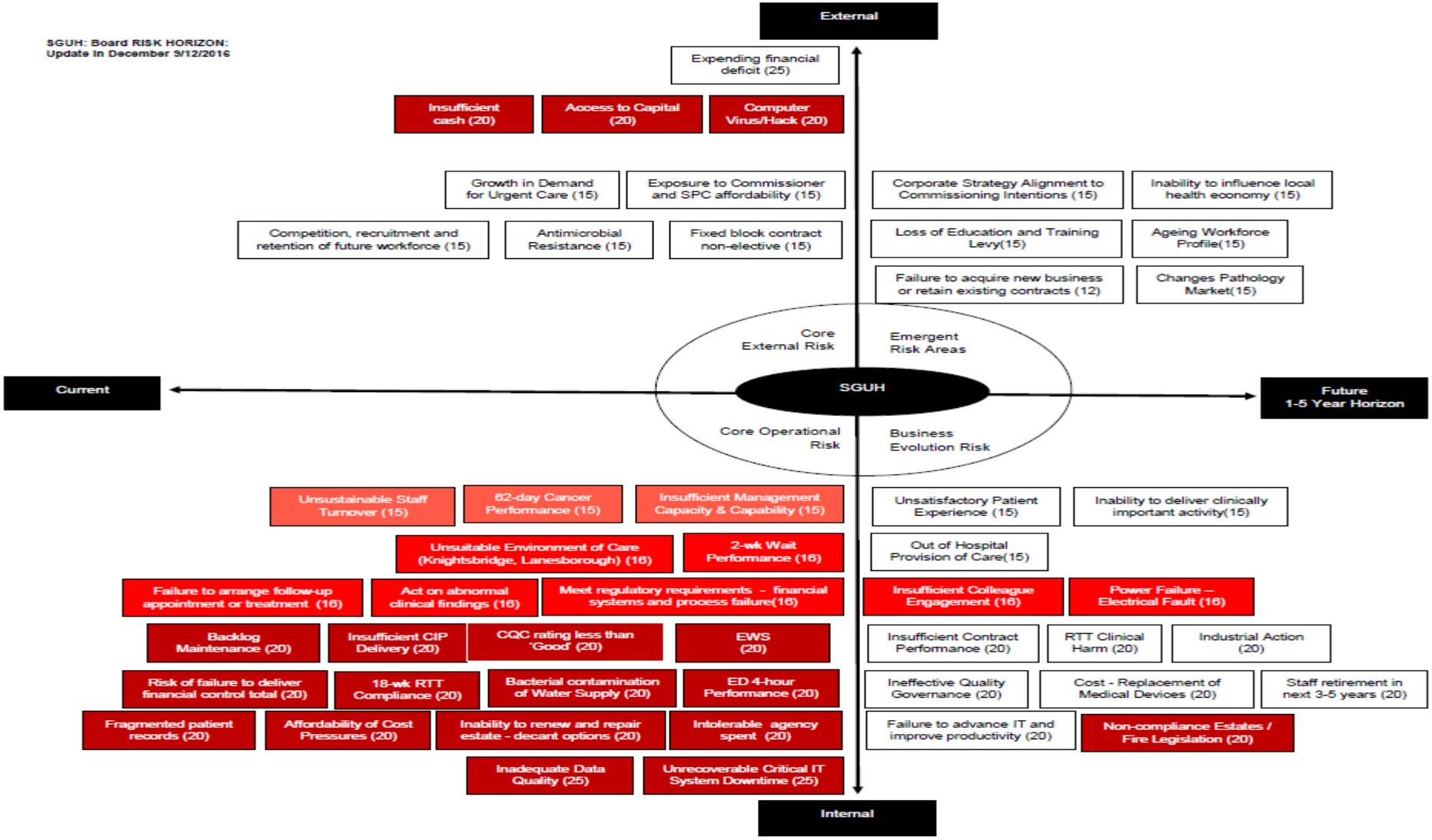
APPENDIX [B]

