Trust Board Meeting

Date and Time: Thursday 1 December 2016, 10:00 – 13:00
Venue: Boardroom H2.8, 2nd Floor, Hunter Wing

PATIENT STORY
A parent who currently has a three year old son in PICU will be attending to describe her experiences.

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 3 November 2016**	Approve	Chairman	Paper
	1.4	**Action Log and Matters Arising**	Review	All	Paper
	1.5	**CEO's Report**	Inform	CEO	Oral
PATIENT SAFETY, QUALITY AND PERFORMANCE					
	2.1	**Trust Quality Improvement Plan**	Assure	DQG	Paper
	2.2	**Response to Section 29A Letter**	Assure	DQC	Oral
	2.3	**Performance & Quality Report**	Review	COO/CN	Paper
	2.4	**Report from the Quality Committee**	Inform	Chair of Committee	Oral
	2.5	**Workforce Performance Report**	Inform	DHR&OD	Paper
	2.6	**Update on the Workforce Race Equality Standards (WRES) Action Plan**	Assure	DHR&OD	Paper
	2.7	**Report from the Workforce and Education Committee**	Inform	Chair of Committee	Paper
	2.8	**Briefing on Referral to Treatment (RTT)**	Inform	RTT PD	Paper
FINANCE					
	3.1	**Month 7 Finance Report**	Assure	CFO	Paper
	3.2	**Report from Finance & Performance Committee**	Inform	Chair of Committee	Oral
GOVERNANCE & RISK					
	4.1	**Response to NHS Improvement Enforcement Undertakings**	Assure	CEO	Paper
	4.2	**Corporate Risk Report**	Review	DQG	Paper
	4.3	**Report from Audit Committee**	Inform	Chair of Committee	Paper
CLOSING ADMINISTRATION					
12.55	**5.1**	**Questions from the Public**	-	Public	Oral
	5.2	**Summary of Actions**	-	Co Sec	Oral
	5.3	**Any New Risks or Issues**		All	-
	5.4	**Items for Next Meeting** Briefing on Safeguarding		-	-
	5.5	**Any Other Business**	-	Chair	-
	5.6	**Reflection on Meeting**	-	All	Oral
13:00		**Close**			

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

Date and Time of Next Meeting: Thursday 5 January 2017 10:00 – 13:00
Trust Board
Purpose, Membershipand 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	
Suzanne Banks	Chief Nurse	CN
Margaret Pratt	Chief Financial Officer	CFO
Andrew Rhodes	Medical Director	MD
Thomas Saltiel	Associate Non-Executive Director	Name/NED
Executive Team		
Karen Charman	Director of Workforce & Organisational Development	DWOD
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
Diana Lacey	Referral to Treatment (RTT) Programme Director	RTTPD
Iain Lynam	Chief Restructuring Officer	CRO
Paul Moore	Director of Quality Governance	DQG
Larry Murphy	Chief Information Officer	CIO
Executive Team		
Alison Benincasa	Divisional Chair, CSD	DC/CSD
Tunde Odutoye	Divisional Chair, SCTN	DC/SCNT
Lisa Pickering	Divisional Chair, MedCard	DC/MedCard
Justin Richards	Divisional Chair, CWDT	DC/CWDT
Secretariat		
Fiona Barr	Corporate Secretary and Head of Corporate Governance	Co Sec

Trust Board Dates 2016-17			
Thursday 01.12.16 13:00 – 15:30	Thursday 05.01.17 13:00 – 15:30	Thursday 09.02.17 13:00 – 15:30	Thursday 09.03.17 13:00 – 15:30

Trust Board (Public)
3 November 2016 – From 10:00
H2.8 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
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Gillian Norton	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Margaret Pratt	Chief Financial Officer	CFO
Andy Rhodes	Medical Director	MD
Suzanne Banks	Chief Nurse	CN
IN ATTENDANCE		
Thomas Saltiel	Associate Non-Executive Director	NED
Karen Charman	Director of Workforce	DWOD
Mark Gordon	Chief Operating Officer	COO
Richard Hancock	Director of Estates & Facilities	DE&F
Iain Lynam	Chief Restructuring Officer	CRO
Paul Moore	Director of Quality Governance	DQG
Larry Murphy	Chief Information Officer	CIO
Alison Benincasa	Divisional Chair, CSD	DC - CSD
Lisa Pickering	Divisional Chair, MedCard	DC - MedCard
Justin Richards	Divisional Chair, CWDT	DC - CWDT
APOLOGIES		
Tunde Odutoye	Divisional Chair, Surgery	DC - SNTC
SECRETARIAT		
Fiona Barr	Interim Corporate Secretary & Head of Corporate Governance	Co Sec

PATIENT STORY

Monika Kupper joined the meeting to tell them about her experiences of giving birth at the Trust; she had given birth to two children though the second birth was difficult for a number of reasons. Her story gave the Board an insight into how her care had been provided and how that felt, as a patient, to receive. The Trust had already learned a great deal from the experience as Monika had actively supported the Trust in making a number of improvements as a result – and continued to do so. The Chairman thanked Monika on behalf of the Board.

OPENING ADMINISTRATION

1A Welcome and Apologies

1.1	The Chairman opened the meeting and welcomed everyone, in particular the two new Non-Executive Directors, Ann Beasley and Stephen Collier, who had recently joined the Board.
1.2	The apologies were as set out above.

1B Declarations of Interest

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1.3	The Chairman asked for declarations of interest. None were made.
1C Minutes of Meeting held on 06.10.16	
1.4	These were accepted as a true and accurate record of the meeting held on 06.10.16, save for a minor formatting change.
1D Matters Arising and Action Log	
1.5	The Board received the Action Log and noted that the actions were closed. There were no matters arising.
1E Chief Executive's Report	
1.6	The CEO explained that the Trust had been given an overall rating of Inadequate by the Care Quality Commission (CQC): i. Inadequate for being safe and well-led; ii. Requires Improvement for being effective and responsive; iii. Good for being caring.
1.7	The CQC's report, published on 01.11.16, followed an inspection of services provided by the Trust in June 2016. The Trust was also required to meet a number of requirements set out in a CQC Warning Notice relating specifically to: i. providing safe and fit premises at St George's Hospital; ii. obtaining consent under the Mental Capacity Act; iii. running a sound system of governance; iv. complying with the *Fit and Proper Person* requirement.
1.8	The CQC had also recommended St George's be put into special measures and the Trust had now received a letter from NHS Improvement setting out Enforcement Undertakings and an additional Licence Condition. The CEO explained that being in special measures would entitle the Trust to receive support to make the required improvements.
1.9	He also set out a number of positives in the report. The Trust's 9,000 staff were found to be caring, and doing a good job in challenging circumstances and its renal unit was praised for delivering some of the best survival rates and outcomes for patients in the country. The care provided by the maternity and neonatal teams was singled out for showing a real drive to improve the experience of families using the services and the clinical outcomes achieved by our specialist medical and surgical teams were also praised.
1.10	The CEO advised that there had been a full programme of briefings for staff and stakeholders since the announcement and the Trust had held a Quality Summit with the CQC where Stephen Russell, Executive Regional Managing Director of NHS Improvement confirmed that St George's was a safe hospital and would be happy to recommend it to friends and family for treatment.
1.11	A key area of concern for the CQC had been the hospital estate though the Director of Estates & Facilities announced that in the last week there had been 100% compliance on Legionella Flushing. He noted further work to be done on Pseudomonas.
1.12	The CEO closed by setting out the work to address the concerns raised in the CQC report and the enforcement notice from NHS Improvement and committed to keep the Board fully apprised of progress.
1.13	The Chairman thanked the CEO for his report adding that the priority was now to stabilise the Trust's performance, consolidate the improvements being made and continue to provide strong leadership.
PATIENT SAFETY, QUALITY AND PERFORMANCE	

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2A Trust Quality Improvement Plan	
2.1	The DQG introduced the Quality Improvement Plan, explaining the action that had been undertaken at pace to address the identified compliance concerns (Appendix 2 of the report set out the Trust's position). The work was progressing well overall though a strong focus was needed to meet all the requirements of the Warning Notice by the end of November.
2.2	He summarised the workstreams which were delivering over 160 action, 27 (16%) of which had been completed and reported as embedded (subject to internal verification). Of the remaining active actions (137 or 84%), well over half were rated as "Green".
2.3	The Board discussed the content of the Quality Improvement Plan and the progress being made. In particular there were discussions about the need to address the shortcomings in the strategy for End of Life Care (EOLC). The Executive was encouraged to review local best practice and work with commissioners to strengthen current arrangements – though these were currently well regarded by patients' relatives.
2.4	The Board also briefly discussed the Referral to Treatment (RTT) workstream and agreed to receive a fuller briefing about RTT actions and progress at its next meeting.
ACTION TB.03.11.16/01	**Brief the Board on progress with achieving the RTT actions. LEAD: RTT Programme Director**
2.5	The Board was assured by the DQG that he had to see evidence of compliance before turning an assurance rating to "Green" and was happy to note the current position on the Quality Improvement Plan and the actions to address compliance concerns set out in the Warning Notice.
2B Performance & Quality Report	
2.6	The COO introduced the performance report advising that the Trust was performing positively against a number of indicators though particular challenges remained in the achievement of the Emergency Department (ED) Four Hour target, RTT and cancelled operations on the day by the hospital for non-clinical reasons. Cancer waiting time targets had been achieved in July and August and the Trust was also on target to achieve the September STF and national targets - though sustaining this would be challenging. There was still work to do to address the RTT backlog though this would be addressed by the RTT recovery programme.
2.7	There were improvements in diagnostic waits greater than six weeks for which there had been a week on week reduction. A new daily COO-led Performance Control meeting was placing focus on key issues and risks for the day, performance against key standards and activity plans and this was beginning to yield good results. In addition a new Flow Programme was being finalised to address local ED and system challenges to support performance improvement.
2.8	The Board supported the improvements in ED performance and commended the work done – including introducing internal professional standards, having specialist doctors visit ED to make decisions on patients. The Board extended its thanks to the ED teams for the steps they had taken – which had had an impact across the hospital.
2.9	Whilst the NEDs supported the improvements being made in a range of areas, they challenged the Executive to compare the Trust against the best teaching hospitals in the country and use their performance as benchmark, most particularly in relation to day case surgery rates and enhanced recovery after surgery. Sir Norman Williams agreed to provide the benefit of his experience and discuss this further with the COO.
2.10	The Chief Nurse led the Board through the quality metrics noting that: i. Mortality indicators remained better than expected. ii. Safety thermometer for was 95.65%, in line with the national average of 95%. iii. There had been a reduction in the number of Serious Incidents (SIs) being declared and more were being dealt with and closed down quicker.

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	iv. There had been no falls resulting in severe harm or moderate harm in September and there had been an overall reduction in falls month on month (134 versus 166). v. There had been no grade 3 or 4 Pressure Ulcers for three consecutive months; this was a year on year reduction. vi. There were three Trust apportioned C. Difficile cases in September with a cumulative total of 12 (Trust threshold being 31 for the year). vii. An MRSA case was reported in October which was the first this year though the investigation did not suggest a lapse in care. viii. Safeguarding children level 3 compliance, conducted through a manual count, was at 89% across the Trust (exceeding the 85% target) though adult safeguarding training fell short of the target 83.2% and would be monitored through Divisional Performance Review meetings. ix. Work was being done to check that training in Deprivation of Liberty (DOLS) and Mental Capacity Act (MCA) represented practice. x. Main complaints themes were: clinical treatment, communication and appointment delay/cancellation. xi. Friends and Family Test score was 94% Trust-wide. xii. Nursing workforce fill rates were 95%.
2.11	The Chief Nurse advised that she was working on a ward level dashboard so that there would be ownership of quality performance at ward level – this was welcomed by the NEDs. She also agreed to return to the Board with benchmarked Pressure Ulcer performance per 1000 bed days. It was agreed that the Quality Committee would receive a deep dive on mortality statistics every six months.
2.12	The Board received the report.
ACTION TB.03.11.16/02	**Include benchmarked Pressure Ulcer performance per 1000 bed days in January 2017 Quality Performance Report.** **LEAD: Chief Nurse**.
ACTION TB.03.11.16/03	**Undertake a deep dive into mortality statistics at the Quality Committee every six months.** **LEAD: Medical Director and Chief Nurse**.
2C Workforce Performance Report	
2.13	The DWOD presented a redesigned workforce report which presented the Trust's position against a number of key workforce performance indicator, noting that the Workforce & Education Committee received a more detailed report at its meeting every two months.
2.14	She advised that the main points to note were that vacancy rates had fallen by 0.85% though sickness absence had risen (though was below levels for the same time last year). Bank and agency spend remained high despite increased staff in post and headcount reductions were starting to take effect though further measures were required to control pay spend.
2.15	The DWOD drew the Board's attention to the Workforce Race Equality Standard (WRES). She reminded the Board that during the summer, the Workforce department had prepared an action plan, with input from an internal WRES steering group and the Staff Network Advisory Group, which had also been presented to the Trust's commissioners and placed on the Trust website. To ensure that the Board remained apprised of progress on this key target, she agreed to return an updated WRES action plan to the Board for review in December 2016. The Board confirmed that it was satisfied that it had effective arrangements in place to implement WRES within the Trust and looked forward to receiving an update the following month.

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ACTION TB.03.11.16/04	**Present an updated WRES action plan to the Board in December 2016 to retain a Board focus on this key area of work. LEAD: Director of Workforce & OD**
2.14	The Chairman thanked the DWOD for the update and the Board received the report.
2D Referral to Treatment (RTT) Access Policy	
2.15	The COO briefly presented the policy which had first been presented to the Board in April 2016. The Board requested to see the final version for approval once it had incorporated the revised national guidance for RTT as this was a key component of the Trust RTT recovery programme. He explained that the policy provided a set of standards for the management of referrals, waiting lists and appointments and admissions to ensure that the Trust maintained clinical priorities and met its statutory responsibilities in relation to 18 Week RTT maximum waiting time for elective patient pathways. The policy would also harmonise working practice across the hospital.
2.16	The Board approved the revised policy.
FINANCE	
3A Month 6 Finance Report – Including Update on Cost Improvement Programme	
3.1	The CFO reported that the Trust had an in-month deficit of £7.3m in September 2016 which was £6.7m worse than plan. Included in month was non-pay overspend (£3.4m), excess pay costs of £2.0m and below plan Service Level Agreement (SLA) income (£2.6m; mainly attributable to the STF (£1.5m) and RTT non-reporting penalty (£2.0m)). She advised that £1.0m of pay and £2.0m of income were costs that were unforeseen and outside of the control of the Trust. The year to date deficit was £42.2m and the forecast outturn submitted to NHS Improvement at Month 6 was £55.5m; these values being £26.4m and £38.3m worse than plan respectively.
3.2	The CFO noted that there was a lot more work to be done to improve the financial position and that each of the Divisions was working through a detailed re-forecasting of budgets to gain a clearer position of the likely outturn.
3.B Report from Finance & Performance Committee (F&PC)	
3.3	The Trust Chairman advised the Board that at the October 2016 F&PC meeting, there had been detailed discussions on the Trust's Month 6 financial position, Divisional recovery plans, the Trust recovery plan, the cash position and overall forecast at Month 6. He confirmed that discussions were underway with NHS Improvement on the Trust's financial position with a meeting planned in November following which the Board may reconvene to discuss next steps.
GOVERNANCE AND RISKS	
4A Corporate Risk Report	
4.1	The DQG presented the Corporate Risk Report which was taken as read. He focused on the Interim Risk Appetite Statement on which he sought comments and views, advising that it was necessary for the Board to have an understanding of its appetite for risk. The Board indicated that it was content to accept the Interim Risk Appetite Statement and received the Corporate Risk Report.
4B Quarterly Report on Serious Incidents 2016-17	

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4.2	The DQG briefly presented the report which provided an overview, year to date, of the SIs that had been declared by the Trust, including a summary assessment of Trust-wide learning resulting from things going wrong.
4.2	The Board discussed the content of the report, in particular the use of safer surgery checklists, and broadening the learning to include human factors training. The DQG was also asked about the Trust's insurance position (including the premium for 2017-18) and overall level of litigation and clinical negligence claims. He agreed to bring a report back to a future Board meeting.
4.3	The Board received the report.
ACTION TB.03.11.16/05	**Present a report to the Board on the Trust's insurance arrangements and overall level of litigation and clinical negligence claims. (January 2017) LEAD: Director of Quality Governance**
ITEMS FOR INFORMATION	
5A Use of Trust Seal	
5.1	The Seal had not been used since the last meeting.
5B Questions from the Public	
5.2	As the Trust had received a number of questions in response to extensive media coverage in October 2016 about potential changes to the way we look after patients from overseas who access our maternity services at St George's, he read out a statement to explain what changes were being proposed, and the steps being taken to ensure patients continue to receive the care and treatment they need. He emphasized firstly that they were proposals and had yet to be rolled out and secondly, were not designed to discriminate, as had been reported. *"Like many Trusts, we treat a high number of patients from overseas who are not eligible for NHS treatment. Of course, all patients in need of emergency NHS are treated and prioritized accordingly, regardless of their eligibility. Our priority at all times is to provide care and treatment to patients accessing our services. However, we also have a duty to ensure we use our resources wisely.* *In fact, we have a legal duty to do so - Department of Health guidance published in 2015 requires us to identify all chargeable overseas visitors and recover the cost of treatment from them.* *The new pilot approach – which has been supported by the Department of Health and Home Office - would simply involve us following these existing guidelines more effectively. We are not doing this well enough at present.* *What we are proposing would involve every non-emergency patient accessing maternity treatment to show a form of photo ID, or proof of their right to remain in the UK. Any patient who is unable to do this would be referred to our Overseas Patient Team for specialist document screening.* *In short, what we are proposing is that by identifying patients in 'real-time', we are able to offer them advice and support, rather than the current situation whereby they are invoiced retrospectively. We have never said that women will be refused care if they are unable to provide the relevant documentation – we do, however, have an obligation to inform patients that charges may apply.* *This would be trialled as a pilot study at St George's. We hope to agree a start date for*

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	the pilot shortly, but only after further work is undertaken to look at the practical and logistical challenges involved."
5.3	The Lead Governor asked about the Trust's policy on allowing smoking on its premises. The DE&F agreed to look into the matter and report back.
ACTION TB.03.11.16/06	**Report on the Trust's policy on smoking on its premises. LEAD: Director of Estates & Facilities**
CLOSING ADMINISTRATION	
6A Reflection on Meeting	
6.1	The Chairman thanked the Board for their input and contribution.
6B Any Other Business	
6.2	As 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 1 December 10:00 – 15:30

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Action Ref	**Theme**	Action	**Due**	**Revised Date**	**Lead**	**Commentary**	**Status**
TB.03.11.16/01	RTT Progress	Brief the Board on progress with achieving the RTT actions.	01-Dec-16		RTT PD	On the Trust Board agenda - 01.12.16	Propose for closure
TB.03.11.16/02	Pressure Ulcer Performance	Include benchmarked Pressure Ulcer performance per 1000 bed days in January 2017 Quality Performance Report	TBC		CN	This action is not yet due.	Open
TB.03.11.16/03	Mortality Statistics	Undertake a deep dive into mortality statistics at the Quality Committee every six months.	29-Mar-17		MD & CN	This action will be added to the Quality Committee Action Tracker for reporting at the March meeting.	
TB.03.11.16/04	Workforce Race Equality Standards (WRES)	Present an updated WRES action plan to the Board in December 2016 to retain a Board fosuc on this key area of work.	01-Dec-16		DWOD	On the Trust Board agenda - 01.12.16	Propose for closure
TB.03.11.16/05	Legal Arrangements	Present a report to the Board on the Trust's inusurance arrangements and overall level of litigation and clinical negligence claims.	05-Jan-17		DQG	This action is not yet due.	Open
TB.03.11.16/06	Smoking Policy	Report on the Trust's policy on smoking on its premises.	01-Dec-16		DE&F	Oral update to be provided at the Trust Board meeting: 01.12.16	Propose for closure

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	25.11.16	**Agenda No**	**2.1**
Report Title:	Quality Improvement Programme progress report		
Lead Director/ Manager:	Paul Moore Director of Quality Governance		
Report Author:	Anne O' Connor QIP Manager		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:			
Recommendation:			
Supports			
Trust Strategic Objective:			
CQC Theme:	All CQC Domains		
Single Oversight Framework Theme:			
Implications			
Risk:	Failure to make the improvements set out in the Warning Notice could result in the CQC: • Requiring NHS Improvement, to make an order under Section 65D (2) of the National Health Service Act 2006 (appointment of trust special administrator) • Prosecution of the accountable person.		
Legal/Regulatory:	Health and Social Care Act 2008		
Resources:			
Previously Considered by:	Quality Committee and Quality Improvement Board	**Date 23/11/16**	
Equality Impact Assessment:			
Appendices:	Overview of QIP workstreams		

1.0 PURPOSE

1.1 To advise and update the Board on the CQC 29A Warning notice progress

1.2 To advise on progress against the QIP

2.0 BACKGROUND OR CONTEXT

2.1 In June 2016, St Georges University Hospitals NHS Foundation Trust received a planned inspection by the Care Quality Commission (CQC). A team of 60 inspectors interviewed staff, talked to patients about the care they received, inspected premises and monitored the care provided.

2.2 Following the inspection visit the Trust was issued with a Section 29A warning notice in respect of concerns around patient safety, and was mandated to comply with the requirements by 30/11/17.

2.3 The final inspection report was published on 01/11/16, rating St Georges overall as Inadequate. The Trust was subsequently placed in special measures by NHSI.

The five domains were rated as following:

Ratings	
Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

3.0 Summary of Actions

3.1 The Trust was required to submit a response to the CQC regarding their Section 29A Warning Notice. The responsive letter was signed by the Accounting Officer and was reviewed and agreed by the Quality Improvement Board and Quality Committee prior to signing. The letter was circulated to Board Members immediately after submission.

3.2 In response to the findings contained within the final report, the Trust has further developed the of the Quality Improvement Plan (QIP), which defines and tracks the improvements we need to make in order to take it from Inadequate to a 'Good" or an outstanding position. It incorporates all of the immediate requirements and 87 Must Do/ Should do recommendations arising from the CQC's visit and subsequent report. It also is a focal point for our longer-term

improvement journey, and the various quality improvement initiatives occurring across the organisation – both now, and in the future. It is recognised that this will not be achieved overnight, but is a journey that requires the engagement of all staff within the Trust.

The Trust will have 9 months from 01/11/16 to complete the actions or show significant progress against them. This will be closely monitored by both the CQC and NHSI.

3.3 There is now a total of 9 work streams involved in the QIP, into which 323 actions are incorporated. Of those actions, 34 have assurance (11%) and 289 (89%) remain active. Of the active actions, 4% are red, 6% amber and 90% are green. Please note that the high number of green actions reflect the inclusion of new actions with future completion target dates.

See Appendix A for breakdown of actions by workstreams. provides additional information on each workstream.

3.4 The QIP plan will be submitted to NHSI by 30/11/16 for sign off. On sign off it will then be submitted to the CQC for agreement.

4.0 IMPLICATIONS

Risks

4.1 Failure to comply with the requirements of the S29A Warning Notice could result in prosecution of the accountable person.

4.2 Compliance with the Acceptance of the QIP by NHSI and the CQC is key to removing the Trust from special measures.

4.3 Failure to implement the actions within the QIP will result in the Trust remaining 'inadequate' '

Legal Regulatory

4.4 Health and Social Care Act 2008

Resources

6.0 RECOMMENDATION

6.1 To note the current position of the overall QIP
6.2 To note and consider the progress to address compliance concerns set out in the warning notice
6.3 Advise on any additional action required.

