Trust Board Meeting

Date and Time: Thursday 9 March 2017, 10:00 – 12:00
Venue: Boardroom H2.5, 2nd Floor, Hunter Wing

PATIENT VIDEO
Sara Watson is receiving care from a number of specialities in the Trust, both hospital and community based. In her video she shares her experiences of a number of these services.

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 09.02.17**	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**	**Quality Improvement Plan**	Assure	HoG	Paper
	2.2	**Performance & Quality Report**	Review	COO/CN	Paper
	2.3	**Renal Services Update - Renal Dialysis Trailer Location**	Assure	MD	Paper
	2.4	**Smoke Free Trust Paper**	Update	GMF	Paper
FINANCE					
11:10	**3.1**	**Month 10 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**	Inform	HRAB	Paper
GOVERNANCE & RISK					
11:40	**5.1**	**Corporate Risk Report**	Review	MD	Paper
CLOSING ADMINISTRATION					
11:55	**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. Strategy Approval (April 2017) • Long Term Trust Strategy • Clinical Strategy • Estates Strategy i. Update on Leadership Development (April 2017) ii. Communications Strategy and Annual Plan (April 2017) iii. Committee Terms of Reference & Annual Plan's 2017-18 (April 2017) iv. Review of Trust's Insurance Arrangements (April 2017) v. Lanesborough Wing, Electrical HV/LV Infrastructure Upgrade (April 2017) vi. Update on Outpatients Programme and Business Case (May 2017) vii. IPC Annual Report (June 2017) viii. Safeguarding Report (June 2017) ix. Evaluation of Overseas Visitors and Migrant Cost Recovery Pilot (June 2017)		-	-
	6.5	**Any Other Business**	-	Chair	-
	6.6	**Reflection on Meeting**	-	All	Oral
12:00		**Close**			

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

Date and Time of Next Meeting: Thursday 6 April 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
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
Larry Murphy	Chief Information Officer	CIO
Marie-Noelle Orzel	Improvement Director	ID
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 2017-18 (Thursday's)		
06.04.17 10:00 – 13:00	04.05.17 10:00 – 13:00	08.06.17 10:00 – 13:00
06.07.17 10:00 – 13:00	10.08.17 10:00 – 13:00	07.09.17 10:00 – 13:00
05.10.17 10:00 – 13:00	09.11.17 10:00 – 13:00	07.12.17 10:00 – 13:00

11.01.18 10:00 – 13:00	08.02.18 10:00 – 13:00	08.03.18 10:00 – 13:00

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

Name	Title	Initials
PRESENT		
Sir David Henshaw	Non-Executive Director (Chair)	
Simon Mackenzie	Chief Executive	CEO
Ann Beasley	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
Avey Bhatia	Chief Nurse	CN
Margaret Pratt	Chief Financial Officer	CFO
Andy Rhodes	Medical Director	MD
IN ATTENDANCE		
Thomas Saltiel	Associate Non-Executive Director	NED
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
Diana Lacey	Elective Care (Data Quality) Recovery Programme Director	ECRPD
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
APOLOGIES		
Stephen Collier	Non-Executive Director	NED
SECRETARIAT		
Fiona Barr	Interim Corporate Secretary & Head of Corporate Governance	Co Sec

STAFF STORY
Tom Howard, who manages the Trust's Central Booking Service (CBS), presented the first staff story that the Board had received. He explained the work that he had done in CBS, particularly in dealing with a number of long standing issues which had made a significant impact on staff morale and the responsiveness of the service. The Board was very impressed with the manner in Tom tackled the problems he had found and how his work had improved staff relations. Tom had used the Trust's Listening into Action Team which is an innovative listening and signposting service for staff.

1. OPENING ADMINISTRATION

1A Welcome and Apologies

1.1	The Chair opened the meeting and welcomed everyone. He welcomed Avey Bhatia, the new Chief Nurse who had joined the Trust on a year's secondment. On behalf of the Board, the Chair also thanked Paul Moore, the Director of Quality Governance, who was leaving the Trust on 10.02.17.

1.2	The apologies were as set out above.
1B Declarations of Interest	
1.3	The Chairman asked for declarations of interest. None were made.
1C Minutes of Meeting held on 05.01.17	
1.4	These were accepted as a true and accurate record of the meeting held on 05.01.17 subject to amending the dates in 4.8 and 5.6 from March 2016 to March 2017.
1.5	The HRAB requested that the updated report on Leadership Development be presented to the Board meeting in April 2017, rather than March 2017 as this would allow for proposals to be discussed in the Workforce & Education Committee before being presented to the Board. This was agreed.
1D Matters Arising and Action Log	
1.7	The Board received the Action Log and noted in relation to TB.05.01.17/07, Mr Westcott – who had delivered the patient story in the January Board – had already started helping the Trust develop a Vegan diet and better identify healthy foods. The DE&F also updated on steps which were being taken to reduce smoking around the hospital, a matter previously raised by the Lead Governor. He agreed to provide a fuller update at the next meeting.
TB.09.02.17/13	**Update on the Board on measures being taking to reduce smoking around the hospital at the 09.03.17 meeting.** **LEAD: DE&F**
1E Chief Executive's Report	
1.8	The CEO reported on progress with the Quality Improvement Plan (QIP), noting good progress in some areas (medicines management, end of life care and pain management) though there remained a great deal to do. He reminded the Board that the priority was to make improvements for patients, not regulators, though the Care Quality Commission (CQC) would want to see a clear improvement on its return and he welcomed the arrival later that month of Marie-Noelle Orzel, the new Improvement Director. He added that, like all NHS Trusts, St George's was being tasked to do more with less going forward - which meant developing ambitious cost improvement programmes for 2017/18. This would be challenging and Divisional teams were actively involved in planning for next year's budgets and where savings could be made. The Trust continued to project a year-end deficit.
1.9	The NEDs asked about a recent media story where a mother lost her baby. This had been handled as a Serious Untoward Incident and the Trust had admitted liability though had learned lessons from what had happened.
1E Chair's Report	
1.8	The Chair reflected that the NHS was operating in a tough environment where levels of demand were unprecedented – though he was seeing a picture of improvement at St George's and expressed thanks to the Executive and staff for all their hard work and support. He felt that a number of improvements had been made since the CQC visit, and continued to be made, particularly in terms of productivity and governance, though he agreed with the CEO that there was still more to do and the Trust's financial position remained a challenge.

2. PATIENT SAFETY, QUALITY AND PERFORMANCE	
2A Emerging Outpatient Strategy	
2.1	Steve Sewell, Programme Director - Outpatient Transformation & Dr Oliver Foster, Outpatient Redesign Clinical Lead, attended to update the Board on the progress of Outpatient Programme since September 2016. Since its launch, the Programme had delivered a wide range of improvements, including aligning support services with clinical services, better pathway design and engagement of GPs, and had also contributed around £2m towards the Trust's 2016-17 cost improvement target.
2.2	The Board considered the split of services within hospital and community settings, noting that a number of procedures remained in an acute setting, as a result of custom and practice, when they could be delivered closer to the patient, and probably with more convenience, in a primary care or community setting. The Chair urged the Board not to wait for the Sustainability and Transformation Plan to deliver changes in the local health economy but instead challenge current arrangements and encourage the transfer of non-acute services into the community for the direct benefit of patients. The Board also briefly discussed processes for follow-up appointments, noting that there was scope to reduce the number of follow-up appointments though this had to be informed by more analysis.
2.3	The Board noted progress and looked forward to further updates as the Programme developed.
2B Quality Improvement Plan	
2.4	The DQG led the Board through progress on the QIP, noting that at 30.01.17 • 24.5% of actions had been completed (Blue) (16.8% in December) • 66% of actions were on target (Green) (78.0% in December) • 4.1% were at risk of breaching (Amber) (3.2% in December) • 5.4% had breached their target date for implementation (Red) (2% in December).
2.5	Whilst four workstreams had been rated 'red' overall because of the number of overdue actions, the responsible Executive Director was aware and the QIP Board and Quality Committee had been briefed. The DQG undertook a detailed review of the reasons for the slippage against actions but noted very good progress with actions in the Estates workstream.
2.6	The Board was advised that, on departure, the DQG's workload would be shared between the CN and MD, with the interim Head of Governance looking after the QIP. However as this role was critical to maintain the focus on quality improvements, a substantive DQG would be recruited, reporting to the CN.
2.7	The Board received the report noting the slippage against a number of actions and remedial action being taken.
2C Performance & Quality Report	
2.8	The COO led the Board through the Performance Report advising that it had been challenging period for all services though elective activity had remained at planned levels despite demand and the introduction of new rotas for clinicians. Performance against the Referral to Treatment (RTT) standard had reduced though proactive measures were being taken to improve data quality, and service managers were closely monitoring lists with patients who had waited in excess of 40 and 52 weeks. RTT performance remained a significant challenge for the Trust and it was influenced by a number of factors. To ensure the Board was fully sighted on these factors it was agreed that the ECRPD would provide a detailed briefing to the Board to ensure there was full

	understanding on the rules and principles, the scale of the backlog as well as progress with the RTT project.
TB.09.02.17/14	**Provide a detailed briefing to the Board to ensure there was full understanding on the rules and principles, the scale of the backlog as well as progress with the RTT project. LEAD: ECRPD**
2.9	The Medical Director introduced the Quality Report emphasizing the importance of responsiveness and timeliness in delivering care and how this was essential to underpin a quality service to patients. Whilst there was some good performance on a number of metrics, eg reduction in Serious Incidents and pressure ulcers, he felt that more work was needed to embed a more responsive approach. The new CN gave her reflections on joining the Trust saying she felt the clinical care was very good and staff were clear about their responsibilities in relation to the QIP.
2.10	The Board received the report.
2D Report from Quality Committee	
2.11	The Chair of the Quality Committee reported back from the meeting on 25.01.17 and advised that he was not assured in a number of areas, including complaints, increase in CDiff and compliance with the World Health Organisation (WHO) checklist, though he was assured that the interim Head of Governance was conducting a comprehensive review of the Trust's complaints handling systems to improve the quality and timeliness of the responses provided.
2.12	There was a discussion about the further rollout or electronic prescribing which had been raised at the Quality Committee the CEO confirmed that the Trust could not proceed further until there had been a significant improvement in the stability of the IT infrastructure so that it could reliably support an e-prescribing application.
2.13	The NEDs indicated that they wished to see a number of additional metrics included in the Quality Report and the CEO advised that the Executive was reviewing both the format and content of the Quality & Performance Report and would ensure that NEDs were involved so their views could be captured.
TB.09.02.17/15	**Involve the NEDs in the development of the new Performance and Quality Report. LEAD: COO & MD**
2.14	The Board received the report from the Quality Committee on 25.01.17.
2E Elective Care Recovery	
2.15	The ECRPD explained that a comprehensive review of the systems and processes that manage patients on the elective care pathway which identified multiple issues at every stage of the elective care pathway which posed a significant risk to the quality of care and safety of patients. Specifically, the Trust had a high number of 'open' patient records on its Patient Administration Systems (PAS) dating back to at 2014 and possibly earlier and at the moment, though the Trust could not confirm if these patients had been treated or were at the correct stage of their care pathway.
2.16	A project was now underway to validate and correct historic patient records which would be delivered in three phases. Approval had just been received from NHS Improvement to commence phase one of the project using an external supplier to check records of those patients who were most at risk of clinical harm due to their length of wait; this phase would take about five months to complete.
2.17	The scale of the problem was considered, particularly its complexity as a result of a range factors involved, including data quality, chronology of booking patients, and how patient lists were managed. The Board was clear that this needed urgent resolution and patient safety was the overriding priority. Given the volume of records to be corrected,

	the Trust was unlikely to return to national reporting in 2018-19 (it was suspended in July 2016).
2.18	The Board noted the progress being made and looked forward to the detailed briefing, discussed earlier, to fully understand the issues.
2F Local Escalation Plan	
2.19	In line with the guidance issued by NHS England in October 2016, *Operational Pressures – Escalation Levels Framework,* the Trust has to have a Local Escalation Plan which is Board approved. The draft Local Escalation Plan was withdrawn from the agenda as further work was required and it was agreed that approval would be deferred to the CEO and Chair though the Plan would be circulated to the whole Board.
TB.09.02.17/16	**Updated Local Escalation Plan to be provided to the Board.** **LEAD: COO**
3. FINANCE	
3A Month 9 Finance Report	
3.1	The CFO led the Board through the month 9 financial position, reporting a good position on income, which was ahead of plan for elective services; there had also been an improvement in pay expenditure, including agency costs. Following discussions with Board members and NHS Improvement (NHSI), the Trust was working to an updated year-end deficit of £71m. A key part of the revised position was the recycling of £5m fines though the Trust was reliant on NHSI's best endeavours to achieve this. The CFO, DE&F and CIO were confident that planned levels of capital expenditure would be realised before the year-end though the Board noted that the Trust still had not received formal approval from NHSI for emergency capital and was proceeding at risk. The CFO also reported a technical adjustment relating to a one-off opportunity this year to write off buildings beyond use; this would increase the deficit by £4.8m though would be returned as an impairment cost. Management were now actively involved in producing the budgets for 2017-18 which would be reported to the Board over the coming weeks.
3.2	The Board received the report and noted the Trust's current financial position.
3B Report from Finance & Performance Committee	
3.3	As the Chair had not attended the January Finance & Performance Committee meeting, he asked if NED Gillian Norton, who had chaired the meeting in his absence, had anything to report. She explained that the meeting had undertaken a thorough review of the Trust's position on finance and performance and had also received a report recommending that the Trust, in principle, join the South West London Procurement Hub which was agreed.
4. WORKFORCE	
4A Workforce Performance Report	
4.1	The HRAB presented the Workforce Report for December 2016 which was taken as read. He particularly focused on the work underway with other trusts in South West London to harmonise bank rates and efforts to move agency staff to the bank. He also reported a significant reduction of 18 to 10 weeks in the "time to hire" since the introduction of Trac.
4.2	The Board noted the workforce performance report and actions outlined within it.

4B Report from the Workforce and Education Committee	
4.3	The Workforce and Education Committee Chair, Gillian Norton, reported that it had been a very positive meeting, with good discussions on leadership, appraisal rates (which were poor) and diversity. She noted that inconsistencies between the Electronic Staff Record and the Trust's financial systems meant records and data quality were poor, making it difficult to reconcile the establishment or produce reliable reports on workforce metrics. She welcomed the investment in the Trust's IT architecture but cautioned that there also needed to be an improvement in the Trust's systems and the processes used by staff to support them.
4C Guardian of Safe Working Report (Q3)	
4.4	The MD presented the report and summarised progress in providing assurance that doctors are safely rostered and enabled to work hours that were safe and compliant with Schedules 3, 4 and 5 of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016. He advised that the report had been considered by the Workforce and Education Committee on 31.01.17. The report explained that, as of 17.01.17, there had 115 exceptions reported, four work schedule reviews had been requested and one fine levied.
4.5	The Trust Board received the report and agreed that the Workforce and Education Committee should continue to review this on behalf of the Board, and report findings to the Board, but that the Board should receive an annual report from the Guardian of Safe Working.
5. GOVERNANCE & RISK	
5A Corporate Risk Report	
5.1	The DQG presented the report which was taken as read.
5B Report from Audit Committee	
5.2	The Chair of the Audit Committee presented the report from the meeting on 18.01.17 which was taken as read. She reported good progress with implementing actions arising from Internal Audit reviews and also highlighted recent reviews undertaken, two of which had only received limited assurance.
6 CLOSING ADMINISTRATION	
6A Questions from Public	
6.1	There were no questions from the public, only a strong commitment from patient representatives that they remain enthusiastic, committed and available to support the Trust. The care and understanding of staff in the Rose Centre was also applauded by a recent user.
6B Any Other Business	
6.2	There were no further items of business, the Chair resolved to move to closed session and ended the meeting.

Date and Time of Next Meeting: Thursday 9 March 2017 Time TBC

Trust Board Public - 09.03.17

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.05.01.17/08	**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.05.01.17/11	**Leadership Development**	Present an updated report on leadership development to the March Board meeting (09.03.17).	~~TB.09.03.17~~	TB.06.04.17	HRAB	Deferred to TB.06.04.17 on advice of the HRAB and as agreed at TB.09.02.17.	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~~	TB.06.04.17	DQG	Review not yet concluded. Item deferred to TB.06.04.17.	Open
TB.09.02.17/13	**Smoking**	Update on the Board on measures being taking to reduce smoking around the hospital at the 09.03.17 meeting.	TB.09.03.17		DE&F	On the agenda for TB.09.03.17.	Propsed for Closure
TB.09.02.17/14	**RTT and Elective Care Recovery Programme**	Provide a detailed briefing to the Board to ensure there was full understanding on the rules and principles, the scale of the backlog as well as progress with the RTT project.	ASAP		ECRPD	Date & time of Board briefing in the process of being agreed.	Open
TB.09.02.17/15	**Perfromance & Quality**	Involve the NEDs in the development of the new Performance and Quality Report.	On Going		COO & MD	New format of Quality & Perfromance report presented on agenda.	Open
TB.09.02.17/16	**Local Escalation Plan**	Updated Local Escalation Plan to be provided to the Board.	Under Development		COO	Currently under development.	Open

2.1**Meeting Title:**	Trust Board		
Date:	9 March 2017	**Agenda No**	**2.1**
Report Title:	Quality Improvement Programme: Progress Report (data to 23 February 2017)		
Sponsor	Paul – Linehan Head of Quality Governance		
Report Authors:	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 23/02/2017 • 25% (n=79) of actions have completed embedded actions (Blue) (24.5% in January) • 63% (n= 199) of actions are on target (Green) (65.4% in December) • 5.0% (n= 16) are at risk of breaching (Amber) (5.5% in December) • 7% (n=22) have breached target date for implementation (Red) (4.7% 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 has been briefed accordingly. An explanation for the slippage is given against each action in the body of this report.		
Recommendation:	The Board of Directors are invited to: 1. note there has been some slippage on planned delivery of the Quality Improvement Plan in February 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 Project Board	**27/02/17**	
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 **Appendix (A) - Review of Gwynne Holford Ward**		

Quality Improvement Programme Update Report: February 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 316 actions. Of those actions: 63%% (n=198) are on track; 25% (n=79) have completed embedded actions; 7% (n=23) have breached the target date for implementation; and 5% (n=16) 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 has been briefed accordingly. An explanation for the slippage is given against each action in the body of this report.

Personalised Care – Exceptions

3.4 The plan for the future development of neurorehabilitation services has been produced by the care group lead and is currently being discussed within the divison. The new Chief Nurse has undertaken a full assessment of the current service delivery on Gwynne Holford ward The new Chief Nurse has undertaken a full assessment of the current service delivery on Gwynne Holford ward to determine whether the services we are delivering today are safe despite ongoing staff challenges in the band 5 nurse cohort. Please see appendix to the QIP report for the Gwynne Holford report

3.5 The Trust made a decision to invest in the purchase of 844 beds with integrated bed rails. These are due to be delivered during March / April 2017. This will simultaneously improve quality, minimise the risk of falls from height, improve comfort for patients and minimise moving and handling risk.

3.6 Significant progress has been made on ensuring there is a fire warden on each shift. A spot audit was carried out on the 17th February 2017 and this looked at the 8 week rota for the wards / clinical areas to see if a fire warden was on duty. 10 rotas out of 31 reviewed did not have one on each shift but staff were being moved to ensure the rota was compliant with this skill set. All nursing staff are absolutely clear about this requirement and training is ongoing to ensure there is sufficient critical mass to ensure cover at all times.

3.7 Infection Prevention Mandatory Training. Overall Trust compliance is 75.65% (against a target of 85%). However it should be noted that the rate for clinical staff compliance is 68.37% and non-clinical 82.93%. This will require a significant drive among divisions and clinical staff to drive this compliance number up. An IPC training role, funded by HE South London has recently been approved. Once appointed this role will focus on hand hygiene and MAST compliance.

Safety Culture - Exceptions

3.8 The appointment of a Radiation Protection Advisor is underway.

3.9 Venous-Thromboembolism prevention training. Medical staff compliance rate at 58% against a target of 85%.

3.10 Deteriorating patient. The roll out of the SAFER bundle is in progress, but recent audit shows inconsistent application. A focused workshop has taken place for clinical staff to improve engagement and further roll out across the Trust.
The management of Early Warning Scores remains a concern across the Trust. A detailed plan for the management and embedding of the key steps; identification, escalation and response of Early Warning Scores, is to be developed and led by the Medical Director.

Governance - Exceptions

3.11 The Board is advised that Executive Director Of Quality Governance is no longer in post. The Director of Governance post has been advertised and Paul Linehan (Head of Governance) will continue with the leadership of the QIP. The QIP Project lead also finishes her contract 28/02/17.

Human Resources – Exceptions

3.12 The Trust continues to rate as ‘red’ the action requiring a reduction by 10% or more in bank and agency expenditure. A deep dive with associated recommendations into the bank and agency processes is expected to be complete the end of March 2017.

3.13 Mandatory and Statutory Training – access to, development of modules and recording of completion are not yet assured. A paper is currently being reviewed for action by the Workforce Committee. The Trust has achieved an overall compliance rate of 82% against a target of 85% for MAST, however it should be noted that resuscitation, infection prevention, VTE and Safeguarding (Level 2) show low levels of compliance. These areas are discussed in the other workstreams.

3.14 Clinical Staff supervision – Further discussion is due to take place between the Director of HR and the CN to ensure nursing supervision is adequately captured and managed within the Trusts future plans for supervision, training and staff development.

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. We await the February flushing report for assurance.

3.16 Installation of UPS in Richmond Ward. This action is not on track. The equipment is in place waiting testing and commissioning. A revised completion date of mid March 2017 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 24 February 2017 where it was confirmed that the CQC would initiate an unannounced inspection of the Trust focused on Section 29A issues prior to the the Trust's full reinspection.

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 S29A requirements and the 'must do' actions to the CQC's satisfaction; 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: Anne O'Connor – Quality Improvement Plan Project Manager
Date: 28/02/2017

Appendix 1 Summary of QIP Workstream Ratings:

QIP Workstream	Total Actions	B	R	A	G	Overall Status	Comments
Personalised Care		24	8	6	61		Risks relate to • Plan for the provision of rehabilitation services for the Trust • MCA/DoLs roll out of audit tool to measure compliance across the Trust. • Overall compliance of infection prevention and control training 75.65% (clinical staff 68.37%) • Fire wardens
Safety Culture		16	5	3	58		Risks relate to: • Compliance with VTE training • Deteriorating patient
Governance		10	0	1	17		• Four of the eight QIP workstreams are currently off track
Human Resources		6	5	5	6		Risks relate to: • Reduction in agency staff to no more than 10% of total pay bill, • MAST training • Clinical supervision
Estates		20	3	0	17		• Water safety management (Pseudomonas) • UPS to Richmond Ward (currently underway) • Completion of environmental work on Paediatric wards to ensure safe for MH patients.
Operations		2	1	1	28		• OPD: answering telephone within SLA of ≥ 95%
H/C Informatics		0	0	0	8		• The 8 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.
Elective Care Recovery							Evidence presented to RTT Board for assurance. Opportunity to provide challenge at the QIP workstream.
Total		**79**	**23**	**16**	**198**	**316**	

Table 1: Summary of BRAG rating by workstream.

Overall workstream BRAG rating

Lead: Title: Head of Governance Paul Linehan							
Reporting Period: (February 2017)	**Action BRAG rating analysis**						
	B	**R**	**A**	**G**	**B/G**	**Active Actions**	**Assurance Actions**
						237	**79**
	79	**23**	**16**	**198**		**Total Actions**	
						316	

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.