[Table 1: Core Operational Risk Drivers – Jan 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 Material Breach of Licence Conditions 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	⇔		
Recognising, escalating and responding to the sign of deteriorating patient	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	⇔		
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	25	⇔		
↑ = Risk Increase; ↓ = Risk reduced; ⇔ = No change from previous report to Board				

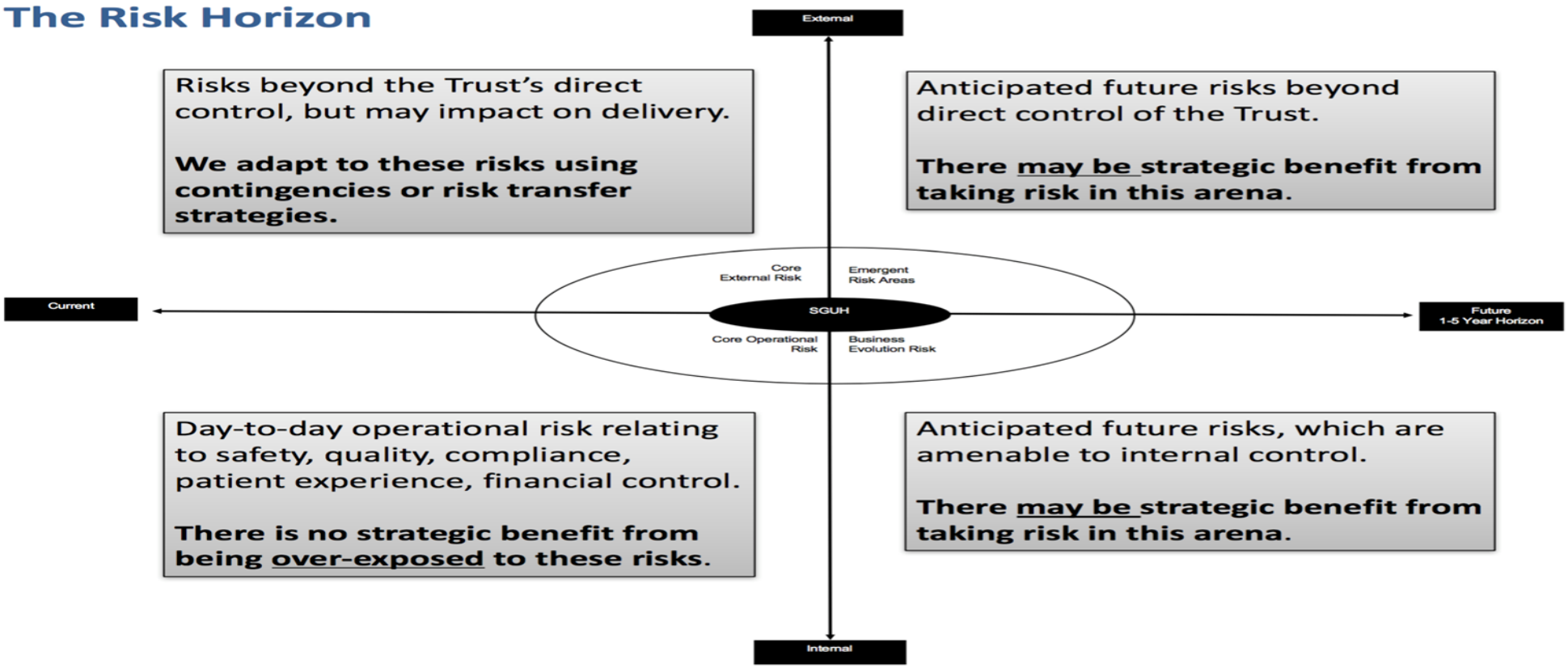
APPENDIX [C]

[Figure 2: Emergent Risk Horizon Scan – Jan 2016]



APPENDIX [D]

[Figure 3: Guidance - Interpreting the Risk Horizon]



APPENDIX [E]

[Table 2: Extreme Risks contained within divisional risk registers]