Author: Anne O' Connor
Date: 25/11/2016

APPENDIX A

Summary Of QIP Work Streams

QIP Workstream	Total Actions	B	R	A	G	Overall Status	Comments
Personalised Care	97	9	4	13	71		Risks in compliance with End of Life Care strategy and governance, Gwynne Holford staffing, Paediatric staffing, MCA/DoLs compliance, Bedrails availability
Safety Culture	55	4	2	0	49		Radiation safety missed target dates, although progressing actions.
Governance	26	5	0	0	21		
Human Resources	28	4	0	2	22		
Estates	36	12	4	3	17		Water safety management (Pseudomonas), theatre refurbishment and PPM, demolition of buildings.
Operations	50	0	0	0	50		New actions
H/C Informatics	6	0	0	0	6		New actions
Leadership	15	0	0	0	15		New actions
RTT	10	0	0	0	10		Although the RTT Plan was approved by NHSI 24/11/16 there remains a considerable delay to its implementation from application of the Section 29A Warning Notice and the risk of harm arising as a direct consequence of extended waiting times for patients remains high, therefore it has been rated Red. The QIP will monitor compliance with the time scales on the RTT work plan.
Total	323	34	10	18	261		

Key

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

Summary of progress against actions within workstreams

Workstream	Sub Area	BRAG analysis					
		B	R	A	G	Total by WS	Overall BRAG
1.Personalised Care							
1.1	EOLC	1	0	8	13	**22**	**A**
1.2	Gwynne Holford	5	1	2	14	**22**	**A**
1.3	Bedrails	0	1	1	12	**14**	**A**
1.4	MCA/DoLs/Safeguarding	2	0	1	2	**5**	**G**
1.5	Infection Prevention	0	0	0	5	**5**	**G**
1.6	Pain Management	1	0	0	11	**12**	**G**
1.7	Privacy & Dignity	0	0	0	4	**4**	**G**
1.8	Dementia Care	0	0	0	6	**6**	**G**
1.9	Paediatric Care	0	2	1	4	**7**	**R**
Total for PC		**9**	**4**	**13**	**71**	**97**	
2.Safety Culture							
2.1	Medicines Management	4	0	0	22	**26**	**A**
2.2	Radiation Safety	0	2	0	9	**11**	**R**
2.3	Deteriorating patient	0	0	0	8	**8**	**G**
2.4	WHO safer surgery	0	0	0	6	**6**	**G**
2.5	Clinical records security	0	0	0	4	**4**	**G**
Total for SC		**4**	**2**	**0**	**49**	**55**	
3.Governance		**5**	**0**	**0**	**21**	**26**	**G**
4.Human Resources		**4**	**0**	**2**	**22**	**28**	**G**
5.Estates		**12**	**4**	**3**	**17**	**36**	**R**
6. Operations							
6.1	Patient Access	0	0	0	18	**18**	**G**
6.2	Safe Staffing levels	0	0	0	6	**6**	**G**
6.3	Equipment requirements	0	0	0	3	**3**	**G**
6.4	Neuro rehab & amputation service strategy	0	0	0	8	**8**	**G**
6.5	Community Adult Health Strategy	0	0	0	6	**6**	**G**
6.6	Divisional Trust Ops communications	0	0	0	1	**1**	**G**
6.7	Data Management	0	0	0	4	**4**	**G**
6.8	Health Visiting	0	0	0	4	**4**	**G**
Total for SC		**0**	**0**	**0**	**50**	**50**	

7. H/C Informatics		**0**	**0**	**0**	**6**	**6**	**G**
8. Leadership		**0**	**0**	**0**	**15**	**15**	**G**
9. RTT		**0**	**0**	**0**	**10**	**10**	**R**
Total numbers		**34**	**10**	**18**	**261**	**Overall Actions 323**	**Overall rating**

Personalised Care Workstream Overview report

QIP Work stream: Personalised Care		**Executive Lead:** Title: Chief Nurse Suzanne Banks						
Overall BRAG	**Reporting Period:** (Nov 2016)	**Action BRAG rating analysis**						
		R	**A**	**G**	**B**	**B/G**	**Active Actions**	**Assurance Actions**
							90	**9**
		4	**13**	**71**	**9**	**0**	**Total Actions in Workstream**	
							97	

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
EOLC	Overall Rating			
1.1.1 S 29A requirement 3 year EoLC integrated strategy and implementation plan with key milestones completed and implemented	30/11/16		A draft strategy has been developed and is subject to scrutiny at the new EoLC steering group (first meeting 28/11/16) with subsequent final EMT sign off. It is unlikely that it will be agreed and ready for roll out by 30/11/16. It will require more time to embed this new way of working.	30/11/16
1.1.2 Governance arrangements included within strategy	30/11/16		Included in draft strategy, Medical leadership agreed	30/11/16
1.1.3 Best practice framework included in strategy	30/11/16		To be agreed by the steering group on 28/11/16	30/11/16
1.1.5 KPIs included within strategy	30/11/16		Baseline KPIs developed. To be agreed by the steering group on 28/11/16	30/11/16
1.1.6 Outcome measures included within strategy	30/11/16		To be agreed by the steering group on 28/11/16	30/11/6
1.1.7 Divisional/service implementation plans approved	30/11/16		To be agreed by the steering group on 28/11/16	30/11/16
1.1.8 Staff and patient engagement plan developed	30/11/16		To be agreed by the steering group on 28/11/16	30/11/16
1.1.10 Establish an EOLC steering group under governance arrangements	30/11/16		Established. First meeting 28/11/16	30/11/16

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
Gwynne Holford Ward	Overall Rating			
1.2.7. Recruit into substantive posts as approved by VCP Explore R&R premiums within this.	30/07/16		Outstanding posts are: 1 band 6, 1 band 7 & 7 band 5. 1 ward receptionist awaiting VCP. On-going efforts to recruit to these posts continue. These vacancies have received VCP approval	TBC
1.2.6 Reduce high levels of staff stress and work overload	05/11/16		Clinical Supervision in place for staff fortnightly Matron/HON has regular ward meetings (with mins). Evidence gained for this action will be from staff satisfaction. Closure of 10 beds with subsequent decline in use of agency staff will also improve stress levels and work overload. Evidence gained for this action will be from staff satisfaction survey. To use current staff survey as a baseline to measure against	31/12/16
1.2.15 S29A requirement Ensure the correct application of , MCA, best interest, DoLs and restraint	30/10/16		Currently all patients are assessed, if unable to write, family are asked - need to make sure this process lines up with audit tool used by other areas in Trust. September Audit evidenced poor compliance. All staff have now received MCA/DoLs training For re-audit January 2017, to enable embedding of policy and training.	31/01/17

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
Paediatrics	Overall Rating			
1.9.1 The paediatric ward environment is safe and suitable for treating and caring for children and young people with mental health conditions.	31/01/17		Risk assessment completed. Ligature risks identified in A+E, ED & Peds. All immediate dangling cords and other ligature points removed. Other risk areas such as glass, curtain rails, showers and non-conforming doors require further work. Specification prepared for remedial works, going out to tender as of 07/11/16. Once tender is returned it is anticipated that the work will be completed by the 31/12/16.	
1.9.4 Continued recruitment into substantive posts across all 3 paediatric wards	TBC		Current vacancies: 10 Band 6 (1 - Nicholls, 9 - PICU), 2 Band 7 (1 - Pinckney, 1 - PICU), 20.8 Band 5 (8 - Frederick Hewitt, 8 - Pinckney, 1 - Nicholls, Jungle - 2.8, PICU - 1). National difficult with recruiting paediatric nurses. There is an on-going recruitment and retention plan looking at how we can improve the vacancy rate. Review of skill mix, introduction of Associate Nurse practitioner roles. Discharge coordinators to release nursing time. Review of Bank Rates to reduce agency. Working with St Helier to look at a sustainable plan for paediatric care across the region.	TBC
1.9.5 NNU recruitment	TBC		National shortage of NNU nurses. The majority of agency nurses working on NICU are regular staff who have a substantive post on other level 3 NICUs. Although continuity of care is not always achieved, having regular agency staff ensures a degree of safety. Agreed an RRP for NNU staff	TBC

Exception Report: Red / Amber Actions				
Action	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
Bed Rails	Overall Rating			
1.3.1 Review current business plan for bed frame to consider need for ultra low bed frames, urgency of replacement and resubmit.	30/09/16		Point prevalence review of current bed, mattress and cot side stock due to be carried out 13/12/16 to prioritise bed replacement plan. This is to go before next IDDG, as current plan and time line is not adequate	TBD
1.3.2 Review current information available on access to bed rails out of hours	30/09/16		Pictorial Guide and posters now produced and has been distributed to all wards. Pictorial guides in Care Folders, posters to be put up in bedrail storage areas. Pictoral guide has been produced. Update Training to be opened up to nurses as well as porters to commence 1/11/2014 Clarity required around responsibilities for cot sides OOH	TBD

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
Safeguarding and MCA/DoLs	Overall rating			
1.4.2 Audit against the MCA & DoLs and safeguarding policies to demonstrate compliance and embedding of all procedures	01/01/2017		9/11 – Baseline audit was completed but figures show poor compliance. Training programme currently being rolled out against new policy. Repeat audit will be carried out in Jan.	31/03/17

Risk/Issue to Highlight to QIB	Mitigating Action	Status
EOLC CQC 29A Warning notice included: 1. EOLC service provision and the lack of integration across acute and community services 2. Governance arrangements 3. Lack of outcome measures and activity data monitoring	Awaiting agreement and sign off of draft strategy with Governance arrangements. Consultant lead has now been identified	
Gwynne Holford Ward CQC Section 29A Warning Notice Ensure the correct application of , MCA, best interest, DoLs and restraint (cot sides) In association with the Safeguarding and Bed rails/ prevention of falls work streams implement MCA and DoLs policy and audit programme to monitor compliance.	Amber as above (due to poor audit results in relation to documentation)	
Non-compliance with the MCA and DoLs compliance is included in the CQC Section 29A warning notice (Sept 2016.) raising the level of risk within this work stream. Identified that 65% doctors caring for children are trained in Safeguarding Level 3. This is a new area on the QIP with a target date of 31/03/17, therefore currently green.	New MCA policy includes DoLs. This will be underpinned by an audit and training programme for clinical staff. Focus for training to be on clinical staff paediatric and maternity wards, to ensure 100% compliance. Dir. of HR to re-run figures to confirm training compliance after data cleansing. (update 24/11/16)	

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	**Blue Action Form Submitted? Yes / No**	**Comments**
EOLC 2.1.3 Identify NED lead for EOLC		Sarah Wilton (non - exec director) has been identified and agreed as NED executive lead
G.H. 1.2.5 Introduce ward meetings with the leadership team and staff outlining when the senior team will be on site		Meetings established
G.H 1.2.10 To ensure safe staffing levels on Gwynne Holford by utilising the therapies for basic care e.g. washing and dressing.		Process implemented
G.H. 1.2.17 Review and improve patient record keeping and the safe storage of clinical records as patients move between floors.		Patients now on one floor. All notes now stored together in one cupboard and accessed by MDT
GH 1.2.13 Achieve above 85% compliance with MAST		All training sessions undertaken and training continues on a rolling basis. Evidence obtained November 2016
GH 1.2.14 Work with pharmacy to deliver medicines management training		Evidence of training provided to nursing staff November 2016
Safeguarding 1.4.4. Ratify safeguarding policy upload to the intranet		Completed and available on the Trust intranet.
MCA/DoLs 1.4.1 Finalise, ratify and re-launch the Mental Capacity Act policy including DoLs To reference specialist areas with specific DoLs requirements in policy		Completed and available on the Trust intranet.
1.6.11 There is an area to store analgesia within the streaming area of ED triage to prevent delay in administration.		Cupboard in place. Photographic evidence

Safety Culture Workstream Overview report

QIP Work stream: Safety Culture		Executive Lead: Title: Medial Director Andy Rhodes					Workstream Lead: Name: Multiple	
Overall BRAG	**Reporting Period:** (Nov 2016)	**Action BRAG rating analysis**						
		R	**A**	**G**	**B**	**B/G**	**Active Actions**	**Assurance Actions**
							51	**4**
		2	**0**	**49**	**4**			
							55	

Key

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

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
2.2.3 Update current IRMER procedures to reflect new committee structure	14/11/16		Missed target date	30/11/16
2.2.5 Strengthen the current policy for reporting radiation incidents and include in as an appendix in both radiation policies	14/11/16		Missed target date	30/11/16

Risk/Issue to Highlight to QIB	**Mitigating Action**	**Status**

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	**Blue Action Form Submitted? Yes / No**	**Comments**
2.1.2 Review the fluid storage within the ED major incident cupboard to ensure that no fluids are out of date.		Numerous spot checks. No out of date fluids
2.1.3 Provide report on monthly basis identifying outliers in compliance.		Reported to Medicines Risk Management Committee (MRMC) in Complete 15/11 - Audits completed; good compliance
2.1.18 Medicines reconciliation		100% compliance October 2016
2.1.20 Develop and implement patient Group Directive (PGD) to enable radiographers administer medication (contrast media)		16 PGD's signed off and in use in Radiology

Governance Workstream Overview report

QIP Work stream: Governance		Executive Lead: Title: Director of Quality Governance Name: Paul Moore					Workstream Lead: Name: Sal Maughan	
Overall BRAG	**Reporting Period:** (Nov 2016)	**Action BRAG rating analysis**						
		R	**A**	**G**	**B**	**B/G**	**Active Actions**	**Assurance Actions**
							21	**5**
		0	**0**	**21**	**5**	**0**	**Total Actions in Workstream**	
							26	

Key

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

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

Risk/Issue to Highlight to QIB	**Mitigating Action**	**Status**
CQC Section 29A Warning notice listed a number of requirements under the Governance umbrella. All but Incident management has been dealt with through the other work streams. Re: Incident management: The CQC highlighted delay in logging serious incidents on STEIS and in carrying out investigations into this category of incident.	Back log of SI's have all been cleared as of 11/11/16	Active, Green

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	**Blue Action Form Submitted? Yes / No**	**Comments**
3.1.1 Establish and appoint a Director of Quality Governance to lead on governance, risk management and the Quality Improvement Plan		In post 04/07/16
3.3.1 Develop and write a paper outlining the requirements for a Freedom to Speak Up Guardian (FTSUG)		Presented and agreed 27/07/16.
3.6.4 Ensure risk registers are handled through Datix Web in order to pass control to managers, speed up recording, and improve monitoring and reporting. Ensure identified risks are included on the divisional Risk register		All four clinical divisions have now reported Risk Registers through RMC (Sept/Oct 2016). Everyone currently using apart from Projects.
3.8.2 Upgrade Datix system to enhance functionality and feedback mechanisms to reporters		Upgraded 28/07/16
3.8.3 Appoint Datix Administrator to support enhanced training programme for staff around Datix use		In post 31/08/16

Changes to previous QIP

Additions

3.9.1
Introduce a consistent process for feeding back information, learning and action points from incidents and complaints to staff both within acute and community services.
Target date 31/03/17

3.10.1
Trust complaints and compliments procedure is publicised and readily available to all patients. Staff to know how to sign patients to process

HR Workstream Overview report

QIP Work stream:	Executive Lead:	Workstream Lead:
HR	Title: Executive Director of Human Resources & OD Name: Karen Charman	Name: Karen Charman

Overall BRAG	Reporting Period:	Action BRAG rating analysis				
		R	A	G	B	B/G
	(Nov 2016)	0	2	22	4	0

Active Actions	Assurance Actions
24	4

Total Actions in Workstream
28

Key

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

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
4.2.6 We will expand our apprentice programme to support work opportunities in the communities we serve and achieve over 200 placements by April 2017-18	31/03/17		No transfer forecasting to achieve 200 placements by April 2017 as levy is not operative until after April 2017. Funding challenge.	2017/18
4.4.3 Agree and implement new process plan for Bank and Agency/temporary staff and demonstrate reduction in the use of agency size.	31/03/17		Progress in creating an application of direct controls approved 16/11. Whilst process has been implemented, need to be able to demonstrate that the process is effective.	31/03/17

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	**Blue Action Form Submitted? Yes / No**	**Comments**
4.1.1. Revise Fit and Proper Person Policy in discussion with, and support from, our Improvement Director		Policy in place
4.1.2 Ensure all current Executive Director and Non-Executive Director personal files, are compliant with Fit and Proper Persons requirements.		All complete and reported to the Board. Requirement under S29A Warning Notice.
4.1.3 Evidence in file of licensed accountant on the Board		Licensed accountant currently on the Board.
4.2.2 Workforce Race Equality Standard presented to and approved by the Board		Presented to the Nov Board.

Changes to previous QIP

Added:
4.2.3
Workforce Race Equality Standard action plan to the Board

4.3.3
Review and improve staff supervision, training and staff development.

4.5.3
Address the low morale among theatre staff and consultant surgeons.

4.5.4
Address the atmosphere of isolation from the Trust within community services

4.5.5
Staff engagement

4.5.6
Managing bullying and harassment

4.8.1
MAST training compliance

4.9.1
Staff induction

Estates Workstream Overview report

QIP Work stream:	Executive Lead:	Workstream Lead:
Estates	Title: Director Of Estates & Facilities Name: Richard Hancock	Name: Richard Hancock

Overall BRAG	Reporting Period:	Action BRAG rating analysis				
		R	A	G	B	B/G
	(Nov 2016)	4	3	17	12	0

Active Actions	Assurance Actions
24	12

Total Actions in Work stream
36

Key

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

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
5.2.1 Renal ward in Knightsbridge Wing - to be relocated - Trust to identify and approve appropriate ward closure and impact to revenue	30/09/16		Have not met original time line Phased plan to relocate services Moves have started. Acute bed wards expected to have moved by 12/12/16.	12/12/16
5.3.1 Relocate 15% outpatient services in Lanesborough Wing	30/09/16		Missed trajectory 14% complete. 1% in discussion with Wandsworth CCG re: Phlebotomy services. Expected completion date now 15/12/16. General renal OPD has moved into Lanesborough Wing. 2 services have been relocated from Lanesborough Wing, Urology service QMH on 17-Oct. The walk-in Phlebotomy service has moved to Community Pathways (GP's) as at 31-Oct. BPU, will relocate to Nelson by 30/11/16.	15/12/16

5.5.7 Divisional Directors of Nursing to ensure that there is a nominated nurse for each ward who acts as the Fire Warden and receives relevant fire awareness and evacuation preparedness on Lanesborough Wing.	31/07/16		Confirmed in Chief Executive's letter to CQC 07/07/16. Update: We are currently verifying training records to provide assurance that there is a fire warden available on every shift in Lanesborough Wing.	31/12/16
5.10.1 Daily flushing carried out and documented for pseudomonas prevention	31/08/16		Returns show poor compliance in clinical areas, ranging from 48% - 100% (although there is an gradual improvement from previous)	31/12/16
5.1.3 Immediately initiate survey and inspection of fixed wiring in Buckland.	05/08/16		Infrastructures including circuits have all been tested and repaired. Outstanding area of testing is Buckland Ward - due to clinical risk - clinicians don't want power turned off as high risk patients require continuous power supply. Knightsbridge Wing will be fully decanted by end of Dec-16; all staff and patients will be relocated and this risk will be removed.	31/12/16
5.7.1 Demonstrate rolling programme for refurbishment of theatres in Lanesborough Wing, St James' Wing and Paul Calvert	30/09/16		We have produced a plan to refurbish operating theatres across the Trust. A schedule of refurbishment is with the Chief Operating Officer for sign off. Work is due to commence in November 2016. Two theatres at a time will take approximately 5 months to complete with theatres out of commission during this period. Estimated time to complete full refurbishment programme for 16 theatres is 3.5 years	2019
5.7.2 Design and implement a maintenance schedule for air handling unit. This will have to include some theatre down time to allow the work to happen.	30/11/16		The maintenance schedule is outlined in the theatre refurb programme plan and includes the maintenance of the AHU's. Awaiting sign off by the COO. Maintenance will be carried out annually. Maintenance schedule now with contracted 3rd party	30/11/16

Risk/Issue to Highlight to QIB	Mitigating Action	Status
5. CQC Section 29A Warning Notice **5.7.1 & 5.7.2** Theatre refurbishment and PPM of air handling units.	Scheduling of theatre refurbishment with Director of Estates and Facilities and Director of Operations	Amber until full compliance can be demonstrated.

Down time within theatres will be required in order to carry out necessary refurbishment and PPM. This programme will have to be phased with two theatres at a time being out of action and taking approximately 5 months to complete. **5.10.1** Inability to demonstrate assurance of how the risk of water contamination and infection is being managed for pseudomonas. Insufficient capacity within the Estates and Facilities team carry out necessary testing under the regulations. In addition a schedule of sink replacements is required	Plan to contract 3rd party contractor as using Band 1& 2 flushers not sustainable due to high attrition rate. Interim water manager n post. Recruiting to substantive post.	

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	**Status**	**Comments**
5.1.1 Immediately repair known leaks to the roof on Buckland Ward, Knightsbridge Wing		Completed and confirmed to CQC in Chief Executive's Letter 07/07/2016. Cleared Gutters and drains. Vegetation pruning and removal of tree and roots.
5.1.2 Close beds in those areas within the Ward affected by the ingress of water and declare those areas unusable until the electrical works have been certified.		Completed and confirmed to CQC in Chief Executive's Letter 07/07/2016. Beds have now been removed, the area has been zoned off and secured, this area has been taken out of use.
5.4.1 Continue weekly fire alarm testing, routine servicing and independent testing		Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016 Work has been completed certificates supplied
5.7.3 Replace 2 faulty air handling units in St James Wing theatres.		Completed. Air handling units installed.

5.4.2 Introduce fire compartmentation to second floor Plant Room Lansborough Wing		Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016 Work has been completed certificates supplied
5.4.3 Complete audit and replacing where necessary fire extinguishers to all locations including plant rooms		Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016
5.4.4 Upgrade fire compartmentation, including fire doors, to the vertical escape routes in Lanesborough Wing		Completed and confirmed to CQC in Chief Executive's Letter 04/07/2016
5.5.8 Targeting high risk areas initiate a series of table top fire exercises covering two clinical areas each week.		Confirmed in Chief Executive's Letter to CQC 07/07/2016. 11/10 - This has been complete 30/09/16. This will become a rolling programme across all clinical areas.
5.5.9 Complete fire risk assessments for whole site and verify mitigation plans are in situ and accessible to staff		Confirmed as completed in Chief Executive's Letter to CQC 07/07/2016. This action was a requirement for Lanesborogh Wing however this is being rolled out across the site.
5.5.10 Fire Safety Advisors to meet London Fire Brigade Inspection Team and invite LFB to undertake independent inspections to provide further assurance. Fire Brigade inspecting officers have met with Estates.		Completed inspection and sign off 31/08/16 from London Fire Brigade MOU between SGHT and LFB
5.6.1 Relocate staff working in Wandle Annex and demolish this facility.		Staff have been relocated. Building is now demolished.
5.8.1 Replace ceiling tiles Replace fixed lighting Repair cause of condensation leaks from hot water tank above maternity staff room.		Complete 31/08/16

Changes to previous QIP

Additions

ED
5.11.1 Replace furniture within patient areas in the Emergency Department
5.12.1 Repair two ceiling leaks in a corridor in the emergency department.

5.13.1
Mortuary: Repair the leak from the from the heating system in the viewing area waiting room and the replace the carpet
5.14.1
Richmond Ward: Provide an uninterrupted power supply on Richmond Ward to ensure continuous power supply to ventilated patients.
5.15.1
Gray Ward: Review and improve space within Gray ward both around bed areas and storage space.

Duke Elder Ward: SLA
5.16.1 - Review the need for en-suite toilets for 2 isolation rooms
5.16.2 Upgraded ventilation system within the DE theatres
5.16.3 Adequate heating within DE theatres that prevent any closures in winter.
5.16.4 Possibility of single sex accommodation

Operations Workstream Overview report

QIP Work stream:	Executive Lead:	Workstream Lead:
Operations	Title: Chief Operating Officer Mark Gordon	Name: Sandra Shannon

Overall BRAG	Reporting Period:	Action BRAG rating analysis				
		R	A	G	B	B/G
	(Nov 2016)	0	0	50	0	0

Active Actions	Assurance Actions
50	0

Total Actions in Workstream
50

Key

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

Risk/Issue to Highlight to QIB	Mitigating Action	Status
Rated green due to working within Target dates. However areas such as safe staffing levels in some clinical areas, data management provide a challenge for the Trust.		

St George's University Hospitals NHS
NHS Foundation Trust

Health Care Informatics Workstream Overview report

QIP Work stream:	Executive Lead:	Workstream Lead:
Health care Informatics	Title: Larry Murphy	Name: TBC

Overall BRAG	Reporting Period:	Action BRAG rating analysis				
		R	A	G	B	B/G
	(Nov 2016)	0	0	6	0	0

Active Actions	Assurance Actions
6	0

Total Actions in Workstream
6

Key

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

Risk/Issue to Highlight to QIB	Mitigating Action	Status
Rated green due to working within Target dates. However IT systems and integrity of data is a significant risk for the Trust.	Full review currently under way.	