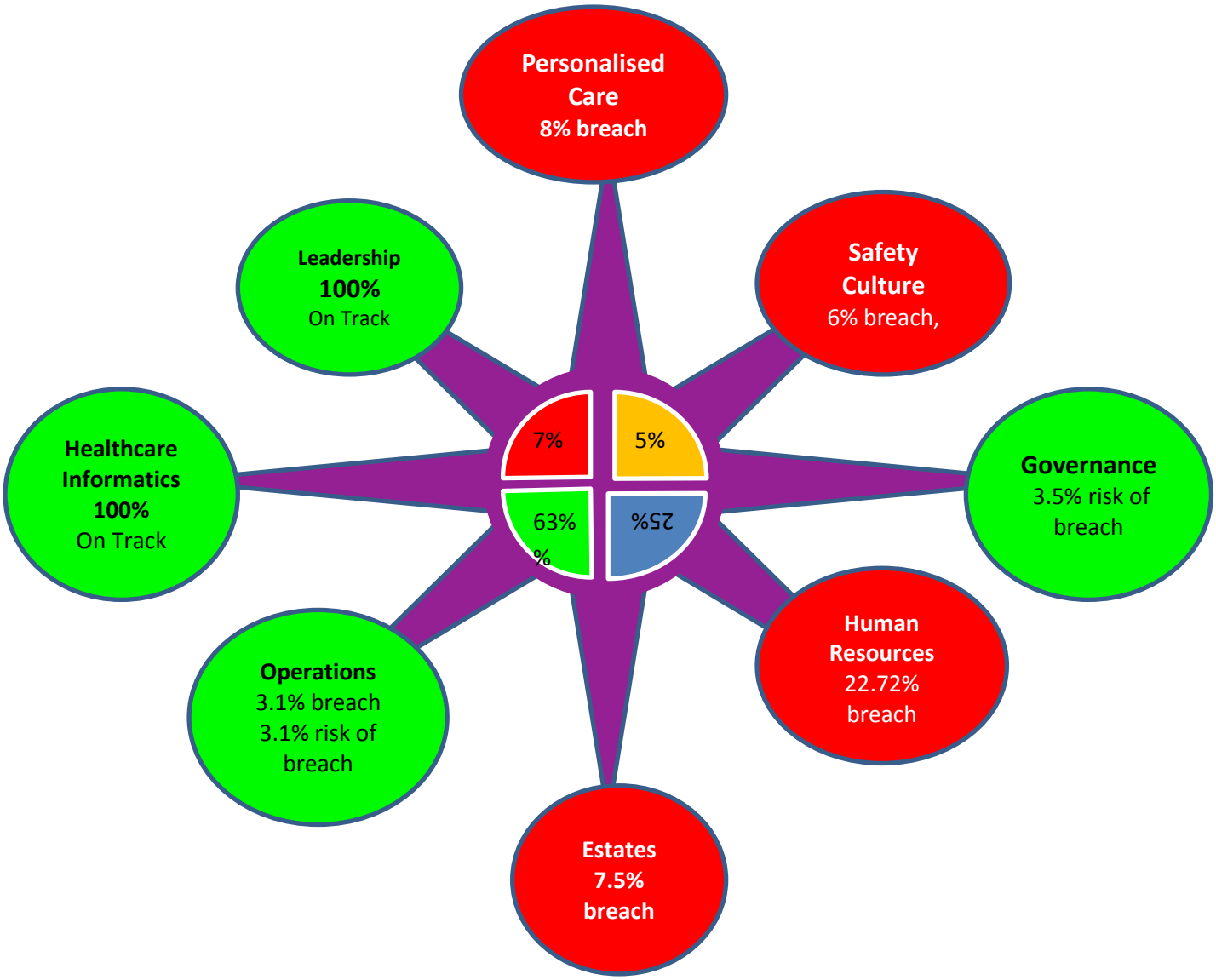
Summary of progress against actions February 2017

Workstream	**Sub Area**	**BRAG analysis**				
		B	**R**	**A**	**G**	**Total by WS**
Personalised care						
1.1	EOLC	8	0	0	9	**17**
1.2	Gwynne Holford	9	1	2	10	**22**
1.3	Bedrails	3	1	1	9	**14**
1.4	MCA/DoLs/Safeguarding	2	1	0	3	**6**
1.5	Infection Prevention	0	2	1	2	**5**
1.6	Pain Management	1	1	0	6	**8**
1.7	Privacy & Dignity	0	1	0	9	**10**
1.8	Dementia Care	0	0	0	10	**10**
1.9	Paediatric Care	1	0	2	3	**6**
1.10	Fire wardens	0	1	0	0	**1**
Total for PC		**24**	**8**	**6**	**61**	**99**
2.Safety Culture						
2.1	Medicines Management	12	1	0	14	**27**
2.2	Radiation Safety	4	2	0	5	**11**
2.3	Deteriorating patient	0	2	3	27	**32**
2.4	WHO safer surgery	0	0	0	6	**6**
2.5	Clinical records security	0	0	0	6	**6**
Total for SC		**16**	**5**	**3**	**58**	**82**

3.Governance	N/A	**10**	**0**	**1**	**17**	**28**
4.Human Resources	N/A	**6**	**5**	**5**	**6**	**22**
5.Estates	N/A	**20**	**3**	**0**	**17**	**40**
6. Operations						
6.1	Patient Access	0	1	0	17	18
6.2	Equipment requirements	1	0	0	1	2
6.3	Community Adult Health Strategy	0	0	0	6	**6**
6.4	Divisional Trust Ops communications	0	0	1	2	**3**
6.5	Health Visiting	1	0	0	2	**3**
Total		**2**	**1**	**1**	**28**	**32**
7. H/C Informatics	N/A	**0**	**0**	**0**	**8**	**8**
8. Leadership	N/A	1	0	0	4	**5**
Total numbers		**79**	**22**	**16**	**199**	**316**

Table 2: Summary of number of actions and rating by workstream.

Overall workstream BRAG rating; Progress as at 23/02/17



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

Appendices 1-8: Workstream Overview Reports

1: Personalised Care Workstream Overview report

QIP Work stream Personalised Care		Executive Lead: Title: Chief Nurse Name: Avey Bhatia						
Overall BRAG	Reporting Period: February 2017	Action BRAG rating analysis						
		B	R	A	G	B/G	Active Actions	Assurance Actions
							75	24
		24	8	6	61		Total Actions in Workstream	
							99	

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**
Gwynne Holford 1.2.1.b Develop a plan for the provision of rehabilitation services	**31/01/2017**		The plan for neurorehabilitation has been produced by the Care Group and is currently being consulted on within the division. This will need to be incorporated into the overall clinical services strategy. The action will no longer be red once it has been submitted for inclusion into the overall strategy.	**31/03/2017**
Bed Rails 1.3.1a Ensure sufficient and appropriate bed stock and bed rails availability	**30/09/2016**		This will go green on delivery of the beds. Purchase of 844 integrated beds (which are also appropriate as paeds beds). Expected delivery in March/April 2017.	**31/03/2017**
1.4.1b MCA/DoIs/Safeguarding Audit against compliance with the MCA, DoLs and safeguarding policy	**31/01/2017**		Audits completed 21/02/17, awaiting results w/c 13/03/2017. Plan is to evaluate the tool and produce a plan to audit across the rest of the Trust.	**13/03/2017**
1.5.3 Infection Prevention 100% IPC MAST Training compliance for clinical staff	**31/01/2017**		• The overall Trust compliance is 75.65%, clinical staff at 68.37% this will require a significant drive among divisions clinical staff to	**31/03/17**

			• drive this compliance number up. • IPC training role being recruited to help improve training compliance (post funded externally).	
Infection Prevention 1.5.5 There are systems in place to ensure medical equipment across the trust is cleaned prior to storage and that the state of cleanliness of equipment returned to the ward is monitored.	**31/01/2017**		The National guidance on cleaning and decontamination will be incorporated in the Trust Decontamination policy. This has not yet been completed. Turned red as missed target date. On track to be completed within next 2 weeks.	**31/03/17**
Pain Management 1.6.2 To audit compliance against Trust policy	**01/02/2017**		January results showed significant improvement. However Medicines was an outlier with only 44% compliance. The pain management team will do focussed work in this area.	**30/04/17**
Privacy, Dignity & Compassion 1.7.1.a Review where the curtains or screens used to screen beds within clinical areas fit correctly.	**31/12/2016**		Currently in the procurement phase with the outcome that the completed project (tracking and curtains provision) will be completed by July due to a phased approach required. The Chief Nurse is assessing the current status and impact that this is having on patient dignity whilst the full programme of lowering the curtain rails is being delivered.	**31/07/17**
Fire Wardens 5.1.6g 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.	**31/07/2016**		Spot audit on 17/02/17 indicated that 21/31 clinical areas had 8 weeks of fire wardens covered per shift. Focus is now on ensuring that those areas not covered increase the number of staff trained where required or review the roster to ensure better cover.	**31/03/17**
Gwynne Holford 1.2.2a To stabilise the workforce on GH	**30/07/2016**		10 beds have been closed to help stabilise staffing levels and manage workload. Stabilised usage of interim and agency staff. On-going recruitment drive for Band 5 and 7. See report appended to QIP	**TBC**
Gwynne Holford 1.2.3 Ensure the environment is safe as is reasonably possible for rehabilitating patients.	**31/10/2016**		Awaiting installation of swipe card system. Low risk of patients absconding after 20.00 when reception staff leave. See report appended to QIP	**TBC**
Bedrails 1.3.2.c Development of an e-learning package to include use of bedrails & MCA	**31/03/2017**		The post for a falls lead has been approved, and has gone out to advert. This individual will have responsibility for developing the e-learning programme.	**31/03/17**
Infection Prevention 1.5.4 Audit compliance with infection control standards	**28/02/2017**		Absolute focus on hand hygiene compliance and 'bare below the elbow' Remove rest of text please	**31/03/17**

with particular emphasis on hand hygiene.				
Paediatrics **1.9.3a** Continued recruitment in substantive posts across all 3 paediatric wards. Until this is possible stabilise usage of agency staff using returning, high calibre nurses.	**31/12/2016**		There has been a slight improvement in paediatric nurse recruitment but it remains difficult to recruit to these posts nationally. 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.	**TBC**
1.9.3b **NNU** Continued recruitment to substantive posts in NNU Until this is possible stabilise usage of agency staff using returning, high calibre staff.	**31/03/2017**		Successful bid for 4 nursery nurses to extend their role to degree level. This will free up nurses to work in high dependency and NICU. Vacancy rate is at 35%	**TBC**

2: Safety Culture Workstream Overview report

QIP Work stream Safety Culture		Executive Lead: Title: Medical Director Name: Andrew Rhodes						
Overall BRAG	Reporting Period: February 2017	Action BRAG rating analysis						
		B	R	A	G	B/G	Active Actions	Assurance Actions
							66	16
		16	5	3	58		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**
Medicine Management 2.1.8.b 85% Compliance with VTE/anticoag training on MAST for all clinical staff. In addition develop bespoke and refresher training.	**31/12/2016**		VTE training model is on MAST but is not part of the core 10 mandatory training bundle. It is currently completed on a one off basis by all medical staff (Current compliance 58%). There have been no nurses or other non medical clinical staff included in VTE training. Discussions to take place with CN re: the cohort of non medical staff requiring VTE Training. A significant piece of work still needs to be done on this action to achieve compliance.	**31/05/17**
Radiation Safety 2.2.2b 'Appoint fulltime Band 8c Radiation Protection Advisor (RPA)	**31/12/2016**		Role approved by VCB. Awaiting appointment	**30/04/17**

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**		Dir. of Estates has approved this role, This role went to VCP on 20/02/2017. Not approved.	
Deteriorating Patient 2.3.1b Embed the improvement of the first wave of the SAFER Bundle roll out (Marnham, Rodney Smith and Heberden)	**12/12/2016**		Slow to embed in the 3 wards. Inconsistent application. Workshop held for staff held in February to improve engagement.	
Deteriorating Patient 2.3.4f Develop & approve a business case for a critical outreach team.	**28/02/2017**		Require re-submission with cost neutral business case.	
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. Likely to be in place end of March – review progress at the end of February. A detailed action plan to improve and embed the key steps within EWS required. MD to lead.	
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. Going into the contract for locums and agency to be required to complete on MAST.	
Deteriorating Patient 2.3.4e Identify and train senior medical, nurse and & HCA champions on each ward to lead implementation of local EWS process	**01/02/2017**		Confident with nursing HCA champion – this role will be completed by the ward manager. Still some uncertainty around Medical champions. For discussions with the Deputy Medial Director	

3. Governance Workstream Overview report

QIP Work stream Governance		Executive Lead: Title: Director of Quality Governance Name: Paul Linehan?						
Overall BRAG	**Reporting Period:** February 2017	**Action BRAG rating analysis**						
		B	**R**	**A**	**G**	**B/G**	**Active Actions**	**Assurance Actions**
							18	**10**
		10	**0**	**1**	**17**		**Total Actions in Workstream**	
							28	

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
3.1.3b Implement a quality improvement plan to meet CQC domains for safe care where workstreams remain on track	31/07/2017		Measured against achievement of the overall QIP. Four of the eight workstreams currently have an overall Red rating. These are: Personalised Care, Safety Culture, Human Resources and Estates.	31/07/17

4. HR Workstream Overview Report

QIP Work stream HR		Executive Lead: Title: Director of Human Resources Name: Mark Gammage						
Overall BRAG	Reporting Period: February 2017	Action BRAG rating analysis						
		B	R	A	G	B/G	Active Actions	Assurance Actions
							17	6
		6	5	5	6		Total Actions in Workstream	
							22	

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
4.1.2e We will develop and launch a values based recruitment programme for all managerial roles	**31/12/2016**		When this is complete, all stages from advert to appraisal will include questions and evaluation around the Trust values for Band 8A and above. Following implementation of this stage other roles will be included	**31/07/27**
4.1.3c Review and improve staff supervision, training and staff development.	**31/01/2017**		Paper prepared which covers current and future plans for education, training and supervision. However it does not adequately outline supervision plans for nursing staff. This requires further discussion and agreement between HR and CN	**31/03/17**
4.1.4c Completion of a deep dive into the bank and agency staff process.	**30/01/2017**		Expecting a report and recommendations at the end of March.	**31/03/17**
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**		Overall there has been 4-5,000 fewer hours/month agency requests since controls implemented, but it still remains high. The number of nursing agency requests has been higher in February 2017.	**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**
4.1.3a All managers at all levels will be required to demonstrate that they have the necessary skills to engage and lead their staff	**31/03/2017**		New leadership development and change strategy being developed to be implemented in 2017. Expected to go to EMT and Board in April / May 2017.	
4.1.5.b Address the low morale among theatre staff and consultant surgeons.	**31/03/2017**		The Staff Survey results are currently embargoed but will be reviewed when the embargo is lifted to see if there is a particular problem in theatres.	
4.1.5d Develop and implement a staff engagement strategy.	**31/03/2017**		A staff engagement strategy is currently being developed; this will need to go to the EMT for approval. It will take a further 3 months before it is implemented.	
4.1.6 Reinvigorate performance management and appraisal system.	**31/03/2017**		A paper has gone to the workforce development committee. Recent appraisal compliance 68% against a target of 90% by 31/03/17. At risk of slippage.	
4.1.8 Compliance with MAST training is 85% for clinical staff (95% for IG).	**31/03/2017**		Overall compliance 82% against 85% threshold. Resus, IPC, VTE and Safe Guarding Children (level 2) low compliance. At risk of slippage. Particular focus needs to be on the above areas	

5. Estates Workstream Overview Report

QIP Work stream Estates		Executive Lead: Title: Director of Estates and Facilities Name: Richard Hancock						
Overall BRAG	**Reporting Period:** February 2017	Action BRAG rating analysis						
		B	**R**	**A**	**G**	**B/G**	**Active Actions**	**Assurance Actions**
							21	**20**
		20	**3**	**0**	**17**	**0**	**Total Actions in Workstream**	
							40	

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
5.1.11e Daily flushing carried out and documented for pseudomonas	30/11/2016		Dialysis is no longer in Knightsbridge (which is shut down and isolated) therefore they are longer flushing. Anticipate this action will turn Green on the 01/03/17 when the monthly flushing report will be available via Mitie.	**31/03/17**
5.1.16 Ensure continuous power supply to ventilated patients on Richmond Ward.	31/12/2016		The UPs is in position. Waiting commissioning and testing of the equipment. Final sign off expected mid March. Can turn green on receipt of final sign off.	**18/03/17**
5.1.22b The paediatric ward environment is safe and suitable for treating and caring for children and young people with mental health conditions.	31/01/2017		Subject to an EMT approval process on the 27/02/17 where it is anticipated that two items will be funded - ceilings in the toilets of FH, ED and Richmond, and the work needed in FH ward.	**TBC**

6. Operations Workstream Overview report

QIP Work stream Operations		Executive Lead: Title: Chief Operating Officer Name: Mark Gordon						
Overall BRAG	Reporting Period: February 2017	Action BRAG rating analysis						
		B	R	A	G	B/G	Active Actions	Assurance Actions
							30	2
		2	1	1	28	0	Total Actions in Workstream	
							32	

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		Further deterioration to 70% against a target of 95%. This is due in part to staff being diverted to manage cancelled OPD clinics. Report to be produced for DCOO for analysis and learning.	**28/02/17**
6.5.1b **Divisional operational information cascade** A standard cascade approach will be developed for all divisions to ensure information priorities are cascaded in a consistent way	31/01/17		The cascade paper has undergone a number of iterations following consultation. It is currently in its final draft and is expected to be finalised first week in March.	**3/03/17**

7. Healthcare Informatics

QIP Work stream Healthcare Informatics		Executive Lead: Title: CIO & SIRO Name: Larry Murphy						
Overall BRAG	**Reporting Period:** February 2017	**Action BRAG rating analysis**						
		B	**R**	**A**	**G**	**B/G**	**Active Actions**	**Assurance Actions**
							8	**0**
		0	**0**	**0**	**8**	**0**	**Total Actions in Workstream**	
							8	

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.

8. Leadership Workstream Overview Report

Leadership Workstream Overview report

QIP Work stream Leadership		Executive Lead: Title: Chief Executive Officer Name: Simon Mackenzie						
Overall BRAG	**Reporting Period:** February 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
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.	Chair has been recruited February 2017 Interviews for a new Chief Executive will take place 09/03/2017. The process for appointing permanent staff to positions on the executive team will begin thereafter. Strategy under development with updated paper to the Board in February 2017.

Appendix A

Review of Gwynne Holford Ward

1) Situation

The Care Quality Commission (CQC) during their inspection in June 2016 found significant patient safety and staffing concerns on Gwynne Holford Ward. The Trust took prompt action to close 10 beds, change the way in which patients were managed and strengthened management support.

There are a number of actions within the Quality Improvement Plan (QIP) that relate to Gwynne Holford. As the new Chief Nurse and Director of Infection Prevention & Control it was important that I assure myself of the current status of the ward in terms of progress made against the QIP and an overall assessment as to whether or not patients are receiving safe and effective care.

2) Background

St George's University Hospital NHS Foundation Trust's provides specialist neurorehabilitation services that are not available at other hospitals across Southwest London or the Home Counties. St George's provides these services at St George's Hospital in Tooting and Queen Mary's Hospital, Roehampton. Gwynne Holford ward currently has 36 open beds (10 used for amputee patient rehabilitation, 16 beds are level 1 and 10 beds are for level 2 rehabilitation). The average length of stay is 12 weeks with a pre-determined rehabilitation programme for each patient.

When the CQC undertook it's inspection of the services provided by St George's Hospital's Community Health Inpatient Services, of which Gwynne Holford is part in June 2016 it received and overall rating of 'Inadequate'.

The key concerns highlighted were:

- Patient safety which was compromised by the challenges faced in managing patients across two floors
- Staff shortages and reported staff feeling stressed
- Poor practice with the implementation of Deprivation of liberty safeguards regulations (DoLs)

3) Assessment

Through the QIP monitoring process there is evidence of numerous actions that have been taken in response to the CQC's findings. These include the immediate closure of 10 beds reducing the current bed base to 36 which has facilitated a change in the way patients are managed across a single floor. Whilst there has been progress against the QIP timelines, there still remains a number of outstanding actions and these include:

- Recruitment to staffing establishment
- Agreeing the strategy that will underpin the future delivery of St George's neurorehabilitation services.

Recognising the continued recruitment challenges, an assessment was completed to understand what, if any impact, the continued vacancies were having on the ward's ability to deliver acceptable patient safety and patient experience standard as well as the continued impact on staff well being

To gain robust assurance the assessment process reviewed a range of quality indicators pulled from central databases and crossed checked where relevant with local records. These included (see Appendix 1 for full detail):

- Staff appraisals
- Mandatory and statutory training records for staff
- Patient safety and experience data including: pressure ulcer & falls rates, medication errors, DATIX incidents, patient experience data, complaints, medication audit data and Infection Prevention & Control compliance
- Review of Healthwatch 'Enter and View' visit undertaken on 14 December 2016 report published February 2017
- Review of Pharmacy pilot in administering patient medication (3 month pilot) and therapy roles to support nursing care

As well as above the following was undertaken;

- Assessment of patient day to day management on and off the ward in terms of care and rehabilitation and access to facilities
- Review of the management of patient records
- Review of the administration of patient medication
- Sought views of multi professional staff, patients and relatives on the ward at the time of the assessment
- Assessment of staff understanding of Mental Capacity Act and Deprivation of Liberty Safeguards and how these were assessed and documented
- Interviews with Acting Ward Sister and Matron

Current establishment

At the time of the CQC inspection there was a 50% vacancy factor within the nursing establishment. Coupled with the fact that patients were being managed across 2 floors this put significant stress on staff and compromised patient safety particularly in relation to medication administration. Since the CQC visit the agreed establishment has been altered in line with the reduction in beds. Table 1 outlines the current vacancies against the current establishment.

Table 1

Role and band	Establishment (for current bed base)	In post WTE	Vacant WTE	Comments
Head of Nursing band 8b		Vacant since January 2017		Post out to advert
Matron band	1 WTE	1	0	Based on Ward full time In post Dee

Role and band	Establishment (for current bed base)	In post WTE	Vacant WTE	Comments
8a				Kapfunde
Ward Sister / Charge Nurse Band 7	1 WTE	0	1	Out to advert currently Post being covered by Catherine Chambers who is the substantive practice educator for GH (currently covering both roles)
Senior Staff Nurse band 6	6 WTE	5	1	1 WTE being interviewed 28/2/17
Staff nurse band 5	15.5 WTE	8	7.5	In pipeline 2 WTE due to commence within next 6 weeks plus see therapy line Two agency nurses on rota since July 2016
Healthcare assistants band 2 / neuro rehab assistants	21.5 WTE	15.5	6	Vacancies but all recruited and are commencing employment over next 4-6 weeks
Activities coordinators band 2	2 WTE	0	2	
Therapy roles Band 5/6	2 WTE	2	0	Support and work with nursing staff delivering hands on care especially during busy times
Housekeeper band	1WTE	0	1	At Vacancy Control Panel for approval
Ward Clerk Mon-Sat	2WTE	0	2	
Pharmacy led drug administration band 6	1WTE	0	1	Was done as a trial and has been effective so current plan is to continue with this role
TOTAL	53 WTE	31.5	21.5	9 WTE starting over next few weeks reducing vacancy to 12.5

The above demonstrates an ongoing 23% vacancy rate that impacts particularly on the Band 5 complement. This indicates that further work needs to be done. In mitigation there are 2 band 5 agency nurses who have been working regular agency shifts since July 2016 and who are very much part of the team and familiar with the ward processes and patient group. The risk is further mitigated by the additional therapy and pharmacy roles on the ward which assist with drug administration as well as hands on nursing care. There are also the activities coordinators within the establishment whom provide the stimulation through various activities that the patients need.

The ward is further supported by a lead therapist and 1 WTE Clinical Nurse Specialist in Neurorehabilitation who spends most of her time on Gwynne Holford. There is also a band 6 0.75 WTE discharge coordinator dedicated to supporting complex discharges.

The **trained nurse to patient ratio** during the day is 1:9 and 1:12 at night and this should now be reviewed in the context of the various other supporting roles.

The lead Consultant for the ward is Dr Sancho Wong who is also the Care Group Lead. There is also a dedicated Neuro psychiatrist – Dr Mike Dilley.Having visited the ward there is clear evidence of excellent multi professional team working on the ward.

The other roles that remain vacant at present are the Head of Nursing for Neurosciences and the Practice Educator post (due to secondment of current postholder into Ward Sister post).

Staff Concerns

The nursing staff on the ward raised the following concerns:

- No medical cover out of hours but they were clear on the procedure of calling 999 if a patient became unwell and needed transfer to St George's hospital

No other concerns were raised by staff on the ward. They stated that since the 10 beds were closed and patients were being cared for on one floor as opposed to over 2 floors the pressures had been relieved. They were proud of the care they were delivering. One Health Care Assistant gave an example of how they worked as a team by creating a WhatsApp group which they used to support each and that it was working really well.

Quality Indicators:

The Quality indicators are detailed in appendix 1.

The current appraisal rate is 79% (although stated as 66% on the central database). There are 7 appraisals outstanding all of whom have dates. The overall appraisal rate will need to be addressed

There have been no formal complaints received since April 2016. The main issue raised through the Friends and Family Test is noise at night with only a 50% positive score.

The table below details the number of falls per month and is compared to Allingham ward (medical ward) and Thomas Young (neurorehabilitation ward at St George's Hospital.

Table 2: Falls per month by ward

Ward	April 16	May 16	June 16	July 16	Aug 16	Sept16	Oct 16	Nov 16	Dec 16	Jan 17	Total
Gwynne Holford 36 beds	7	9	4	6	7	6	4	4	7	9	63
Thomas Young 26 beds	7	9	5	1	7	4	7	4	8	4	72
Allingham 24 beds	10	7	5	10	8	10	8	5	8	8	79

Whilst we should not be complacent, the above data demonstrates that Gwynne Holford has a lower number of falls than Thomas Young and Allingham with 10/12 additional beds respectively. I am further assured to note that none of the falls on Gwynne Holford have resulted in moderate or above harm. They were all assessed as having caused no or minor harm. This does not mean that further work should be considered to further reduce the risk of patient falls.

Gwynne Holford has reported no grade 3 or 4 pressures ulcers since January 2016 (haven't reviewed data further back than this). Since April 16 Gwynne Holford has had 5 grade 2 pressures ulcers. This compares with Thomas Young ward which has reported 5 pressure ulcers and Allingham ward which has reported 16 pressure ulcers. In view of these numbers I will further review the practices on both Allingham and Thomas Young ward but I am pleased to note that Gwynne Holford is not an adverse outlier.

Hand hygiene compliance on Gwynne Holford was 100% in November 2016, 45% in December and 95% in January 2017. In December there was an issue with one particular member of staff which has now been addressed.

MAST training compliance is generally good with one particular outlier which is Basic Life Support compliance, this need to be addressed urgently.

The DATIX incidents are also detailed in appendix 1. The incidents related to staff violence and aggression is being further reviewed to understand the detail. I have requested a briefing from DDNG to further understand the causes.

MCA / DoLs

The Matron and Ward Manager were asked to describe to process in place for MCA assessments and DoLs applications. A multi professional approach was described with both the doctors and Matron undertaking MCA assessments. The DoLs applications were led by the medical staff with input from the MDT.

Healthwatch Richmond visit 14 December 2016

Healthwatch undertook an 'Enter and View' visit and have published a report which has just been received. The report doesn't raise any concerns in relation to patient safety or care. The overall view of Healthwatch Richmond was that the *"care they observed was of a high standard, the ward was clean and well-kept and patients looked well cared for". There appeared to be enough staff on the ward to respond to patients' needs and the patients overall view of the staff and the care they were receiving was very positive.*

Staff feedback

Staff focus groups have been held in December 2016 and there are regular fortnightly staff meetings which staff spoke very positively about. They talked about the staff feedback box that was available to them and that they had clinical supervision every two weeks. They knew how to raise concerns and stated they felt comfortable doing so.