Ref	Title	Opened	Manager	Description	C	L	Current Risk Scoring	Current Risk level	Division / Directorate	Incorporated in CRR….
EF690	(Electrical Infrastructure) Potential interruption to electrical supply (whole site).	01/11/2015	Alesbury*, Peter	(EF113 & EF114)Potential interruption to whole site power supply as a result of HV - Air cooled transformers reaching end of useful life.	5. Catastrophic	3. Possible	15	Extreme	Corporate Directorate Estates & Facilities	CRR-0006 - Power failure - electrical fault
IT0016	Risk that pressure on ICT capital programme could affect capability and capacity to deliver key strategic objectives.	13/05/2011	Salmon, Ian	The reduction in capacity to deliver new infrastructure, systems and change programmes increases the risk to operational capability.	4. Major	5. Almost Certain	20	Extreme	Corporate Directorate ICT	CRR-0015 - Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressure
EF701	(Legionella) Legionella infection Cooling towers	01/03/2014	Hancock*, Richard	(EF131)There is a risk of legionella infection associated with the three cooling towers on the roof of St James Wing. This risk has increased as a result of the opening of the helipad as it creates down draft which may increase the risk of spreading water droplets.	4. Major	4. Likely	16	Extreme	Corporate Directorate Estates & Facilities	CRR-0016 - Bacterial contamination of water supply (Legionella, Pseudomonas)

EF702	(Mechanical Infrastructure) Failure of steam main to Knightsbridge	17/12/2015	Hancock*, Richard	(EF133)Steam main to Knightsbridge - Old, poor condition and leaking. Risk of failure. Steam main leak has now caused a catastrophic failure of the aged electrical distirbution system in Knightsbridge. Numerous parts of the distrbution now require urgent replacement.	5. Catastrophic	4. Likely	20	Extreme	Corporate Directorate Estates & Facilities	CRR-0018 - Unsuitable environment of care (Renal Unit, Lanesborough OPD) - risk of premises closure, prosecution, fire
EF687	(Theatre Ventilation) Theatre ventilation breakdowns/failures	18/08/2015	Hancock*, R	(EF108)Several theatre ventilation plants beyond their economic life and subject to increases in breakdowns/failures Unchanged	4. Major	4. Likely	16	Extreme	Corporate Directorate Estates & Facilities	CRR-0008 - Inability to address backlog maintenance requirements
IT0044	2016/17 NHS England Standard Contract to send Discharge Summaries that comply with the standards of the Academy of Medical Royal	14/09/2016	Salmon, Ian	The adoption of AoMRC standards for discharge summaries was first set out in The National Information Board (NIB) Personalised Health and Care 2020, framework for action (November 2014). The delivery of this standard is mandated by the the 2016/17 NHS England Standard Contract by the 1st December 2016 and is, also, an objective of South West London's digital road map. Discharge summaries are produced either in a legacy system Merlin or in Cerner Millennium (where electronic clinical documentation and ePMA is in use) both systems are currently non-compliant. Failure to deliver compliant discharge summaries by the required date may result in penalties and criticism from our local GP community.	5. Catastrophic	3. Possible	15	Extreme	Corporate Directorate ICT	CRR-0009 - IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems

EF734	Automatic Change Over Controllers obsolete.	08/08/2015	Alesbury*,	(EF216)If there was a failure with these controllers, there is nothing to replace them on the shelf. These changeover controllers apply both from mains to generator and generator to mains.	5. Catastrophic	3. Possible	15	Extreme	Corporate Directorate Estates & Facilities	CRR-0008 - Inability to address backlog maintenance requirements
EF738	Bacterial contamination of water supply (Legionella, Pseudomonas)	01/01/2015	Hancock*, Richard	(EF132)There is a risk to patient safety from water-borne infection. This risk has been increased as a result of legionella being found in isolated areas in the St George's Hospital site. There are different water-bornes infections in different buildings; Legionella and Pseudomonas.	5. Catastrophic	4. Likely	20	Extreme	Corporate Directorate Estates & Facilities	CRR-0016 - Bacterial contamination of water supply (Legionella, Pseudomonas)
SM-MC87	Breakdown of the ventilation system on Ruth Myles unit t and McEntee ward leading to uncontrolled temperatures in the department	01/12/2015	Bleasdale*, Robert	Risk to patient safety and experience in the event of a catastrophic failure of the ventilation system. The system has been inspected by an external company and deemed to be irreparable due to the age and degradation of the system. Patients undergoing allogeneic stem cell transplants would have to be relocated to other positive pressure areas. New patients who are due to undergo treatment would have to be relocated or treated at another organisation or cancelled. This would have a financial implication for the trust.	4. Major	4. Likely	16	Extreme	Medicine & Cardiovascular Division	CRR-0008 - Inability to address backlog maintenance requirements