St George's University Hospitals NHS
NHS Foundation Trust

Leadership Workstream Overview report

QIP Work stream: Leadership and strategy		Executive Lead: Title: Simon Mackenzie					Workstream Lead: Name: Emma Woollett	
Overall BRAG	**Reporting Period:** (Nov 2016)	**Action BRAG rating analysis**						
		R	**A**	**G**	**B**	**B/G**	**Active Actions**	**Assurance Actions**
							15	**0**
		0	**0**	**15**	**0**	**0**	**Total Actions in Workstream**	
							15	

Key

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

Risk/Issue to Highlight to QIB	Mitigating Action	Status
Rated green due to working within Target dates, however, a Trust strategy and a stable, substantive leadership team are fundamental for moving the Trust from an inadequate rating to good or outstanding.	Interim EMT and Chair in place. On-going recruitment of NEDS. Strategy development under way.	

RTT Workstream Overview report

QIP Work stream: RTT		Executive Lead: Diana Lacy					Workstream Lead: Name: Chris Nolan Karen Brown	
Overall BRAG	**Reporting Period:** (November 2016)	**Action BRAG rating analysis**						
		R	**A**	**G**	**B**	**B/G**	**Active Actions**	**Assurance Actions**
							10	**0**
				10		**0**	**Total Actions in Work stream**	
							10	

The RTT project team has developed a new project plan which has been agreed with NHSI. In order to prevent duplication of actions, going forward the QIP will measure compliance against time scales for each work area (10) within the RTT work plan.

Although the RTT Plan was approved by NHSI 18/11/16 there remains a considerable delay to its implementation from application of the Section 29A Warning Notice and the risk of harm arising as a direct consequence of extended waiting times for patients remains high, therefore it has been rated Red

Risk/Issue to Highlight to QIB	Mitigating Action	Status
The risk of harm arising as a direct consequence of extended waiting times for patients remains high. Included in the CQC Section 29A Warning notice	Overarching statement The Elective Care Recovery Plan and supplementary documentation for SGHT developed in conjunction with MBI Associates has been approved by NHSI as of 25/11/16 Phase 1: Forensic Deconstruction, a sub section of the above overall plan, has been provisionally accepted by NHSI subject to the agreement via a business case and financial approval. A business case was submitted to NHSI on 04/11/16. Supplementary requirements were issued by NHSI and returned to the Finance Director by the Operational team on 17/11/16. This currently sits with the Finance Director awaiting financial agreement with NHSI.	Risk remains high.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	1 December, 2016	**Agenda No**	**2.3**
Report Title:	Quality Report		
Lead Director/ Manager:	Mark Gordon, COO, and Suzanne Banks, Chief Nurse		
Report Author:	I Hussain, and Hazel Tonge, Deputy Chief Nurse		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	This paper summarises the Trust's current performance against a range of core indicators for quality and clinical effectiveness.		
Recommendation:	The Trust Board is invited to receive the Quality report for assurance.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Addresses all five key themes: Safe, Effective, Caring, Responsive and Well-led		
Single Oversight Framework Theme:	Quality of Care		
Implications			
Risk:	BAF Risk 7: Failing to provide safe, high quality and a satisfactory experience of care for service users. Controls against this risk were reviewed in November 2016 by the Director of Quality Governance.		
Legal/Regulatory:	The Trust is currently in special measures for quality with the Care Quality Commission and subject to enforcement action by NHS Improvement		
Resources:	There are no resource implications.		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	N/A		
Appendices:	Appendix A – Quality Paper		

Quality Report
Trust Board, 1 December 2016

1.0 PURPOSE

1.1 To provide assurance to the Trust Board of performance against national access targets, quality of care and clinical effectiveness against core indicators.
1.2 To highlight areas that require improvement and provide an update on actions

2.0 KEY MESSAGES

2.1 There are several key points of note for the Board in relation to November Quality performance:

2.2 Performance against key national performance indicators:

2.2.1 The trust is performing positively against a number of indicators within the framework, however existing challenges continue in particular: ED 4 hour target, RTT, and cancelled operations on the day by the hospital for non-clinical reasons.
2.2.2 14 day and 62 day cancer national standards met in September. STF trajectory standard was also met for the 62 day standard.
2.2.3 Diagnostic waiting time's standard achieved both against the national target and STF trajectory.
2.2.4 Trust is not meeting the RTT national standard. However, October backlog of patients waiting greater than 18 weeks reduced further, totaling a reduction of 694 patients since August with a corresponding reduction in the total waiting list size in comparison with previous months.
2.2.5 Continued non-compliance against the cancelled operations at last minute target. However, positive improvement is being observed with a reduction in the number of patients not being treated within 28days of original cancellation.
2.2.6 Daily Chief Operating Officer led Performance Control meetings are now established discussing issues and risks for the day, performance against key standards and activity plans.
2.2.7 The trust shows the quality governance score against the Monitor risk assessment framework of 2. However, 'RAG' rating remains red due to the Monitor imposed additional license conditions in relation to governance.

Clinical Effectiveness

2.3 Mortality indicators remain better than expected:
- i. Safety thermometer for this month is 96.65% which were better than the national average (95%)
- ii. Significant number of non or partial (National Institute for Health and Care Excellence (NICE) compliance which are being monitored through Patient Safety & Quality Board (PSQB).

Patient Safety

2.4 The following summarizes the overall position:
- i. There has been a reduction in Serious Incidents (SIs) declared Apr-Oct: 2016/17: 58 compared with 90 SIs declared Apr-Oct 15/16, this represents a 35% decrease.
- ii. There were two Never Events (wrong site surgery) declared Apr-Oct 2016/17, compared with seven in Apr-Oct 2015/16.
- iii. The number of Patient Safety Incidents (PSI) reported each month continues to

increase, as does the proportion of incidents graded as moderate or above severity (5.7%).

iv. There has been a slight increase in falls this month, attributable to a spike in Mary Seacole and Amyand. A substantial amount of work has been undertaken around policies, assessments and training/ awareness.

v. No grade 3 or 4 for four consecutive months.

vi. There has been an increase in the number of Clostridium Difficile (C.Diff) cases this month to 6, which has placed the Trust close to, but still on trajectory. C.Diff cases were: two on Gray, one on Buckland, Allingham, Vernon and neuro ITU; root cause analyses (RCAs) are underway. In addition there was one MRSA case, the first this financial year.

vii. Safeguarding Level 3 children training has improved at 88% for the whole Trust, based on a manual reconciliation of data, although adult safeguarding training is below target at 83%.

Patient Experience

2.5 Complaints performance has improved since August 2016 but varies between divisions. A new improvement plan is being designed by the Patient Experience Manager.

2.6 Number of PALS concerns received in October remain high: up13% (346) when compared with October 2015 (305).

2.7 Overall FFT scores indicate 93% would recommend the Trust, which is slightly lower than September at 94%.

Workforce

2.8 Overall the Trust fill rate is 94.18%.

2.9 The number of staffing alerts reduced this month, although community division still has a high number. The Community division have employed a recruitment nurses to assist in reducing vacancies and improving retention.

3.0 NEXT STEPS OR TIMELINE

3.1 A new board report is being designed and will be presented at the next Board meeting (January 2017).

4.0 RECOMMENDATION

4.1 The Trust Board is invited to receive the Quality report for assurance.

Author: **Imran Hussain and Hazel Tonge**
Date: **22.11.16**

APPENDIX [insert letter]

Appendix A Trust Quality and Performance Report

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St George's University Hospitals NHS
NHS Foundation Trust

Performance and Quality Report

For Trust Board

Month 7 – October 2016

Excellence in specialist and community healthcare

CONTENTS

St George's University Hospitals NHS
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Performance against Frameworks

Excellence in specialist and community healthcare

1. Executive Summary - Key Priority Areas October 2016*

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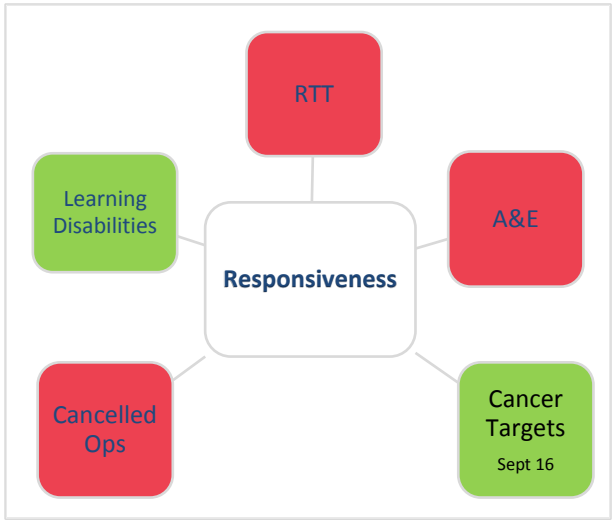
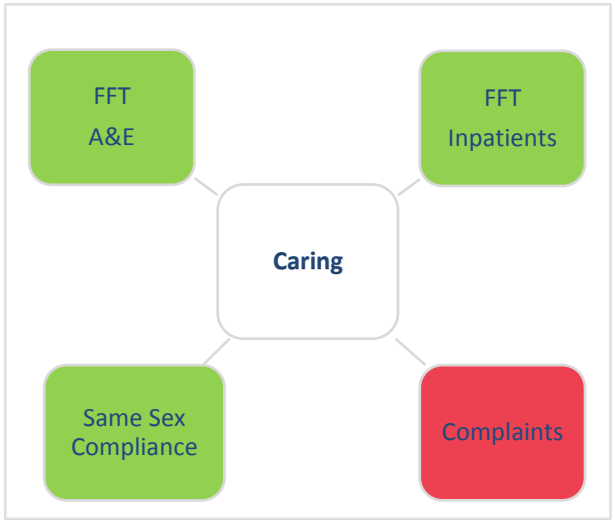
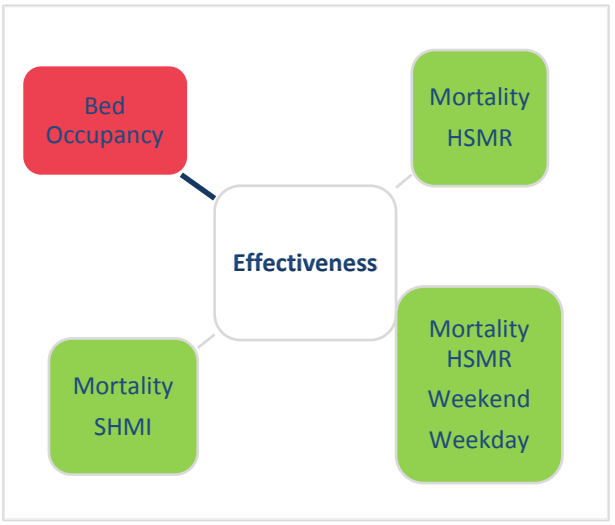
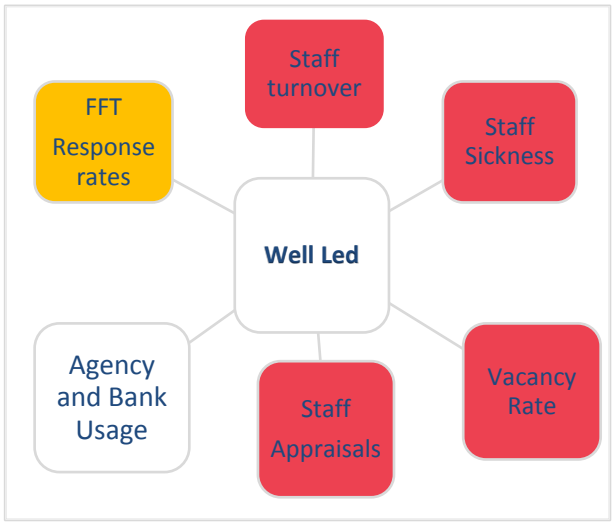








The above shows an overview of October 2016 performance for key areas within each domain and also as detailed in the Monitor Risk Assessment Framework.

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

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

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

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

St George's University Hospitals NHS
NHS Foundation Trust

	Metric	Standard	Weighting	Score	YTD	Sep-16	Oct-16	Movement
ACCESS	Referral to Treatment Admitted	90%	N/A	N/A		64.51%		-64.51%
	Referral to Treatment Non Admitted	95%	N/A	N/A		82.77%		-82.77%
	Referral to Treatment Incomplete	92%	1	1		86.68%	86.40%	-0.28%
	A&E All Types Monthly Performance	95%	1	1	92.96%	92.20%	93.20%	1.00%
	Metric	**Standard**	**Weighting**	**Score**	**YTD**	**Q1**	**Q2**	**Movement**
	62 Day Standard	85%	1	0	84.50%	80.60%	88.50%	7.90%
	62 Day Screening Standard	90%			92.60%	91.50%	94.50%	3.00%
	31 Day Subsequent Drug Standard	98%	1	0	100%	100%	100%	0.00%
	31 Day Subsequent Surgery Standard	94%		0	97.60%	97.80%	97.70%	-0.10%
	31 Day Standard	96%	1	0	97.40%	97.80%	97.10%	-0.70%
	Two Week Wait Standard	93%	1	0	90.90%	88.30%	93.90%	5.60%
	Breast Symptom Two Week Wait Standard	93%	1		92.80%	90.80%	94.50%	3.70%

	Metric	Standard	Weighting	Score	YTD	Sep-16	Oct-16	Movement
OUTCOMES	Clostridium(C.) Difficile - meeting the C.difficile objective (de minimise of 12 applies)	31	1	0	18	3	6	3
	Certification of Compliance Learning Disabilities;							
	Does the Trust have mechanism in place to identify and flag patients with learning disabilities and protocols that ensure the pathways of care are reasonably adjusted to meet the health needs of these patients?	Compliant	1	0	Yes	Yes	Yes	
	Does the Trust provide available and comprehensive information to patients with learning disabilities about the following criteria: - treatment options; complaints procedures; and appointments?	Compliant	1	0	Yes	Yes	Yes	
	Does the Trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	Compliant	1	0	Yes	Yes	Yes	
	Does the Trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	Compliant	1	0	Yes	Yes	Yes	
	Does the Trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	Compliant	1	0	Yes	Yes	Yes	
	Does the Trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	Compliant	1	0	Yes	Yes	Yes	
	Data Completeness Community Services:							
	Referral to treatment	50%	1	0		54.9	54.7	-0.2
	Referral Information	50%	1	0		87.1	86.9	-0.2
	Treatment Activity	50%	1	0		72.2	72.5	0.3
	Trust Overall Quality Governance Score					**3**	**2**	-1

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

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

Areas of underperformance for quality governance are:

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

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

*Cancer Data is reported a month in arrears. Q2 relates to July, August and September performance.

Legend	
⇧	Positive Performance Change
⇩	Negative Performance Change
⇨	No Performance Change

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

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

St George's University Hospitals NHS
NHS Foundation Trust

RESPONSIVENESS

Metric	Standard	YTD	Sep-16	Oct-16	Movement
Referral to Treatment Admitted	90%		64.51%		-64.51%
Referral to Treatment Non Admitted	95%		82.77%		-82.77%
Referral to Treatment Incomplete	92%		86.68%	86.40%	-0.28%
Referral to Treatment Incomplete 52+ Week Waiters	0		6	15	9
Diagnostic waiting times > 6 Weeks	1%		0.99%	0.99%	0.00%
A&E All Types Monthly Performance	95%	93.0%	92.2%	93.2%	1.00%
12 Hour Trolley Waits	0	0	0	0	0.00%
Urgent Ops Cancelled for 2nd time (number)	0	0	0	0	0.00%
Proportion of patients not treated within 28 days of last minute cancellation	0%	12.64%	4.40%	5.70%	1.30%
Certification against compliance with requirements regarding access to health care with a learning disability	Compliant	Yes	Yes	Yes	

Metric	Standard	YTD	Aug-16	Sep-16	Movement
62 Day Standard	85%	84.50%	86.60%	88.28%	1.68%
62 Day Screening Standard	90%	92.60%	96.20%	92.00%	-4.20%
31 Day Subsequent Drug Standard	98%	100%	100%	100%	0.00%
31 Day Subsequent Surgery Standard	94%	97.60%	100.0%	93.8%	-6.20%
31 Day Standard	96%	97.40%	97.40%	96.20%	-1.20%
Two Week Wait Standard	93%	90.90%	94.30%	94.20%	-0.10%
Breast Symptom Two Week Wait Standard	93%	92.80%	93.50%	96.00%	2.50%

EFFECTIVENESS

Metric	Standard	YTD	Sep-16	Oct-16	Movement
Hospital Standardised Mortality Ratio (DFI)	100		88.9	86.7	-2.20
Hospital Standardised Mortality Ratio - Weekday	100	0	86.6	84.2	-2.4
Hospital Standardised Mortality Ratio - Weekend	100	0	94.4	92.0	-2.4
Summary Hospital Mortality Indicator (HSCIC)	100	0	0.90	0.90	0.0
Bed Occupancy - Midnight Count General Beds Only	85%		98.5%	96.9%	-1.6%
LOS - Elective			4.3	4.7	0.4
LOS - Non-Elective			4.2	3.9	-0.30

CARING

Metric	Standard	YTD	Sep-16	Oct-16	Movement
Inpatient Scores - Friends & Family Recommendation Rate	60		94.38%	94.2%	-0.18%
A&E Scores - Friends & Family Recommendation Rate	46		83.10%	86.63%	3.53%
Number of complaints			91	69	-22
Mixed Sex Accommodation Breaches	0	0	0	0	0.0

SAFE

Metric	Standard	YTD	Sep-16	Oct-16	Movement
Clostridium Difficile - Variance from plan	31	16	3	6	3
MRSA Bacteraemia	0	1	0	1	1
Never Events	0	2	0	0	0
Serious Incidents	0	58	4	7	3
Percentage of Harm Free Care	95%		95.7%	96.5%	0.8%
Medication Errors causing serious harm	0	6	0	0	0
Overdue CAS Alerts	0	1	1	1	0
Maternal Deaths	1	0	0	0	0
VTE Risk Assessment	95%		96.30%		-96.30%

WELL LED

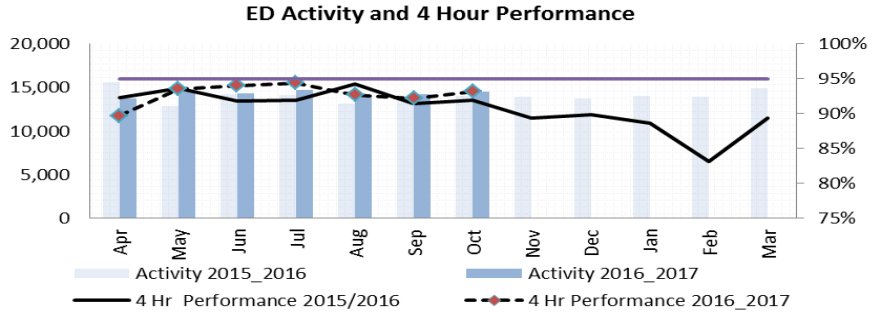
Metric	Standard	YTD	Sep-16	Oct-16	Movement
Inpatient Response Rate Friends & Family	30%		27.9%	28.1%	0.2%
A&E Response Rate Friends & Family	20%		24.3%	24.2%	-0.1%
NHS Staff recommend the Trust as a place to work	58%	62.0%			
NHS Staff recommend the Trust as a place to receive treatment	4	3.78			
Trust Turnover Rate	13%		18.5%	18.9%	0.4%
Trust level sickness rate	3.5%		3.6%	3.6%	0.00%
Total Trust Vacancy Rate	11%		15.5%	15.0%	-0.5%
% of staff with annual appraisal - Medical	85%		81.00%	91.60%	10.6%
% of staff with annual appraisal - non medical	85%		69.90%	66.20%	-3.7%

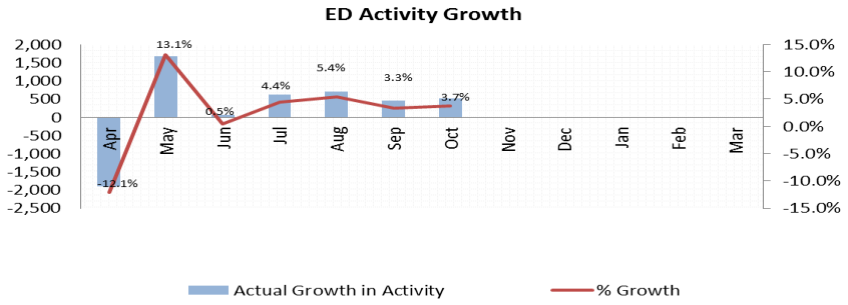
The trust continues to monitor the above key performance indicators following authorisation as a Foundation Trust. The indicators are grouped into domains parallel to that defined by the CQC. The trust is currently reviewing additional indicators for inclusion which will be incorporated in forthcoming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

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

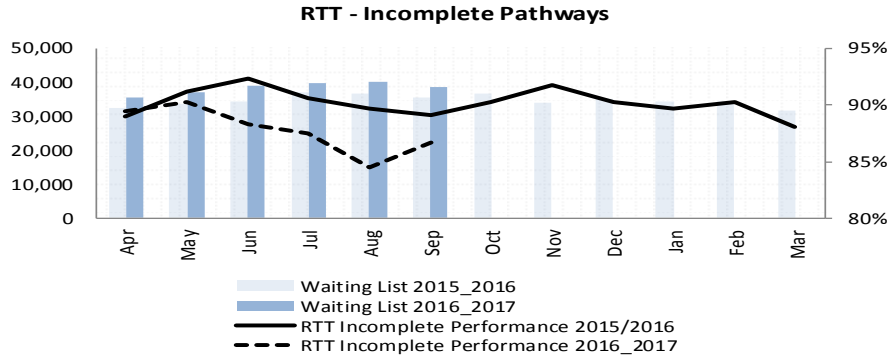
St George's University Hospitals NHS
NHS Foundation Trust