Recommendations and next steps

- Increase compliance levels with Basic Life Support training and consider other training needs of staff in managing deteriorating patients
- Risk assessment of out of hours response to deteriorating patients and clinical staff skill set to manage these situations
- Review whether additional resource needs to be secured for Practice Educator role
- The Neurorehabilitation strategy has been written but not yet consulted on and thus needs to be formally considered within the division and then put out for wider consultation
- Continued focussed effort to fill all vacancies
- Determine long term future following 3 month pilot of pharmacy drug administrator role
- Reduce noise levels at night
- Continued support for Matron and Ward Manager by Directorate and Divisional Management Teams
- Chief Nurse to support and work with the teams in working through the above recommendations
- **Full quality review to be repeated in 6-8 weeks' time**

4) Summary

Based on the information received and from my visit I am assured that despite the ongoing challenges faced on Gwynne Holford Ward, staff are able to deliver safe and effective care. There is good evidence of a workforce that is working well together as a multi professional team. Although vacancies remain particularly at band 5 level there is sufficient mitigation in place to safeguard patient safety and experience. The most significant improvement has been achieved by implementing the change to manage patients on one floor as opposed to previously managing patients across 2 floors, the reduction in bed base (closure of 10 beds) and focus on patient safety processes by a dedicated and focussed Matron and Acting Ward Sister with multi professional support.

I will continue to work closely with the neurosciences team to deliver the above recommendations and review the recruitment strategy. I intend to benchmark the ward outcomes and quality metrics with similar units in the country and would recommend that the team should aspire to work towards being in the upper quartile on all indicators for its speciality. Once the staffing levels have stablished the plan should be to incrementally open the closed beds.

This review was supported by Helene Anderson, Divisional Director of Nursing and Governance for Neurosciences and Stephanie Sweeny, Head of Nursing for Surgery.

I would like to thank all the staff who I had to opportunity to speak to and a particular acknowledgment of Acting Ward Sister Catherine and Matron Dee for all their hard work and leadership.

Report author: Avey Bhatia, Chief Nurse and Director of Infection Prevention & Control, 1st March 2017

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality and Performance Report
Trust Board

Board Meeting – 9 March 2017
Reporting period January 2017

Excellence in specialist and community healthcare

Quality and Performance Executive Summary

In this month (page 5)

Compared to last January, this activity in the Trust has been high. We have seen increased activity in non-elective admissions, outpatient consultations, elective and day case procedures. Of note there has been a reduction in GP referrals that may translate through to decreased demand in future months.

Are we safe? (pages 7,8,9)

The Trust is a safe place for patients to be treated, although there are clearly some areas where we could improve:

- Infection control
- There has been 1 Never Event reported in February as a result of a retained swab post cardiac surgery
- There was one medication related Serious Incidents which is currently being investigated

We continue to provide Harm Free care (All Harms) above the national target, and new harms remains above the target and the national average at 98% for January.

Are we effective? (page 6)

Clinical effectiveness as assessed by the HSMR / SHMI is not signalling concern. At a specialty level the mortality signals are tracked and assessed through the mortality monitoring group. We are given assurance that all signals identified as outliers can be fully explained. We are developing mechanisms for tracking avoidable mortality that we will report on in future months.

Are we caring? (pages 10, 11)

Our FFT survey results would suggest that we are caring although we have identified shortcomings in our complaints management performance that we are addressing.

Are we well-led? (pages 21,22

- Our workforce metrics still remain a significant concern in terms of sickness, vacancy rates, appraisal completions and use of agency staff. We remain above the agency cap in terms of spend and are reviewing staffing establishments and HR processes to reduce this.
- We remain concerned about staff morale and staff engagement. Early data from the staff survey confirm our suspicions. There is still a lot of work needed to re-engage with our staff and to improve morale. This will be important for is to deliver the challenges in the year ahead.

Executive Summary

Are we responsive? (pages 14-20)

Unplanned Care

Emergency Department – Performance in January decreased compared to December and four hour performance for the month (86.6%) YTD performance is currently 91.84%. Following a very difficult first week in February the final three weeks have shown significant improvement at 92% and we are likely to end the month at just below 92%.

ED attendances are higher compared to the same period last year with increased numbers of medical admissions and high patient acuity levels. This is evidenced by non elective activity for the month of January being 30% above plan.

Planned Care

52 week waiters – 23 reported breaches 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. Current breaches as at the end of February is 41.

As at the end of January elective Inpatient activity was only marginally below plan (-9%, 135 patients) in line with the winter plan to reduce bed occupancy, but this was offset by the increase in day case which is currently 7% above plan.

Diagnostics 6 Week Wait – Diagnostic performance in January fell below national standard and the Trust did not achieve STF Trajectory. In total 372 breaches were reported (94.9% performance) Nearly 70% of the 6 week breaches were within Endoscopy, particular Gastroscopy and Cystoscopy.

A recovery plan is in place.

Cancer

All Standards were met in December with Two Week Wait achieving 93.3% and 62 day performance achieving 85.2%. January's performance wont be confirmed until the final upload on March 6th.

Two Week Wait Standard – performance was 93.3% against a target of 93%, with a high number of breaches within Skin (58% of all breaches). This is a result of capacity pressures due to clinical vacancies. Recruitment is on-going and a recovery plan in place. Performance in all other tumour sites met national standard.

62 Day Standard –Performance increased in December to 85.2% against the target of 85%. The top three reasons contributing to breaches are: Delay in Diagnostics, Late ITT, Complex pathways.

Unvalidated 62 day performance for January is 82.09% with a total of 12 breaches expected .

Trust Overview

Domain	Ref	Theme	Management priority (last month)	Management priority (this month)	Forecast	Briefings
Safe	1.1	Patient Safety Incident Reporting	On Track	On Track	At Risk	There has been 1 Never Event reported in February
	1.2	Patient Safety Harm free care	On Track	On Track	Stable	Harm Free care (All Harms) has dropped below the target this month, however new harms only remains above the target and national average at 98.02% for January
	1.3	Infection control and cleanliness	Moderate	Significant	At risk	C-Difficile 29 cases YTD against target of 31.
Effective	2.1	Mortality Indicators	Excellent	Excellent	Stable	The Trust continues to be below the standard for weekday and weekend Hospital Standard Mortality ratio and also HSCIC
	2.2	Length of Stay	On Track	On Track	Stable	
Caring	3.1	Admitted Patient Experience	Excellent	Excellent	Stable	
	3.2	ED Patient Experience	Excellent	Excellent	Stable	
	3.5	Single Sex Breaches	Excellent	Excellent	Stable	
	3.6	Complaints	Significant	Significant	At Risk	Improved performance in December however remains below target, to be monitored through divisional performance reviews and weekly challenge meetings with complaints
Responsiveness	4.1	ED Access	Significant	Significant	At Risk	ED operational target remains below the national and STP target, however our position remains good against the national picture
	4.2	Elective Care Access	Significant	Significant	At risk	
	4.3	Cancer Access	Moderate	Moderate	Stable	
	4.4	Diagnostic Access	Significant	Significant	At Risk	
	4.5	Bed Capacity and Management	Moderate	Moderate	Stable	
	4.6	Cancelled Operations	Significant	Significant	At risk	
Well Led	5.2	Staff Experience	On Track	On Track	Stable	
	5.3	Workforce Indicators	Significant	Significant	At risk	Division have been requested to set trajectories for MAST and appraisal as we remain below target
	5.4	Safe Staffing	Moderate	Moderate	Improving	
Operational Dependencies	6.1	Activity Volumes	Moderate	Moderate	At Risk	
	6.2	Data Quality	Significant	Significant	At risk	

Scorecard Assessment Key

Management priority

Significant	An externally reported metric is below standard and therefore significant interventions are planned or in progress due to one or more factors
Moderate	An important internal metric is below agreed level and therefore moderate interventions are planned or in progress
Minor	Trends are adverse therefore some interventions are in place or in progress
On Track	All areas are on track
Excellent	Targets consistently met

Forecast

At Risk	Performance expected to worsen by next reporting period
Stable	Performance not expected to change significantly by next reporting period
Improving	Performance expected to improve by next reporting period

In this month

	Jan-17	Compared to last Year	
		Same Month	YTD
The Trust received….			
 Referrals from GP	11,929	-3.5%	-4.12%
 Urgent Cancer Referrals	1,405	-7.4%	10.2%
The Trust treated….			
 ED Attendances	14,057	0.4%	3%
 Non Elective Admissions	4,450	3.5%	10.6%
 Outpatient Attendances	54,778	4.3%	-0.7%
 Day cases	3,205	3.5%	7%
 Elective Inpatients	1,353	4.6%	2%

Trust Key Performance Indicators 2016/17: January 2017 Performance

RESPONSIVENESS

Metric	Standard	YTD	Dec-16	Jan-17	Movement
Referral to Treatment Incomplete	92%		81.70%	77.50%	-4.20%
Referral to Treatment Incomplete 52+ Week Waiters	0		23	41	18.00
Diagnostic waiting times > 6 Weeks	1%		0.98%	0.94%	-0.04%
A&E All Types Monthly Performance	95%	91.9%	89.1%	86.6%	-2.51%
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%	25.00%	11.50%	-13.50%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Nov-16	Dec-16	Movement
62 Day Standard	85%	83.10%	80.00%	85.20%	5.20%
62 Day Screening Standard	90%	92.20%	92.68%	92.70%	0.02%
31 Day Subsequent Drug Standard	98%	100%	98.04%	100.00%	1.96%
31 Day Subsequent Surgery Standard	94%	98.2%	96.0%	96.0%	0.00%
31 Day Standard	96%	97.70%	96.89%	96.60%	-0.29%
Two Week Wait Standard	93%	89.40%	85.71%	93.30%	7.59%
Breast Symptom Two Week Wait Standard	93%	91.60%	94.81%	93.20%	-1.61%

* Cancer Stabdrads reported externally one month in arrears

EFFECTIVENESS

Metric	Standard	YTD	Dec-16	Jan-17	Movement
Hospital Standardised Mortality Ratio (DFI)	100		84.1	84.1	0.0
Hospital Standardised Mortality Ratio - Weekday Emergency	100	0	82.4	82.0	-0.4
Hospital Standardised Mortality Ratio - Weekend Emergency	100	0	86.7	86.4	-0.3
Summary Hospital Mortality Indicator (HSCIC)	100	0	0.88	0.90	0.02
Bed Occupancy - Midnight Count General Beds Only	85%		88.2%	88.2%	0.00
LOS - Elective			4.8	4.4	-0.4
LOS - Non-Elective			4.2	4.2	0.00

CARING

Metric	Standard	YTD	Dec-16	Jan-17	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		95.9%	96.2%	0.27%
A&E Scores - Friends & Family Recommendation Rate	46		82.30%	84.9%	2.60%
Number of complaints			56	85	29.0
Mixed Sex Accommodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	Dec-16	Jan-17	Movement
Clostridium Difficile - Variance from plan	31	29	4	3	-1
MRSA Bacteraemia	0	1	0	0	0
Never Events	0	2	0	0	0
Serious Incidents	0	80	4	8	4
Percentage of Harm Free Care	95%		93.8%	95.5%	1.7%
Medication Errors causing serious harm	0	8	0	1	1
Overdue CAS Alerts	0	1	1	1	0
Maternal Deaths	1	0	0	0	0
VTE Risk Assessment	95%		95.9%	96.6%	0.7%

WELL LED

Metric	Standard	YTD	Dec-16	Jan-17	Movement
Inpatient Response Rate Friends & Family	30%		29.3%	44.7%	15.4%
A&E Response Rate Friends & Family	20%		21.6%	21.3%	-0.3%
NHS Staff recommend Trust as a place to work (Q1 & Q2)	58%		50.0%	37.0%	-13.0%
NHS Staff recommend Trust as a place to receive treatment (Q1 & Q2)	58%		79.0%	73.0%	-6.0%
Trust Turnover Rate	13%		18.1%	18.4%	0.2%
Trust level sickness rate	3.5%		3.6%	4.2%	0.63%
Total Trust Vacancy Rate	11%		15.2%	15.3%	0.1%
% of staff with annual appraisal - Medical	85%		76.31%	81.90%	5.6%
% of staff with annual appraisal - non medical	85%		63.78%	69.59%	5.8%

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.

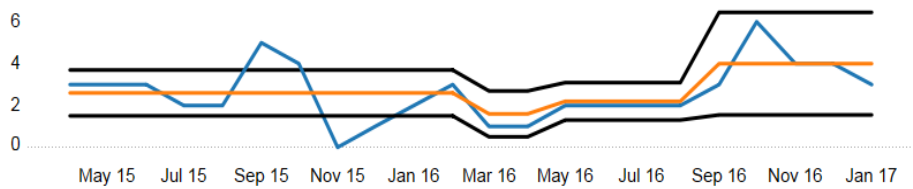
SAFE – Infection Control and Cleanliness

Average LCL Metric Measure UCL

Incidence of c.difficile

National Target applied for the Trust is 31 reported cases per year

Standard: 31 YTD: 29 Dec 16: 4 Jan 17: 3 Movement: ▼-1

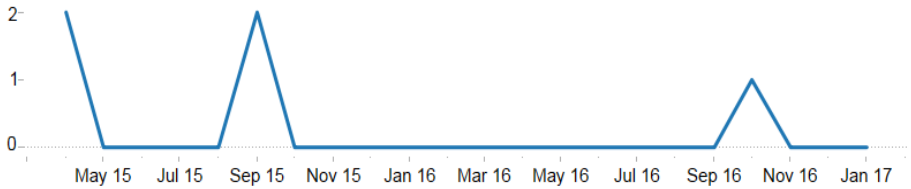


3 reported C-difficile incident reported in January. Incidents occurred in Daly, Heberden and McEntee. YTD this is a total of 29 cases against a target of 31. The trust is at risk of non compliance against this target

Incidence of MRSA

National objective is zero tolerance of avoidable MRSA bacteraemias

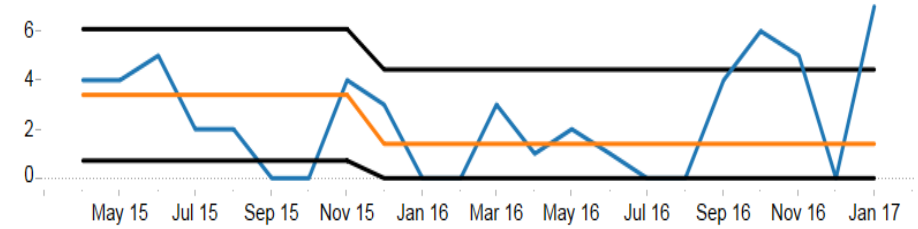
Standard: 0 YTD: 1 Dec 16: 0 Jan 17: 0 Movement: ▸0



There has been a single episode of a Trust-assigned MRSA case YTD , this occurred in October 2016. There were no MRSA incidents reported in January .

MSSA Cases

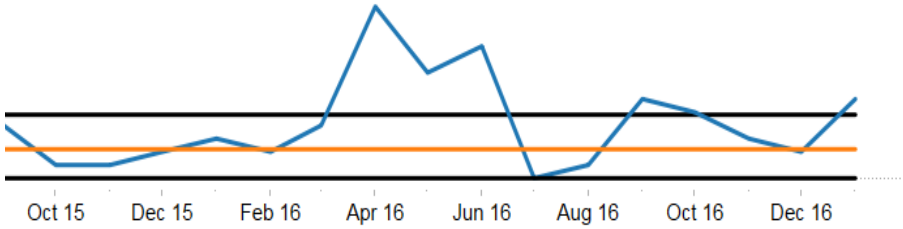
Standard: 0 YTD: 26 Dec 16: 0 Jan 17: 7 Movement: ▲7



There were 7 MSSA cases for the month of January

Incidence of E-Coli

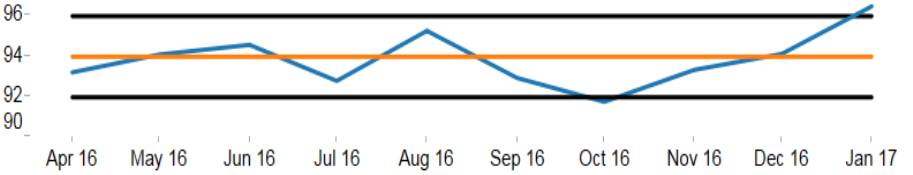
Standard: 0 YTD: 54 Dec 16: 2 Jan 17: 6 Movement: ▲4



6 Incidents of Ecoli were reported in January

Saving Lives Audits - Cleaning and Decontamination

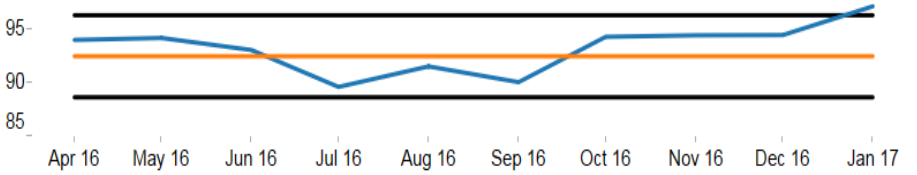
Standard: 100% YTD: N/A Dec 16: 94.04% Jan 17: 96.40% Movement: ▲2.36%



Ensuring that all equipment is correctly cleaned and decontaminated. In January the trust reported 96.40% against a target of 100%

Saving Lives Audits - Hand Hygiene

Standard: 95% YTD: N/A Dec 16: 94.39% Jan 17: 97.08% Movement: ▲2.69%



Ensuring that all staff complete the hand hygiene process correctly. In January the trust reported 97.08% against a target of 95%

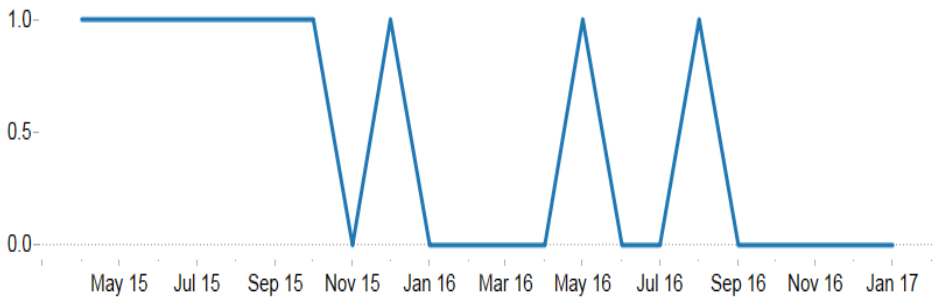
SAFE –Incident Reporting

Average LCL Metric Measure UCL

Never Events

Serious Incidents that are wholly preventable Threshold is 0

Standard: 0 YTD: 0 Dec 16: 0 Jan 17: 0 Movement: ▸0

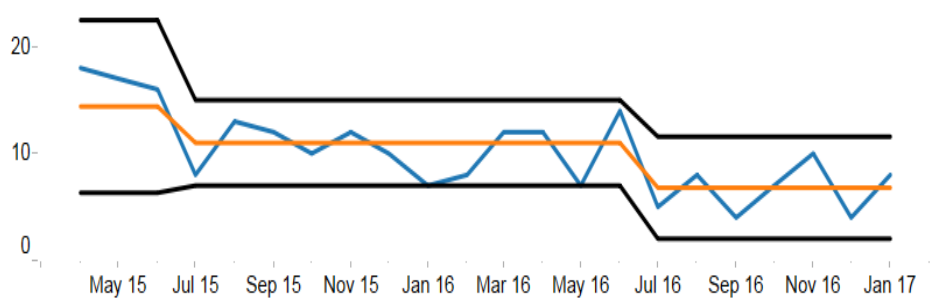


There were no Never Events reported in January . 2 Never Events (wrong site surgery) were declared between Apr – Dec 2016/17, compared with 8 in Apr-Dec the previous year

Serious Incidents

Number of serious incidents reported Threshold is zero

Standard: 0 YTD: 79 Dec 16: 4 Jan 17: 8 Movement: ▲4

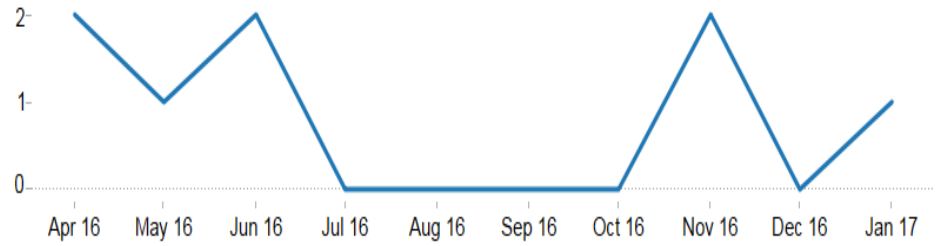


There have been 79 (Sis) declared for the period Apr-Jan 2016/17 which represents . In January there were 8 Sis compared to 4 in December

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

Standard: 0 YTD: 8 Dec 16: 0 Jan 17: 1 Movement: ▲1



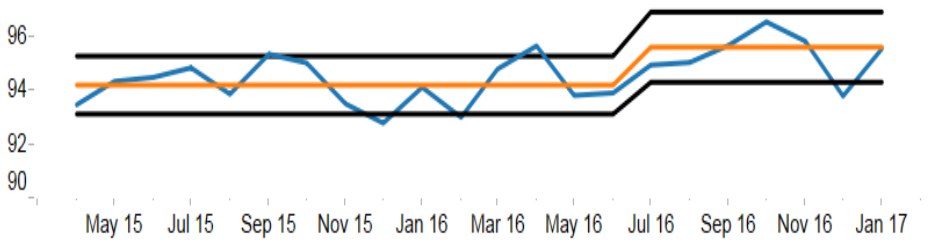
1 medication errors resulting in serious harm was reported in January. There have been a total of 8 in the period April to January 4 of which occurred on wards

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 95%

Standard: 95% YTD: N/A Dec 16: 93.77% Jan 17: 95.53% Movement: ▲1.76%



95.53% of patients received harm free care in January. This meets our target of 95% and is an increase of 1.76% on last month

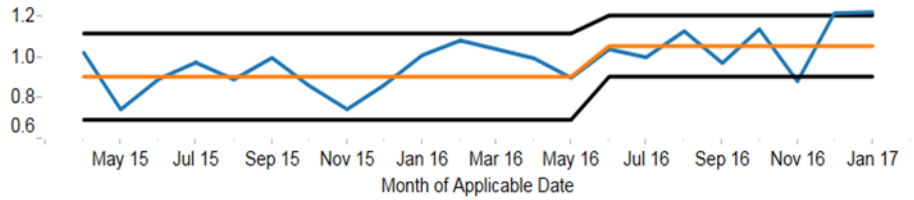
SAFE – Harm Free Care

Average LCL Metric Measure UCL

Falls Per 1000 Bed Days

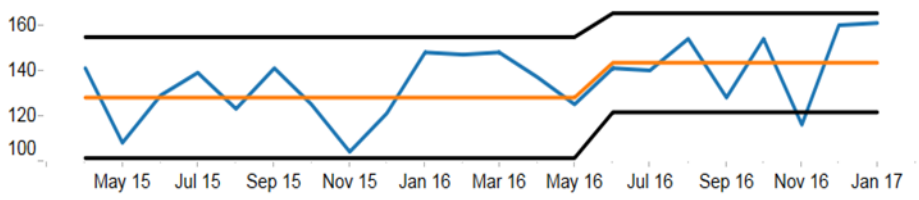
Number of Beds Occupied Per 1000 Bed Days Threshold is 3.1%

Standard: 3.1% YTD: N/A Dec 16: 1.21% Jan 17: 1.22% Movement: ▲0.01%



Total Patient Falls

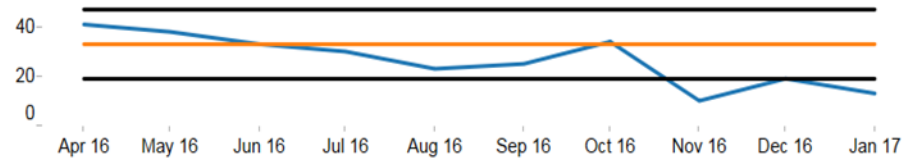
Standard: 0 YTD: 1416 Dec 16: 160 Jan 17: 161 Movement: ▲1



The graph shows a slight increase in the number of falls reported in the month of January. Total falls for the month was 171 (of which 161 occurred on the wards)

Attributable Grade 2 Pressure Ulcers

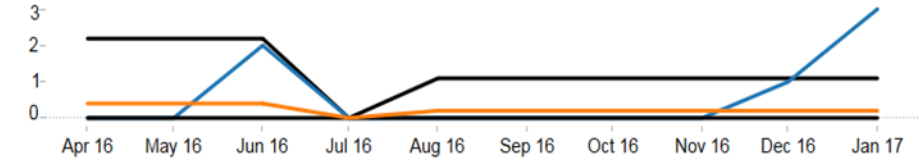
Standard: 0 YTD: 266 Dec 16: 19 Jan 17: 13 Movement: ▼-6



13 Grade 2 Pressure Ulcers reported in January

Avoidable Grade 3 and 4 Pressure Ulcers

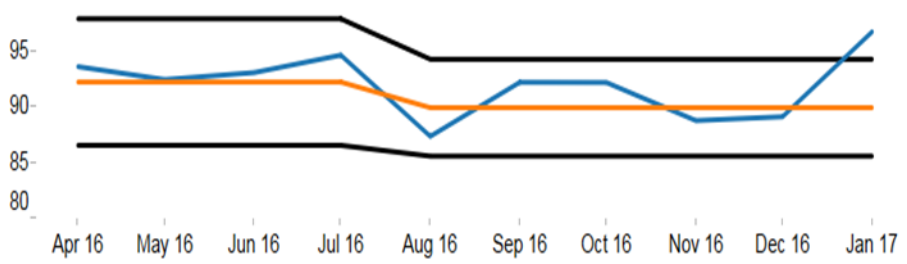
Standard: 0 YTD: 6 Dec 16: 1 Jan 17: 3 Movement: ▲2



3 case reported in January 1 on Caroline Ward, 1 Community patients home and 1 Benjamin Weir. 6 cases YTD against a target of 0.

VTE Risk Assessments Completed

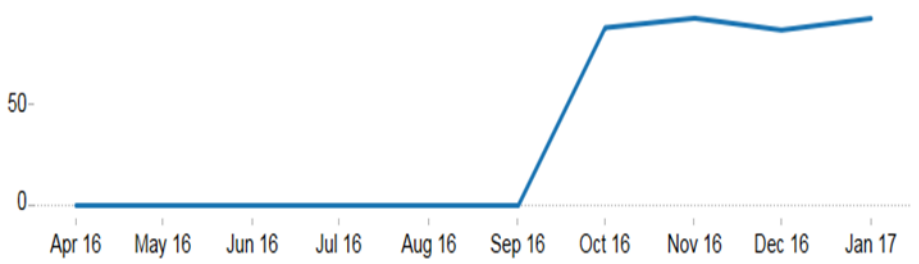
Standard: 95% YTD: N/A Dec 16: 89.09% Jan 17: 96.75% Movement: ▲7.66%



Ensuring that all VTE assessment forms are completed correctly. Performance in January was 96.75% against a target of 95%

Bed Rails Audit

Standard: 95% YTD: N/A Dec 16: 87.23% Jan 17: 92.99% Movement: ▲5.76%



Completion of Bed Rail audits commenced in October 2016. Performance in January was 92.99% against a target of 95%.