IT0011	Computer hardware in clinical areas slow and unreliable.	27/11/2010	Bogdanowicz*, Lech	Computer hardware in clinical areas slow and unreliable.Risk to patient care if patient information not available in timely manner. There is a risk that the computer hardware in the clinical areas is too slow and too unreliable for the roll out of clinical functionality within iCLIP. This might result in a delay accessing a patient's clinical record, detracting them from delivering more care at the bedside.	3. Moderate	5. Almost Certain	15	Extreme	Corporate Directorate ICT	CRR-0009 - IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems
1115	End of Life Care	01/11/2016	Ludlam*,	CQC warning Notice 29A: insufficient governance and leadership framework for EoLC (Aug 2016)	4. Major	4. Likely	16	Extreme	Community Services Division	CRR-0021 - CQC rating less than 'Good'
EF730	Failure of electrical switchgear due to age of equipment	04/07/2015	Alesbury*,	(EF211)Failure of electrical switchgear causing loss of essential power in St James's Wing for most of the wards and other departments.	5. Catastrop	3. Possible	15	Extreme	Corporate Directorate Estates & Facilities	CRR-0006 - Power failure - electrical fault
CW781	Failure of Responsible Persons to address and/or rectify Significant Findings contained in Fire Risk Assessments	10/09/2015	McHugh*, Helen	(CW109)The failure of responsible persons to address significant findings in risk assessment may lead to an increased risk of injury or loss of life in the event of a fire or fire evacuation	5. Catastrophic	5. Almost Certain	25	Extreme	Children & Women Division	CRR-0007 - Potential unplanned closure of premises / non-compliance with estates or Fire legislation

FinNew7	Failure of the Trust to meet externally set control total results in regulatory action	20/10/2016	Pratt, Margaret	The Trust is tasked with delivering an externally set control total. This requires challenging budgets to be set based on a number of assumptions on activity, costs and efficiency plans.To meet the control total departments may be set budgets that cannot be delivered.	4. Major	4. Likely	16	Extreme	Corporate Directorate Finance	CRR-0027 - Risk of failure to deliver the financial control total
FinNew4	Failure to agree the loans exposes the Trust to a risk of a cash shortfall and inability to meet payment demands	03/10/2016	Pratt, Margaret	The financial position of the trust requires careful cash management to ensure payment demands can be met. Trust has applied for loan funding. This has been agreed on a 30 day basis. Failure to secure this loan on an ongoing basis will result in the trust not being able to meet its payment demands. In addition, the trust requires funding for the backlog maintenance programme and is expecting a £39m capital loan from bthe DoH. The trust is spending at risk against this loan.	4. Major	5. Almost Certain	20	Extreme	Corporate Directorate Finance	CRR-0005 - Insufficient cash to meet payment demands
C21	Financial risk – cost.	01/04/2016	Cox*, Chloe	Financial risk – cost. Failure to achieve a balanced budget in 2016/17	4. Major	5. Almost Certain	20	Extreme	Surgery, Trauma, Neuroscience, Theatres & Cancer Division	CRR-0004 - Insufficient Cost Improvement/Transformation Programme in 2016/17