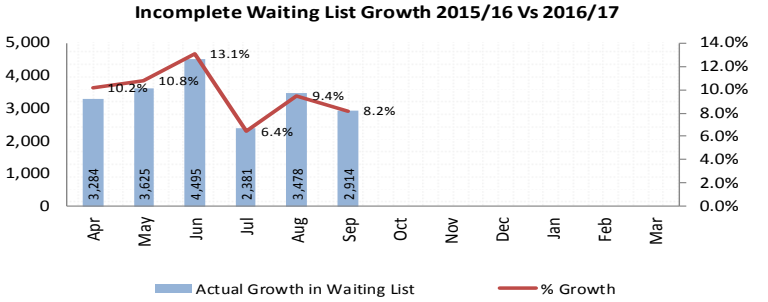
ED Performance

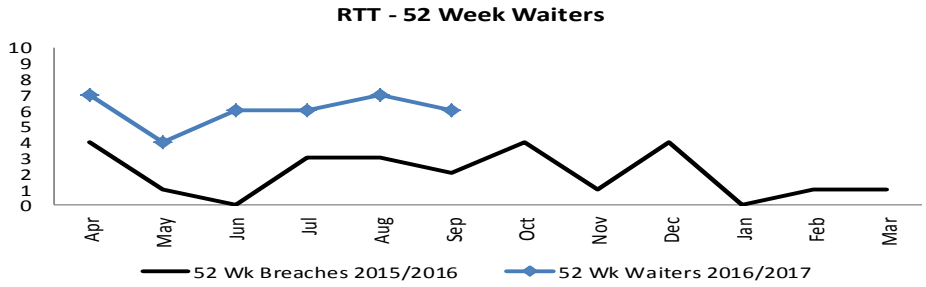


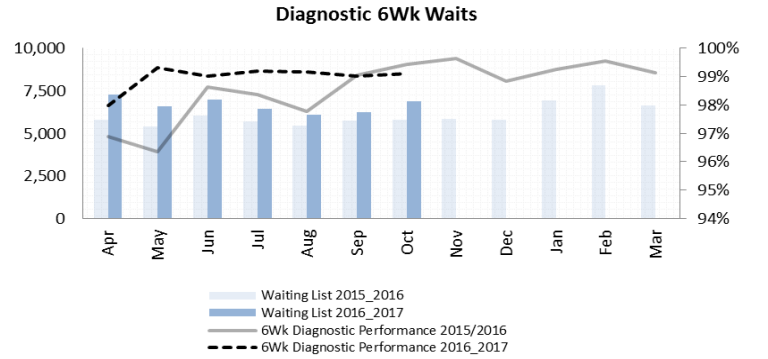


RTT and Diagnostics

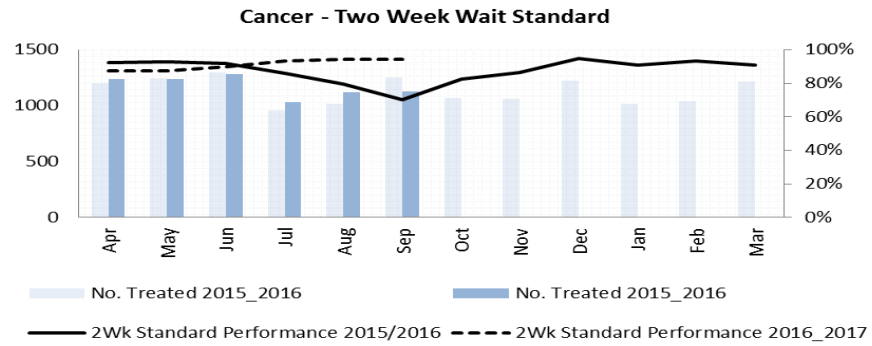


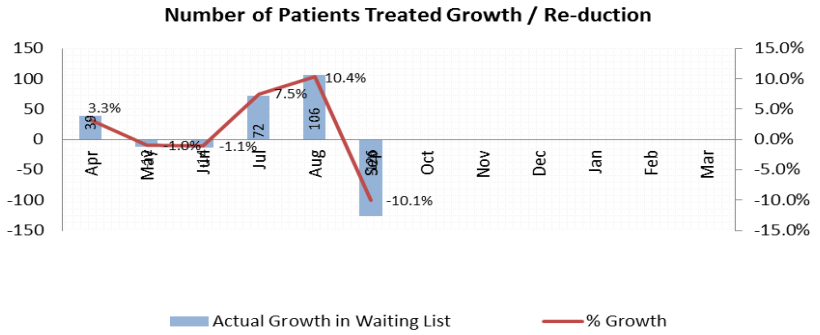




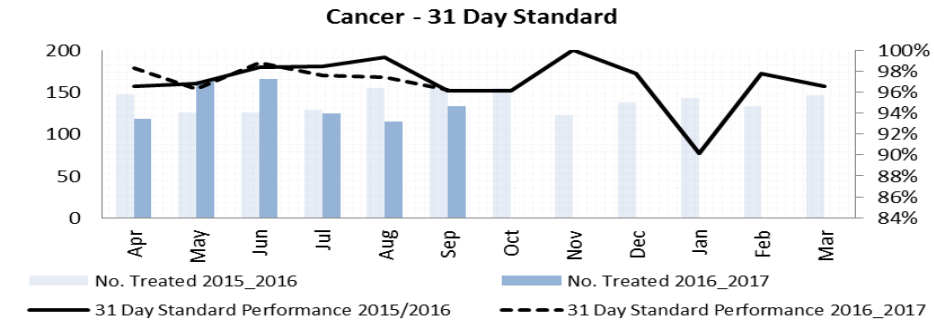


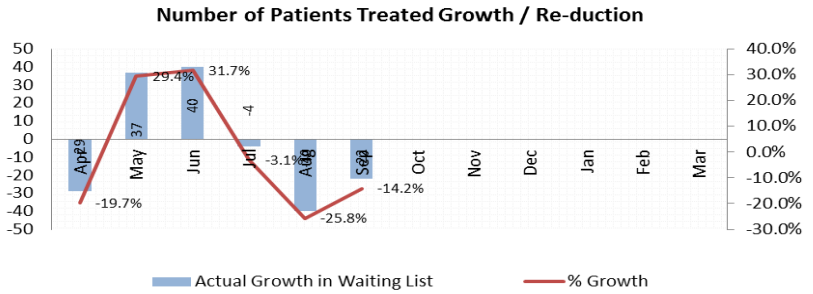
Cancer - Two Week Wait Standard



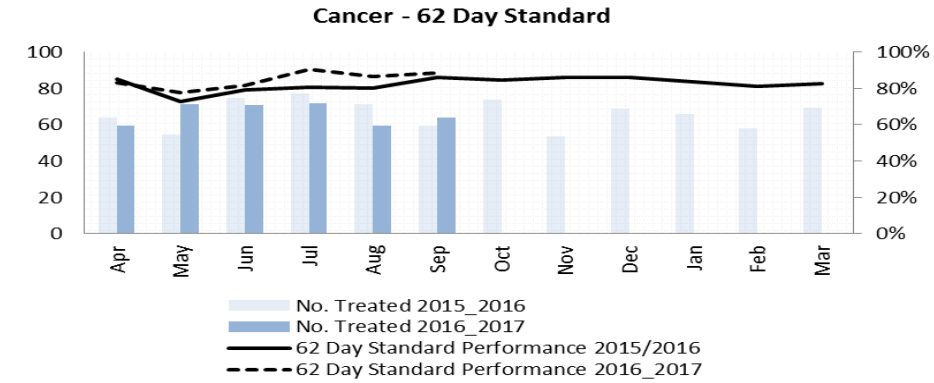


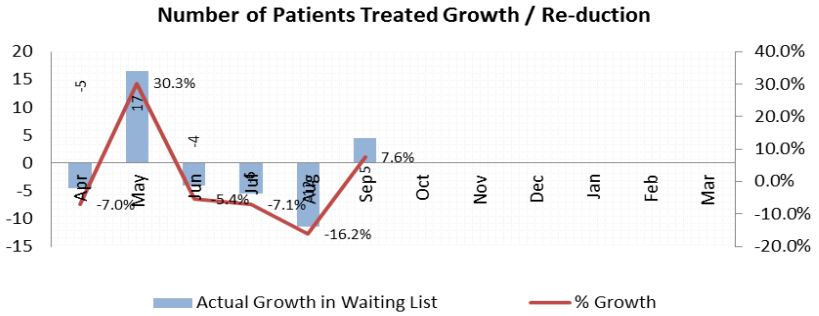
Cancer - 31 Day Standard





Cancer - 62 Day Standard





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Performance – areas of escalation

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

St George's University Hospitals NHS
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Total time in A&E - 95% of patients should be seen within 4hrs							
Lead Director	Sep-16	Oct-16	Movement	2016/2017 Target	Forecast for Oct-16	Forecast for Nov-16	Date expected to meet standard
FA	92.20%	93.20%	↑ 1.00%	>= 95%	R	R	TBC

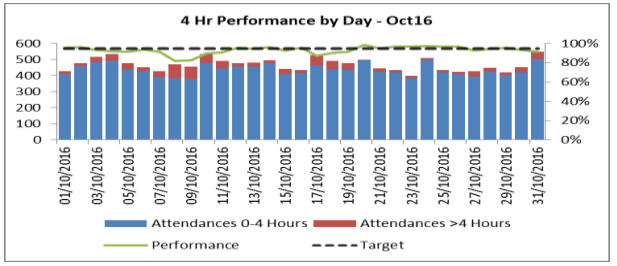
Peer Performance September 2016 (Rank)				
STG	Croydon	Kingston	King's College	Epsom & St Helier
3	4	2	5	1
92.20%	88.20%	92.30%	82.00%	97.20%

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Total Attendances	13,606	14,521	14,523	14,413	13,373	14,075	14,317
Attendances<4 Hours	12,085	13,098	13,286	13,176	12,407	13,086	13,252
Breaches >4 Hours	1,521	1,423	1,237	1,237	966	989	1,065
Performance Trajectory	88.8%	90.2%	91.5%	91.4%	92.8%	93.0%	92.6%
Performance Actual	89.7%	93.6%	94.0%	94.4%	92.7%	92.2%	93.2%
Meeting STF Trajectory	✓ 0.9%	✓ 3.4%	✓ 2.5%	✓ 3.0%	✗ -0.1%	✗ -0.7%	✓ 0.65%

Overview

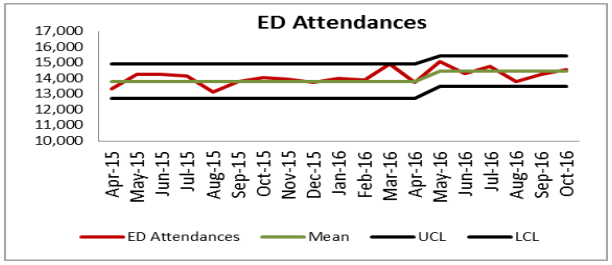
Improved performance in October achieving 93.20% against the 4 hour target of 95%, improvement continuing into early November. The Trust has met the STF trajectory in Q2 with a performance of 93.1% against a trajectory of 92.4% This in line with an acknowledged improvement in performance seen since April 2016. Improvement continues into Q3 meeting October STF trajectory and above Q3 trajectory to date. LAS ambulance turnover times have both observed significant increases in performance in comparison to last year with SGH ranked 3rd best in London measuring time lost by LAS crews.

Quarterly Actual	Q1	Q2	Q3
Total Attendances	43,114	42,827	20,978
Attendances<4 Hours	39,874	39,888	19,638
Breaches >4 Hours	3,240	2,939	1,340
Performance	92.5%	93.1%	93.6%
Meeting STF Trajectory	✓ 2.3%	✓ 0.8%	✓ 1.4%



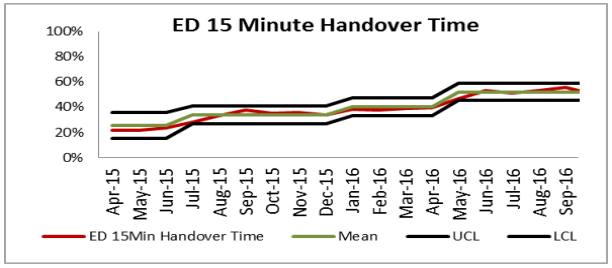
Breach Performance

Total of 14,558 patients attended the department in October (3.7% higher than same period last year and 2% compared to previous month) and a total of 989 breaches which when compared to September have reduced by 188 patients waiting greater than 4 hours. Treatment decision and wait for specialist opinion remain the highest contributing factors however these have reduced. An increase in the numbers of delayed transfer of care patients (DTOC) in comparison to last month and the number of days delayed have continued to increased significantly. This remains a focus area for the organisation as this has a significant impact on flow through the hospital and impact upon ED flow into the organisation. As at 14/11/2016 there were 23 DTOC and 27 Non-DTOC patients. Overall improvements in Bed flow have focussed more attention on improved specialty support into ED to assist in the management of intense surges of patients.



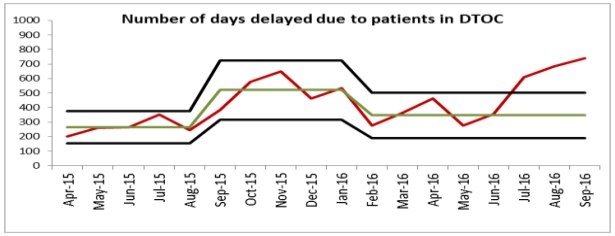
Improvements

- Significant changes have been made to working systems to improve care (4-5% improvement)
- Improved ED process with a focus on earlier decision making and increased level of evening staff.
- Improved bed availability with earlier allocation.
- SAU effective at decompressing ED and maintaining flow
- Increased engagement through consultant leads from ED to improve response rates with increased medical cover
- Significant improvement in 15 minute LAS handover performance since April 2016
- ED focus on planning exit strategy for each patient at 2 hours, through increase of senior team shop floor time



Actions

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



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

St George's University Hospitals NHS
NHS Foundation Trust

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

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

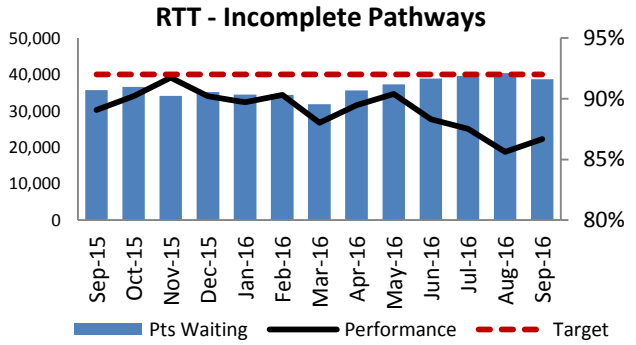
Overview

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

Breach Performance

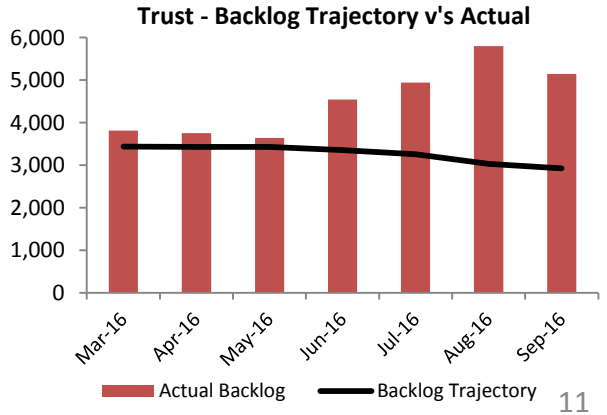
The largest cohort of patients breaching 18 weeks remains within ENT, followed by Trauma & Orthopaedics and General Surgery for admitted pathways and for non admitted Dermatology , ENT and T&O continue to have patients waiting over 18 weeks for an appointment .Over the last month there continues to be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

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



Improvements

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



Actions

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

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

St George's University Hospitals NHS
NHS Foundation Trust

Proportion of Cancelled patients not treated within 28 days of last minute cancellation							
Lead Director	Sep-16	Oct-16	Movement	2016/2017 Target	Forecast for Oct-16	Forecast for Nov-16	Date expected to meet standard
CC	4.40%	5.70%	⇩ 1.30%	0%	G	G	

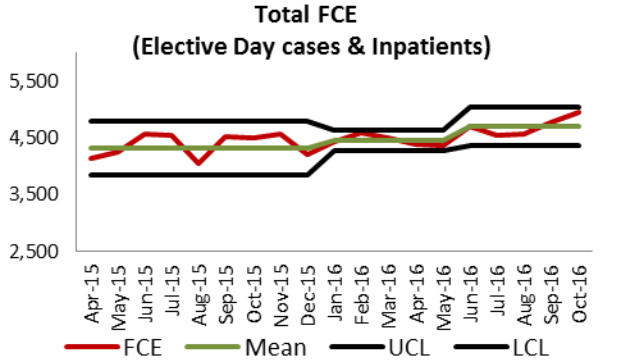
Peer Performance Comparison – Latest Available Q2 2016/17				
STG	Croydon	Kingston	King's College	Epsom & St Helier
4	1	1	4	3
11.1%	0.0%	0.0%	15.5%	0.7%

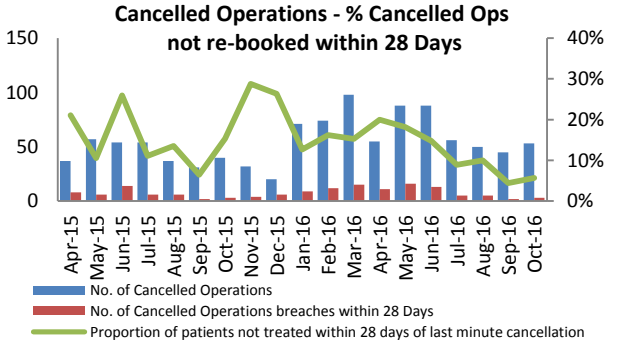
Overview

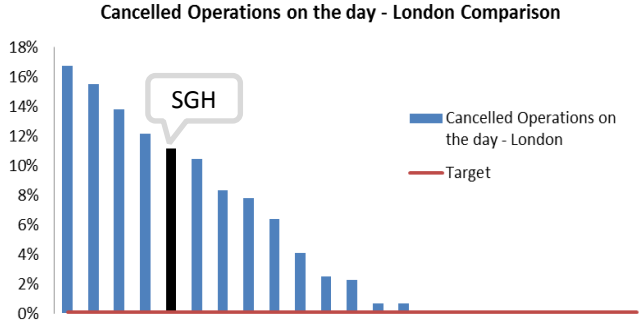
The national standard is that all patients whose operation has been cancelled for non clinical reasons should be re-booked for treatment within 28 days. The Trust reported a total of 53 on the day cancellations in the month of October of which 3 were not re-booked within 28 days accounting for 5.7% of all cancellations. The total number of FCE's reported (including day case and IP) have seen an increase in recent months and a step change is observed in the SPC chart. There was an increase of 8 cancelled operations compared to the previous month, with the highest proportion of breaches occurring within Cardiothoracic and Surgery. Cases were cancelled due to bed availability, emergency cases, and list's over running / lack of theatre time. The level of cancellations remain high compared with London Trusts and this remains a priority area for St George's. Key areas of focus: 1) to fully utilise theatre lists, 2) Improved planning with divisions, 3) improved data quality and validation to ensure accurate and timely data, 4) Firm action plans in place to address capacity constraints. It should also be noted that due to the complex nature of many of our patients that a cancellation rate will be expected due to 'on the day' clinical reasons.

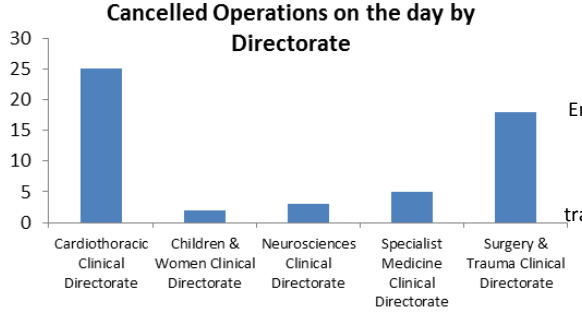
Improvements & Actions

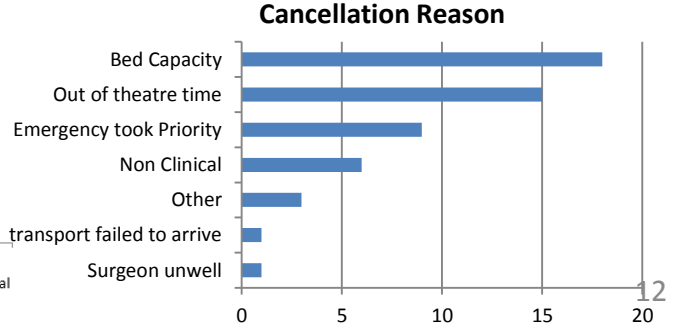
- Fortnightly reviews of cases with Directorate leads to ensure efficient forward planning
- Daily Theatre dashboard now in operation to allow improved daily management and analysis
- General Managers now approve all cancelled operations after discussion with Clinical Director and Divisional Director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











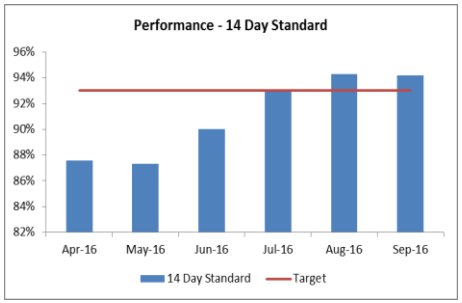
4. Performance Areas of Escalation (Page 4 of 4)
- Cancer Standard

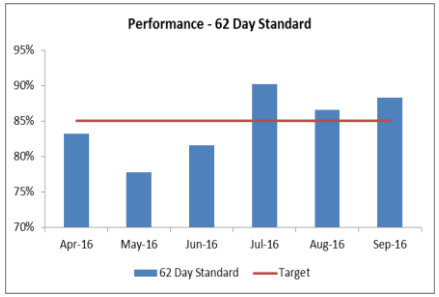
St George's University Hospitals NHS
NHS Foundation Trust

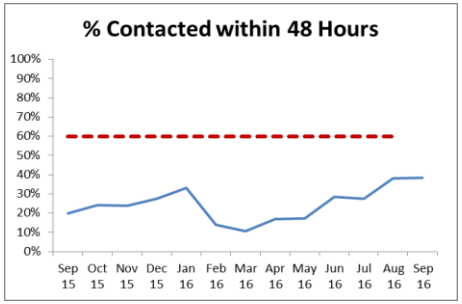
Overview

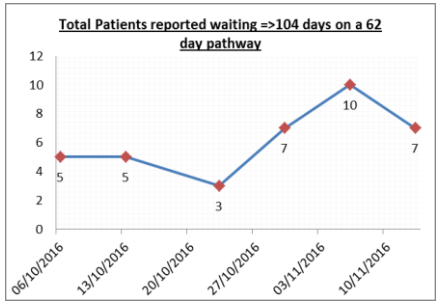
All Cancer Standards were achieved in July and August. All standards with the exception of 31 Day subsequent Surgery treatment were also achieved in September for the third consecutive month.

Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
14 Day GP Referral for all Suspected Cancers	93%	87.60%	87.30%	90.00%	93.10%	94.30%	94.20%
14 Day Breast Symptomatic Referral	93%	94.80%	95.20%	85.90%	93.80%	93.50%	96.00%
31 Day First Treatment	96%	98.30%	96.30%	98.80%	97.60%	97.40%	96.20%
31 Day Subsequent Surgery Treatment	94%	100.00%	94.70%	96.70%	100.00%	100.00%	93.80%
31 Day Subsequent Drug Treatment	98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
62 Day GP Referral to Treatment	85%	83.20%	77.80%	81.60%	90.20%	86.60%	88.28%
62 Day Screening Referral to Treatment	90%	93.90%	84.80%	94.80%	95.00%	96.20%	92.00%
62 Day Consultant upgrade to Treatment	85%	100.00%	100.00%	-	90.00%	100.00%	100.00%









Positive Changes

- The 7 day booking programme which includes increasing first contact with patients within 48 hours has seen a positive increase, however there is still on-going improvement work to increase performance for the lower achieving tumour sites with high throughput.
- Improved performance of ITT patients referred in treated within 24 days.
- Approval for the recruitment to MDT vacancies from establishment and recruitment to data team vacancies
- Surgeon now sits in outpatient clinic to run MDT clinic alongside chest physician, reducing surgical pathways by multiple days

Continued Actions

- Head and Neck recovery plan in place and currently being implemented. Early success indicated via a reduction in long waiters and the number of patient tipping over 62+days.
- 7 Day booking Programme continues to analyse core capacity for TWR referrals to increase 7 day boking performance

Risks

- Skin – Performance in all standards will be a continued challenge from October and future months due to an increase in demand above planned activity levels after a longer summer spike. There is currently a significant number of medical vacancies . These are in various stages of the recruitment process, with the majority likely to start employment in February 2017. Additional adhoc support has been mobilised where possible
- Gynae performance is constrained by capacity shortfalls to meet current levels of demand, for both 14 and 62 day standards. Action plan in place which will create additional capacity to support the achievement of both targets.
- Increase in late ITT's received (60% received within national standard of 38 days) – lung and prostate are key challenged areas.