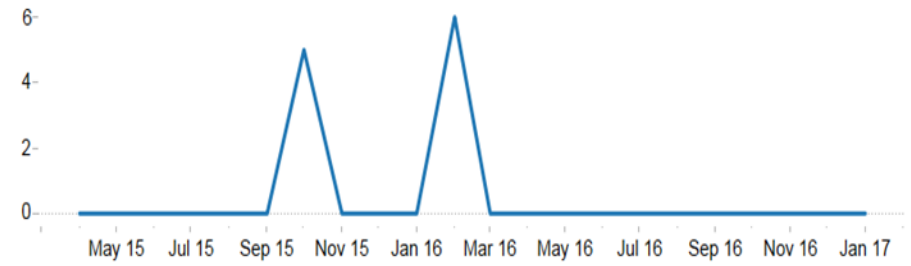
CARING – Mixed Sex Breaches & Complaints

Average LCL Metric Measure UCL

Mixed Sex Accommodation Breaches

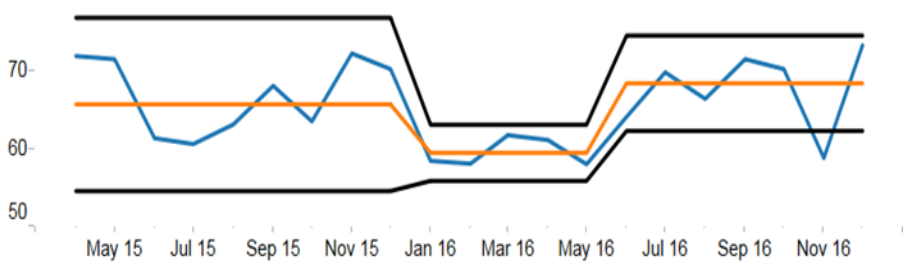
Number of occurances of unjustified mixing in relation to sleeping accommodation

Standard: 0 YTD: 0 Dec 16: 0 Jan 17: 0 Movement: ▸0



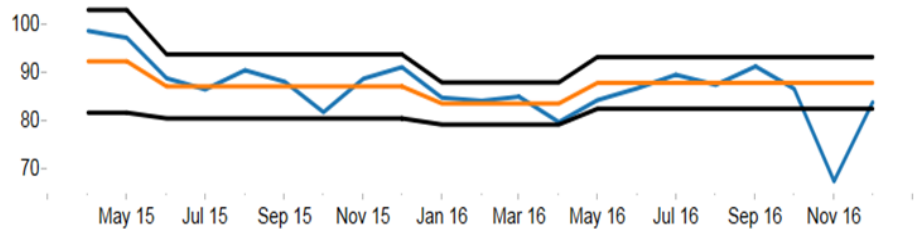
Complaints responded to within 25 days

Standard: 85% YTD: N/A Nov 16: 58.70% Dec 16: 73.21% Movement: ▲14.51%



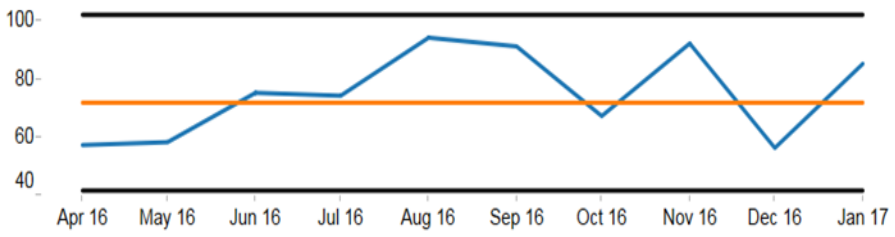
Number of Complaints With Agreed Extensions

Standard: 85% YTD: N/A Nov 16: 67.39% Dec 16: 83.75% Movement: ▲16.36%



Total Number of Complaints Received

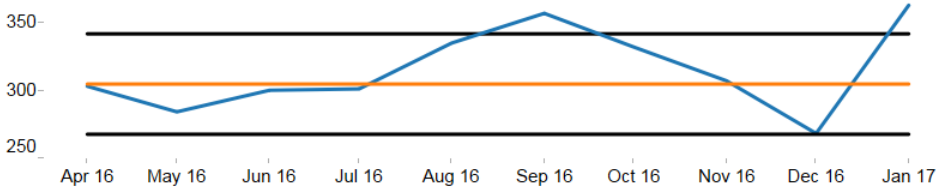
Standard: 0 YTD: 749 Nov 16: 92 Dec 16: 56 Movement: ▼-36



In January there were 85 complaints

PALS by Directorate and Received

Standard: 0 YTD: 3150 Dec 16 268 Jan 17: 363 Movement: ▲95

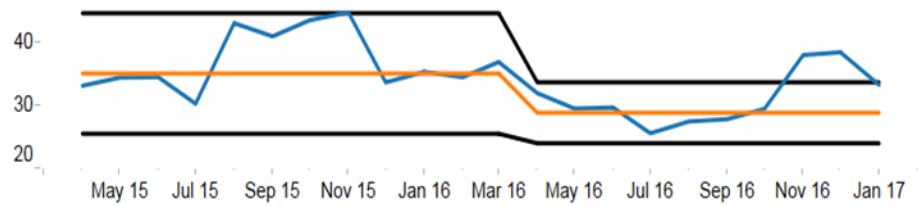


CARING – Friends and Family IP and ED

Average LCL Metric Measure UCL

FFT Response Rate

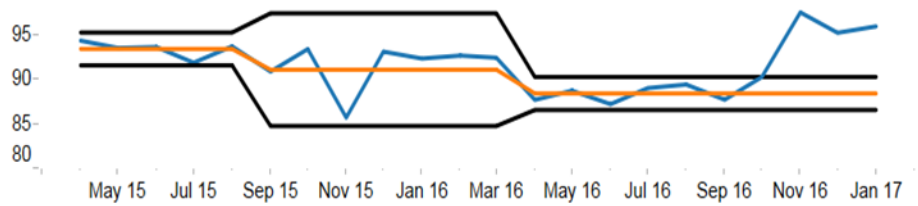
Standard: 20% YTD: N/A Dec 16: 38.31% Jan 17: 33.16% Movement: ▼-5.15%



Total response rate for the month of January was 33.16% a decrease on the previous month performance of 38.31% of which ED is 21.3% and IP 44.7%.

FFT Score

Standard: 90% YTD: N/A Dec 16: 95.16% Jan 17: 95.88% Movement: ▲0.72%



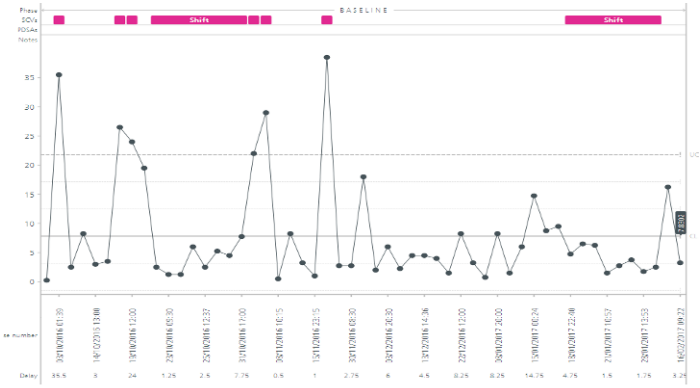
The FFT score for the month of January was 96.2% of which ED; 85%. Results consistent with previous months

National Emergency Laparotomy Network

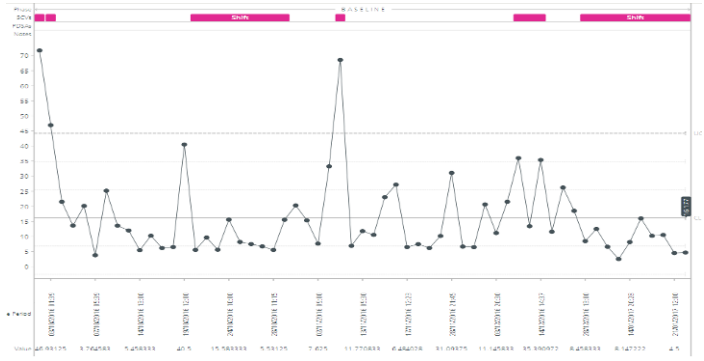
Metric	CQC domain	Performance and comments
Case ascertainment- completion of audit data is assessed annually and RAG rated against HES data	Well led	2015- 13%, 2016- 128% (more cases recorded in NELA than HES) Consistent monthly performance ~80% data captured in perioperative period, other cases recorded retrospectively from notes review
Pre operative documentation of risk of death Patients should have objective risk scoring, to guide intra-operative and post operative management	Effective	20% patients currently meet this standard, rated Red by NELA (<50% cases meeting standard). Theatreman booking form now amended to include risk scoring, training and awareness sessions
Access to theatres in appropriate timescale NCEPOD urgent classification cases- access in <6 hours, NCEPOD immediate- <2 hours	Responsive	See SPC chart. Outliers case notes and theatre schedule review underway.
Cases >5% predicted mortality with consultant surgeon and anaesthetist present in theatres	Effective	90% cases meet this standard. This has been consistent over many months
Cases >10% predicted mortality) admitted to high dependency	Safe	GICU aim to take patients with risk of death >5%, 100% patients meeting admission internal standard
Length of stay	Not reported to CQC	See SPC chart, average >15 days, with significant proportion of patients staying >25 days.
Mortality	Effective	In hospital mortality 10.3% (awaiting risk adjustment), 2015 risk adjusted mortality falls within expected range, 11.3%

NELA National Emergency Laparotomy Audit

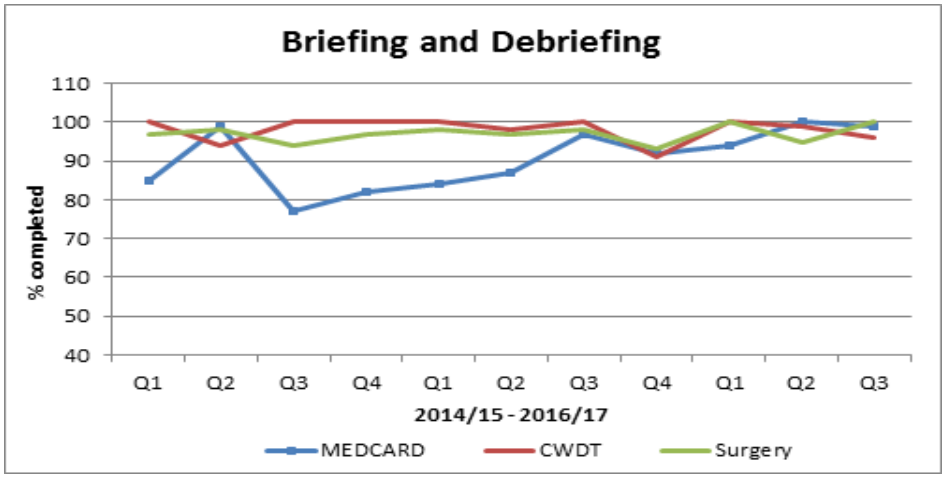
SPC chart of theatre access times- urgent cases



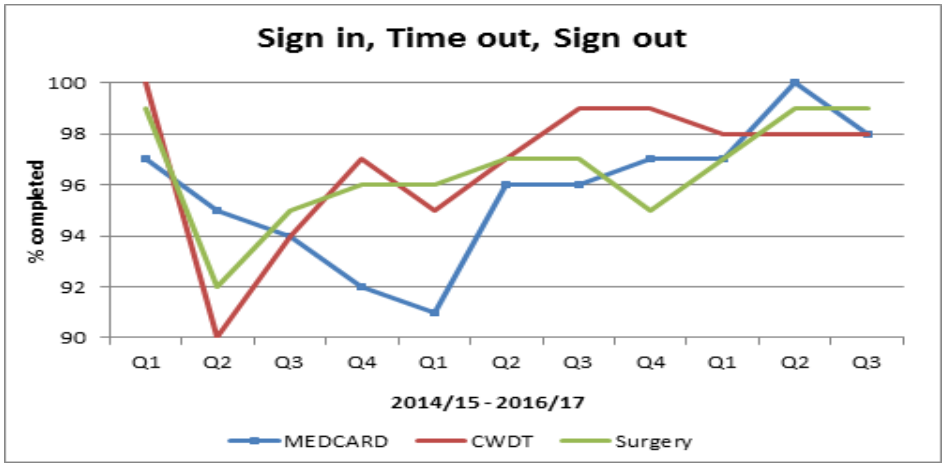
SPC chart of length of stay



WHO Data



Year		Briefing and Debriefing		
		MEDCARD	CWDT	Surgery
2015/16	Q3	97	100	98
	Q4	92	91	93
2016/17	Q1	94	100	100
	Q2	100	99	95
	Q3	99	96	100



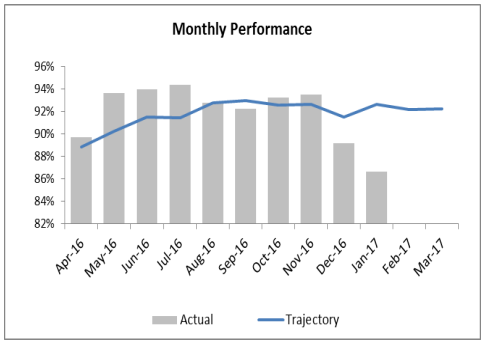
Year		Sign in, Time out, Sign out		
		MEDCARD	CWDT	Surgery
2015/16	Q3	96	99	97
	Q4	97	99	95
2016/17	Q1	97	98	97
	Q2	100	98	99
	Q3	98	98	99

ED Access

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
Total Attendances	13,737	15,067	14,310	14,752	13,814	14,261	14,558	14,025	14,149	14,057	12,519
Attendances<4 Hours	12,321	14,105	13,448	13,923	12,811	13,154	13,569	13,114	12,612	12,178	11,330
Breaches >4 Hours	1,416	962	862	829	1,003	1,107	989	911	1,537	1,879	1,189
Performance Actual	89.7%	93.6%	94.0%	94.4%	92.7%	92.2%	93.2%	93.5%	89.14%	86.63%	90.50%
Performance Trajectory	88.8%	90.2%	91.5%	91.4%	92.8%	93.0%	92.6%	92.6%	91.5%	92.6%	92.1%
Meeting STF	✓ 0.87%	✓ 3.41%	✓ 2.49%	✓ 2.96%	✗ -0.04%	✗ -0.74%	✓ 0.65%	✓ 0.90%	✗ -2.33%	✗ -6.01%	✗ -1.64%

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



Remaining Breach Tolerance – Feb-17

(as of 28/02/2017)

Quarterly Actual	Q1	Q2	Q3	Q4
Total Attendances	43,114	42,827	42,732	14,057
Attendances<4 Hours	39,874	39,888	39,295	12,178
Breaches >4 Hours	3,240	2,939	3,437	1,879
Performance	92.5%	93.1%	91.96%	86.63%
Performance Trajectory	90.2%	92.4%	92.2%	92.3%
Meeting STF	✓ 2.3%	✓ 0.8%	✗ -0.3%	✗ -5.7%

Breach Target Set

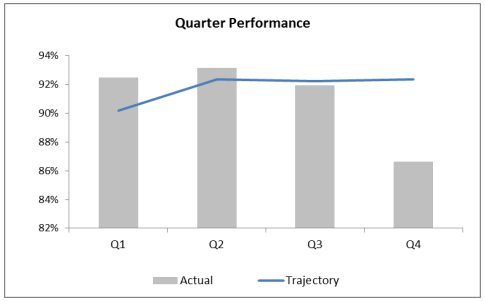
Month	National	SFT
Jan-17	720	1,050
Feb-17	709	1,116
Mar-17	764	1,188
Q4	2189	3,354

Breaches remaining for Month / Q4

Month	National	SFT
Jan-17	-1,159	-829
Feb-17	-480	-73
Mar-17	764	1,188
Q4	-1,165	3,353

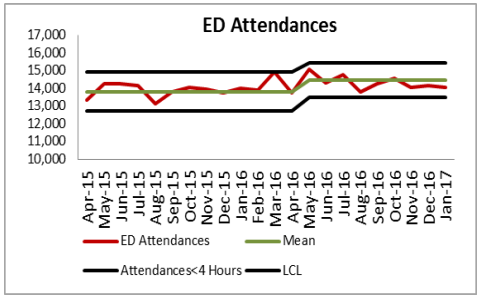
Breaches remaining for Month / Q4 per day

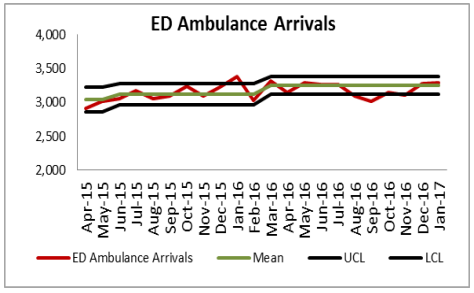
Month	National	SFT
Jan-17	-1,159	-2,708
Feb-17	0	0
Q4	25	38
Q4	0	108

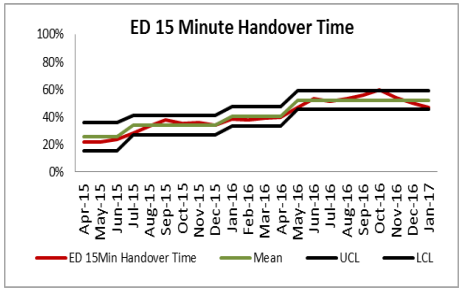


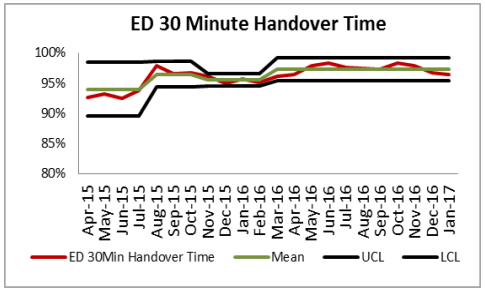
Breach Target Set - Number of breaches set to achieve National and STF
Breaches Remaining for Month - As of w/e how many breaches remain for the month to achieve target
Breaches Remaining per day - Breaches remaining for the month divided by days left to report
Attendances based on projections made as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

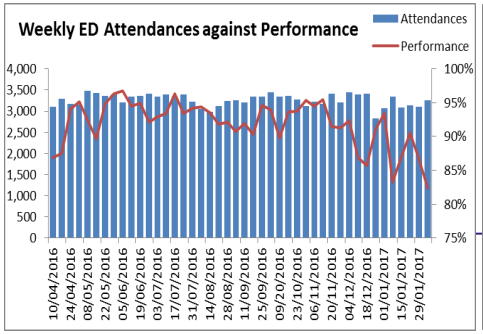
Weekly and Monthly Monitoring

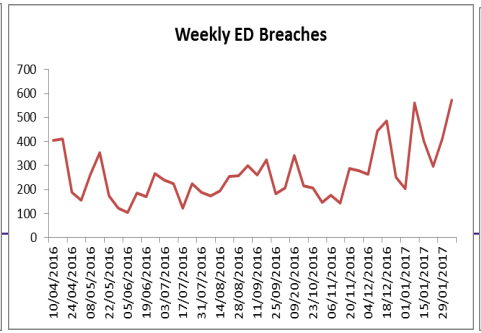


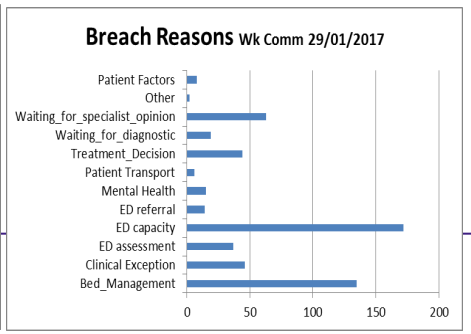


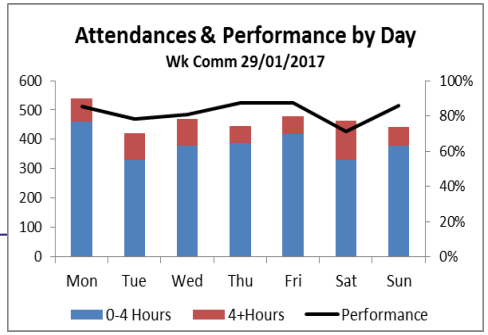












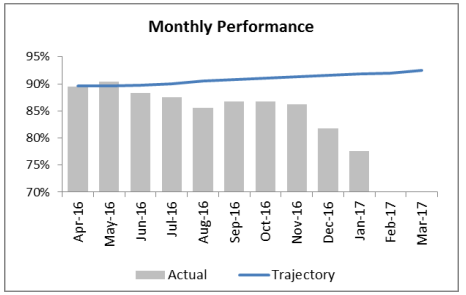
Elective Care Access

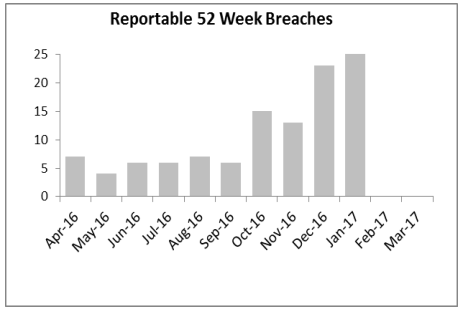
The Sustainability and Transformation Fund Performance against Trajectory 2016/2017

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Total Incomplete Waiting List	32,957	32,957	32,618	32,419	31,985	31,721	31,392	30,943	30,504	30,205
Total waits < 18 Weeks	29,526	29,526	29,261	29,162	28,956	28,794	28,577	28,274	27,932	27,734
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
Performance Trajectory	89.6%	89.6%	89.7%	90.0%	90.5%	90.8%	91.0%	91.4%	91.6%	91.8%
Total Incomplete Waiting List	35,626	37,243	38,849	39,573	40,299	38,635	38,594	37,608	38,247	41,619
Total waits < 18 Weeks	31,873	33,668	34,309	34,635	34,498	33,487	33,454	32,450	31,259	32,269
Total waits > 18 Week Breaches	3,753	3,575	4,540	4,938	5,801	5,148	5,140	5,158	6,988	9,350
Performance Actual	89.5%	90.4%	88.3%	87.5%	85.6%	86.7%	86.7%	86.3%	81.7%	77.5%
Meeting STF	✗ -0.1%	✓ 0.8%	✗ -1.4%	✗ -2.4%	✗ -4.9%	✗ -4.1%	✗ -4.4%	✗ -5.1%	✗ -9.8%	✗ -14.3%

Reportable 52 Week Breaches	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Total Incomplete Waiting List	7	4	6	6	7	6	15	13	23	41

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

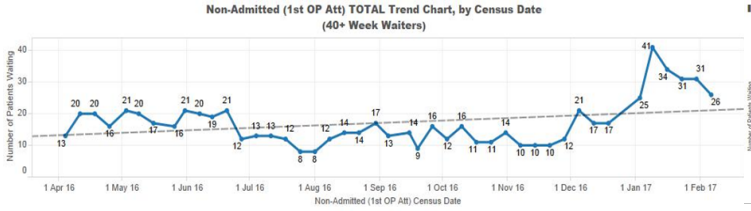


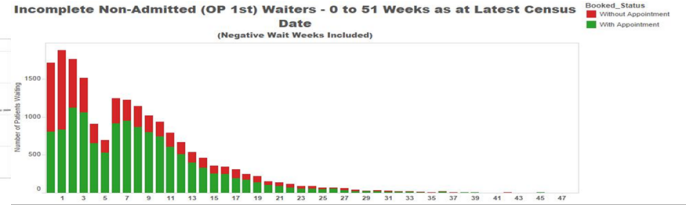


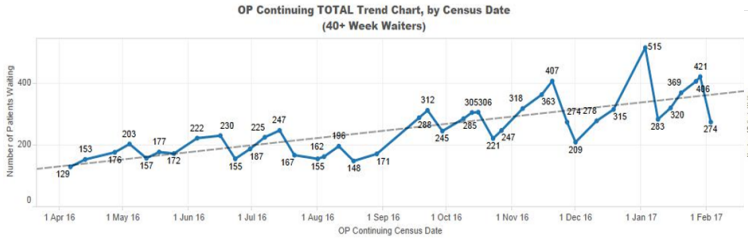
PTL Position (Unvalidated)

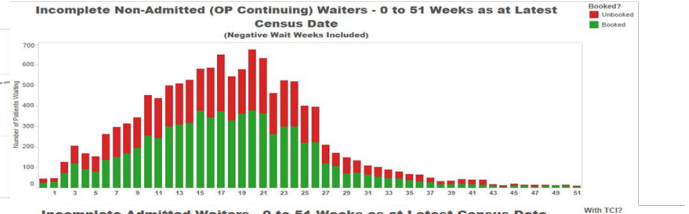
Monitoring the weekly PTLs for the number of patients who have been waiting 40+ weeks

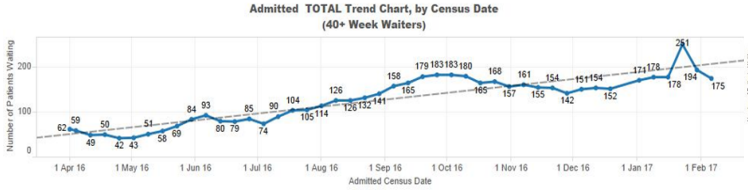
PTL: Booked Vs. Unbooked (unvalidated). An overview of the shape of the PTL's broken down by with / without an appointment booked

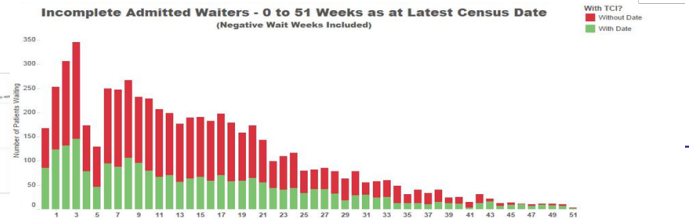


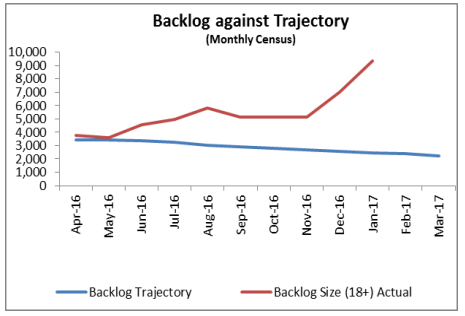


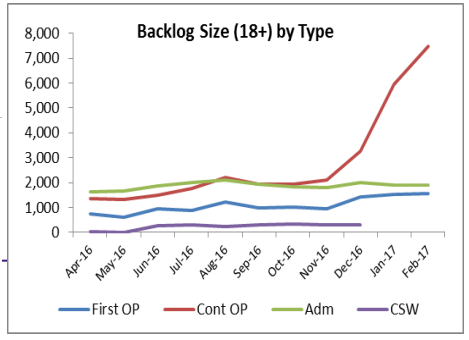












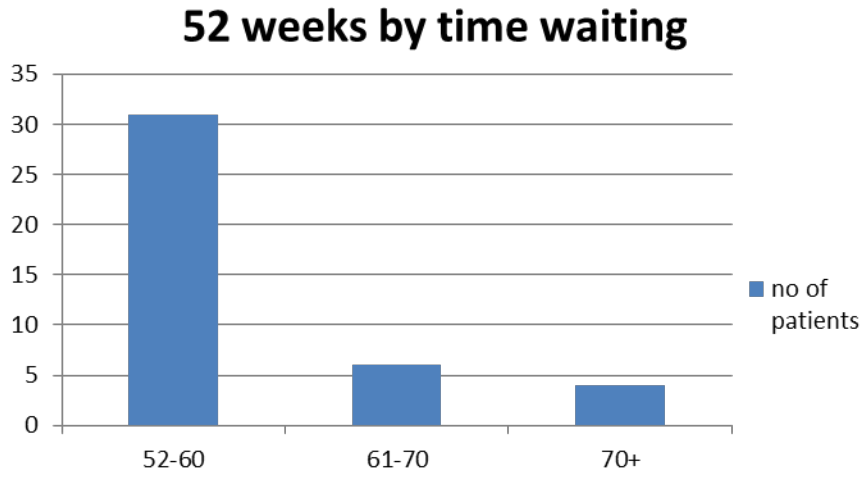
Elective Care Access

52 week wait tracker – validated position

Last Wk	Tip in this week	removed in week	24/02/2017	Pts with treatment date
46	12	17	41	18

Month to date	Waiting	Treated	Tip in this month	Month end Forecast
Feb-17	41	32	30	39

Specialty	
Dermatology	1
Ear, Nose & Throat	15
Gastroenterology	4
General Surgery	8
Gynaecology	1
Neurology	1
Paediatrics Med & Surg	1
Plastic Surgery	1
Trauma & Orthopaedics	7
Urology	1
Upper GI Surgery	1
Grand Total	41



The total number of patients waiting over 52 weeks, validated position, has decreased from 46 to 41.
The current month end forecast is for a total waiting of 39.
The main areas of concern remain: ENT, ; Gen Surgery ; T&O, .