CW786	Health and Safety	12/05/2016	McHugh*, Helen	(CW0086) There is a risk to the health and safety of patients and staff due to the poor fabric, poor temperature control and lack of storage in the following places in the division. • Lanesborough wing: Ground, 1, 4 & 5 floors • St James Wing: Ground & 1 & gym on 3rd Floor • Knightsbridge Wing: Ground floor This negatively impacts on the operation of services and the experience of both patients and staff.	3. Moderate	5. Almost Certain	15	Extreme	Children & Women Division	CRR-0018 - Unsuitable environment of care (Renal Unit, Lanesborough OPD) - risk of premises closure, prosecution, fire
EF722	Inability to address backlog maintenance requirements	18/11/2014	Hancock*, Richard	(EF200)There is a risk to the quality and safety of patient care in the event the Estates and Facilities team are unable to complete required estates works in a timely way due to the impact of capital investment within run-rate schemes. Reduction of the scale of the Trust's capital programme means that not all of the Trust's high priority projects can be funded at the time they are needed. In order to achieve identified savings targets, the Estates and Facilities Department has to reduce labour and materials expenditure on its planned and reactive maintenance service.	4. Major	5. Almost Certain	20	Extreme	Corporate Directorate Estates & Facilities	CRR-0008 - Inability to address backlog maintenance requirements (Capital)
HR1060	Inability to control agency temporary staffing and associated staffing costs	30/09/2016	Gammage, Mark	Inability to control agency temporary staffing cost. Unable to demonstrate a control on agency temporatry staffins as shown by breach of annual cap value.	4. Major	5. Almost Certain	20	Extreme	Corporate Directorate HR	CRR-0026 - Inability to control agency staffing and associated staffing costs

C58	Limited out of hours and weekend medical ward staffing	01/07/2016	Pavett-Downer*, James	Out of hours and weekend medical ward staffing has been identified as a common theme in AI reports - Gunning and Holdsworth. Vacancy factor of 13.0 WTE, 9 registrars and 3 physicians associates. Risk to timeliness of service delivery and patient safety on ward. Also impacts on income due to elective operating and outpatient activity is cancelled to release doctors to cover ward and on-call duties.	4. Major	4. Likely	16	Extreme	Surgery, Trauma, Neuroscience, Theatres & Cancer Division	CRR-0025 - Unssustanable levels of staff turnover
IT0040	Loss of IT leadership due to vacant posts.	07/04/2016	Murphy, Larry	The Trust is experiencing a high turnover in IT senior staff. The Board level exec, CIO, Deputy CIO and Ops lead have either left or are in the process of leaving the organisation. This leaves the Trust with a lack of operational and strategic IT leadership	4. Major	5. Almost Certain	20	Extreme	Corporate Directorate ICT	CRR-0009 - IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems
EF733	Master Pact M Air Circuit Breakers no longer supported by manufacturers.	30/07/2015	Alesbury*, Peter	(EF215)A failure of any of these air circuit breakers (ACB) would leave the hospital vulnerable in the fact that it could cause loss of power from a substation or make the generator back up ineffective should there be an external power failure.	4. Major	4. Likely	16	Extreme	Corporate Directorate Estates & Facilities	CRR-0006 - Power failure - electrical fault
CSD 796	Potential loss of income due to bidding for newly tendered services being unsuccessful	12/06/2014	Reeves*, Stuart	(CSW1024-COM-D5)Activity and associated income/contribution will potentially be lost due to:• Service Line Tenders in Q4 2015/16.e.g. Impact on contract from Q3 2017/18. The values are : HV £5.7m, ISHS £6.4m,& CAHS £14.7m potential overall profit loss £6m.potential overall loss of contribution (20%) £5m.	4. Major	4. Likely	16	Extreme	Community Services Division	