September Performance	14 Day	62 Day
Suspected Brain/CNS Tumour	100.00%	
Suspected Breast Cancer	98.60%	100.00%
Suspected Gynae Cancer	93.30%	60.00%
Suspected Haematological Cancer	96.30%	87.50%
Suspected Head/Neck Cancer	94.50%	80.00%
Suspected Lower GI Cancer	95.30%	83.30%
Suspected Lung Cancer	100.00%	100.00%
Suspected Skin Cancer	92.10%	96.80%
Suspected Upper GI Cancer	87.70%	100.00%
Suspected Urological Cancer	90.50%	81.30%
Suspected Child Cancer	100%	
Grand Total	94.20%	88.28%

Monthly Trajectory	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
STF Performance Trajectory	83.3%	81.7%	83.8%	85.1%	85.1%	85.7%
Performance Actual	83.2%	77.5%	81.6%	90.2%	86.6%	88.3%
Meeting STF	✗ -0.1%	✗ -4.2%	✗ -2.2%	✓ 5.1%	✓ 1.4%	✓ 2.6%

St George's University Hospitals NHS
NHS Foundation Trust

Monthly View

			October 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	A&E waits (4 hours)	%	100	93.2	0	0	93.8
	LAS handover within 15 mins	%					59.7
	LAS handover within 30 mins	%					96.4
	LAS handover within 60 mins	No.					0
	6 week diagnostic waits	%					99.2
	Maternity - Booked By 12 weeks & 6 days	%					85.5
	Maternity - referred by 11+6 weeks and booked by 12 & 6 days	%					97.3
	Maternity – referred after 11+6 weeks and booked within 2 weeks	%					77.7
	No Trolley Waits in A&E - 12 hours	No.					0
	Urgent operations cancelled for the second time	No.	0	0	0	0	0

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

			September 2016				
			COMMUNITY	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Access Metrics	2 week gp referral to first outpatient (breast symptoms) - (c			0	96	0	96
	2 week gp referral to first outpatient (cancer) - (division)			0	94.2	0	94.2
	31 day second or subsequent treatment (drugs) - (division)			0	100	0	100
	31 day second or subsequent treatment (surgery) - (divisior			0	93.8	0	93.8
	31 day standard from diagnosis to first treatment - (division			0	96.2	0	96.2
	62 day urgent gp referral to treatment for all cancers - (divi			0	88.3	0	88.3
	62 day urgent gp referral to treatment from screening - (div			0	92	0	92

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

St George's University Hospitals NHS
NHS Foundation Trust

Monthly View

			October 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Outcome Metrics	Average LOS (elective) (division)	Ratio	0	5.7	4.6	3.2	4.7
	Average LOS (non-elective) (division)	Ratio	9.5	4	5.3	2.7	3.9
	C-sections (applicable to women & children only)	%	0	0	0	26.7	26.7
	CAS alerts	No.					1
	Falls (ward level)	No.	18	85	47	4	154
	HSMR	Ratio					86.7
	Incidence of c.difficile	No.	0	2	2	2	6
	Incidence of e-coli	No.	0	3	0	2	5
	Incidence of MRSA	No.	0	0	0	1	1
	Maternal deaths	No.	0	0	0	0	0
	Medication errors causing serious harm (division)	No.	0	0	0	0	0
	Mixed sex accomodation	No.	0	0	0	0	0
	MSSA (ward)	No.	0	2	3	1	6
	Never events	No.	0	0	0	0	0
	Serious incidents (division level)	No.	0	3	3	1	7
	SHMI	Ratio					0.9
	Trust acquired pressure ulcers	No.	0	0	0	0	0

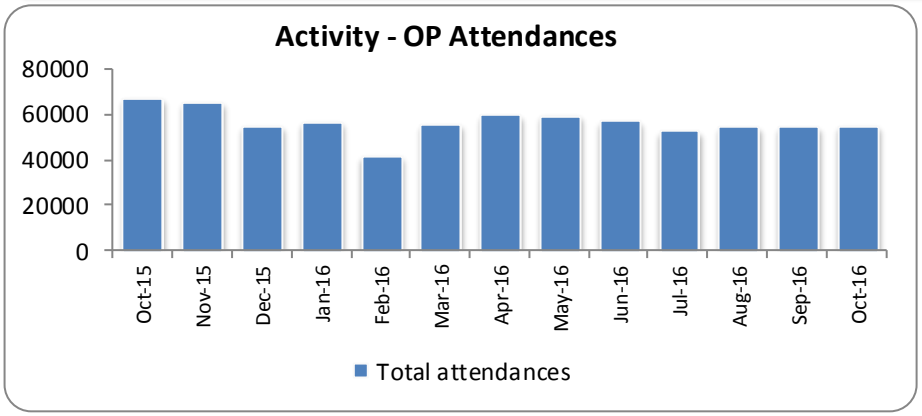
			October 2016				
			COMMUNITY SERVICES	MEDICINE	SURGERY	WOMEN & CHILDREN	TRUST LEVEL
Quality Governance Indicators	Patient satisfaction (friends & family)	%	0	95.8	95.4	86.8	94.6
	Percentage of harm free care	%	0	95	98.1	100	96.5
	Percentage of staff appraisal (medical) - (division)	%	94.7	88.7	94.3	90.4	91.6
	Percentage of staff appraisal (non-medical) - (division)	%	77.4	70.7	66.4	62.4	66.2
	Sickness/absence rate - (division)	%	4.9	3.5	3.8	3.2	3.6
	Sickness/absence rate - (ward)	%	7.1	3.7	4.6	4.1	4.1
	Staff turnover - (division)	%	20.4	17.2	17	19.7	18.9
	Staff turnover - (ward)	%	24.5	18.9	24.8	16.3	19.3
	Vacancy rate - (ward)	%	25.7	17.8	31	9.6	18.5
	Voluntary staff turnover - (division)	%	16	15.5	13.9	16.1	15.6
	Ward staffing: unfilled duty hours	%	1.6	5.5	5.5	5	5.2

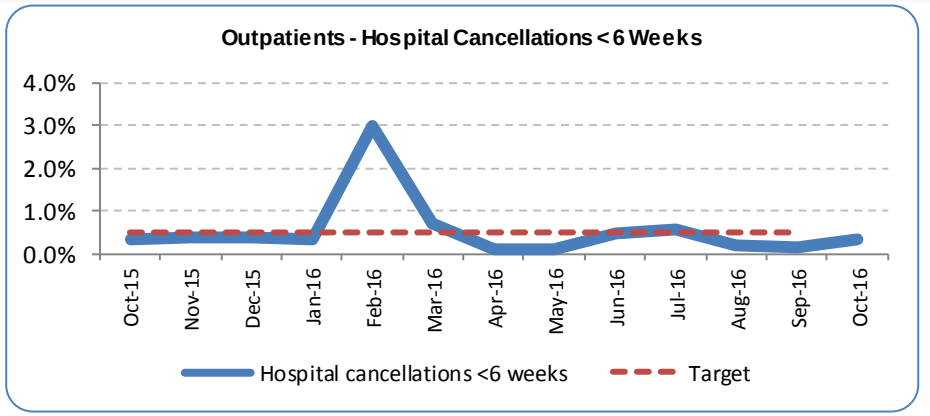
Key Messages:

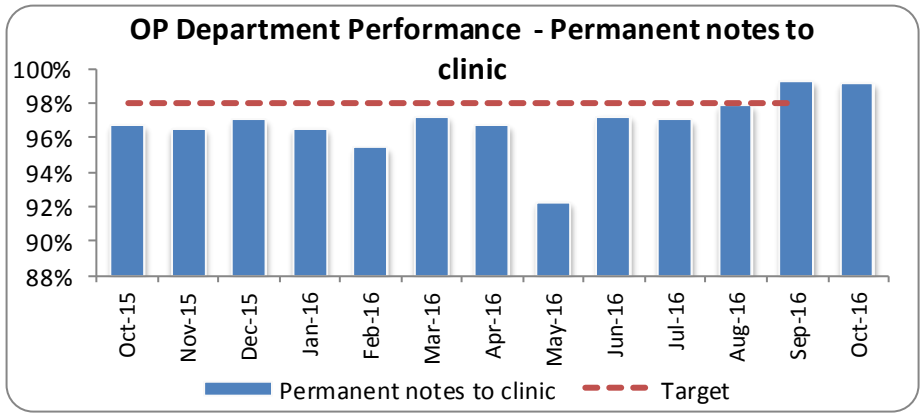
This section headed 'Access' indicates how effective the trust is at providing patients with the appointments and treatment they need and require in accordance with the national standards and the NHS Constitution. The Access section is split into two components,. Cancer performance is reported one month in arrears.
LAS arrivals to patient handover times, continues to fluctuate. At the end of October 59.7% of patients had handover times within 15 minutes and 96.4% within 30 minutes, both of which have improved significantly in recent months and performance higher than last year. The trust had zero reported 60 minute LAS handover in October.

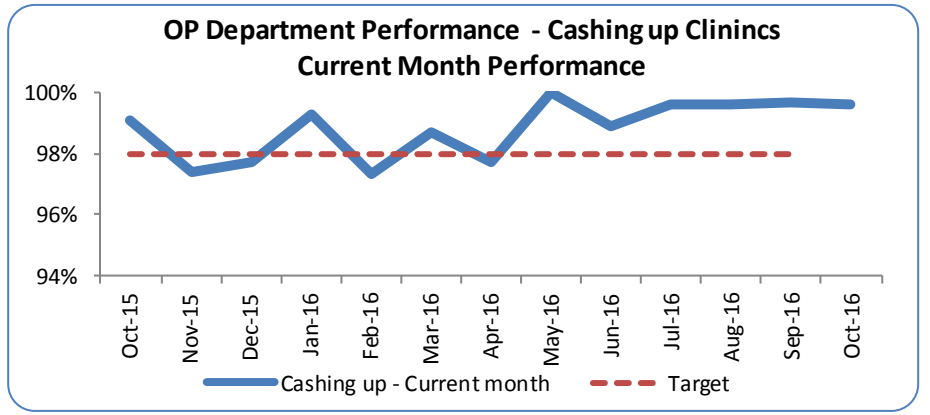
The trust has a zero tolerance policy on avoidable pressure ulcers and has placed significant importance on its prevention. In September the trust had 0 grade 3 pressure ulcer SI's and no Grade 4. All grade 3 and 4 pressure ulcers acquired in our care are investigated as serious incidents, and a. full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

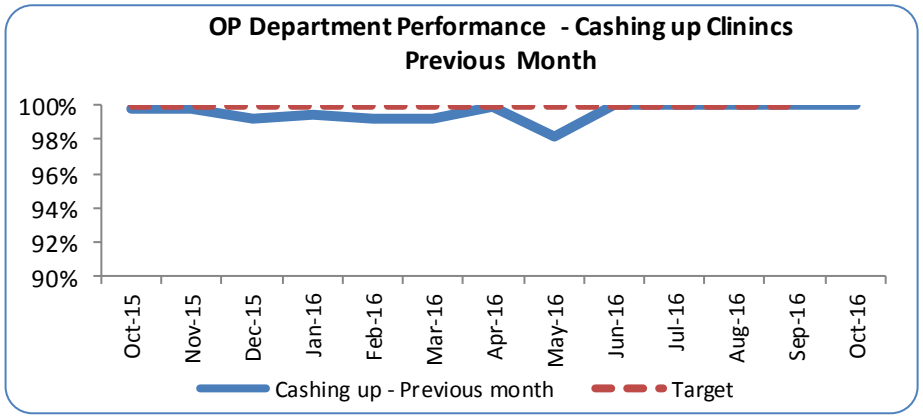
6. Corporate Outpatient Services (1 of 2) - Performance Overview

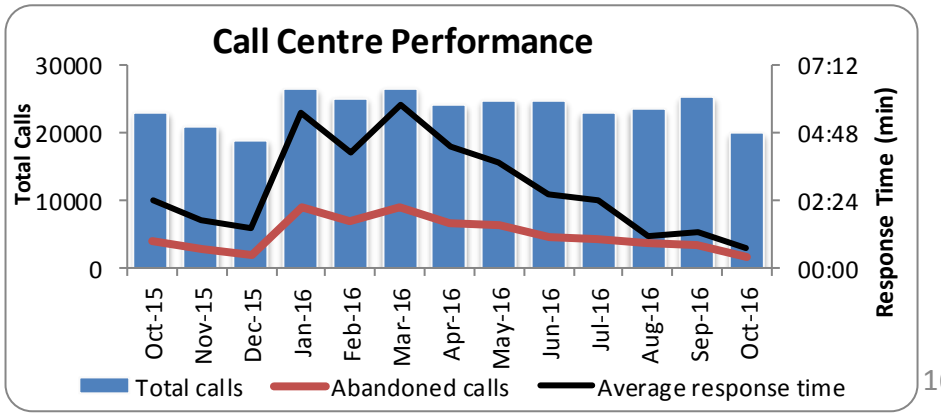












6. Corporate Outpatient Services (2 of 2) - Performance Overview

St George's University Hospitals NHS
NHS Foundation Trust

		Target	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Activity	Total attendances	N/A	66501	64863	54618	56239	41552	55261	59211	59055	56519	52223	54159	54143	54446
	Hospital cancellations <6 weeks	<0.5%	0.32%	0.36%	0.37%	0.35%	2.97%	0.69%	0.11%	0.08%	0.48%	0.54%	0.17%	0.15%	0.34%
OPD performance	Permanent notes to clinic	>98%	96.72%	96.52%	97.02%	96.50%	95.42%	97.20%	96.70%	92.26%	97.22%	97.01%	97.82%	99.25%	99.14%
	Cashing up - Current month	>98%	99.10%	97.40%	97.70%	99.30%	97.30%	98.70%	97.70%	100.00%	98.90%	99.60%	99.60%	99.70%	99.60%
	Cashing up - Previous month	100%	99.80%	99.75%	99.20%	99.40%	99.20%	99.20%	99.90%	98.20%	100.00%	100.00%	100.00%	100.00%	100.00%
Call Centre Performance	Total calls	N/A	23138	21082	19093	26557	25273	26674	24279	24924	24881	23186	23552	25372	20039
	Abandoned calls	<25%/<15%	3930	2756	1953	9084	6949	9055	6671	6362	4542	4185	3648	3405	1554
	Mean call response times	<1 m/<1m30s	02:24	01:43	01:24	05:30	04:06	05:49	04:20	03:45	02:37	02:26	01:10	01:18	00:43

Key Messages:

- Activity remains consistent with previous month with 54,446 attendances compared to 54,143 last month.
- Percentage of Hospital cancellations <6 weeks maintains improvement and within target
- Permanent notes to clinic has maintained improvement since February, and has achieved the target in September and October.
- The level of call activity and the number of abandoned calls significantly improved in August and has been maintained in both September and October.
- Total number of total calls have decreased slightly in October with the number of abandoned calls significantly reducing and performance against the target of mean call response times has been maintained for the third consecutive month and in October response times were within a minute

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

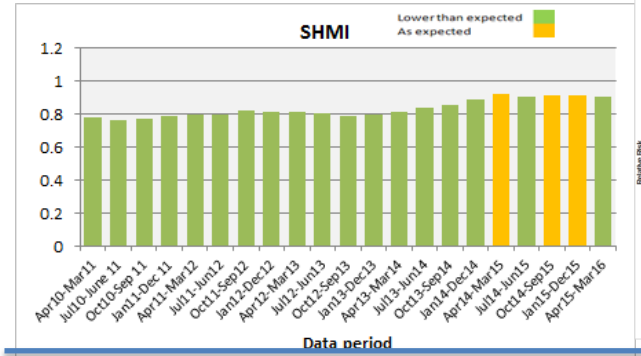
Quality Report

Oct-2016

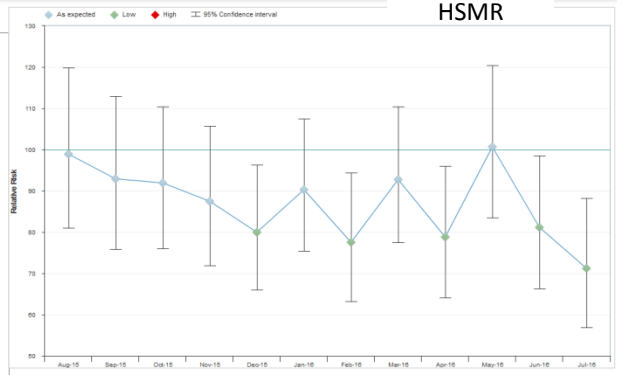
Excellence in specialist and community healthcare

7. Clinical Effectiveness

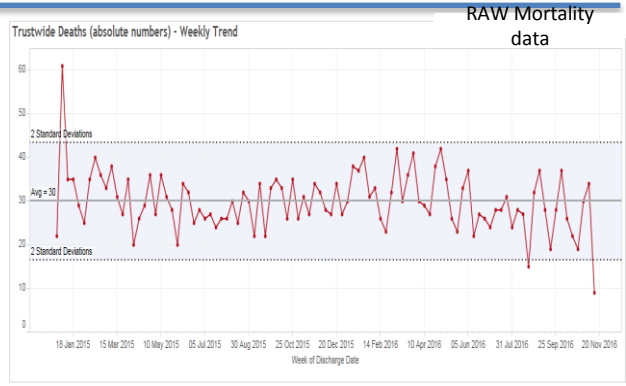
St George's University Hospitals NHS
NHS Foundation Trust

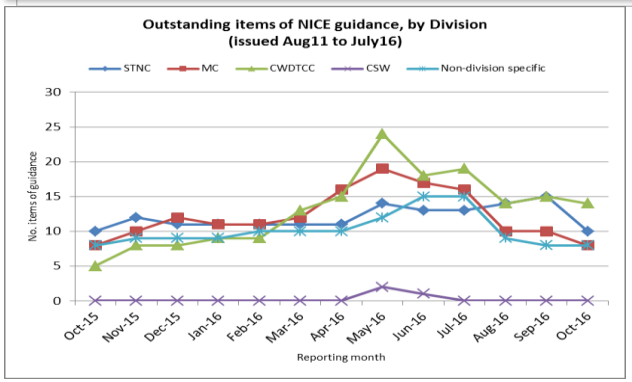


HSMR



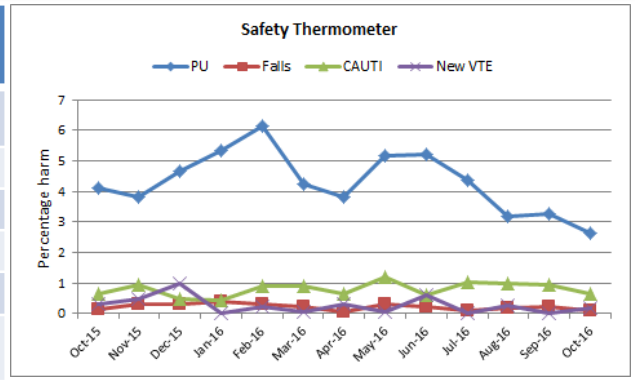
RAW Mortality data





Items of NICE Guidance with Compliance Issues (Jun 2010 to July 2016)

Division	2010	2011	2012	2013	2014	2015	2016
STNC (n=17)	0	1	2	1	3	2	8
M+C (n=17)	2	0	1	1	2	7	4
CWDTCC (n=16)	3	1	0	2	5	2	3
CSW (n=0)	0	0	0	0	0	0	0
Non-division specific (n=14)	0	2	0	3	1	4	4



Mortality

- HSMR remains better than expected: Aug 15 – Jul 16 = 86.7 [weekend emergency admissions = 92.0 (as expected); weekday emergency admissions = 84.2 (better than expected)].
- Latest SHMI April 15 – March 16 = 0.90 – lower than expected. One of 16 Trusts in England in this banding.
- Raw mortality within usual limits.
- Key workstreams underway: Dr Foster Imperial Unit Outlier Alert Coronary Atherosclerosis - investigation being finalised, no clinical concerns identified; National Mortality Case Record Review pilot completed and to present at national launch; Ongoing coding issues (delays and accuracy) remain very concerning to MMC.

NICE Guidance

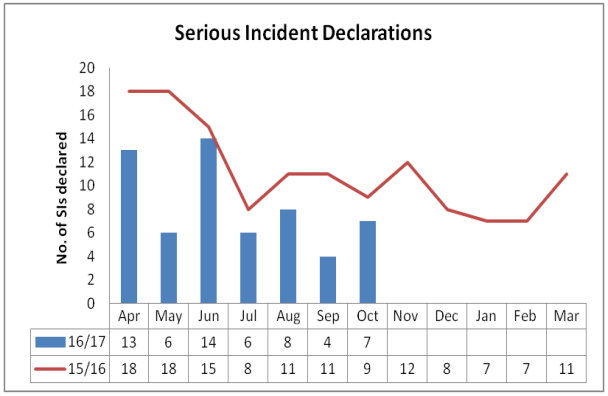
- 64 items of guidance with compliance issues that are with the Divisions for action; either to agree deviation and submit to PSQB or to devise an action plan.
- 40 items of guidance for which there has been no assessment of compliance. These have been escalated to each division for resolution.
- Monthly reports detailing the above are provided to divisions to support action and elimination of backlog.

Safety Thermometer

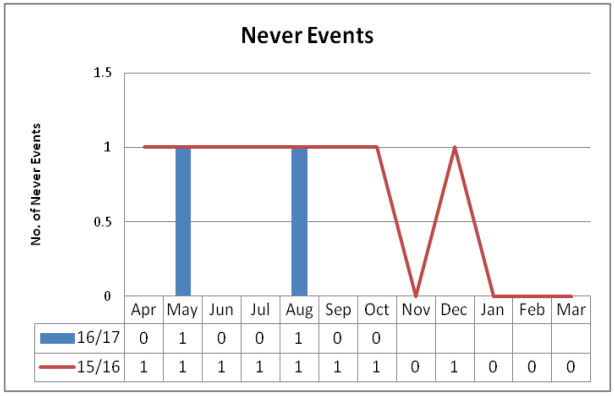
- 96.55% patients received harm free care in October. This is an improvement on the previous month and is better than our target and the national average (94.16%).
- 39 harms to 38 patients: 37 patients experienced 1 harm and 1 patient experienced 2 harms.
- 26 harms (66.7%) were old and cannot be attributed to care delivered by the Trust. Monthly RAG sheets detailing proportion of patients free from new harms have been introduced and will link to the Quality Dashboard.

8. Patient Safety

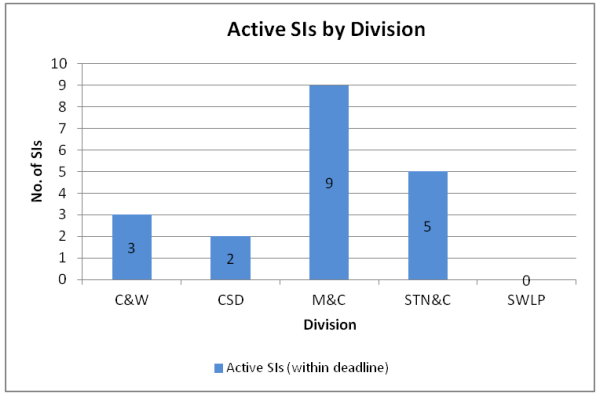
St George's University Hospitals NHS
NHS Foundation Trust

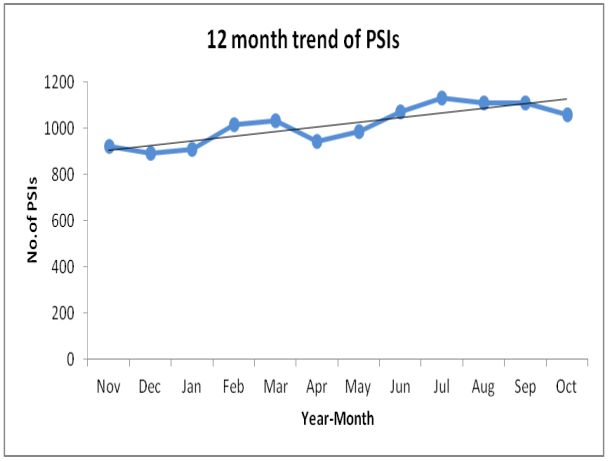


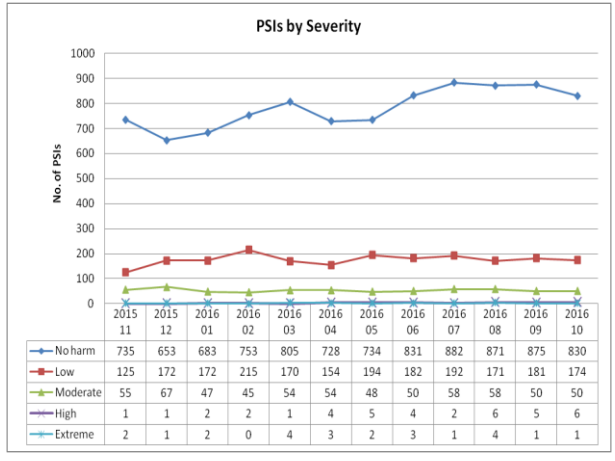
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	13	6	14	6	8	4	7					
15/16	18	18	15	8	11	11	9	12	8	7	7	11



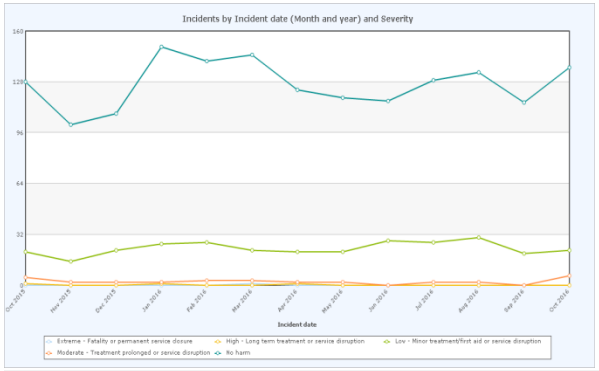
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	0	1	0	0	1	0	0					
15/16	1	1	1	1	1	1	1	0	1	0	0	0







	2015 11	2015 12	2016 01	2016 02	2016 03	2016 04	2016 05	2016 06	2016 07	2016 08	2016 09	2016 10
No harm	735	653	683	753	805	728	734	831	882	871	875	830
Low	125	172	172	215	170	154	194	182	192	171	181	174
Moderate	55	67	47	45	54	54	48	50	58	58	50	50
High	1	1	2	2	1	4	5	4	2	6	5	6
Extreme	2	1	2	0	4	3	2	3	1	4	1	1



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	169	125	143	164	139	169	155	118	132	179	171	171
16/17	147	141	144	158	166		165					

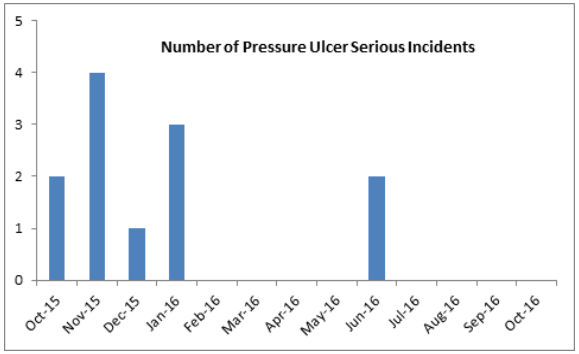
Patient Safety Incidents (PSIs) including Serious Incidents and Never Events

- Reduction in Serious Incidents (SIs) declared Apr-Oct: 2016/17: 58 compared with 90 SIs declared Apr-Oct 15/16, this represents a 35% decrease.
- 2 Never Events (wrong site surgery) declared Apr-Oct 2016/17, compared with 7 in Apr-Oct 2015/16
- The number of PSIs reported each month continues to increase, as does the proportion of incidents graded as moderate or above severity (5.7%).