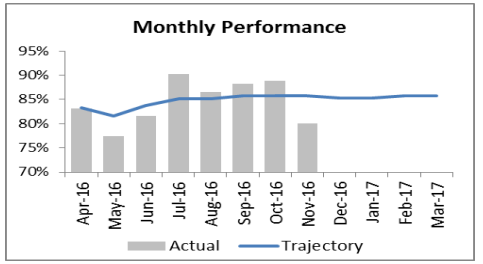
Cancer Access

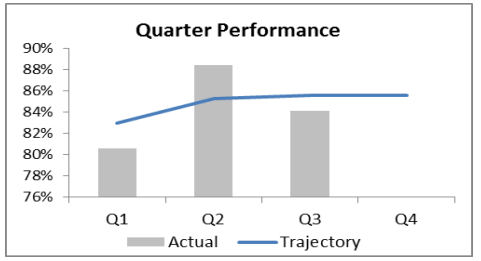
The Sustainability and Transformation Fund Performance against Trajectory 2016/2017 - 62 Day Standard

All Cancer Standards achieved in the month of December however 62 day Standard was below STF Trajectory.

National submission deadline for Cancer standards is one month in arrears, therefore January performance will be submitted early March.

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Total Treatments	60	60	74	74	74	63	70	63	68
Treatments <62 Days	50	49	62	63	63	54	60	54	58
Breaches >62 Days	10	11	12	11	11	9	10	9	10
Performance Trajectory	83.3%	81.7%	83.8%	85.1%	85.1%	85.7%	85.7%	85.7%	85.3%
Total Treatments Actual	59.5	71	70.5	71.5	59.5	64	61.5	70.0	64.0
Total Treatments within 62 Days Actual	49.5	55	57.5	64.5	51.5	57	54.5	56.0	54.5
Total Breaches Actual	10	16	13	7	8	8	7.0	14.0	9.5
Performance Actual	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.6%	80.0%	85.2%
Meeting STF	✗ -0.1%	✗ -4.2%	✗ -2.2%	✓ 5.1%	✓ 1.4%	✓ 2.6%	✓ 3.1%	✗ -5.7%	✗ -0.1%





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
Total Treatments	201	195	195.5
Treatments <62 Days	162	172.5	165
Breaches >62 Days	39	22.5	30.5
Performance	80.6%	88.5%	84.4%
Meeting STF	✗ -2.4%	✓ 3.2%	✗ -1.2%

Met STF not National

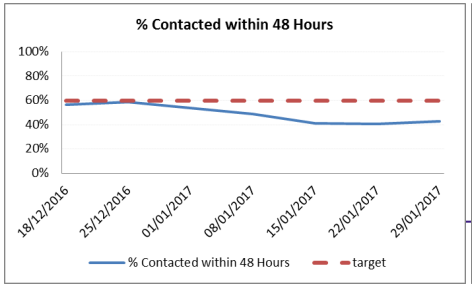
Not met STF or National

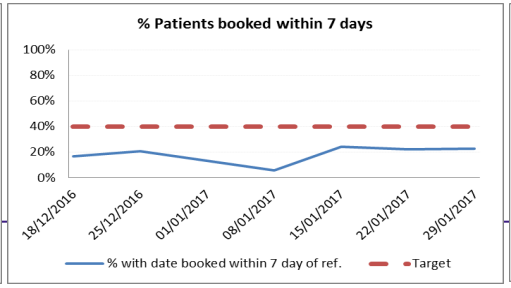
Met STF and National

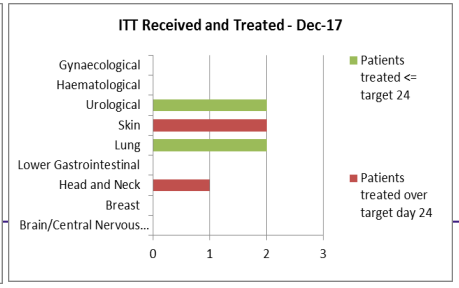
All Cancer Standards Performance Indicators

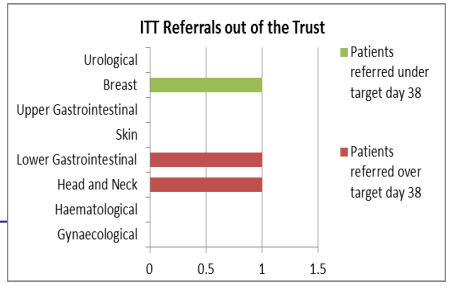
All Cancer Standards	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Performance Trend
14 Day GP Referral (93%)	86.6%	87.3%	90.0%	93.1%	95.1%	94.2%	93.2%	85.7%	93.3%	
14 Day Breast Symtomatic (93%)	94.8%	95.2%	85.9%	93.8%	94.2%	96.0%	98.9%	94.8%	93.2%	
31 Day First Treatment (96%)	98.3%	96.3%	98.8%	97.6%	97.4%	96.2%	97.2%	96.9%	96.6%	
31 Day Subsequent Treatment Surgery(98%)	100.0%	94.7%	96.6%	100.0%	100.0%	93.8%	98.8%	96.0%	96.0%	
31 Day Subsequent Treatment Drug(98%)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%	
62 Day Referral (85%)	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%	88.8%	80.0%	85.2%	
62 Day Screening (90%)	93.9%	84.8%	94.8%	95.0%	95.8%	92.0%	96.2%	92.7%	92.7%	
62 Day Consultant Upgrade (85%)	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	92.6%	87.5%	97.1%	

Key Metrics





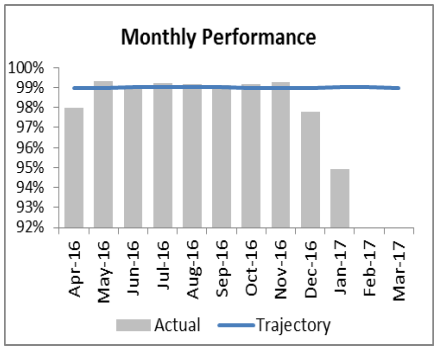




Diagnostics Access

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
Total Waits	5,788	5,386	6,046	5,718	5,429	5,750	5,803	5,860	5,776	5,813
Total Waits <6 Weeks	5,730	5,332	5,986	5,661	5,375	5,693	5,745	5,801	5,718	5,755
Total Waits >6 Weeks	58	54	60	57	54	57	58	59	58	58
Performance Trajectory	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	7,358
Total Waits <6 Weeks	7,142	6,542	6,908	6,386	6,034	6,202	6,777	6,828	6,755	6,986
Total Waits >6 Weeks	148	46	69	50	51	56	57	50	151	372
Performance Trajectory	98.0%	99.3%	99.0%	99.2%	99.2%	99.1%	99.2%	99.3%	97.8%	94.9%
Meeting STF	✗ -1.0%	✓ 0.3%	✓ 0.0%	✓ 0.2%	✓ 0.2%	✓ 0.1%	✓ 0.2%	✓ 0.3%	✗ -1.2%	✗ -4.1%



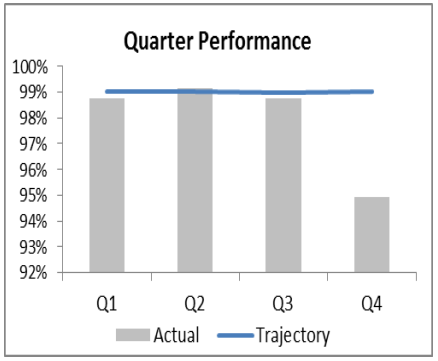
Met STF not National

Not met STF or National

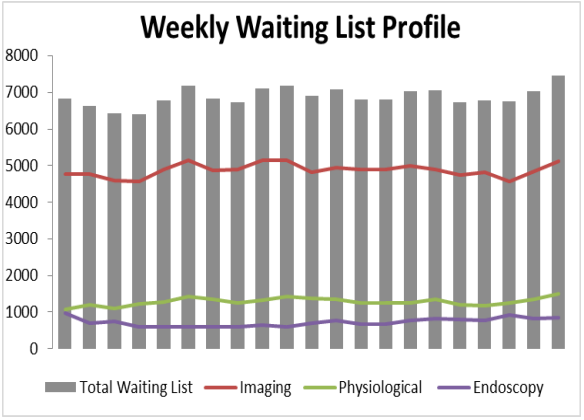
Met STF and National

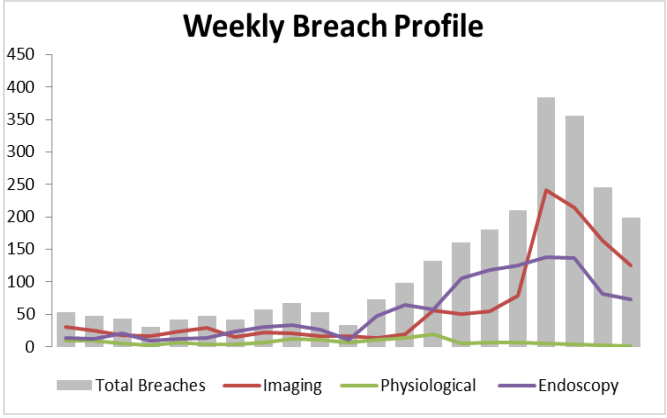
Quarterly Trajectory	Q1	Q2	Q3	Q4
Total Waits	17,220	16,897	17,439	17,431
Total Waits <6 Weeks	17,048	16,729	17,264	17,257
Total Waits >6 Weeks	172	168	175	174
Performance	99.0%	99.0%	99.0%	99.0%

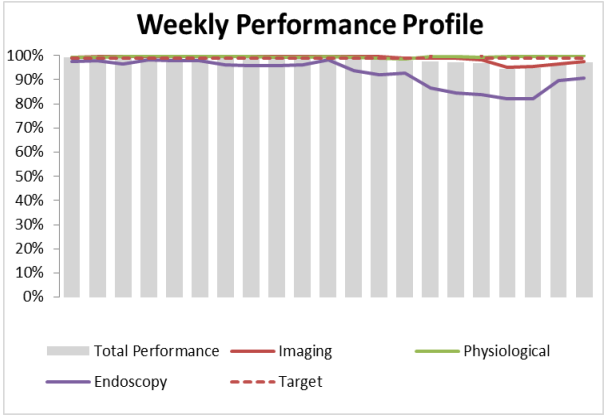
Quarterly Actual	Q1	Q2	Q3	Q4
Total Treatments	20,855	18,779	20,618	7,358
Treatments <62 Days	20,592	18,622	20,360	6,986
Breaches >62 Days	263	157	258	372
Performance	98.7%	99.2%	98.7%	94.9%
Meeting STF	✗ -0.3%	✓ 0.2%	✗ -0.25%	✗ -4.06%



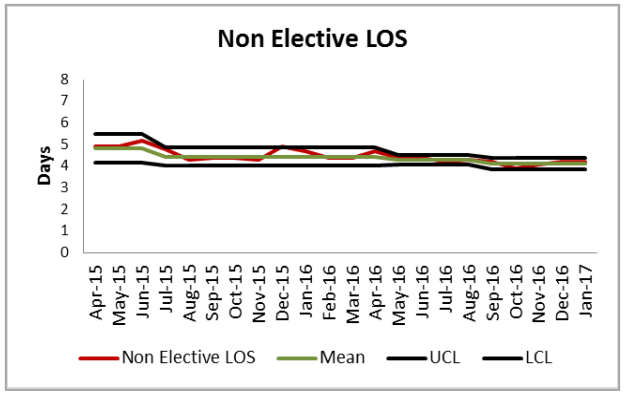
Weekly Performance Monitoring up to 19/02/2017

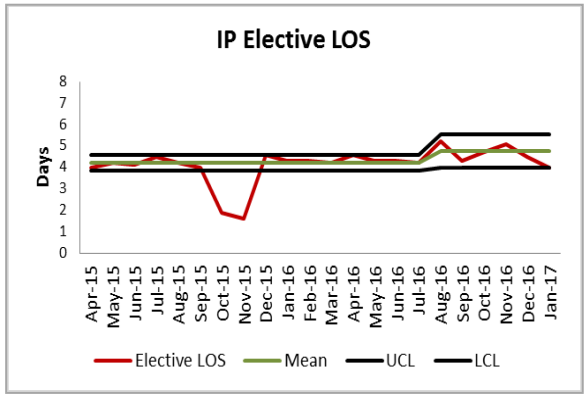


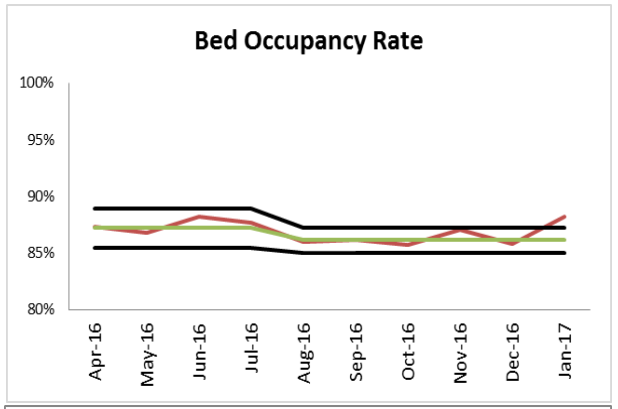


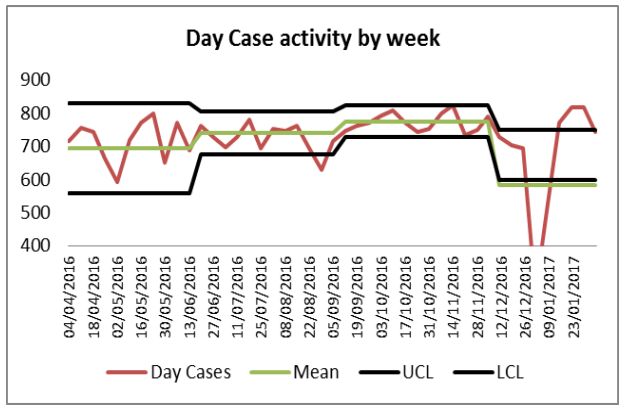


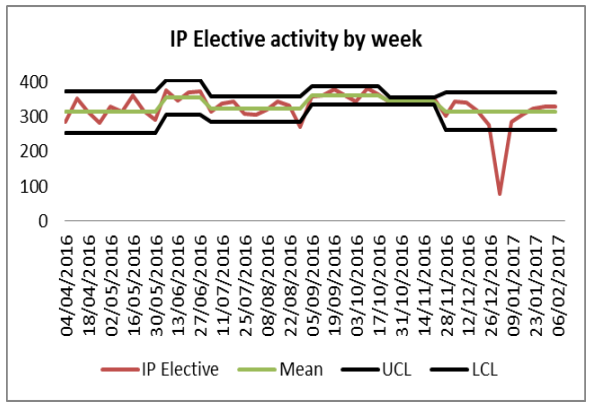
Operational Dependencies

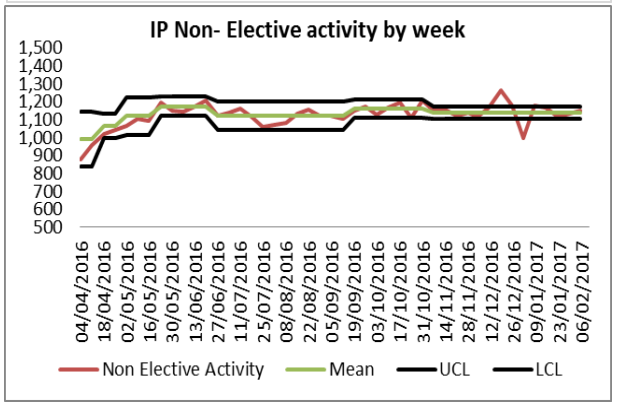


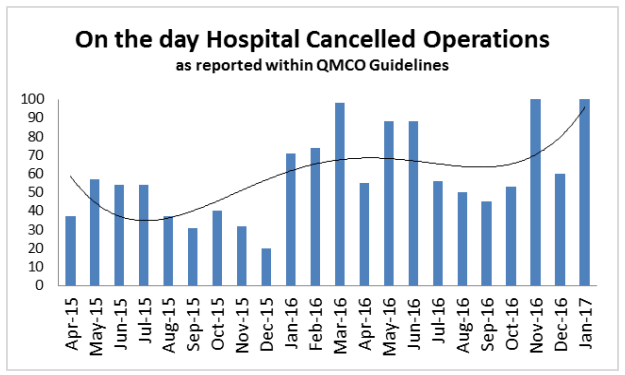


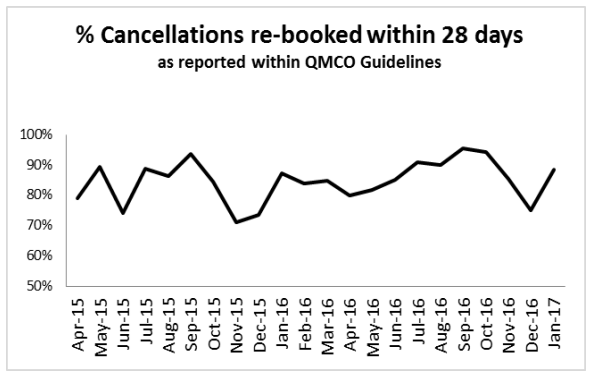


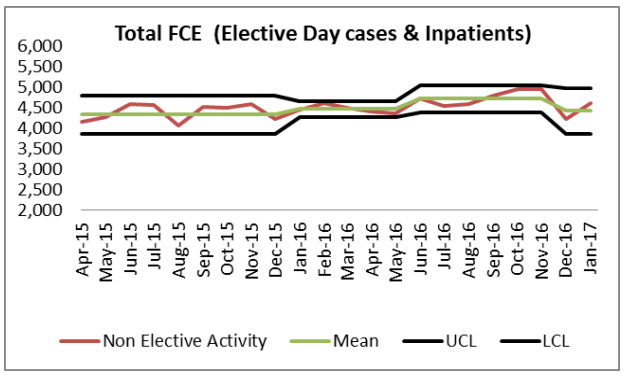




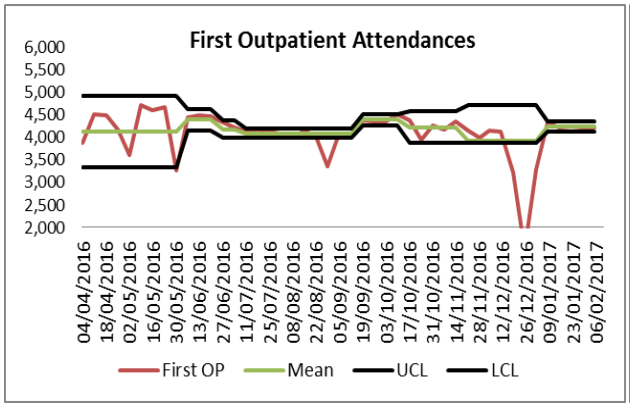


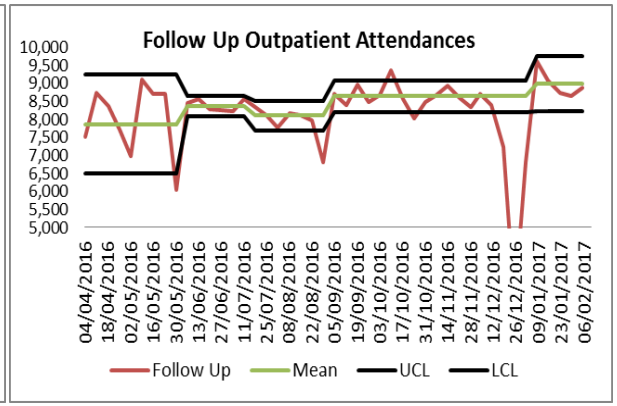


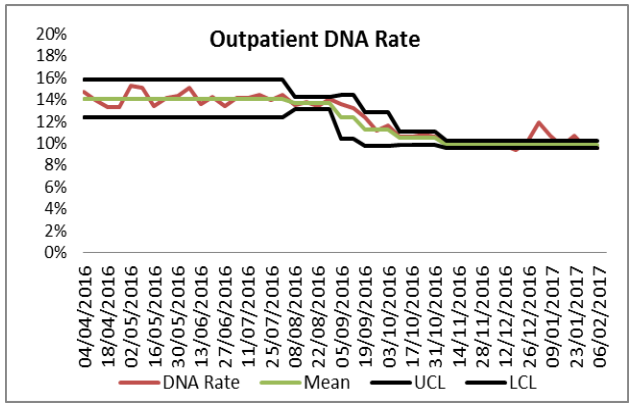




Operational Dependencies





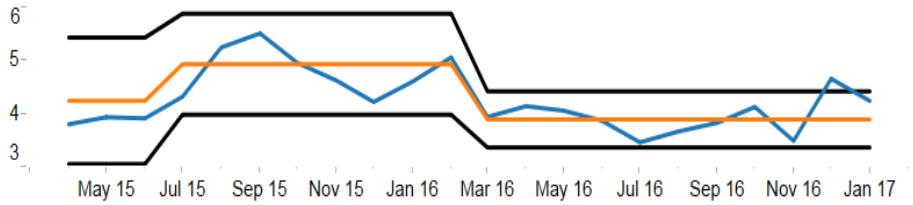


Well Led – Workforce Indicators

Average LCL Metric Measure UCL

Sickness/Absence Rate

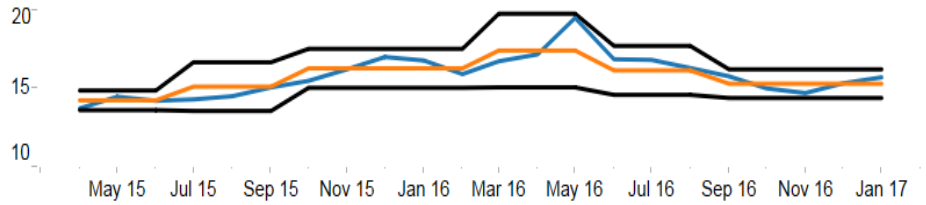
Standard: 3.5% YTD: N/A Dec 16: 4.65% Jan 17: 4.23% Movement: ▼-0.42%



The sickness / absence rate has remained consistent since June 2016, however a slight decrease was observed in January reporting 4.23% against a target of 3.5%

Vacancy Rate

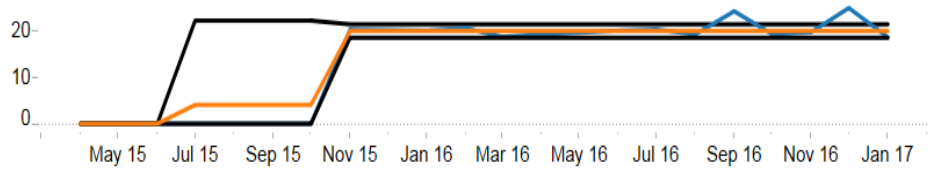
Standard: 11% YTD: N/A Dec 16: 15.29% Jan 17: 15.67% Movement: ▲0.38%