IT0037	Potential risk to ability to store Trust data	23/02/2016	Bogdanowicz*,	High risk to operation viablity of Trust if organic growth for data storage and computing not addressed	5. Catastrophic	5. Almost Certain	25	Extreme	Corporate Directorate ICT	CRR-0009 - IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems
EF721	Potential unplanned closure of premises / non-compliance with estates or Fire legislation	01/09/2014	Hancock*, Richard	(EF198)Risk of premises closure, prosecution and fines as a result of non-compliance with fire regulations in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO). Ability of the Trust to demonstrate its compliance in accordance with the Regulatory Reform (Fire Safety) Order 2005 (RRO)	4. Major	4. Likely	16	Extreme	Corporate Directorate Estates & Facilities	CRR-0018 - Unsuitable environment of care (Renal Unit, Lanesborough OPD) - risk of premises closure, prosecution, fire
MD1141	Recognising, escalating and responding to the signs of deteriorating	07/12/2016	Rhodes*, Andrew	Risk of failure of recognising, escalating and responding to the signs of deteriorating patient. This is coused by the suboptimal use of EWS as observatins not completed correctly, not clezarly escalted or promptly responded in order to commence treatment. This may result in avoidable death, and/or breach of CQC registration requirements	5. Catastrophic	4. Likely	20	Extreme	Corporate Directorate Medical Director	CRR-1143 - Recognising, escalating and responding to the signs of deteriorating
IT0034	Risk of delay to clinical system programme due to inappropriate storage facility.	27/10/2014	Salmon, Ian	Lack of appropriate storage space for IT hardware will delay deployment of clinical IT systems resulting in extending the period of running manual systems.	4. Major	4. Likely	16	Extreme	Corporate Directorate ICT	CRR-0009 - IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems

IT0025	Risk of ICT infrastructure failure due to age of infrastructure.		Bogdanowicz*,	There is an increased risk of infrastructure failure due to age of IT infrastructure and lower than required levels of investment for replacements. IT Infrastructure failure compromises all computer activity.	5. Catastrophic	5. Almost Certain	25	Extreme	Corporate Directorate ICT	CRR-0009 - IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems
IT0038	Risk of inability to access core Trust systems if XP PCs not updated.	23/02/2016	Bogdanowicz*, Lech	The Trust will have extended XP for three years beyond Microsoft end of life date for this operating system. Certificates are no longer available. Further deferrment of VDI replacement not option. Core Trust systems will not be able to be accessed from XP PCs from December 2016.	5. Catastrophic	5. Almost Certain	25	Extreme	Corporate Directorate ICT	CRR-0009 - IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems
IT0039	Risk of loss of Trust data.	07/04/2016	Bogdanowicz*,	A large increase in the computer malware known as "Ransom ware" is affecting Trust computer data. There is a high risk that data that has been affected will be lost if the affected files are not identified and restored within a short time frame.	4. Major	5. Almost Certain	20	Extreme	Corporate Directorate ICT	CRR-0013 - Vulnerability to computer virus or attack 'Ransom ware'

IT0043	Risk of non-compliance with national directive to be paperless by 2018	14/09/2016	Salmon, Ian	There is a national requirement to be paperless by 2018, plus it is expected that there is increasing Digital Maturity to improve patient safety. And finally by 2020, being paperless is a pre-requisite for holding a CQC operating license to provide publically funded healthcare. Although the St George's Hospital site has international recognition at HIMSS level 6 accreditation for its digital maturity (a high rating) and was nationally ranked eighth in NHSE's survey of digital capabilities these system are only live in approximately 44% of inpatient areas on the main Tooting site. Queen Mary's Hospital, the Nelson Health Centre and all community sites are not covered and the majority of clinical documentation is on paper. It is recognised in other risks that an investment in infrastructure and hardware must be completed before existing clinical systems can be rolled out further. Therefore depending on the completion date for these investment plans and the dates of subsequent project plans to complete roll out of clinical documentation in acute and community areas, these strategic dates could be breached.	5. Catastrophic	3. Possible	15	Extreme	Corporate Directorate ICT	CRR-0015 - Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressure
IT0045	risk of penalties or lost income through the inability to evidence activity due to an out-of-date version of their clinical syst	14/09/2016	Salmon, Ian	RiO is the enterprise clinical system for the Community Division providing administrative and clinical functionality. The system has not been updated since before the Trust exited from the National Programme for IT and the current version is now over two years old. Many important enhancements to support new data	5. Catastrophic	3. Possible	15	Extreme	Corporate Directorate ICT	CRR-0015 - Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressure