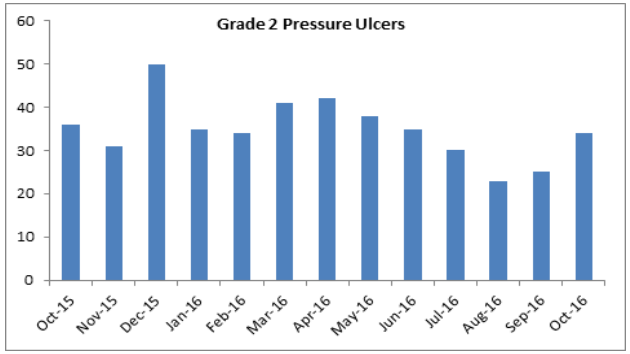
Falls

- The graph shows that there has been a small increase in the number of falls reported over the last month. This is attributed to a spike on Mary Seacole and Amyand ward in October.
- The "Safe Use of Bed Rails" policy has been updated and the bed rails risk assessment has been amended following clinicians' feedback. The revised risk assessment includes capacity assessment and further clarity on the considerations for bed rails use. The electronic version of the bed rails risk assessment will be updated in line with the paper based version.

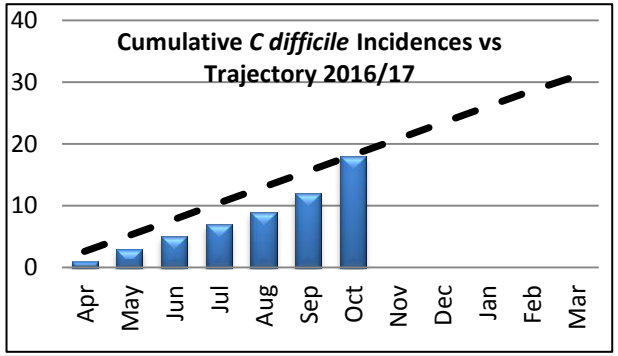
8. Patient Safety



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



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct
16/17	41	38	35	30	23	25	34
15/16	32	50	46	48	46	36	36



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	3	3	3	2	2	5	4	0	1	2	3	1
16/17	1	2	2	2	2	3	6					

VTE Compliance (Target >95%)

Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Unify 2: Data extracted from system on patient discharge via discharge summary or iClip											
96.8%	96.5%	96.6%	96.7%	97.04%	96.45%	97.59%	97.6%	96.9%	96.74%	96.3%	96.17%
Safety Thermometer: Audit data collated from patient record on set date during month											
93.24%	88.56%	94.10%	90.2%	94.04%	95.47%	92.9%	94.5%	95.7%	89.2%	94.3%	93.9%

Safeguarding Training rates (target 85%)

Division	Safeguarding Children	Safeguarding Adults
CWDTCC	88%	83%
M&C	86%	82%
STNC	93%	84%
CSD	86%	88%
Corp	100%	77%
Trust	**88%**	**83%**

Pressure Ulcers

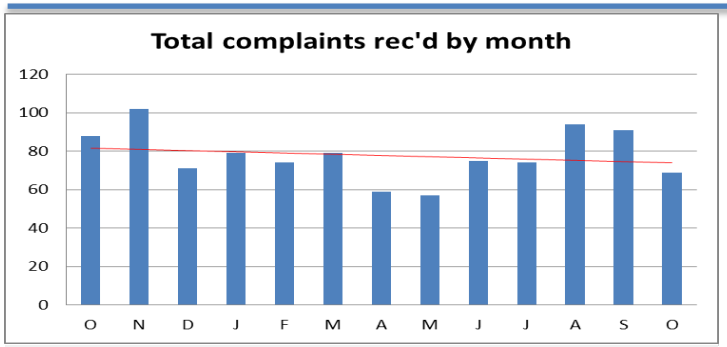
- October provided the trust with another month without any pressure ulcer serious incidents, this puts us in line to meet our yearly trajectory of 19 incidents.
- There was a rise in the number of Grade 2 pressure ulcers across the trust. In 2015/16 we had 485 Grade 2 PU's, there for a 10% reduction would be 436 target for 16/17. We are currently YTD at 226 Grade 2's, therefor we are on trajectory for meeting this target.
- IHI improvement work continues to roll-out across the trust with the Tissue Viability Team working on a way of porting this across to work within Community Services. The team has planned to increase the number of pressure ulcer study days running in 2017 from 5 to 7, this has been well received with most days fully booked already.

C Diff

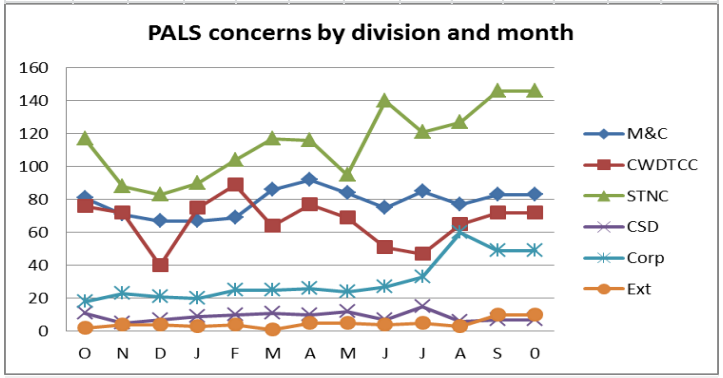
- The number of C Diff cases is 6 this month

9. Patient Experience

St George's University Hospitals NHS
NHS Foundation Trust



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	71	73	84	90	79	87	88	101	72	78	75	79
16/17	57	58	75	74	94	91	69					



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
15/16	248	227	294	302	257	304	305	264	222	264	303	308
16/17	330	289	304	306	338	367	346					

Friends & Family Test

	Apr	May	Jun	Jul	Aug	Sep	Oct	
M&C	97%	96%	95%	97%	96%	96%	96%	⇔
STNC	94%	95%	94%	97%	96%	94%	95%	⇧
CWD TCC	90%	96%	91%	93%	90%	95%	92%	⇩
CSD	93%	92%	94%	92%	96%	87%	89%	⇧
Trust	94%	95%	94%	95%	95%	94%	93%	⇩

Complaints Performance	% within 25 working days (target 85%)		% within 25 working days or agreed timescales (Target 100%)	
Division	**August**	**September**	**August**	**September**
CWDTCC	29%	50% ▲	(5) 64%	(9) 85% ▲
M&C	68%	84% ▲	(8) 100%	(5) 100% ◇
STNC	63%	73% ▲	(4) 75%	(3) 86% ▲
CSD	100%	75% ▼	(0) 100%	(1) 100% ◇
Corp	75%	57% ▼	(3) 100%	(2) 86% ▼
Trust	**65%**	**69%** ▲	**(20) 86%**	**(20) 91%** ▲

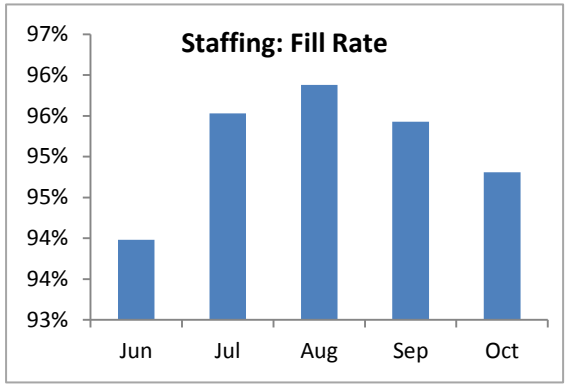
Complaints & PALS

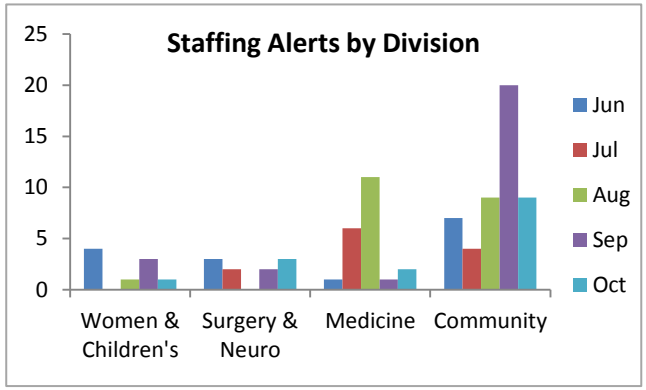
- Number of complaints reduced significantly from 91 in September to 69 in October.
- Top themes are: clinical treatment, communication and appointment delay/ cancellation (outpatient).
- Complaints performance has improved overall in September but remains inconsistent across divisions. Medicine and Cardiovascular Division is the best performing with the worst performing area being Children's, Women's, Diagnostics and Therapeutics. Although performance has improved since August. Action plans for improvement are in place in all divisions. Patient Experience Manager is developing a new high level action plan to attempt to address quality, timeliness and learning.
- Number of of PALS concerns received in October remain high: +13% (346) when compared when compared with October 2015 (305)

Friends & family test

- Our Friends and Family Test scores (percentage of people who said they were "Extremely likely" or "Likely" to recommend a service to friends or relatives) are reported by division. This report draws data from all patient surveys conducted on the RaTE system; including accessible versions that were created for any patient or relative that would have trouble understanding the standardised survey question. Further breakdowns are available for services and location type.
- Overall FFT scores indicate 93% would recommend the Trust, which is slightly lower that September at 94%.
- Outpatient based services underperforms all other settings in the Trust, while Critical Care and Day case services are scoring the highest.

10. Workforce





Care Hours per patient day (CHPPD)					
	Jun	Jul	Aug	Sep	Oct
Number of patients	23,137	21,043	20,335	23,562	22,497
Registered nurse/registered midwife	9.44	10.55	10.72	9.06	9.49
Care staff	3.24	3.74	3.75	3.11	3.11
Overall total	12.68	14.29	14.48	12.17	12.6

Key messages

Safe staffing relies on good rostering management so that budgeted posts are filled and deployed effectively and the staff employed are available to work (e-rostering rosters to be completed 8 weeks in advance to assist in planning staffing). There has been a significant improvement in medicine and surgery divisions. The other two divisions require improvement.

Anecdotal evidence suggests that many areas will not complete the safe staffing audit or datix forms accurately because they do not believe that any intervention will be forthcoming. No area should remain on alert / unsafe. The fact that this still occurs indicates that the escalation process is not being utilised effectively and the safe staffing policy is not being effectively utilised.

The corporate nursing team are reviewing the safe staffing procedures.

Community division have employed a recruitment nurses to assist in reducing vacancies and improving retention .

From May 2016, all acute trusts with inpatient wards/units began reporting monthly care hours per patient day (CHPPD) data to NHS improvement. Over time this will allow trusts to review the deployment of staff within a speciality and by comparable ward. When looking at this information locally alongside other patient outcome measures, trusts will be able to identify how they can change and flex their staffing establishment to improve outcomes for patients and improve productivity. Guidance and support on the use of this tool will be forthcoming from NHS improvement to assist the trust in implementation.

Overall the Trust Fill rate is 94.18%.

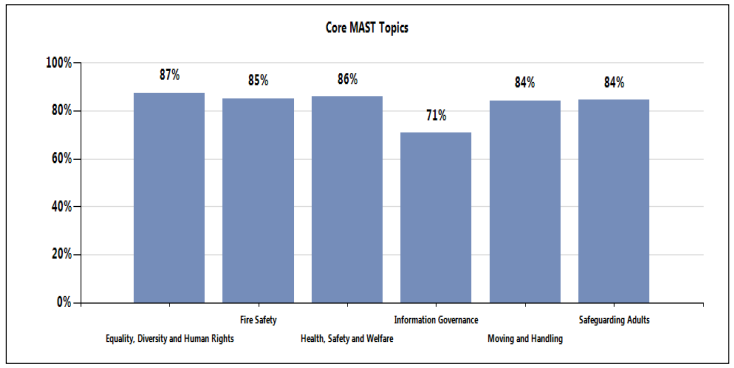
11. Fill Rates by Ward

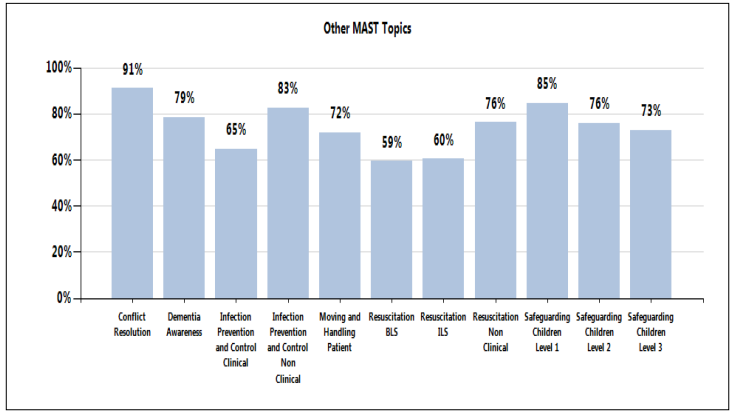
Trust Total	94.81%

Ward name	Overall %
Cardiothoracic Intensive Care Unit	98.51%
Carmen Suite	105.92%
Champneys Ward	67.18%
Delivery Suite	105.31%
Fred Hewitt Ward	94.04%
General Intensive Care Unit	96.37%
Gwillim Ward	93.83%
Jungle Ward	83.38%
Neo Natal Unit	87.81%
Neuro Intensive Care Unit	95.66%
Nicholls Ward	93.07%
Paediatric Intensive Care Unit	97.55%
Pinckney Ward	93.24%
Dalby Ward	98.25%
Heberden	93.91%
Mary Seacole Ward	98.35%
A & E Department	94.28%
Allingham Ward	84.18%
Amyand Ward	97.90%
Belgrave Ward AMW	92.62%
Benjamin Weir Ward AMW	90.33%
Buckland Ward	91.22%
Caroline Ward	96.03%
Cheselden Ward	99.07%

Ward name	Overall %
Coronary Care Unit	100.79%
James Hope Ward	97.60%
Marnham Ward	95.02%
McEntee Ward	98.89%
Richmond Ward	97.51%
Rodney Smith Med Ward	98.12%
Ruth Myles Ward	95.24%
Trevor Howell Ward	96.05%
Winter Ward (Caesar Hawkins)	92.84%
Brodie Ward	92.46%
Cavell Surg Ward	94.60%
Florence Nightingale Ward	93.78%
Gray Ward	95.54%
Gunning Ward	94.08%
Gwynne Holford Ward	93.88%
Holdsworth Ward	95.30%
Keate Ward	94.98%
Kent Ward	95.99%
Mckissock Ward	97.39%
Vernon Ward	94.02%
William Drummond HASU	90.25%
Wolfson Centre	94.72%
Gordon Smith Ward	87.01%

MAST Compliance





12.Nursing and Midwifery Heatmap – October 2016

St George's University Hospitals NHS
NHS Foundation Trust

Division	Ward	Incidence of c.difficile	Incidence of MRSA	Trust acquired pressure ulcers	Percentage of harm free care	Patient satisfaction (friends & family)	Ward staffing: unfilled duty hours	Falls (ward level)	Serious incidents (ward level)	Sickness/ absence rate - (ward)
COMMUNITY SERVICES	Mary Seacole	0.0	0.0	0.0			1.6	14.0	0.0	7.1
MEDICINE	ALLINGHAM	1.0	0.0	0.0	85.7	94.1	15.8	8.0	0.0	4.3
	AMYAND	0.0	0.0	0.0	96.8	90.5	2.1	9.0	0.0	8.0
	BELGRAVE	0.0	0.0	0.0	85.7	98.6	7.4	1.0	0.0	0.5
	BENJAMIN WEIR	0.0	0.0	0.0	100.0	96.7	9.7	3.0	0.0	0.4
	BUCKLAND	1.0	0.0	0.0	100.0	100.0	8.8	1.0	0.0	0.8
	CAESAR HAWKINS	0.0	0.0	0.0	90.5	100.0	7.2	8.0	0.0	6.1
	CARDIAC CARE UNIT	0.0	0.0	0.0	100.0	100.0	-0.8	0.0	0.0	4.8
	CAROLINE	0.0	0.0	0.0	100.0	94.8	4.0	3.0	0.0	1.0
	CHESELDEN	0.0	0.0	0.0	95.5	94.9	0.9	1.0	0.0	3.4
	DALBY	0.0	0.0	0.0	93.1	83.3	1.8	8.0	0.0	3.5
	EMERGENCY DEPARTMENT	0.0	0.0	0.0			5.7	2.0	0.0	3.9
	GORDON SMITH	0.0	0.0	0.0	100.0	100.0	13.0	2.0	0.0	6.5
	HEBERDEN	0.0	0.0	0.0	95.8	90.9	6.1	4.0	1.0	6.1
	JAMES HOPE	0.0	0.0	0.0	100.0	100.0	2.4	1.0	0.0	0.6
	MARNHAM	0.0	0.0	0.0	83.3	96.0	5.0	3.0	0.0	2.9
	MCENTEE	0.0	0.0	0.0	100.0	100.0	1.1	4.0	0.0	0.8
	RICHMOND	0.0	0.0	0.0	98.1	90.1	2.5	9.0	0.0	6.1
	RODNEY SMITH	0.0	0.0	0.0	91.3	100.0	1.9	7.0	0.0	0.9
	RUTH MYLES DAY UNIT	0.0	0.0	0.0	100.0	95.0	4.8	2.0	0.0	3.0
	TREVOR HOWELL	0.0	0.0	0.0	100.0	93.3	3.9	5.0	1.0	2.7

12. Nursing and Midwifery Heatmap – October 2016

St George's University Hospitals NHS
NHS Foundation Trust

Division	Ward	Incidence of c.difficile	Incidence of MRSA	Trust acquired pressure ulcers	Percentage of harm free care	Patient satisfaction (friends & family)	Ward staffing: unfilled duty hours	Falls (ward level)	Serious incidents (ward level)	Sickness/ absence rate - (ward)
SURGERY	BRODIE NEURO	0.0	0.0	0.0	96.4	86.4		4.0	0.0	
	CAVELL	0.0	0.0	0.0	100.0	95.9	5.4	1.0	0.0	7.5
	FLORENCE NIGHTINGALE	0.0	0.0	0.0	100.0	100.0	6.2	1.0	0.0	6.7
	GRAY WARD	2.0	0.0	0.0	100.0	94.8	4.5	6.0	1.0	6.0
	GUNNING	0.0	0.0	0.0	96.4	84.4	5.9	6.0	0.0	4.2
	GWYN HOLFORD	0.0	0.0	0.0	94.7	60.0	6.1	4.0	0.0	4.7
	HOLDSWORTH	0.0	0.0	0.0	100.0	92.3	4.7	3.0	1.0	1.5
	KEATE	0.0	0.0	0.0	100.0	92.3	5.0	0.0	0.0	4.8
	KENT	0.0	0.0	0.0	100.0	100.0	4.0	3.0	0.0	2.7
	MCKISSOCK	0.0	0.0	0.0	93.8	100.0	2.6	3.0	0.0	6.5
	THOMAS YOUNG	0.0	0.0	0.0	100.0	100.0	5.3	7.0	0.0	5.2
	VERNON	0.0	0.0	0.0	96.4	98.8	6.0	6.0	0.0	3.8
	WILLIAM DRUMMOND HASU	0.0	0.0	0.0	100.0	100.0	9.8	3.0	0.0	2.5
WOMEN & CHILDREN	CARDIOTHORACIC INTENSIV..	0.0	0.0	0.0			1.5	0.0	0.0	1.8
	CARMEN SUITE	0.0	0.0	0.0	100.0		-5.9	0.0	0.0	21.8
	CHAMPNEYS	0.0	0.0	0.0			32.8	0.0	0.0	0.5
	DELIVERY	0.0	0.0	0.0	100.0	93.1	-5.3	0.0	0.0	5.8
	FREDDIE HEWITT	0.0	0.0	0.0		70.0	6.0	2.0	0.0	1.8
	GENERAL ICU/HDU	1.0	1.0	0.0			3.6	1.0	1.0	4.6
	GWILLIM	0.0	0.0	0.0	100.0	91.4	6.2	0.0	0.0	4.1
	JUNGLE	0.0	0.0	0.0			16.7	0.0	0.0	8.5
	NEONATAL ICU	0.0	0.0	0.0			12.2	0.0	0.0	3.5
	NEURO ICU	1.0	0.0	0.0			4.3	1.0	0.0	3.5
	NICHOLLS	0.0	0.0	0.0			6.9	0.0	0.0	6.4
	PICU	0.0	0.0	0.0			2.5	0.0	0.0	4.6
	PINCKNEY	0.0	0.0	0.0			6.8	0.0	0.0	0.9

12.Nursing and Midwifery CSD Heatmap – October 2016

	Patiend Safety & Experience																
Domain	**Indicator**	**Frequency**	**2015/2016 Target**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**
				Q2 15/16	**Quarter 3 2015/16**			**Quarter 4 2015/16**			**Quarter 1 2016/17**			**Quarter 2 2016/17**		
Patient Safety	SI's REPORTED	Monthly		4	1	3	1	1	0	0	0	1	0	0	0	1
Patient Safety	Number of SI's breached	Monthly	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Patient Safety	Grade 3 & 4 Pressure Ulcers	Monthly	0	2	1	1	0	1	0	0	0	0	0	0	0	0
Patient Safety	Grade 4 Pressure Ulcers	Monthly	0	0	0	0	1	1	0	0	0	0	0	0	0	0
Patient Safety	Number of Fall of No Harm and Low Severity	Monthly	0	13	10	11	13	10	13	18	6	19	19	6	8	5
Patient Safety	Number of moderate falls	Monthly	0	0	0	2	1	0	0	0	1	0	0	1	0	0
Patient Safety	Number of major falls	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	Number of falls resulting in death	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	MRSA (cumulative)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	CDiff (cumulative)	Monthly	31	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety	CAS ALERTS - Number ongoing-received (Trust)	Monthly	0	2	2	2	2	2	2	2	2	2	2	2	2	1
Patient Safety	Number of Quality Alerts	Monthly		4	6	7	4	7	5	5	3	3	4	1	1	1
Safeguarding	% of staff compliant with safeguarding adults training	Monthly	85%	81%	77%	74%	70%	70%	68%	79%	82.0%	84.0%	85% as at 08/7	87%	88%	88%
Safeguarding	% of staff compliant with safeguarding childrens training	Monthly	Level 1 85%	88%	89%	86%	85%	89%	79%	79%	80.0%	81.0%	80%	82%	85%	88%
			Level 2 85%	66%	67%	63%	83%	80%	85%	92%	66.0%	73.0%	79%	75%	75%	75%
			Level 3 85%	85%	87%	84%	84%	84%	80%	80%	82.0%	82.0%	82%	87%	87%	80%
Patient Outcomes	Mortality SHMI ratio (Trus)	Monthly	<100	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.9	0.9	0.9	0.9	0.9	tbc
Patient Experience	Active Claims	Monthly		0	1	0	0	0	1	0	1	1	0	1	0	tbc
Patient Experience	Number of Complaints received	Monthly		5	5	5	5	4	6	7	2	2	5	6	12	4
Patient Experience	Number of Complaints responded to within 25 days (reporting 1 month in arrears)	Monthly	85%	85%	100%	100%	89%	100%	50% (3)	71%	100%	100%	100%	83%	100.00%	100% (3)
Patient Experience	Number of Complaints responded to within 25 days with an agreed extension	Monthly	95%	92%	100%	0%	78%	100%	67% (1)	50%	100%	100%	-	100%		100% (1)
Patient Experience	FFT Score (Mary Seacole and MIU until August) MS from sept 2016	Monthly Mary Seacole A		84.2%	94.4%	94.4%	100.0%	90.0%	95.0%	95.0%	90.0%	85.7%	87.1%	78.6%	100.00%	78.5%
		Monthly Mary Seacole B		75.0%	90.0%	94.0%	100.0%	85.0%								91.6%
Patient Outcomes	Catheter related UTI (Trust)			1.03	0.67	0.96	0.47	0.46	0.9	0.9	0.65	1.22	0.63	1.04	0.97	0.93
	Number of new VTE (Trust)		National 0.005	0.17	0.3	0.48	1.01	0	0.23	0.08	0.33	0.08	0.63	0.00	0.27	0.39
Workforce	Number of DBS Request Made	Quarterly	annually	N/A	N/A	N/A	N/A	N/A	N/A	N/A						
Workforce	Sickness Rate -	Monthly	3.50%	5.53%	5.90%	5.71%	6.00%	6.50%	6.19%	4.70%	4.72% Mar16	5.67%	4.98%	4.80%	4.50%	4.90%
Workforce	Turnover Rate-	Monthly	13.00%	21.15%	20.75%	20.76%	21.20%	20.80%	21.59%	20.50%	20.54% Mar16	20.3%	21.03%	20.83%	22.09%	20.59%
Workforce	Vacancy Rate-	Monthly	11.00%	12.59%	15.67%	18.50%	19.40%	18.90%	18.70%	19.40%	19.43% Mar16	20.81% Apr 16	38.06%	22.58%	25.53%	26.12%
Workforce	Appraisal Rates - Medical	Monthly	85.00%	84.00%	79.41%	81.26%	87.10%	87.10%	83.87%	88.90%	88.89% Mar16	92.59% Apr 16	87.50%	79.17%	70.00%	71.43%
Workforce	Appraisal Rates - Non-Medical	Monthly	85.00%	68.22%	64.91%	62.92%	62.40%	63.20%	63.53%	63.20%	63.25% Mar16	64.48% Apr 16	66.58%	77.81%	77.33%	78.91%

12. Nursing and Midwifery Heatmap Comments– October 2016

CWDT

- General Intensive Care Unit (GICU) - Had one incident of MRSA which is now being investigated as an SI. GICU also has an incidence of C Diffcile a root cause analyse is being done. Discussed at HAIC meeting.
- Neurology Intensive Care Unit (NICU)- Had an incidence of C Diffcile a root cause analyse is being done. Discussed at HAIC meeting.
- Sickness - Staff sickness has increase this month which will be reviewed at SSaW meeting. All sickness is managed in line with the HR policy.