The Trust vacancy rate was 15.29% in December increasing slightly to 15.67% in January

Turnover Rate

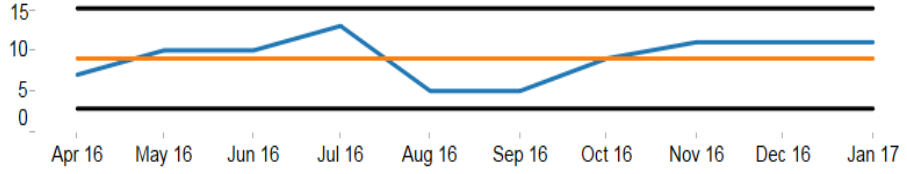
Standard: 13% YTD: N/A Dec 16: 24.94% Jan 17: 18.62% Movement: ▼-6.32%



The Trust Turnover rate increased fell by 6.32% in January to 18.62% against a target of 13%

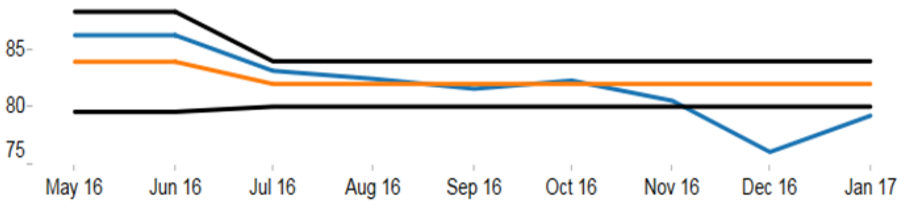
Safe Staffing Alerts

Standard: 0 YTD: 92 Dec 16: 11 Jan 17: 11 Movement: ▸0



IPR Appraisal Medical

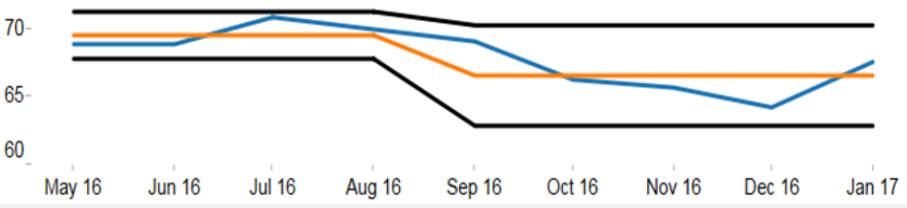
Standard: 85% YTD: N/A Dec 16 76.05% Jan 17: 79.22% Movement: ▲3.17%



In January the trust reported 79.22% of medical staff had completed their appraisal an increase of 3.17% on the previous months performance

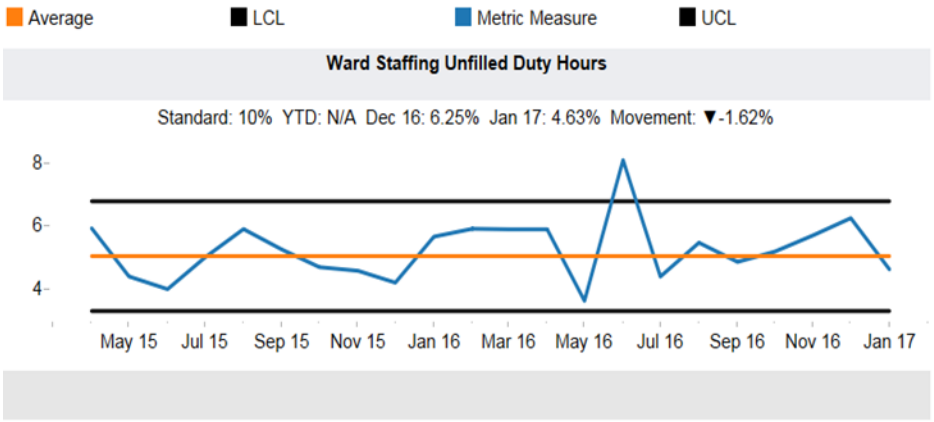
IRP Appraisal Non-Medical

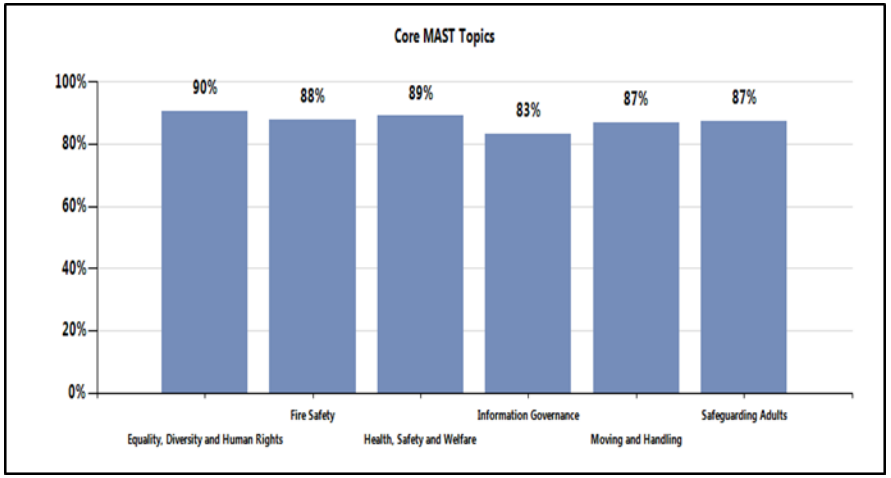
Standard: 85% YTD: N/A Dec 16 64.18% Jan 17: 67.53% Movement: ▲3.35%

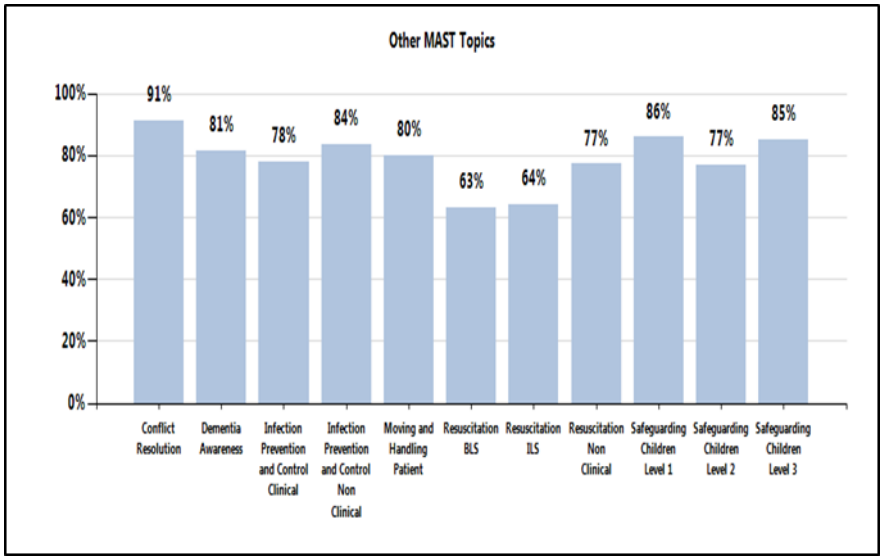


In January the trust reported 67.53% of non-medical staff had completed their appraisal an increase of 3.38% on the previous months performance

Well Led – Workforce Indicators







A look ahead

Daily Activity & Performance Report

Activity Wk 1 (30th Jan - 5th Feb)								
Indicator	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total
ED Attendances	538	422	469	446	479	462	441	3,257
ED 4 Hr Breaches	78	91	91	57	61	133	62	573
ED Performance	85.5%	78.4%	80.6%	87.2%	87.3%	71.2%	85.9%	82.41%
Ambulance Arrivals	113	101	98	114	97	119	90	732
Re-Pat Waiting	7	51	44	45	38	34	28	35
DTOC	24	26	27	29	28	28	28	27
Non DTOC	21	17	23	28	25	28	28	24
Non Elective admissions	167	171	163	192	190	146	123	1,152
Discharges	153	153	152	171	172	133	101	1,035
Discharge Lounge Use	39	29	36	32	38	0	0	174
Occupancy Rates	95.29%	95.29%	96.60%	96.17%	93.80%	91.90%	91.4%	94.34%
Electve IP	69	68	54	58	41	6	23	319
Elective Day Case	141	164	156	142	123	16	0	742
Cancelled Operations	7	15	9	10	3	1	1	46
OP New	830	892	844	813	686	63	49	4,177
OP Follow Up	1,735	1,823	1,808	1,576	1,584	20	16	8,562

Activity Wk 2 (6th Feb - 12th Feb)								
Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total
497	444	412	440	406	421	408	3,028
54	29	25	26	31	31	30	226
89.1%	93.5%	93.9%	94.1%	92.4%	92.6%	92.6%	92.54%
112	100	109	105	106	104	109	745
26	28	33	33	31	24	21	28
28	29	26	33	29	29	29	29
28	28	26	26	22	22	22	25
184	224	187	215	166	147	126	1,249
172	192	165	189	157	112	117	1,104
17	24	33	26	22	0	0	122
93.21%	97.59%	96.39%	95.62%	97.26%	95.84%	92.11%	95.43%
54	46	62	46	57	11	12	288
142	121	124	139	133	0	0	659
7	10	8	9	4	0	0	38
906	887	780	784	588	84	47	4,076
1,771	1,826	1,733	1,693	1,518	37	15	8,593

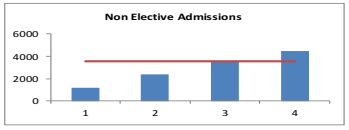
Activity Wk 3 (13th Feb - 19th Feb)							
Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total
476	407	440	425	437	392	431	3,008
26	21	27	36	47	25	12	194
94.5%	94.8%	93.9%	91.5%	89.2%	93.6%	97.2%	93.55%
106	99	106	103	110	95	106	725
18	18	20	25	27	21	19	21
25	25	21	24	24	25	25	24
18	25	32	33	26	26	26	27
183	193	168	169	235	147	115	1,210
167	173	151	150	187	123	96	1,047
23	12	25	29	18	0	0	107
92.88%	93.9%	93.4%	91.7%	89.9%	85.0%	86.8%	90.50%
59	58	48	45	83	11	18	322
128	104	146	124	110	7	0	619
9	5	3	8	3	2	1	31
659	877	683	686	520	65	47	3,537
1426	1679	1536	1342	1282	16	5	7,286

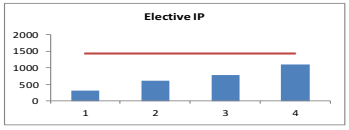
Activity Wk 4 (20th Feb - 26th Feb)							
Mon	Tue	Wed	Thur	Fri	Sat	Sun	Total
568	470	465	434	469	399	414	3,219
66	58	55	24	29	21	9	262
88.4%	87.7%	88.2%	94.5%	93.8%	94.7%	97.8%	91.86%
103	96	101	99	104	100	106	709
19	26	29	31	30	30	27	27
25	22	21	20	20	23	23	22
26	22	21	18	18	20	20	21
172	205	163	213	215	150	107	1,225
167	200	162	204	200	135	101	1,169
18	24	21	29	23	0	0	115
88.32%	91.0%	91.9%	95.0%	90.6%	86.5%	86.3%	89.96%
75	66	66	57	51	9	14	338
130	134	177	157	132	19	0	749
12	11	13	11	8	5	1	61
834	972	770	725	624	79	44	4,048
1727	1803	1933	1568	1441	40	1	8,513

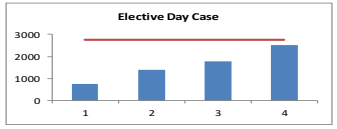
Activity Month to date against Plan

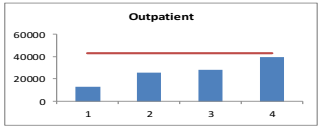
Indicator	Activity	Plan	Variance	% Diff
Non Elective Admissions	4493	3302	1191	26.5%
Electve IP	1090	1278	-188	-17.2%
Elective Day Case	2510	2329	181	7.2%
Outpatient Activity	39525	38934	591	1.5%

Cumulative Weekly Activity against Monthly Plan







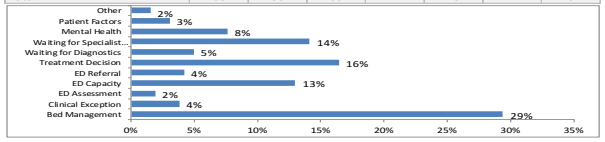


Performance

ED Performance

	Wk 1	Wk 2	Wk 3	Wk 4	MTD	Q4	YTD
ED Patients within 4 Hours	82.4%	92.5%	93.6%	91.9%	90.6%	88.4%	91.9%

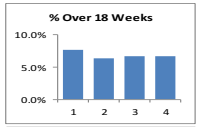
Daily ED Breach Reasons	20/02/2017	21/02/2017	22/02/2017	23/02/2017	24/02/2017	25/02/2017	26/02/2017
Bed Management	18	20	24	7	5	2	1
Clinical Exception	2	0	2	3	3	0	0
ED Assessment	1	3	1	0	0	0	0
ED Capacity	20	7	6	0	1	0	0
ED Referral	2	2	1	3	2	0	1
Treatment Decision	8	4	6	4	10	8	3
Waiting for Diagnostics	1	6	2	1	2	1	0
Waiting for Specialist Opinion	7	11	9	3	4	1	2
Mental Health	6	2	2	2	1	5	2
Patient Factors	1	3	2	0	1	1	0
Other	0	0	0	1	0	3	0
Total	66	58	55	24	29	21	9

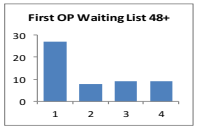


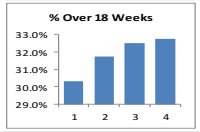
RTT Performance

	Apr-16	#######	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Incomplete Waiting List Size (All)	35,626	37,243	38,849	39,573	40,299	38,935	38,594	37,608	38,249	41,619	43,848
Incomplete 18+ (All)	3,753	3,575	4,540	4,938	5,801	5,148	5,140	5,158	6,988	9,350	10,946
Incomplete 18+ (All)	89.5%	90.4%	89.5%	87.5%	85.6%	86.8%	86.7%	86.3%	81.7%	77.5%	75.0%

Weekly PTL Updates	09/01/2017	16/01/2017	03/02/2017	17/02/2017
First OP Waiting List	19,133	23,187	22,529	23,119
First OP Waiting List 18+	1,473	1,470	1,515	1,543
% Over 18 Weeks	7.7%	6.3%	6.7%	6.7%
First OP Waiting List 48+	27	8	9	9
Admitted Waiting List	5,957	6,197	6,189	6,264
Admitted Waiting List 18+	1,806	1,966	2,012	2,050
% Over 18 Weeks	30.3%	31.7%	32.5%	32.7%
Admitted Waiting List 48+	32	61	53	51







Summary 52 Wk Breaches First OP, Continuing OP & Admitted

Report Date	Last Wk	Tip Ins this Wk	Removed	Total
27/01/2017	42	0	6	36
03/02/2017	42	11	13	40
10/02/2017	41	9	4	46
17/02/2017	46	12	17	41

52+ Breaches	Admitted PTL	Outpatient PTL
Total 52 Wk Pts	20	21
Without TCI Date	0	0
With TCI Date	18	19
ROTT	2	2

Patients on Tracker	
ENT	15
Gastro	4
Gen Surg	8
Neurology	1
Plastics	2
T&O	7
Dermatology	1
Urology	1
Paediatrics	1
Gynae	1
Upper GI	1

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 March 2017	**Agenda No.**	**2.3**
Report Title:	Renal Services Update - Renal Dialysis Trailer Location		
Lead Director/ Manager:	Dr Lisa Pickering – Divisional Chair, Medicine and Cardiovascular Division		
Report Author:	Fiona Ashworth- Divisional Director of Operations, Medicine and Cardiovascular Division		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion		
Executive Summary:	The purpose of this paper is to update the trust board on clinical risk and the mitigating actions taken relating to patients in the external dialysis trailer (SDU) who may become unwell and require emergency care, including collapse or cardiac arrest. The risk relates to the physical isolation of the dialysis trailer (SDU) for staff and patients, which is located to the rear of Knightsbridge wing. In addition a briefing is required on a decision taken by IDDG to reject an EMT decision to approve a 2nd Trailer for dialysis, including patient who require acute dialysis without clinical input and review.		
Recommendation:	The Trust Board is asked to note the actions taken.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Effective, Well Led, Safety		
Single Oversight Framework Theme:	Quality of Care (safe, effective, caring, responsive)		
Implications			
Risk:	This risk is on the divisional risk register. The initial risk grading was 20 (extreme), but following mitigating actions, the risk has reduced to 12 (high). The residual risk grade of 12 means that it will be reviewed at least quarterly and reported to the directorate and divisional governance meetings, as well as the renal board which meets on a monthly basis.		
Legal/Regulatory:	If the Trust had not taken action, this could have resulted in a Section 29A notice.		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Equality Impact Assessment:	No issues		
Appendices:			

Renal Services Update- Renal Dialysis Trailer (SDU) Location
Trust Board Meeting, 9 March 2017

1.0 PURPOSE

The purpose of this paper is to update the Trust Board regarding emergent risks relating to the external dialysis "trailer" (SDU). The key risk relates to the physical isolation of the trailer which is located to the rear of Knightsbridge wing and affects patients who require emergency care and staff caring for patients in this environment.

2.0 BACKGROUND

Following the CQC inspection of June 2016 a letter was received by the Trust on the 6th July 2016 advising of concerns regarding the physical environment of Buckland Ward and Knightsbridge Wing. To prevent a Section 29a notice being issued the trust was given with a time limited instruction to secure alternative accommodation for the totality of the service. In response, an options appraisal for a decant plan was developed between the operations teams and estates services.

The preferred decant option involved the use of Champneys ward to accommodate renal inpatients and acute dialysis; re-provision of some outpatient clinics and a purpose built trailer (SDU) to accommodate the most unwell patients who require chronic dialysis. Other chronic dialysis moved offsite to satellite locations including Fresenius facilities.

The decant planning has been overseen through a Renal Board, chaired by the Divisional Chair for Medicine and Cardiovascular Division, and attended by Renal services team, Estates and patient representation from the Kidney Patients Association.

3.0 RISKS

The renal dialysis trailer (SDU) is located in the courtyard clinic car park, on St George's Hospital Perimeter Road.

Following the closure of Knightsbridge Wing, due to the trailer's (SDU) location, it is now isolated from the main hospital leading to patient and staff safety challenges. The impact is that from 10pm to midnight patients and staff are required to gain access to the main hospital via Atkinson Morley or Grosvenor Wing.

The risks are:

1. Delay for the cardiac arrest team to reach patients in the trailer.
2. Isolated working.

4.0 Risk Management

The renal team has been working closely with the Health and Safety Lead with reference to the Lone Worker policy to develop plans and interventions to manage the risks. These are similar to plans for units including the day surgery unit, with the added need to manage out of hours up until midnight. Several actions have now been implemented to mitigate the risk to patients and staff. These are:

1. The service has worked with the cardiac arrest team in developing a specific SOP for cardiac arrests in the trailer:

    - The cardiac arrest team will have a designated bleep for any cardiac events in the trailer
    - Access for staff to and from the trailer will be enabled through Atkinson Morley Wing
    - The cardiac arrest team will congregate in the basement of Atkinson Morley Wing and move to the dialysis trailer together
    - The renal team will dial 999 at the same time as 222

2. Renal team members are all Intermediate Life Support (ILS) trained.

3. The cardiac arrest team is conducting additional specific ILS training with the renal team.

4. The Lone Worker policy has been applied to staff working in the trailer (SDU). This includes badges that have a GPS system to show where staff are located. In addition staff can alert to any issues through the talk system embedded in the badges function.

5. The service has arranged for security to chaperone staff when required.

4.1 Potential Gaps in Control

- If security is busy, there may be delays in supporting patients/staff. This will be monitored and further addressed in the event of any adverse events.

5.0 Risk Monitoring and Assurance

This risk has been reviewed, and is on the divisional risk register. The initial risk grading was 20 (extreme), but following mitigating actions, the risk has reduced to 12 (high).

The residual risk grade of 12 means that it will be reviewed at least quarterly and reported to the directorate and divisional governance meetings, as well as the renal board which meets on a monthly basis. The data being monitored are;

- Number and levels of datix incidents.
- Number of SIs.
- Number of complaints.
- Staff and patient feedback.

6.0 Summary

The renal service has implemented a number of actions in order that the risks to accessing the dialysis trailer (SDU) both out of hours, and at the weekend are mitigated. The actions have been implemented with the support of the Health and Safety Manager, and will be closely monitored and managed.

Author: **Fiona Ashworth - Divisional Director of Operations**
Medicine and Cardiovascular Division

Date: **2 March 2017**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 March 2017	**Agenda No.**	**2.4**
Report Title:	Smoke Free Trust Paper - Update		
Lead Director/ Manager:	Richard Hancock – Director of Estates & Facilities		
Report Author:	Mary Prior – General Manager Facilities		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Decision Ratification Assurance Discussion Update Steer Review Approval Other (specify)		
Executive Summary:	To provide an update on the Smoke Free Trust project.		
Recommendation:	To proceed to create a project that will submit a paper to IDDG ahead of EMT requesting funds to enable this to happen.		
Supports			
Trust Strategic Objective:	To agree a strategy for stopping smoking on St George's University Hospital's Trust sites		
CQC Theme:	Regulation 15: Premises & Equipment.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	Covered in the paper.		
Legal/Regulatory:	Covered in the paper.		
Resources:	Covered in the paper.		
Previously Considered by:	Previous Trust Board	**Date:**	3 March 2017
Equality Impact Assessment:	N/A		
Appendices:	None		

Smoke Free Trust

1.0 PURPOSE

1.1 To agree a strategy for stopping smoking on St George's University Hospital's Trust sites. This should apply to staff, patients and visitors. Since 1 July 2007, England introduced a new law to make virtually all enclosed public spaces and workplaces in England smoke free. St George's University Hospital's NHS Trust and St George's University of London does not permit any smoking in its buildings, car parks, grounds and gardens.

2.0 BACKGROUND OR CONTEXT

2.1 The NHS went smoke free in 2005. At the time all Trusts had to remove any smoking shelters and ensure policies were in place for staff, patients and visitors to not smoke anywhere on Trust sites. This paper seeks to continue the smoke free policy and increase enforcement and compliance.

2.2 Whilst there has been a reduction in on site smoking we are still not smoke free.

2.3 The Board are asked to provide executive support to the proposals below. Some of these actions will need funding – the approximate costs for these is £50,000.

3.0 PROPOSAL

3.1 Set up a working party to revisit the Smoke Free policy with a formal launch in September 2017 (taking into account the funding process and compliance issues). Key stakeholders would be invited to the working party (including the local authority and Tooting Gardens representation).

3.2 To reduce the number of staff smoking by embedding strict no smoking policy into employees contracts. Provide staff who smoke with 3 months notice of a change with the launch of a stricter policy in and around the trust and make it clear there will be sanctions.

3.3 A communications strategy will be prepared to advertise and launch this. Included in this would be larger signage (banners) at the sites entrances (as well as the buildings) to promote smoke free site, improve signage at entrances and messages via core brief and eG news.

3.4.1 Patient and staff correspondence will need updating to include a smoke free strap line and also advise of the options available to support smoking cessation.

3.5 The external environment at each entrance will need redesigning to prevent smoking areas and reinforce areas for staff, patients and visitors to access without being subjected to second hand smoke. This will include improved lighting, planting schemes and a tannoy and CCTV system linked to security to prevent smoking.

3.6 Seek approval for Wandsworth enforcement teams to issue on the spot fines for smoking on Trust sites.

4.0 IMPLICATIONS

Risks

4.1 There are a number of risks linked to a failure to reinforce this policy.

- Fire risk from linked to illicit smoking.
- Health and patient experience risk via passive smoking.

Legal Regulatory

4.2 This supports the Smoke Free Premises and Enforcement Regulation 2006 to make smoking illegal in public spaces.

Resources

4.3 Detailed costings will be confirmed once the proposals have been agreed. The current estimate is £50,000.00

5.0 RECOMMENDATION

5.1 The Board are asked to support the proposals in reinforcing a smoke free Trust.

Author: **Mary Prior General Manager Facilities**
Date: **3 March 2017**

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**TRUST BOARD**		
Date:	**8 March 2017**	**Agenda No**	**3.1**
Report Title:	**Summary Finance Report- Month 10 2016/17**		
Lead Director/ Manager:	Chief Financial Officer		
Report Author:	Michael Armour		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The Trust's month 10 financial position is an in-month deficit of £6.6m, which is £1.4m worse than a £5.2m in-month deficit forecast. The principal components of the shortfall are: Income losses as a result of reductions in Waiting List Initiative (WLI) rates (£0.5m), re-phased increase in depreciation (£0.3m) and NHSE promised rental income for QMH (£0.3m). The YTD deficit is £67.2m and the Forecast Outturn is a deficit of £71m plus £5.1m of losses on disposal of properties as agreed with NHSI.		
Recommendation:	The Trust Board notes 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:		**Date**	
Equality Impact Assessment:			
Appendices:	None		

Summary Finance Report
Month 10 2016/17

Trust Board 9 March 2017

Contents

1. Financial Performance for Month 10 (January 2017)

Income & Expenditure	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	Current Month Reforecast @ M9 (£71m deficit control total) Forecast £'m	Current Month Reforecast @ M9 (£71m deficit control total) Variance £'m
SLA Income	650.3	55.0	54.4	(0.7)	540.7	536.3	(4.4)	56.2	(1.9)
STF Income	17.6	1.5	0.0	(1.5)	14.7	0.0	(14.7)	0.0	0.0
Other Income	112.2	9.0	9.2	0.2	93.7	99.1	5.4	9.5	(0.2)
Overall Income	**780.1**	**65.5**	**63.6**	**(1.9)**	**649.0**	**635.4**	**(13.6)**	**65.7**	**(2.1)**
Pay	(486.3)	(40.5)	(41.3)	(0.8)	(404.8)	(413.3)	(8.5)	(40.7)	(0.6)
Non Pay	(275.9)	(21.2)	(25.3)	(4.1)	(233.5)	(259.5)	(26.0)	(26.8)	1.5
Overall Expenditure	(762.2)	(61.7)	(66.6)	(4.9)	(638.3)	(672.7)	(34.4)	(67.5)	0.9
EBITDA	17.9	3.8	(3.0)	(6.9)	10.7	(37.3)	(48.1)	(1.8)	(1.2)
Financing costs	(35.1)	(2.9)	(3.6)	(0.6)	(29.2)	(29.9)	(0.6)	(3.3)	(0.2)
Surplus/(deficit)	**(17.2)**	**0.9**	**(6.6)**	**(7.5)**	**(18.5)**	**(67.2)**	**(48.7)**	**(5.2)**	**(1.4)**
Memo: Below the Line Items	0.0	0.0	(1.7)	(1.7)	0.0	(14.5)	(14.5)		

Key Messages

The Trust's **month 10 financial position is an in-month deficit of £6.6m**, which is £1.4m worse than a £5.2m in-month deficit forecast. The principal components of the shortfall are: Income losses as a result of reductions in Waiting List Initiative (WLI) rates (£0.5m), re-phased increase in depreciation (£0.3m) and NHSE promised rental income for QMH (£0.3m). The **YTD deficit is £67.2m** and the **Forecast Outturn** *(slides 3a, 3b)* is a **deficit of £71m** plus £5.1m of losses on disposal of properties as agreed with NHSI. The Finance & Performance Committee forecast outturn at M09 was an **£80.7m deficit,** adjusted by a special board meeting on 30th January to a **reforecast £71m deficit** at the request of NHS Improvement.