				standards and interoperability have been made in the intervening time and the Trust is unable to meet many obligations. These include: ● The Trust is unable to produce and submit the mandated Children & Young People's Health Services (CYPHS) data-set which is used to support the commissioning of Health Visiting and School Nursing; ● National Screening Store (NSS) interface to support the submission of Newborn Hearing Screening Programme and Newborn & Infant Physical Examination data submissions are absent; ● PDS birth notifications and Pupil Data upload facility absent. The Trust is at risk of penalities from Commissioners and/or NHS England through the inability of the Trust to make or receive these various submissions. Child Health is to be tendered and the Trust is at risk of losing this contract through its failure to meet these standards.						
IT0015	Risk of slow recovery from ICT disaster if ICT disaster recovery plan lacks sufficient granularity	01/02/2011	Bogdanowicz	Risk of slow recovery for disaster. IT related disaster recovery plans and procedures not as detailed as required.	4. Major	4. Likely	16	Extreme	Corporate Directorate ICT	CRR-0009 IT storage: unrecoverable IT system downtime affecting critical clinical, web and email systems
IT0042	Risk of staff using different systems to record patient care (paper and electronic systems (iCLIP)).	14/06/2016	Murphy, Larry	There is a risk that staff may record or look for clinical information in multiple places or the incorrect place resulting in incomplete documentation or a split record which could lead to concerns regarding quality and safety of care. Or dual systems may lead to an increase in transcribing errors	4. Major	4. Likely	16	Extreme	Corporate Directorate ICT	CRR-0010 - Fragmented Electronic and manual patient records

B253	Theatre Air Handling Unit (AHU)	01/12/2014	Gray*, David	Theatre air handing units(AHU)are at risk of failing intraoperatively due to the age of the plant. This may pose a risk of increase in infection and decreased operational efficiency.	4. Major	4. Likely	16	Extreme	Surgery, Trauma, Neuroscience, Theatres & Cancer Division	CRR-0018 - Unsuitable environment of care (Renal Unit, Lanesborough OPD) - risk of premises closure, prosecution, fire
RHO-MC23 - D1	Unsuitable environment of care in Knightsbridge Wing (Renal department)	11/02/2013	Bleasdale*, Robert	Health & safety risks to patients/staff/trust due to unsuitable environment of care in Knightsbridge Wing infrastructure	4. Major	4. Likely	16	Extreme	Medicine & Cardiovascular Division	CRR-0018 - Unsuitable environment of care (Renal Unit, Lanesborough OPD) - risk of premises closure, prosecution, fire
TA-1148	Turnaround target	01/11/2016	Paice, Jane	The Turnaround target of £42.7m may not be achieved in-year causing a more significant deficit for the Trust	5. Catastrophic	4. Likely	20	Extreme	Corporate Directorate Turnaround	CRR-0022 - Insufficient management capacity or capability to deliver turnaround programme
TA-1150	Lack of appetite or control to make significant changes	01/11/2016	Paice,	The Trust lacks the appetite or control to make some of the significant changes required to address the challenge	4. Major	4. Likely	16	Extreme	Corporate Directorate Turnaround	CRR-0022 - Insufficient management capacity or capability to deliver turnaround programme
TA-1153	Financial savings	01/10/2016	Paice, Jane	Financial savings (i.e. post removed from establishment) are not fully removed from the budget when signed, instead they are reviewed on a monthly basis and are reported upon subjective review of the financial position.	4. Major	4. Likely	16	Extreme	Corporate Directorate Turnaround	CRR-0022 - Insufficient management capacity or capability to deliver turnaround programme