CSD

- Serious incidents Sept – 1 (DIC OHC) : Bed rail audit (28 Oct 2016) : 41 of our 42 beds have bed rails in situ. One bed only has one rail; bed changed: Loccsips: RSH, GUM, podiatry in sop and audits in progress.
- Complaints: Complaints: 100% compliance: FFT: MSW A & B (16 responses): main concern: Noise at night – mainly other patients; Quality Alerts: Nil in September; Annual patient experience (Oct 2016) : results expected Dec/Jan 2016/7; EoLC: CQC 29A Warning Notice: clear accountability for EoLC agreed, No. of patients on EoLC recorded on RIO and reported on care group score card to DGB. First report to November 2016 DGB
- Q2 Level 3 child safeguarding 136 eligible staff : 79% (Aris), 117 in attendance (86%) manual count; CSD Road shows, LIA

SNCT

- The areas where there remain continued improvements in performance are Zero incidences of trust acquired pressure ulcers, Zero incidents of MRSA and patient satisfaction.

Medcard

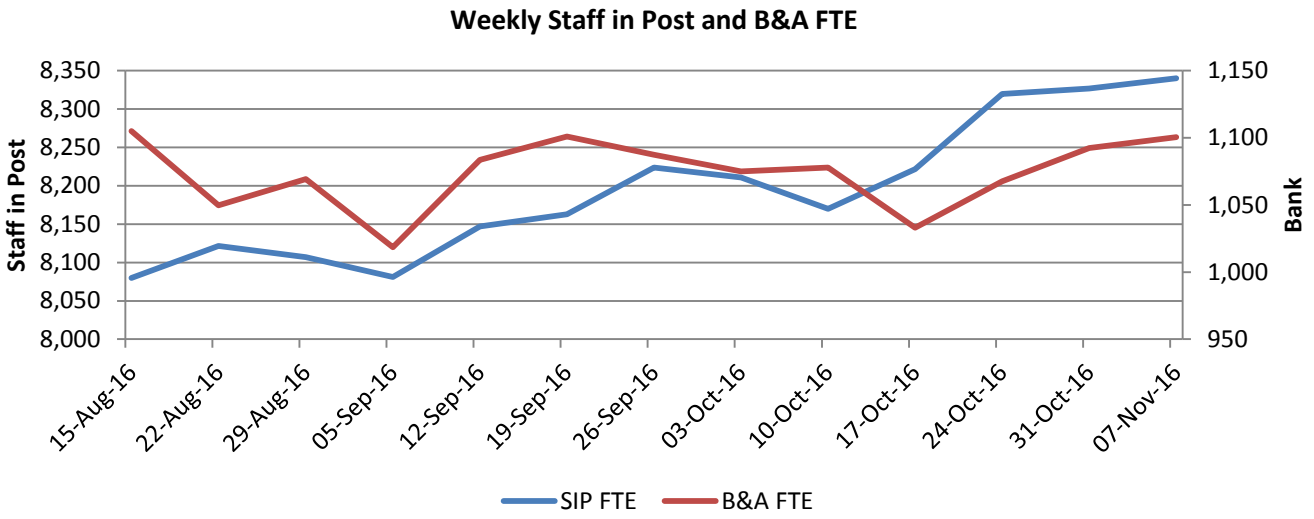
- 2 C.Diff cases reported in month. These have had an RCA completed which has been presented at the Infection Control task group. These have shown no lapses in care;
- Harm Free care for the division is at an average of 96.2% against the national average of 94.16%. When reviewing new harms for the division against the safety thermometer all areas other than Dalby ward were a 100%. Dalby ward scored 93.10% due to catheter care and the Head of Nursing and infection control have been asked to complete spot checks and education on the ward.
- Falls in the division remain high in areas, however this in part is contributed to by the number of admissions and client group within AMU and Allingham. The staff on AMU and Caesar Hawkins are reviewing these with the Physio team and looking at alternative walking aids for patients. A falls action place is in place in RHO to address the number of falls.
- There have been 2 Serious Incidents declared in month which are currently being investigated by the division, these relate to a fall and fracture and an omission of antiplatelet medication. Initial review of the patient fall shows that all nursing actions were completed.
- Sickness for the division remains below the trust target, but has risen in month which is being reviewed in conjunction with the ward managers and HR;

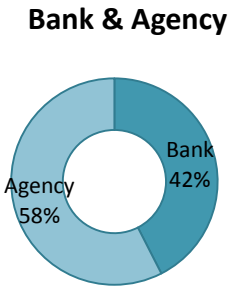
St George's University Hospitals NHS
NHS Foundation Trust

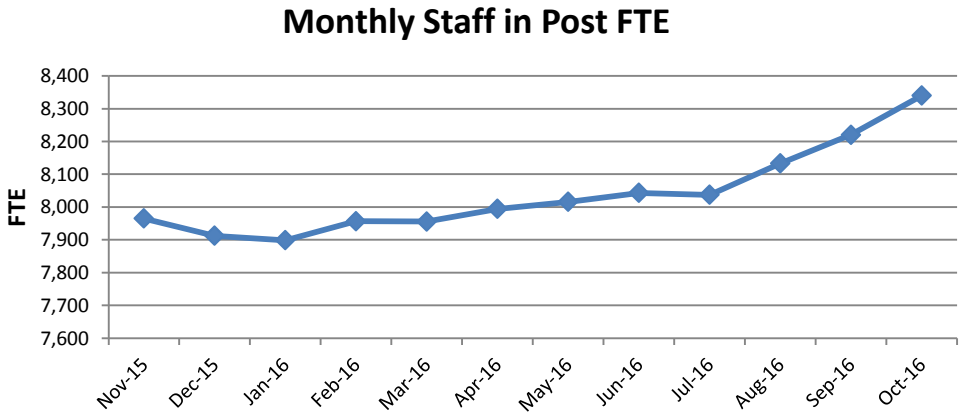
Meeting Title:	Trust Board		
Date:	1 December 2016	**Agenda No**	**2.5**
Report Title:	Workforce Performance Report		
Lead Director/Manager:	Karen Charman – Director of Workforce & OD		
Report Author:	Karen Charman – Director of Workforce & OD		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The figures for October 2016 continue to show an increase in substantive staff which is a positive move for the Trust in both quality of care and financial terms. However the figures have yet to demonstrate an accompanying reduction in temporary staffing costs particularly agency costs. Positive Movements within the report • Vacancy rate for substantive staff is below average for London Teaching Hospitals of 15.75% • Stability at 84.1% is in line with London Teaching Hospitals • Percentage of bank to agency bookings at 42% is the highest level since June Areas of concern with focused work in November • Failure to realise reduction in temporary staff usage • Non medical appraisal at 67% and MAST compliance 78% The key workforce outputs from the 2016 Workforce Race Equality Standard (WRES) are also attached with an action plan to be discussed by the Trust Board in a separate paper.		
Recommendation:	To receive the report.		
Supports			
Trust Strategic Objective:	Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience.		
CQC Theme:	Workforce impacts across all five themes		
Implications			
Risk:	Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost.		
Legal/Regulatory:			
Resources:	There are no resource implications.		
Previously Considered by:	Executive Management Committee Workforce and Education Committee	**Date**	21.11.16 24.11.16
Equality Impact Assessment:	N/A		
Appendices:	Workforce Performance Report		

Section 1: Current Staffing Profile and Bank & Agency

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







COMMENTARY

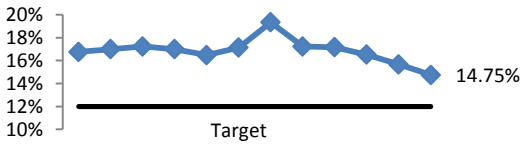
The Trust currently employs 8896 people working a whole time equivalent of 8340 which is 120 FTE higher than September. The growth rate in the directly employed workforce since April 2016 is 4.23%.

This includes 416 FTE from SWL Pathology. Their growth rate since April 2016 is 21.18%.

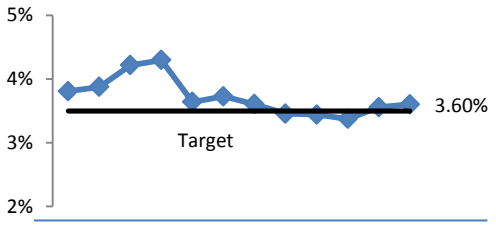
The Trust also employs an additional 485 FTE GP Trainees covering the South London area, which makes the total FTE 8825.

Section 2: Workforce KPI's

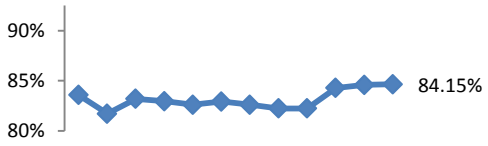
Vacancy Rate
Year Trend



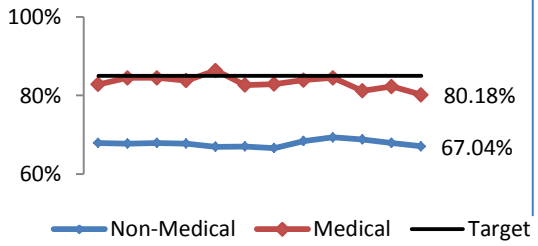
Sickness Rate
Year Trend



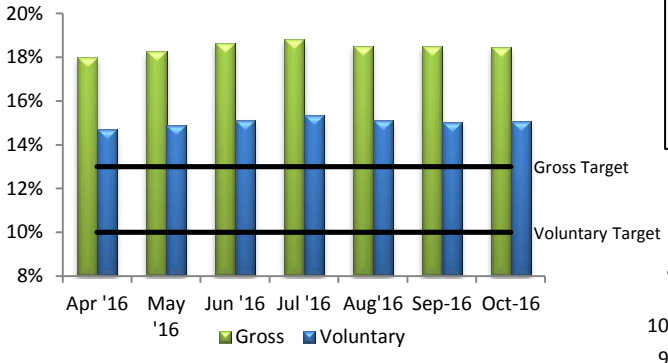
Stability Rate
Year Trend



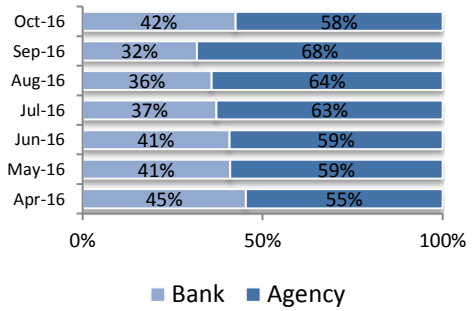
Appraisal Rate
Year Trend



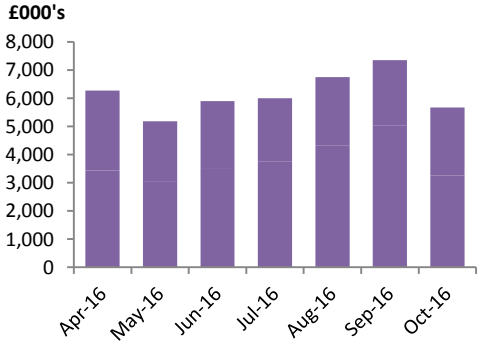
Turnover YTD



Bank/Agency Mix



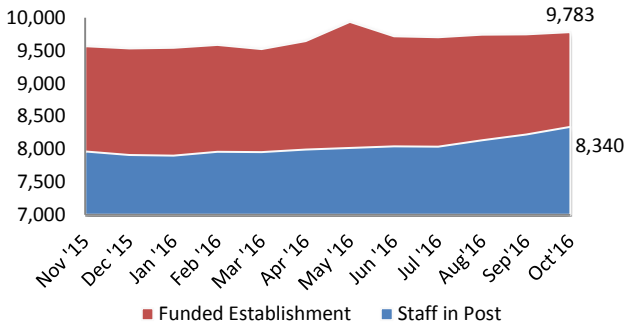
B&A Spend (YTD)



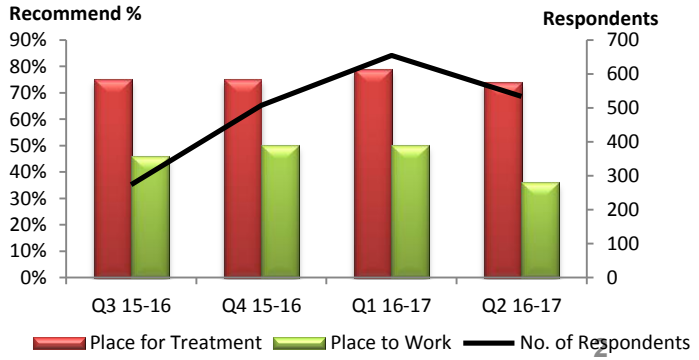
Key points:

- Vacancy has fallen by 0.92%
- Sickness has increased by 0.04%
- Turnover has decreased by 0.06%
- Voluntary turnover has increased by 0.05%

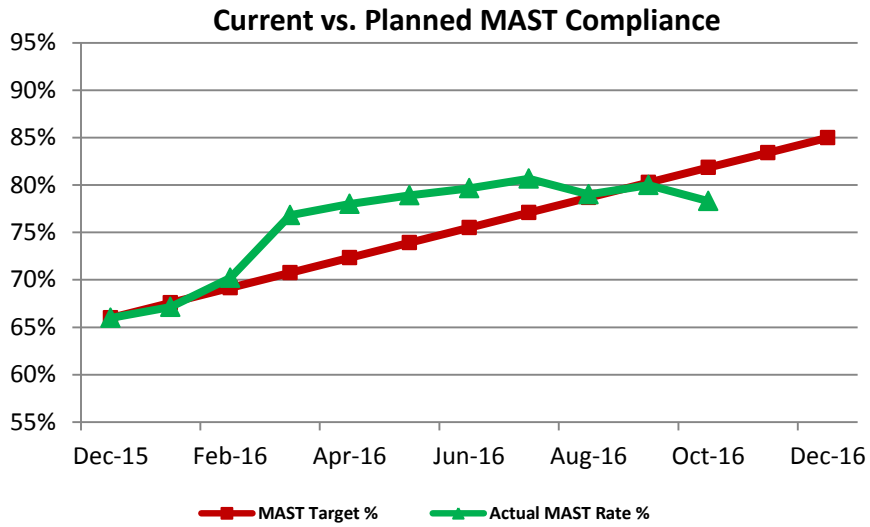
Trust Establishment & Fill Rate



Friends & Family Test



Section 3: MAST Compliance



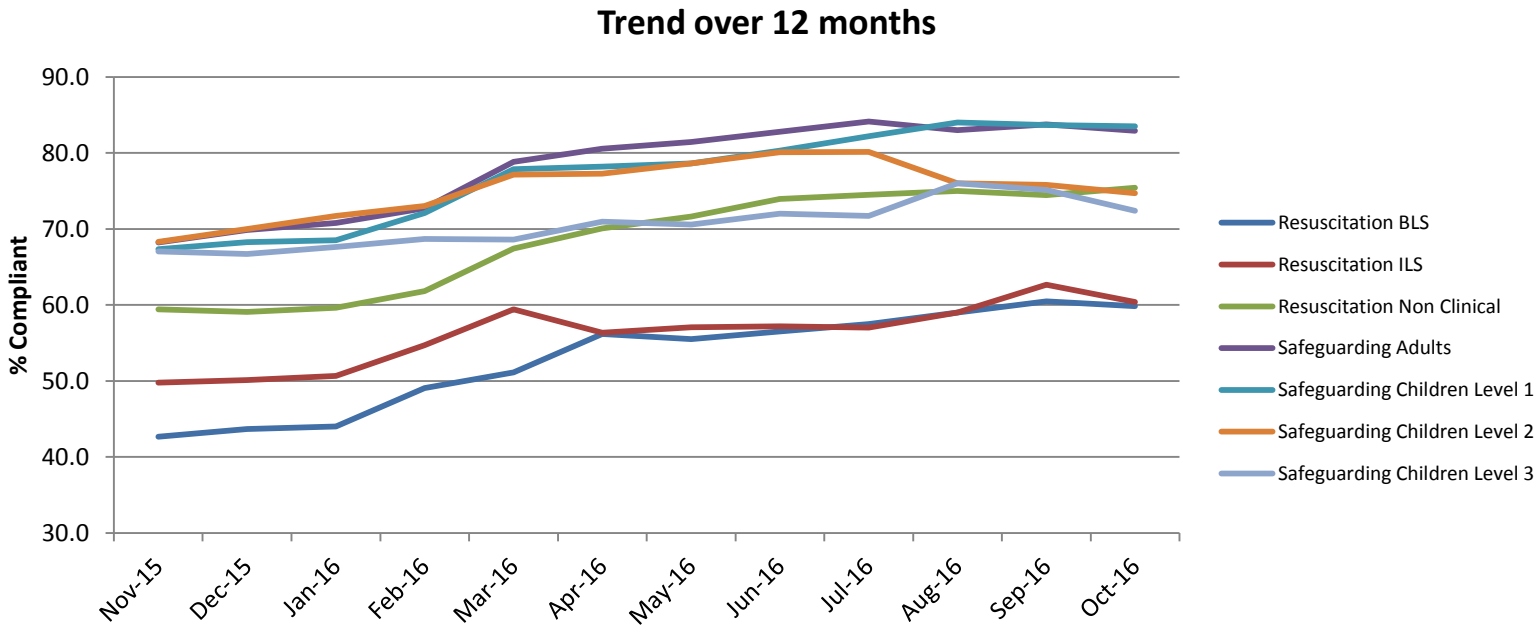
COMMENTARY

A programme of working is taking place including:

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

Current Issues:

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



Section 4: Workforce Race Equality Scheme (WRES)

The Workforce Race Equality Standard (WRES) consists of nine indicators. Four of the indicators relate specifically to workforce data; four are based upon data from the national NHS Staff survey questions, and one considers BME representation on Boards. An excerpt from the data on the Trust website on issues relating to workforce is included below

Indicator	Data for reporting year	Data for previous year
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	BME staff are 2.41 times more likely	BME staff are 3.31 times more likely
Relative likelihood of staff accessing non-mandatory training and CPD.	BME staff are 1.05 times more likely	BME staff are 1.06 times more likely
Percentage believing that trust provides equal opportunities for career progression or promotion.	White 83% BME 59%	White 85% BME 62%
In the last 12 months have you personally experienced discrimination at work	White 8% BME 23%	White 9% BME 21%

Action Plan - The action plan to demonstrate work undertaken and completed , as well as planned for the remainder of the year, is enclosed as an attachment to the Board report

Interim position in the Trust – as at 22 November 2016

	BAU	Project	Total	M7YTD
Chief Executive	7		7	£0.8m
Computing Directorate	8	35	43	£1.3m
Estates Directorate		10	10	£0.4m
Nursing & Governance		3	3	£0.2m
Finance Directorate		8	8	£1.1m
Operations	7	5	12	£0.9m
Turnaround		19	19	£1.6m
Total Hospital	22	80	102	
SWL Pathology	7		7	£0.4m
Total	**29**	**80**	**109**	£6.7m

Turnaround	
PMO	5
Outpatients	6
Diagnostics	2
Recovery Plan	1
Private Patient	3
HR	2
Total	**19**

Banding	
VSM	7
Project – over £750pd	14
Project – under £750pd	88
Total	**109**

109 individuals at month is an increase from the month 6 total of 104 individuals. The increase relates to turnaround and RTT

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	1 December 2016	**Agenda No**	**2.6a**
Report Title:	Update on the Workforce Race Equality Standards (WRES) Action Plan		
Lead Director/ Manager:	Karen Charman – Director of Workforce and OD		
Report Author:			
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Trust WRES reporting template was submitted centrally and loaded onto the Trust website in July 2016. These actions were formally approved by the Trust Board in November 2016. The Trust Board requires an action plan which addresses the deficits identified by the WRES reporting as well as those that have arisen from the Annual Staff Survey and CQC visits. The key areas we are required to address from the sources noted above are • Percentage believing that trust provides equal opportunities for career progression or promotion. – this had declined year on year to 59% from 62% for BME staff and still significantly lower than 83% for white staff. This was also reflected in CQC interviews of BME staff. • BME staff are 2.41 times more likely to enter the formal disciplinary process than white staff – an improvement from 3.31 times the previous year • White staff are 2.0 times more likely to be appointed from shortlisting than BME staff (1.9 times the previous year) A summary of actions that have been completed during 2016 are attached as Appendix 1 and the prospective action plan until the end of this financial year as Appendix 2.		
Recommendation:	To note the report and continued actions		
Supports			
Trust Strategic Objective:	Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost		
CQC Theme:	Leadership and Improvement Capability.		
Single Oversight Framework Theme:			
Implications			

Risk:	Failure to reduce the unacceptable levels of bullying & harassment reported by staff in the annual staff survey Failure to recruit and retain sufficient workforce with the right skills to provide quality of care and service at the appropriate cost		
Legal/Regulatory:	The Trust is required to commit to plans and demonstrate positive movement in it's annual WRES survey.		
Resources:	Continued support of Staff Network Advisory Group		
Previously Considered by:	Workforce and Education Committee	**Date**	
Equality Impact Assessment:			
Appendices:	Appendix 1 – WRES Completed work Appendix 2 - WRES Current Actions		

[Insert the Title of the Report/Paper]
[Insert Name of Meeting and Date of Meeting]

1.0 PURPOSE

1.1

1.2

1.3

2.0 BACKGROUND OR CONTEXT [select]

2.1

2.2

2.3

3.0 PROPOSAL OR ISSUE OR ANALYSIS OR OPTIONS APPRAISAL [select one or provide an alternative]

3.1

3.2

3.3

4.0 IMPLICATIONS

Risks
4.1

Legal Regulatory
4.2

Resources
4.3

5.0 NEXT STEPS OR TIMELINE [select one or do not use if not required]

5.1

5.2

6.0 RECOMMENDATION

6.1

6.2

Author:
Date:

APPENDIX [insert letter]

[Insert Heading of Appendix]