- **Income:**
  - **SLA Income** *(slides 6-9)* - £0.7m shortfall in month 10. This in month position was adversely affected largely by cancelled elective activity as a result of the reduction in WLI payments (£0.5m). The YTD shortfall of £4.4m is in the main adversely affected by business case slippage in Neurosurgery (£4.0m YTD) and the impact of the RTT non-reporting (£1.9m) broadly offset by SLA Outpatients overperformance.
  - **STF Income –** There is an annual budget of £17.6m that the Trust is not expecting to receive this financial year and has been factored into the forecast outturn.
- **Pay** *(slides 10-12)* - £0.8m overspent in month, and £8.5m YTD. The in-month overspend is as a result of unbudgeted interim staff spend and divisional vacancies covered by bank and agency. Staff costs have decreased as WLI payments have reduced, although the negative consequences have been seen in Income. Underlying pay has remained relatively stable since month 6 (September 2016).
- **Non Pay** *(slide 13)*- £4.1m adverse to budget in month and £26m adverse YTD. Both the in-month and YTD adverse movements are largely due to non-delivery of CIP plans. In addition, drugs spend is higher than planned, both in-month and YTD in the commercial pharmacy, partly offset by income.
- **Below the Line** *(slide 5)* - £14.5m of YTD costs which relate to items outside the Trust's initial plan regarding unforeseen, one off costs. Forecast outturn is £21.9m.

2a. Analysis of cash movement M10 YTD

Source and application of funds - cash movement analysis:
M10 YTD and forecast vs Plan

	Actual vs Plan YTD			Based on forecast £71m deficit			
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*	*Plan Year £m*	*Forecast Outturn £m*	*Forecast VAR £m*	Notes based on forecast £71m deficit
Opening cash 01.04.16	7.4	7.4		*7.4*	*7.4*		
Income and expenditure deficit	-20.1	-67.2	***-47.1***	*-17.2*	*-76.1*	***-58.9***	
Depreciation	20.7	20.8	***0.1***	*25.0*	*25.0*	***0.0***	
Interest payable	4.2	4.4	***0.1***	*5.1*	*5.8*	***0.7***	
PDC dividend	5.2	4.4	***-0.8***	*6.3*	*5.2*	***-1.0***	
Other non-cash items	-0.2	0.1	***0.3***	*-0.2*	*4.9*	***5.0***	
Operating deficit	**9.9**	**-37.5**	***-47.4***	**19.0**	**-35.2**	***-54.2***	
Change in stock	0.2	-0.6	***-0.8***	*0.6*	*0.6*	***0.0***	
Change in debtors	-0.8	-25.0	***-24.2***	*1.8*	*-20.9*	***-22.7***	does not assume debt targets met
Change in creditors	2.0	30.5	***28.5***	*-5.5*	*8.6*	***14.1***	
Net change in working capital	1.4	4.9	***3.5***	-3.1	-11.6	**-8.5**	
Capital spend (excl leases)	-29.7	-20.7	***9.0***	*-33.4*	*-26.6*	***6.8***	The capital cash spend forecast is £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	-3.9	-3.7	***0.2***	*-5.1*	*-5.6*	***-0.5***	
PDC dividend paid	-3.1	-3.1	***0.0***	*-6.3*	*-5.3*	***1.0***	
Other	-6.7	-5.6	***1.0***	*-8.0*	*-7.8*	***0.2***	
Investing activities	-43.4	-33.2	***10.2***	*-52.7*	*-45.3*	***7.4***	
WCF/ISF borrowing	31.0	63.5	***32.5***	*32.5*	*88.2*	***55.8***	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 £0.8m lower than last month due to higher forecast receipts in March.
Closing cash 31.10.13 / 31.03.17	6.2	5.1	***-1.1***	3.0	3.5	***0.5***	

M01- M10 YTD cash movement
The better performance on working capital (+£3.3m) and cash under spend (+£9m) on the capital programme offset some of the adverse cash impact of the higher operating deficit (-£47.4m) and helped the Trust to restrict the increase in borrowing necessary to finance the higher revenue deficit to £32.5m.

M10 YTD cash movement

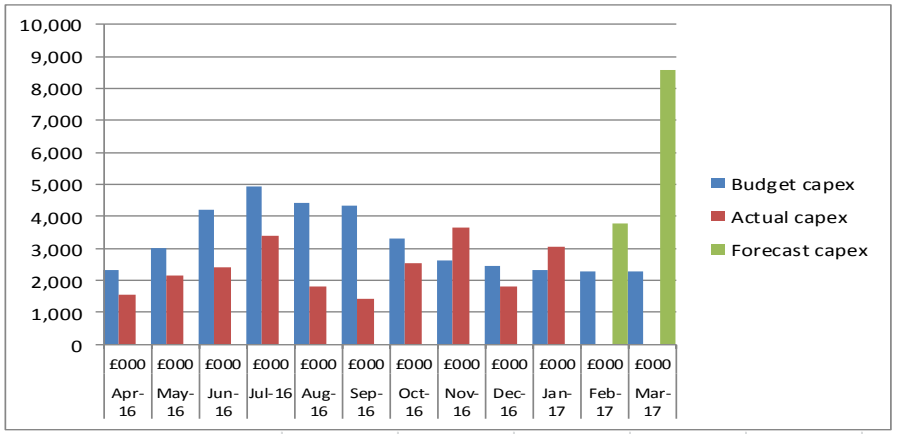
- Within the I&E deficit of £67.2m YTD, depreciation (£20.8m) does not impact cash. The accruals for interest payable (£4.4m) and PDC dividend (£4.4m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £37.5m.
- The operating variance from plan of £47.4m 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 15)
- The Trust has been able to partially offset the worse operating deficit with better performance on working capital (+£3.5m), the cash under spend on capital (+£9m), lower interest paid (+£0.2m), lower finance lease repayments (+£1m) (in 'Other') and a lower cash balance (+£1.1m) enabling the Trust to restrict the increase in borrowing necessary to finance the higher I&E deficit to £32.5m.

Forecast outturn cash movement

- The forecast I&E deficit is £76.1m. When the asset disposals (in 'non-cash items' £4.9m) are excluded the I&E deficit is £71m. After adding back depreciation etc as above, this generates an operating deficit of £35.2m.
- The total forecast borrowing requirement is £88.2m, £55.8m higher than plan. This extra borrowing is required to finance the higher operating deficit. NB the borrowing total excludes emergency capital funding as the Trust will underspend its own capital budget.

2b. Capital programme M10

Capital 2016/17 - budget, actual and forecast expenditure per month



CAPITAL BUDGET & EXPENDITURE - BY SPEND CATEGORY

Row Labels	**2016/17 Budget Total**	16/17 Budget YTD £000	16/17 Actual YTD	16/17 YTD variance	***Forecast outturn £000***	**Forecast variance £000**	M10 commits £000
Infra Renewal -EPC	**9,389**	9,389	5,244	4,145	***7,634***	**1,754**	6,605
Infra Renewal	**7,491**	6,015	1,693	4,322	***5,011***	**2,480**	961
IMT	**4,972**	4,237	5,639	-1,402	***7,421***	**-348**	28
Med Eqpt	**4,613**	3,530	1,933	1,597	***3,115***	**1,499**	1,810
Major Projs	**8,901**	8,149	8,655	-506	***10,312***	**-1,412**	189
Other	**349**	292	239	53	***203***	**145**	152
SWL PATH	**385**	351	401	-50	***403***	**-19**	38
Grand Total	**36,099**	31,963	23,804	8,159	***34,100***	**4,099**	**9,783**

- Capital expenditure in January was £3.1m and year to date expenditure is £23.8m, an underspend of £8.2m (M09: £9.1m). The table above shows the YTD under spend relates mainly to the energy performance contract (EPC) (£4.1m – down £0.6m on M09) for which the programme slipped earlier in the year, and infrastructure renewal (£4.3m), which includes the scheme to replace the stand-by generators. Expenditure on the EPC has accelerated over the last three months.
- The trust is forecasting approx £3m of expenditure this year on CQC related schemes including the Renal unit re-location and the demolition programme against the emergency capital bid, which is yet to be approved by NHSI but, in overall terms, the capital programme is significantly underspent.
- The Trust submitted a gross capital expenditure forecast of £34.1m for the year to NHSI in January and this must not be exceeded.
- The forecast cash underspend relating to capital expenditure is unchanged at £6.75m comprising the £2m expenditure underspend and £4.75m increase in capital creditors.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 March 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:	Over quarter 3 the pay spend has stabilised and reduced by £0.7m, although this remains short of our financial targets. To address the underlying vacancy in the Trust (assuming an approximate 10% reduction in headcount but recruiting to known and accepted vacancies) and turnover, approximately 30-35 posts need to be recruited to each week. All recruitment is being managed through a central vacancy control panel process. Further control is being placed on ensuring only essential posts are recruited for reasons of patient safety and care or other compliance purposes, or where obvious and accepted agency spend would occur as a result if the post was not recruited to. Some of this recruitment is necessary where considerable vacancies already exist within a service and failure to recruit will result in service breakdown and/ or additional costs, even if this is in non-patient facing services. A review of all management posts is being undertaken with the Divisions and recruitment agreed only where there is obvious and immediate need. Compliance rates for MAST 82% and appraisal 69.6% for non-medical staff have improved from 74.4% and 63.8% in December respectively. Medical staff appraisal is at 82%. Further improvements are expected and appraisal rates are subject of particular focus.		
Recommendation:	The Board are 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:	Regular Board report and considered by EMT on 27th February 2017	**Date**	09.01.17
Equality Impact Assessment:	n/a		
Appendices:	Workforce Information slides		

Workforce Information report
Trust Board, 9 March 2017

1.0 PURPOSE

1.1 To provide workforce information up to January 2017 for the Trust Board outlining trends and explaining changes in staffing composition to support decision-making and Board assurance.

2.0 CONTEXT

2.1 The current budgeted establishment on the Trust's Electronic Staff Record is 9,393 wte and the actual in post is 7,921, leaving a theoretical vacancy of 1,472 wte. If the budgeted establishment was reduced by 10% (934 wte) this would reduce the vacancy level to 538 wte. Our current turnover rate of 15% requires us to recruit 1,100 wte per annum to standstill, so to address the underlying vacancy of 538 wte and turnover the Trust needs to recruit approximately 1,600 wte or about 30-35 posts per week, with the majority in clinical areas.

2.2 Over the last quarter the pay spend has stabilised and reduced by £0.7m. Whilst this is positive it is insufficient to meet our cost improvement plan and balance our budgets. The setting of budgets for 2017/18 will ensure we have clarity on the vacancies to be recruited to and managers can be held to account for managing their pay budgets.

3.0 ANALYSIS

3.1 The staff in post in January has increased by 37.2 wte, and the vacancy rate has slightly reduced. The Trust is undertaking work on taking out posts which feature in the HR's workforce system (electronic staff record), but due to restructures in year are no longer budgeted and therefore cannot be recruited to and this will be concluded in early March.

3.2 Bank and Agency usage has returned to a consistent level following the drop over Christmas and the New Year. Staffing levels in nursing are being reviewed to ensure they are appropriate and agency usage for Band 2 staff is being eliminated where ever possible.

3.3 Turnover has increased since last month and at 15% it remains far higher than the target of 10%. Stability has increased by 0.66%.

3.4 Following increased focus on appraisals, the compliance rate has increased from 74.39% to 81.98% for Medical staff and from 63.78% to 69.59% for non-Medical staff. Fortnightly reporting on compliance rates ensures that we can closely monitor Trust progress towards achieving 85% target and are taking action where necessary.

3.5 MAST compliance has increased to 82% (from 79.6% in December).

3.6 Sickness rates have increased to 4.23% although this is following similar pattern to previous years and is 0.10% lower than they were in January 2016. Due to seasonal fluctuations in the sickness figures we have included a graph to show quarterly figures compared with monthly. This illustrates that in quarter 3 2016/17 our sickness rate was lower than quarterly 3 in 2015/16, and we can predict that quarter 4 is likely to be higher than average. The use of 'Bradford scores' to monitor sickness is being introduced; this calculates the number of spells of absence of an individual over a given period as well as the total number of days of

absence, with greater emphasis on the former so that focus is given to frequent intermittent absence[1].

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 which will be discussed at the EMT and Workforce Committee in March 2017.

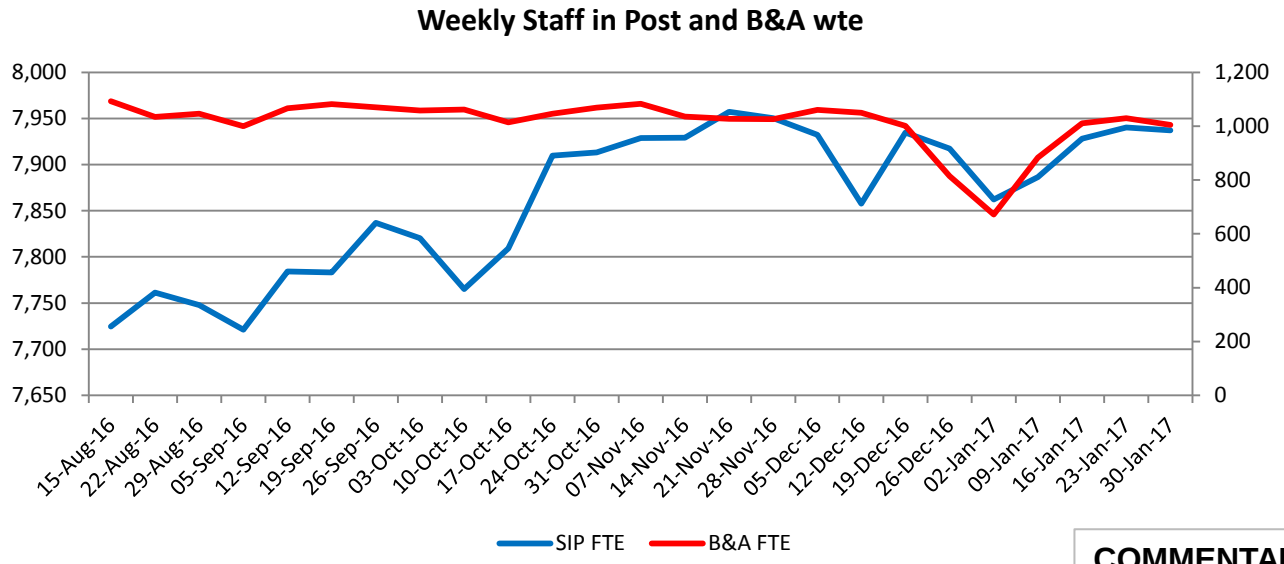
6.0 RECOMMENDATION

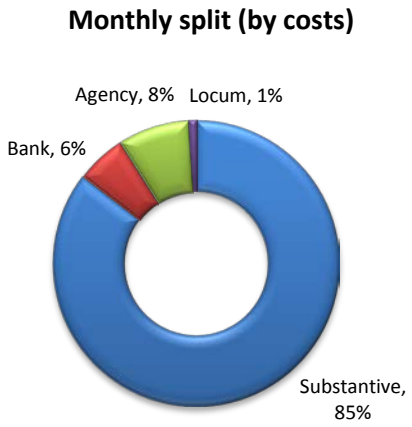
6.1 The Board is asked to note the workforce performance report and actions outlined within it.

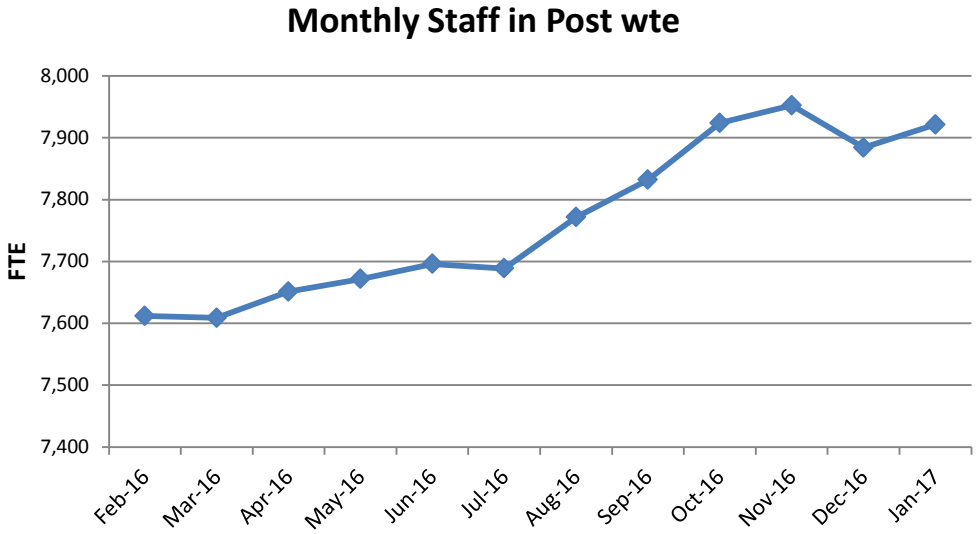
[1] The Bradford Factor is calculated as follows: $B = S^2 \times D$; where B is the Bradford Factor score, S is the total number of spells (instances) of absence of an individual over a set period and D is the total number of days of absence of that individual over the same set period

Section 1: Current Staffing Profile and Bank & Agency

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





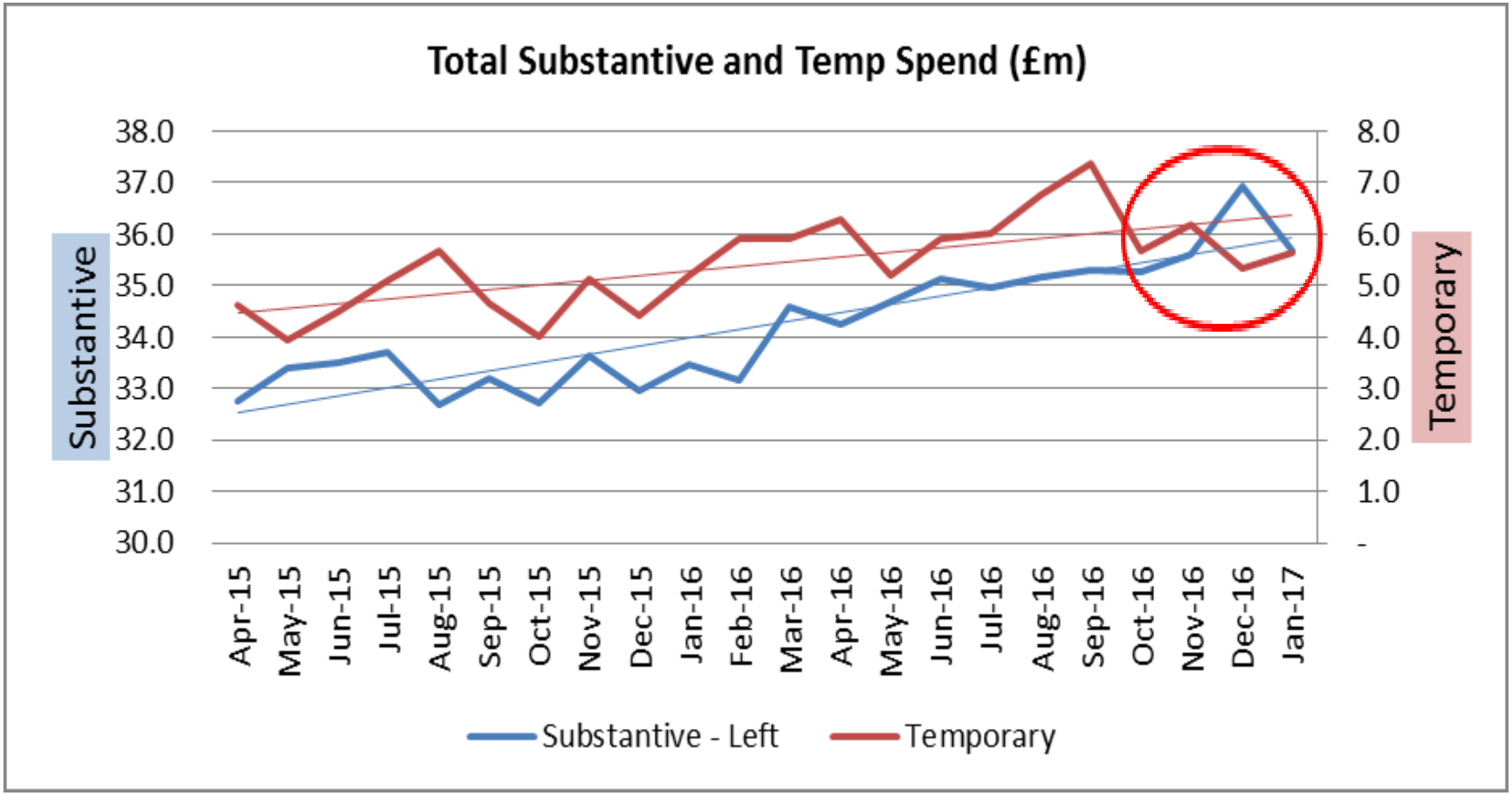


COMMENTARY

Over quarter 3 the pay spend has stabilised and reduced by £0.7m. However it has not reduced as quickly as required. This slide shows the increase in staff in post and a fairly consistent bank and agency spend; the next slide shows the decrease in agency expenditure.

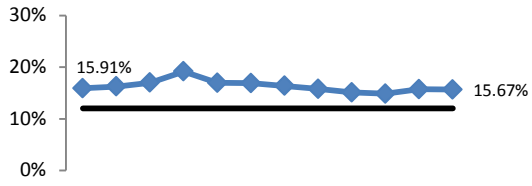
Recovery Plan – Pay Cost Trends

- Direction of travel has changed over the last 4 months (although not as quickly as forecast).
- MO9 substantive pay distorted by increments, accrual and prior period recharges (£1.1m).