REPORT TO THE BOARD FROM: Audit Committee

COMMITTEE CHAIR: Sarah Wilton

DATE OF COMMITTEE MEETING: 18.01.17

REPORT TO THE BOARD FROM THE AUDIT COMMITTEE MEETING ON 18 JANUARY 2017

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

ACTION TRACKER

1. Considerable progress has now been made, driven by our newly appointed internal audit firm TIAA, to confirming that actions arising from the previous auditors' Internal Audits have been or are being progressed by the Trust. Just nine actions are now outstanding, mostly in relation to estates and SWLP. We stressed the importance of implementing all these outstanding actions, together with outstanding actions arising from the Internal Audits completed since April 2016 by TIAA. The Committee noted that delays have unfortunately arisen as a result of recent changes in interim executive responsibilities, and requested that the Executive address the action tracker robustly with at least quarterly oversight from EMT, to be led by the Corporate Secretary and Head of Corporate Governance and the Director of Finance.

   We ask the Board to endorse this approach which will require the Executive to co-operate with TIAA, to take responsibility individually and severally as an Executive team for progressing and implementing agreed actions arising from Internal Audits and to report back progress to the Audit Committee in a timely and regular manner. We will report on progress in our Annual Report to the Board.

INTERNAL AUDIT

2. The Audit Committee received an Internal Audit Report on the Use of Bank Staff which received reasonable assurance.

3. The Audit Committee received an Internal Audit Report on Core Financial Systems which received only limited assurance, with two of the recommendations not accepted. The Committee was very concerned by the Report's conclusions, since several of the issues had been raised in the PwC report in 2015. The CFO provided assurance that the agreed actions are being implemented but the Committee has asked for a full update at its next meeting, as the improvements required in relation to accounting records, aged debt monitoring and compliance by budget holders must be implemented urgently.

4. The Committee received an Internal Audit Report on Budget Maturity and Financial Reporting: this too received only limited assurance. Key findings were that strategic planning and budget setting started later than scheduled, the transformation programme has not realised the anticipated savings, the recovery plans lack detail and timelines and are still considered unrealistic and unachievable and that the high turnover of interim executives and those involved in the budget setting process has not only impacted on the financial resources of the Trust, but also a loss of corporate memory. The CFO has provided assurance that the recommended actions will be completed and have been reflected in the current budget setting process for 2017/18, but again the Audit Committee has asked for a further update at its next meeting.

5. The Audit Committee was also briefed on an operational, rather than assurance, Internal Audit of Mortuary Services which had been completed at the request of the CFO. The

Committee was assured that appropriate follow-up action had been taken to deal with the matters arising.

6. The Committee reviewed the Internal Audit Plan for 2017/18, which had been considered by EMT and the Board, and also by the Director of Risk Management in relation to the Trust corporate risk register and board assurance framework. Audit Committee accepted the Plan as presented subject to adding an audit of MAST compliance, inclusion of a review of the system to manage FOIs and also confirming the executive lead for each audit area.

EXTERNAL AUDIT

7. The areas of significant risk identified so far, largely the same as for 2015/16, were discussed in some detail. On the basis of audit work completed so far, the External Auditors reported that although there is still much improvement required, they are more comfortable with the capacity and capability of the finance function.

8. The detailed year end timetable for completion of the external audit and preparation and approval of the annual report and accounts will be brought to the March Audit Committee for approval.

COUNTER FRAUD

9. The Committee had received an update from the CFO on one case in a private meeting prior to the Audit Committee. The progress on other matters was discussed and noted. Counter Fraud staff confirmed that, where required, the relevant professional bodies had been notified of cases in progress.

CYBER SECURITY

10. The CIO attended Audit Committee to provide an update on progress against the Internal Audit Cyber Security Review completed in September 2016. The Committee was assured that considerable progress has been made, and that work to mitigate the most significant risks has been prioritised. Nevertheless the Committee is still concerned to note the severity of IT risks to the Trust.

AUDIT COMMITTEE: TERMS OF REFERENCE

11. The Committee reviewed and agreed its revised Terms of Reference, and noted that reports of losses and special compensation, the Trust Scheme of Delegation and other matters would be reported to the next Committee meeting, together with the results of the Committee evaluation, to ensure that all requirements of the Committee's terms of reference have been met during 2016/17.

Sarah Wilton
Chair: Audit Committee
January 2017