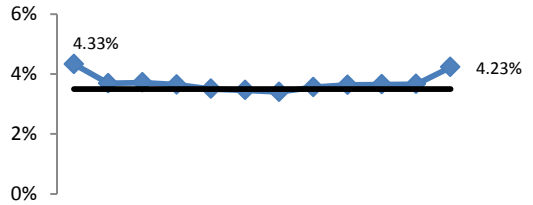


Section 2: Workforce KPIs

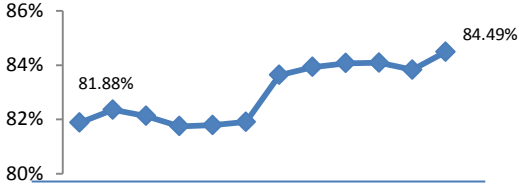
Vacancy Rate Year Trend



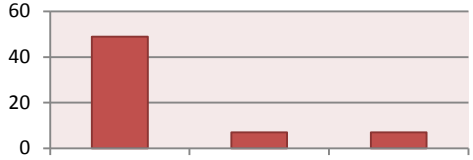
Sickness Rate Year Trend



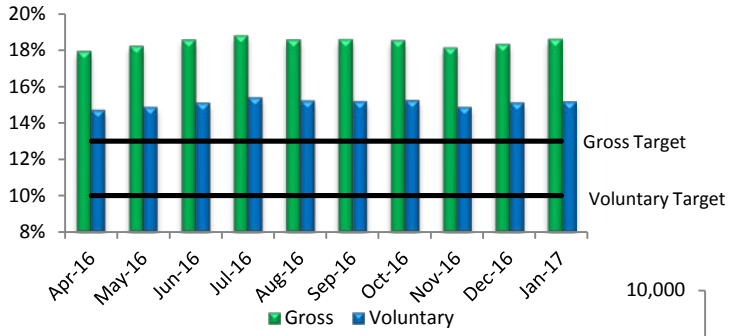
Stability Year Trend



No of Open ER Cases

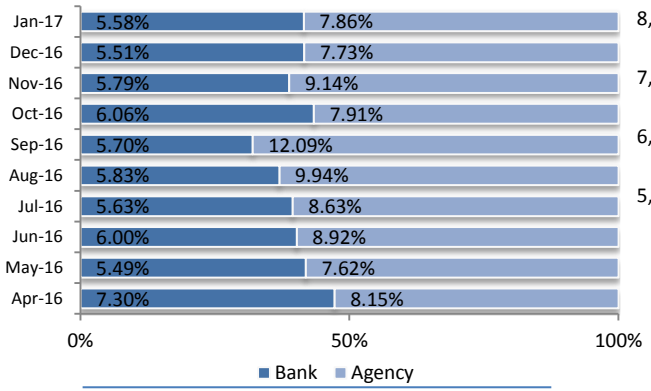


Turnover YTD

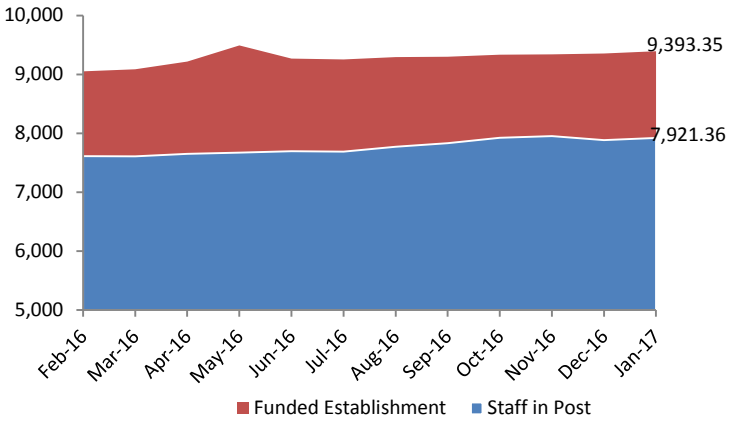


Key Points:		
KPI	Change over the year	Change since last month
Vacancy	-0.24%	-0.05%
Sickness	-0.10%	0.57%
Stability	2.61%	0.66%
Gross Turnover	0.67%	0.27%
Voluntary Turnover	0.47%	0.06%

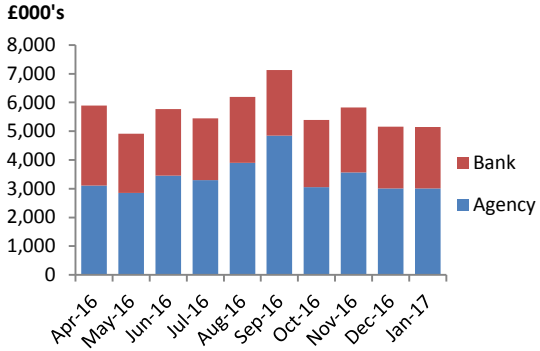
Bank/Agency Mix*



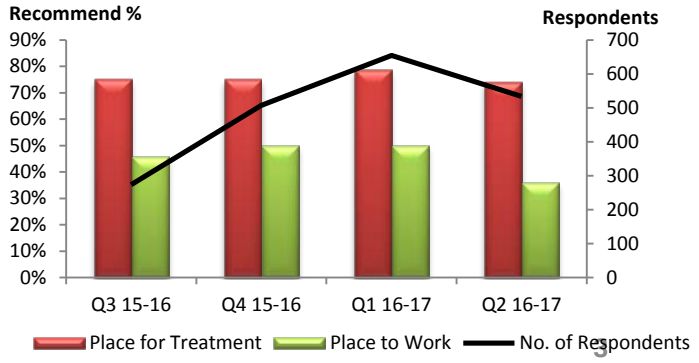
Trust Establishment & Fill Rate



B&A Spend (YTD)*

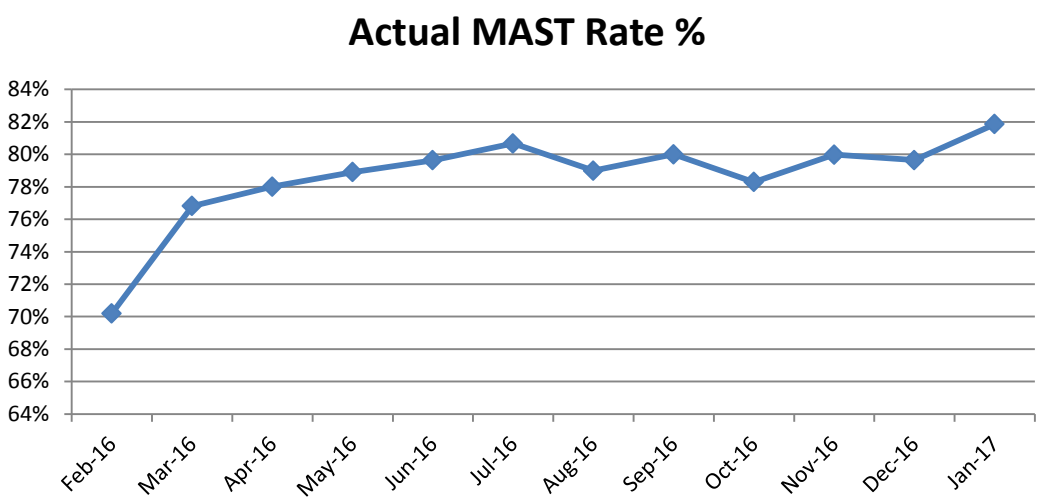


Friends & Family Test



* Does not include SWLP or Central costs

Section 3: MAST Compliance



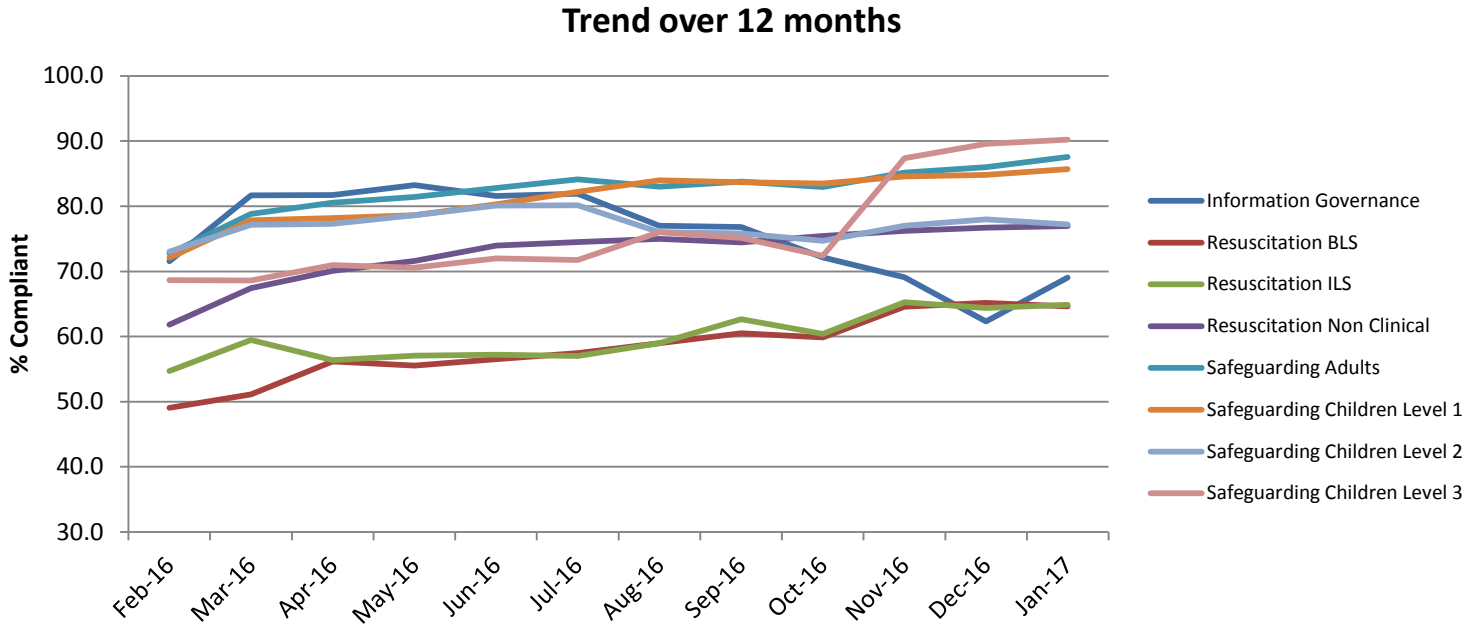
COMMENTARY

The Trust is focussing on improving MAST rates in all areas with an immediate and particular focus on Information Governance, Resuscitation and Safeguarding as noted below.

The overall compliance rate has improved from 70% in February 2016 (and 79.6% in December) to 81.9% in January 2017.

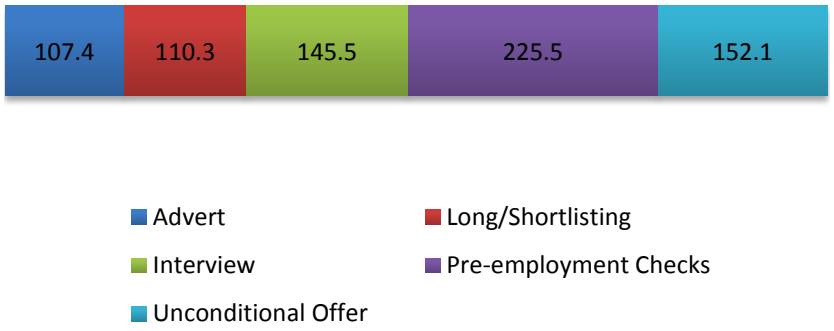
Information governance has improved from 64.4% to 69% in the last month.

However we are behind the target of achieving at least 85% compliance on all areas and remains a key priority for the Trust.



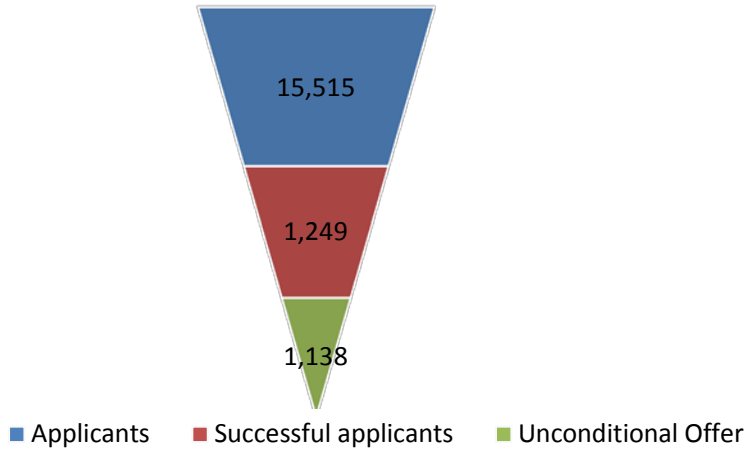
Section 4: Recruitment Pipeline

Non Medical Current Pipeline (wte posts)

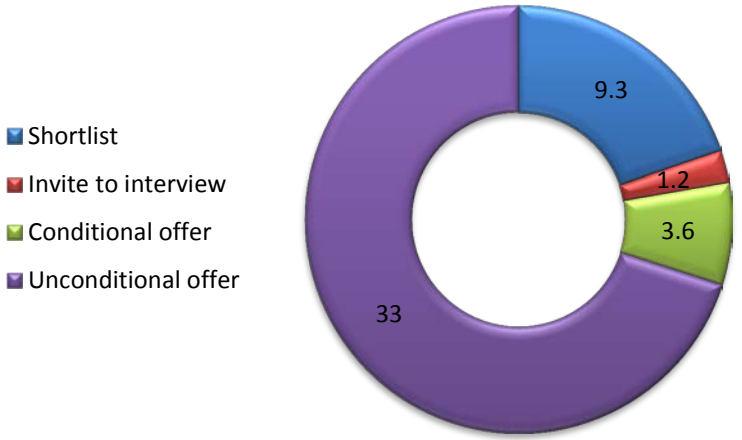


* Data is a snapshot from the end of January

Non Medical Recruitment volumes (over 6 months)



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

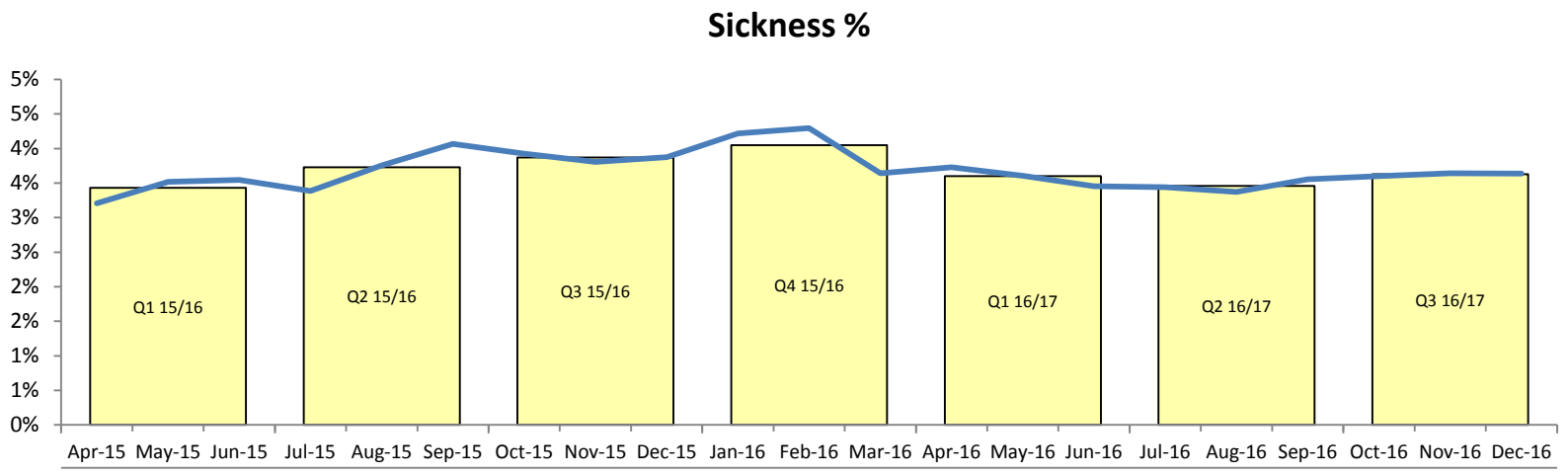


Shortlist – days that Recruiting Managers take to shortlist
Invite to interview – days between shortlisting being received from Recruiting Manager to interview invites being sent out
Conditional offer – days between interview outcome paperwork received to formal conditional offer
Unconditional offer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

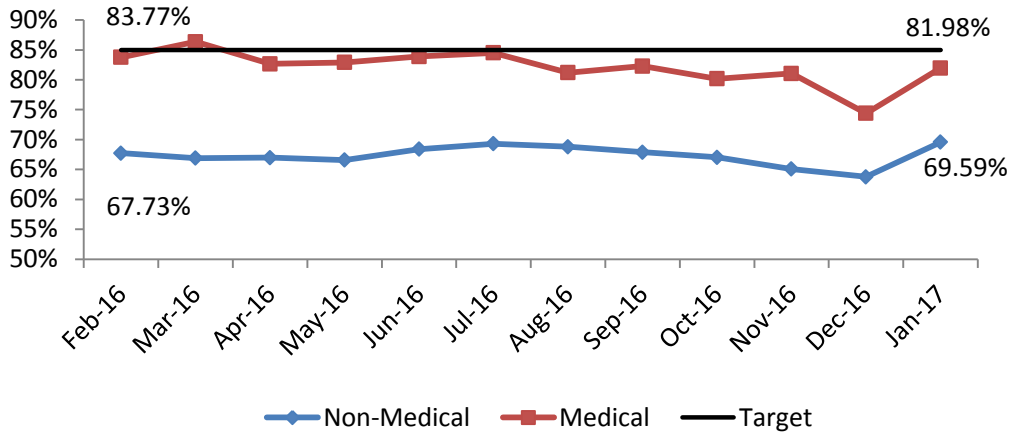
NB: Reporting from the Trac system is relatively new to the Trust and so the figures are intended as a guide only at this stage. Over time this information will ensure we can compare performance month on month and address areas of concern as well as providing better quality data with which to compare ourselves with the best in the sector and other industries.

Section 5: Other

Quarterly vs Monthly comparison:



Appraisals:



Section 6: Month 10 Interim Analysis

Function	Number	Notes	
CEO Office	6		Application of interims: • 36 BAU • 91 major programmes
Operations	11	Includes RTT	
IT	52	Includes stabilisation	
Estates	12	Includes backlog & CQC	
Finance	10	Increase to support coding vacancies	
HR	2		
Governance	4	Includes CQC	
Procurement	-		*Turnaround: • 5 PMO • 8 Outpatients • 2 Revenue/coding • 2 PP, Overseas • 6 major programmes
Turnaround*	23		
Sub-total	**120**		
SWLP	7		
Total	**127**		

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	9 March 2017	**Agenda No**	5.1
Report Title:	Significant Risk Profile		
Lead Director/ Manager:	Paul Linehan		
Report Author:	Maria Prete		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	Core operational risk exposure areas: • Timely Access to Clinical Services/Patient Harm • Insufficient Resilience/Unstable Critical IT/Estates Infrastructure • Unsustainable Financial Position • Inadequate Governance/Reputation Loss		
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**	08.02.2017
Equality Impact Assessment:	N/A		
Appendices:	A. Risk Grading Matrix / Risk Escalation Arrangements (illustrated) B. Table 1: Core Operational Risk Drivers – Feb 2017 C. Figure 1: Emergent Risk Horizon Scan – Feb 2017 D. Figure 2: Interpreting the Risk Horizon Full Corporate Risk Register is available in the reading room for reference		

Corporate Risk Report
Trust Board, 9 March 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 February 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 Board's strategy emerges.

3.0 ISSUE

3.1 Core Operational Risk

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. Table 1 illustrates using a driver diagram the primary cause, effect and potential impact of core operational risks currently on the CRR. The Board remains exposed to extreme risk in the following areas:

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

3.2 Core Strategic Risk

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

3.3 Proceedings of the Risk Management Committee

The Risk Management Committee met on the 8th February 2017 to review the corporate risk register and to review in more detail reportable risk in: (i) Children's, Women's, Diagnostics & Therapeutics Division, and (ii) Communications Department.

- 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.

- Approval for the procurement of 844 beds with integrated bedrails

- NHS England EPRR assurance rating for Business Continuity moved from a Green to Amber in December 2016. This was due to (i) the trust 'suppliers' not being aligned to the international standard ISO22301, and (ii) NHS England changing their rating system for the assurance process after the trust had submitted . The EPLO is liaising with the Head of Procurement about how the Trust achieves this. However the Trust received a rating of Substantial Assurance.

- Closure of 'CRR-0021 - CQC rating less than 'Good' – insufficient safety, effectiveness, caring, responsiveness or not well-led' risk as this has become an actual event. This risk has been replaced with a new risk 'CRR-1179 – Failure to come out of special measure by the next CQC inspection'

- Addition of 'CRR-1179 – Failure to come out of special measure by the next CQC inspection' risk. This risk was raised in view of the progress of the QIP programme. The remediable actions are addressed within the QIP programme

- Addition of 'CRR-1180 – Potential loss of income due to bidding for newly tendered services being unsuccessful' risk. This risk highlights the potential income loss of an aggregate value of £26.8 million. Monthly meetings are being held with commissioners to develop tender model.
- Increased risk score of 'CRR-0014 - Failure to secure colleague engagement' risk from (4x4)=16 to (5x4)=20. Impact of this risk was increased due to inability to give

assurance on existing controls following negative staff survey results and possibly indicating that staff are not engaged and therefore posing high impact.

- Increased risk score of 'CRR-0022 – Insufficient management capacity or capability to deliver turnaround programme' risk from (3x5)=15 to (4x5)=20. Impact of this risk was increased following review of contribution from leader and their importance.

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:

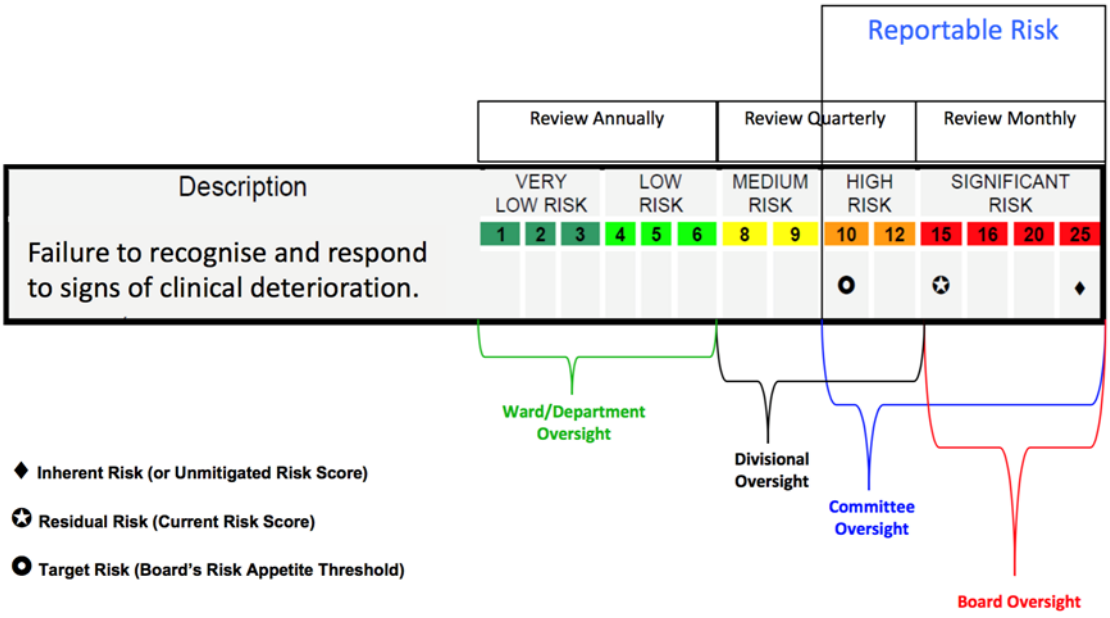
- To satisfy itself that the current level of risk exposure is tolerable or acceptable and that the Board are content with the level of control achieved over those risks;
- Where the Board are not satisfied, to agree further actions required to bring the risks under prudent controls; and
- To consider 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)]



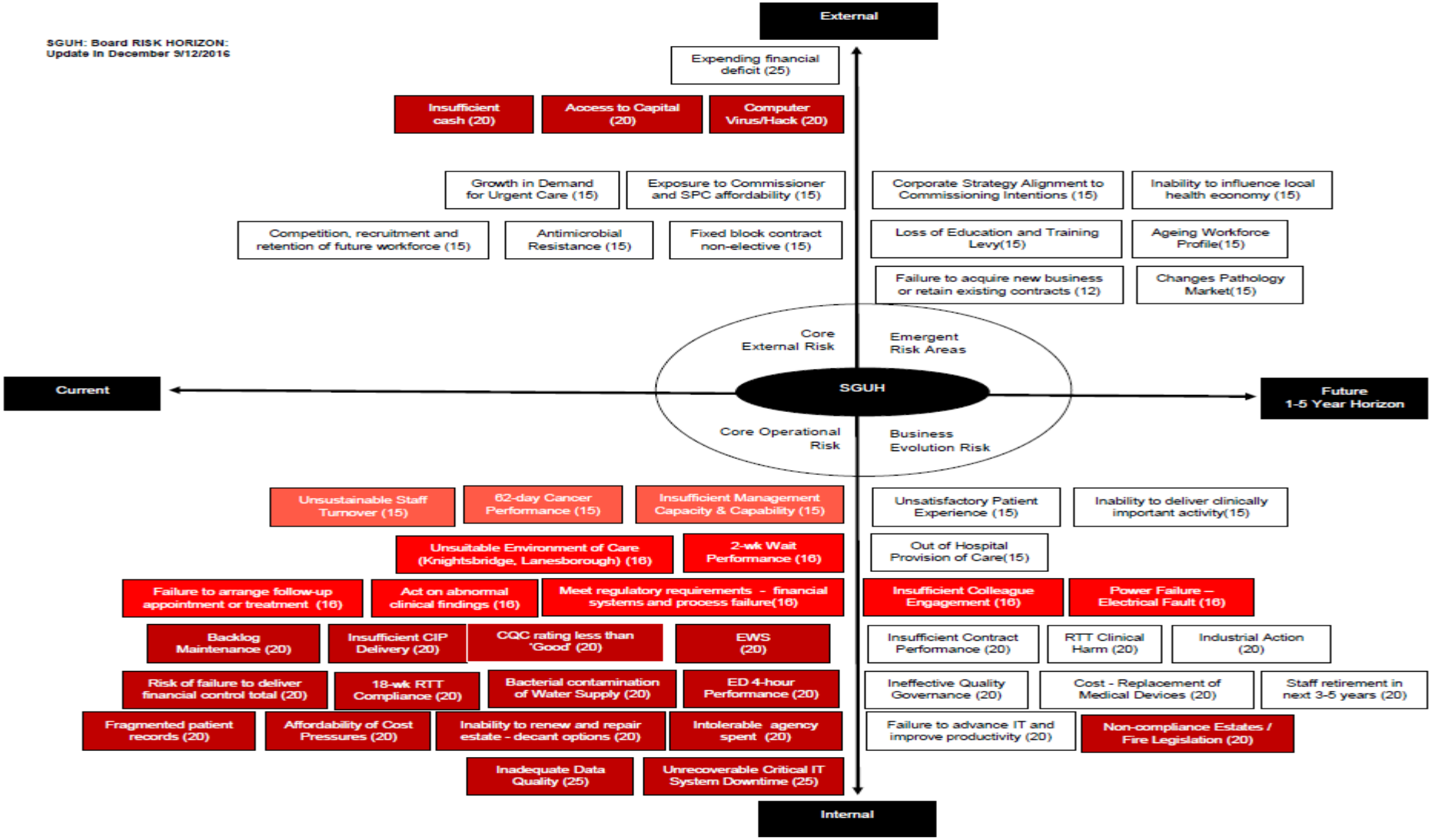
APPENDIX [B]

[Table 1: Core Operational Risk Drivers – Feb - 2017]

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	⇔		
Potential loss of income due to bidding for newly tendered services being unsuccessful	15	NEW		
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	⇔		
Failure to come out of special measures by the next CQC inspection	20	NEW	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	20	↑		
Failure to secure colleague engagement	20	↑		
Inadequate data quality, completeness or consistency	25	⇔		
↑ = Risk Increase; ↓ Risk reduced; ⇔ No change from previous report to Board.				

APPENDIX [C]

[Figure 1: Emergent Risk Horizon Scan – Feb - 2017]



APPENDIX [D]

[Figure 2: Guidance - Interpreting the Risk Horizon]