Workforce Race Equality - November 2016

Completed work: Appendix 1

1	Membership of Staff Network Advisory Group	In response to concerns about being released to attend Staff Network Advisory Group meetings the Director of HR wrote to the line managers of all group members to request their support in freeing up time to attend monthly meetings. **Closed March 2016**
2	Unconscious Bias training	Unconscious Bias training dates confirmed for 2016/17. 30 half day sessions (June '16-March '17) for all staff with line management responsibility. Review of attendees conducted and approximately 30% take up in Bands 7 and above was identified. Commitment to unconscious bias training for 2016/17 confirmed, most likely run in-house. Reported back to Staff network advisory group **Closed March 2016**
3	Review all Acting Up arrangements over 6 months	In response to staff concerns raised by the Staff Network Advisory Group, we reviewed the usage of acting up arrangements and found that there were many (106) where acting up arrangements have been in existence for more than the 6 months that the policy stipulates – in some cases several years. To resolve this issue speedily and fairly, action was taken to review all acting up arrangements lasting beyond 6 months and to bring these to an end when not in line with policy. Regular review to ensure acting up arrangements remain policy compliant is now 'Business as Usual' Reported back to Staff network advisory group **Closed June 2016**
4	Review of acting up /promotions in specifically highlighted area	In response to staff concerns raised by the Staff Network Advisory Group, we reviewed all acting up arrangements within the highlighted area to ensure that local arrangements were policy and guidance compliant. Reported back to Staff network advisory group **Closed June 2016**
5	Review of Employee Relations Case work by ethnicity	In response to staff concerns raised by the Staff Network Advisory Group, we reviewed all available data on Employee Relations Casework including sickness absence and disciplinary cases. Results showed that BME staff were more likely to be managed for sickness than white staff which correlated with higher levels of actual sickness in BME staff. Results showed that BME staff were more likely to enter into a disciplinary process than white staff although WRES data highlighted a significant reduction in that gap during 2015. Reported back to Staff network advisory group **Closed June 2016**
6	Obtain feedback from front line staff on how feelings of	In response to Employee Relations Casework review, feedback from front line staff was sought on how feelings of wellbeing could be improved.

	wellbeing can be improved	**Closed June 2016**
7	Review Dignity at Work (B&H) policy	In response to the NHS staff survey data, the dignity at work policy was reviewed and updated. A draft was shared with the SNAG as requested for comments. **Closed October 2016**
8	Review of recruitment training	In response to the WRES data and information provided by the Staff Network Advisory Group, a review of recruitment training was conducted. In addition to the one day EPM course, all new managers now receive a half day including recruitment training. In addition this is being rolled out to staff appointed recently and those longer in post. **Closed October 2016**

Workforce Race Equality – 1 November 2016

Current Actions: Appendix 2

	Action	By Whom	Completion date
1	Reporting of recruitment decisions to Chief Executive Report to be produced on a monthly basis to identify whether appointments in each division are reflective of the overall ethnicity of the division and benchmarking. Disability is also to be included and the report should enable the Chief Executive to challenge unusual patterns. Draft report to be produced to agree template.	**SM**	**December 2016**
2	Review of recruitment panels Identify how many recruitment panels for 8a+ have been held over the last 6 months (by area) to assess capacity with a view to inviting independent (SNAG member) to observe on panels for senior roles.	**SM**	**December 2016**
3	Half day training session on recruitment to be offered to SNAG or interested staff in preparation for sitting on interview panels.	**SJ / SM**	**January 2017**
4	Obtain stats in response to questions posed by the SNAG	**SG**	**December 2016**
5	Medical records Department Review training records of line managers	**SJ / SG**	**December 2016**
6	Explore processes in use at Royal Free to require all cases to be passed via Chief Nurse before progressing to formal disciplinary investigation	**KC**	**January 2017**
7	Monthly review of all new disciplinary cases, to detail reason, band, work area, ethnicity to identify any patterns	**SG**	**January 2017**
8	"All voices must be heard" Dialogues to gain staff feedback on progress for achieving 'Ten Commitments' (Leading Change,Adding Value) for Nursing, Midwifery & Care staff from General Surgery, Oncology, Urology, Neurology and Out Patients: General Surgery Wards,OP: Cavell, Gray Oncology OP: Trevor Howell, Ruth Myles, McKentee. Urology Wards, OP): Vernon Neurology Wards, OP: Kent Neurological surgical Wards: Brodie, McKissock. Priority areas of concern: recruitment practices, leadership development, project management experience and IPR outcomes. Short paper to be drafted for discussion with KC and Chief Nurse. Chief Nurse to be invited to future WRES meetings**.**	**RP/KC/SB**	**December 2016**

REPORT TO THE BOARD FROM: Workforce & Education Committee

COMMITTEE CHAIR: Gillian Norton

DATE(S) OF COMMITTEE MEETING: 24.11.16

1.0 MATTERS FOR THE BOARD'S ATTENTION

1.1 In relation to the Workforce Race Equality Scheme the Committee noted

BME staff were still disproportionately involved in formal disciplinary processes. However, the relative likelihood of BME staff entering the formal disciplinary processes was now 2.41, an improvement against the previous year's 3.31.
There was a wide ranging discussion on this. It had been a feature of many organisations in the past, the field was well researched and the action required well understood though it needed a consistent strategic approach.

The percentage of staff believing the Trust provides equal opportunities for career progression or promotion had deteriorated amongst all staff and the gap has increased slightly. So currently the figures are 83% for white staff and 59% for BME against a previous position of 85% and 62% respectively. We noted the work that had been successfully completed in relation to acting up allowances and that this was a step in the right direction.

The figures for experience of discrimination showed an increase with 23% of BME staff stating they had personally experienced discrimination (previously 21%). (Figures for white staff 8% and 9% respectively). This was a very disappointing figure and would require sustained effort to address.

In relation to recruitment white staff were 2 times more likely to be appointed against a figure of 1.9 in previous figures.

It was observed that some of the changes were slight but apart from the one on formal disciplinary action, the direction of travel was the wrong way. We had a report detailing work done to date and the further work which is programmed. The Staff Support Group seems to have been actively involved and supportive which was encouraging as they had been rightly critical in the past.

However, this is an area to which the Committee will pay sustained attention and on which it will report regularly to the Board.

1.2 On recruitment a small improvement was described. A lot of work has been done and more is programmed and the Staff Network Advisory Group seems to be actively involved and supportive. However, this is an area on which the Committee in particular but also the Board will need to keep a close eye to ensure that the issues are being addressed effectively and progress being achieved.

2.0 ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

2.1 In relation to the Carter review the Committee were advised of work being done by PWC for SW London, the work underway with Epsom St Helier and some London wide benchmarking. Whilst the latter would be interesting and useful the first two seemed more likely to produce immediate benefit in terms of efficiencies and cost reductions. It was noted that local

government had done a considerable amount of back office sharing and rationalisation so that there were case studies readily available and it was confirmed that these were being drawn on.

2.2 There was a wide ranging discussion about staff morale and a concern that too often the Trust made it harder for itself than it needed. The overall message was that things were improving but we were behind other similar organisations. Whilst pay was sometimes the issue, people's greater concerns were about feeling valued and how difficult it was to get simple things done. Systems were inefficient and time consuming. The work done by IT and Estates was recognised and appreciated but there was a very long way to go. The importance of high quality leadership and management and the work HR were doing on this was appreciated and the required culture change was not a quick fix. We should not forget the fact that we were a teaching and research institute. For many staff this was a potential benefit.
It was agreed managers needed to encourage staff to complete the staff survey - we were still only at about 30%.

2.3 We considered the current staffing profile and bank and agency balance noting that agency numbers appeared to be moving in the right direction . The Agency Spend Self- Assessment which the Board had agreed yesterday was noted. All present understood the need for the tight processes recently introduced and supported them, recognising that some parts of the system needed that kind of challenge.

2.4 On MAST compliance the Director reported on the discussion and actions of the Quality Committee yesterday. She emphasised that compliance was non-negotiable and that attendees had to take this back to their divisions.

2.5 We received the minutes of the Education Board and noted the impending impact of the reduction in education finance, the potential from apprenticeships ableit the Trust has some work to catch up with other sectors, and the view that education needs to be effectively represented at the Trust Board. As a Trust Board we have acknowledged this latter point and have to ensure an appropriate item is timetabled for a future meeting.

3.0 RECOMMENDATION

3.1 The Board is invited to receive the report for assurance

Author: **Gillian Norton – Non-Executive Director**
Date: **24 November 2016**

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Elective Pathway Issues at St Georges

1 December 2016

Excellence in specialist and community healthcare

Background

Following a series of performance and data issues the Trust commissioned a comprehensive review of the systems and processes in place to manage patients along the elective pathway.

These reviews focused on three areas:

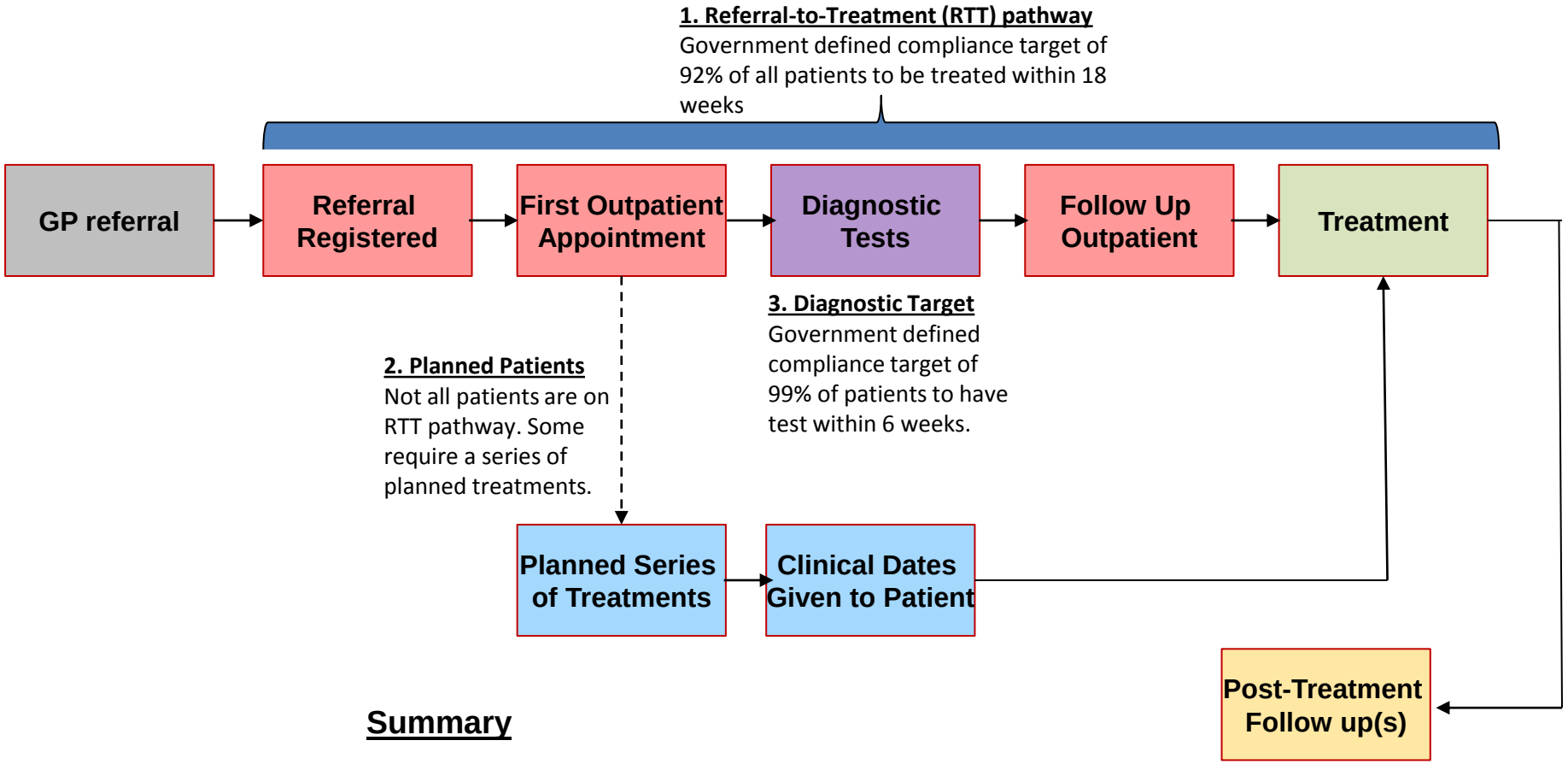
- Referral to Treatment pathways (RTT);
- Cancer pathways and
- Diagnostic pathways.

The outcome of these reviews highlighted multiple operational process and technology issues that pointed to patients receiving a sub-standard level of care and potential clinical risk.

In addition, current mechanisms of reporting elective pathway performance statistics were viewed as fundamentally broken and on this basis the Board made a decision that the Trust should cease national reporting of RTT information.

In the light of these findings we have developed and are implementing a recovery programme, led by a programme director comprising of a number of core workstreams necessary for us to improve both our IT systems and our operational processes of tracking patients to ensure that patients are seen in a timely manner.

The Elective Care Pathway



Summary

- Every organisation should have the ability to track all 4 of these categories of patient;
- Ensuring timely care has huge potential clinical and financial benefits;
- 2 of the 4 categories have a government target attached;

What are the issues at St Georges?

- Lack of confidence that our current waiting lists contain the correct list of patients.
- The waiting lists of most concern relate to patients waiting for follow-ups and patients on a planned series of treatments. However there are issues relating to all waiting lists.
- A set of 'rules' are in place which exclude patients from waiting lists. The records of those on waiting lists may not include the referral (clock start) date.
- Patient records will need to be validated to check that patients have been treated, and have not come to harm whilst waiting. The exclusion rules will need to be removed.
- The causes of these problems are multifactorial but mostly relate to poor levels of governance around the quality of data being entered onto clinical systems at both the Tooting and Queen Mary's site.
- This lack of accuracy of our information has several consequences:
    - Potential for us to have delayed or not seen patients – clinical risk
    - Wasted capacity – because we often don't know the next step in the patient journey the safest thing to do is to bring the patient back for a follow-up. Highly likely a percentage of this is unnecessary
    - Rework – large amounts of workaround and rework are being generated due to poor administrative processes
    - Clinical buy-in – clinical staff are concerned about the potential for harm to occur
    - Failure to meet government targets – reputational & financial consequences for failing these standards

Main Causal Factors

Many of the causes and symptoms are not unique to St Georges however the implementation of the PAS system in 2010 left the organization particularly vulnerable.

Data Quality

Using clean waiting lists to construct PTLs

Information and reporting schedules

Booking

Fragmented

Policy compliance is not achieved

Clinical Leadership

Non-compliance with basic standards

Operational Leadership

Non-compliance with basic standards

Lack of standards

Capacity Management

Special Measures

Impact on organisational administrative resilience

Morale Low

Financial restrictions in place

Elective Care Building Blocks not established → **PAS Replacement 2010** → **2016**

PAS System Replacement

Decision not to use new PAS system for waiting list manangement.

Workarounds created where lists of patients are held in manual systems.

No Standard Operating Procedures in place.

No Training in place.

Cease reporting RTT statistics

Lack of confidence in performance reporting figures.

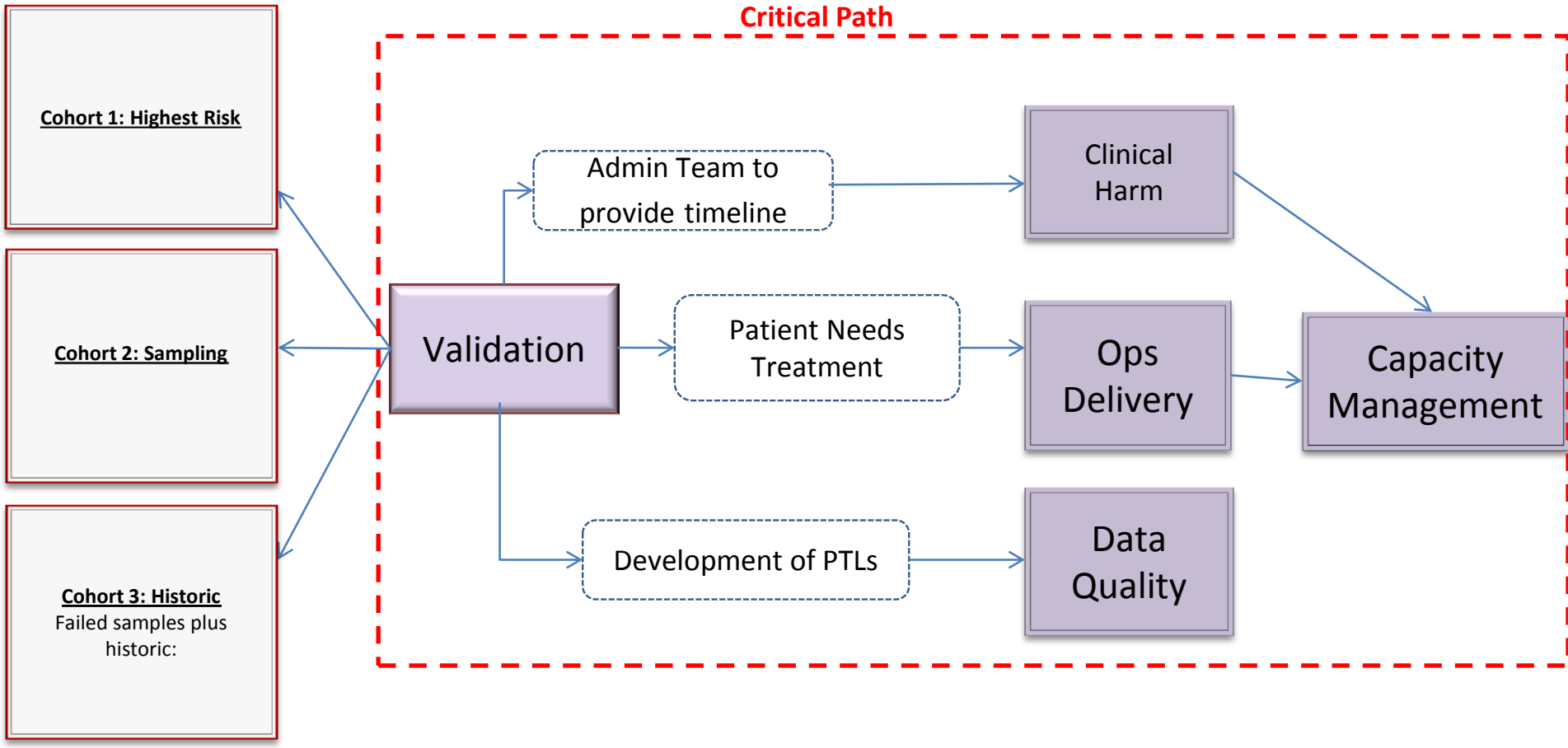
Need to manually check large number of patient records.

Inability to track patients on the IT system.

Significant risk of harm occurring.

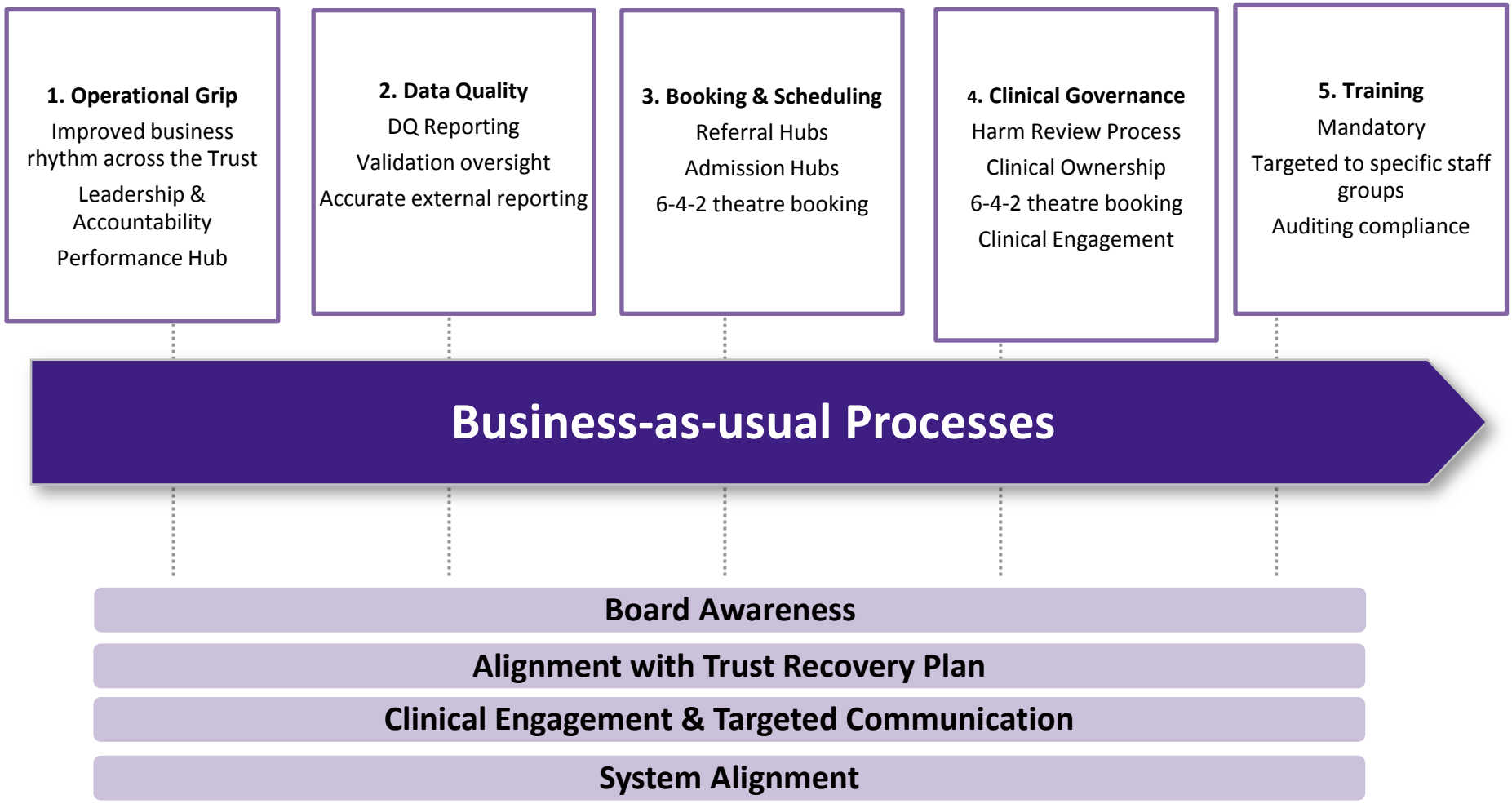
What are we doing about it?

We have established an elective recovery programme led by an Executive Director consisting of a number of workstreams.



Correcting business-as-usual processes

It is tempting to focus on technology issues and validation as key priorities. However, this should not be the focus of the majority of the organisation – fixing broken operational processes is the only way to ultimately correct this.



Validation

Whilst this is central to recovery the Trust has outsourced this to an external company given the scale of the challenge. It is critical that this work is led and managed by the Trust to achieve success but it should be thought of as separate to BAU recovery.

- It is important to understand that this task will take up to 12 months and require significant levels of resource.
- The approach chosen by the Trust has identified the patient cohorts with the most potential for clinical harm to occur. The validation process will feed into the clinical harm review process led by the Medical Director as well as feeding the operational teams with lists of patients that to be reviewed by a clinician.
- **Independent, 3rd party assurance of PTL** will provide the Trust, commissioners and regulators with the confidence that an experienced, independent body has reviewed and reported on the Trust PTL.
- **The use of a systematic approach to PTL review that has been applied a number of times on Cerner sites** will ensure that no records are missed or are un-accounted for.
- **The approach reduces the total validation required through cohort analysis, prioritization and statistically significant sample size creation**. This approach prioritizes cohorts for validation and applies a statistical approach to sample size creation for each cohort. A level of manual validation will still be required to achieve the required assurance.
- **Live repeatable model allows daily updates of the review –** once the data model is created it will draw data from Trust systems daily. This will allow the output to be refreshed providing a repeatable review at any point. This will provide a level of ongoing assurance when signing off the monthly RTT submission.
- Running in parallel to all of this will be the creation of new waiting lists to enable us to track patients on an ongoing basis as the quality of our data improves.

Summary – final messages

- This is an elective pathway and not just an RTT issue
- Elective pathways represent the vast majority of patients we look after. This has huge implications for both clinical and financial sustainability.
- The issues identified are fixable but will require the whole organisation to engage; the areas needing to be fixed cover the whole elective pathway.
- Independent external experts have approved our approach and estimate the recovery will take up to 2 years.
- The data quality issues identified raises questions about our ability to record the work we are doing - which could have significant financial implications.
- This work will likely result in the identification of services where demand and capacity is not aligned and we will need to work with the wider system to achieve balance with regard demand for our services.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	1 December 2016	**Agenda No**	**3.1**
Report Title:	Summary Finance Report- Month 07 2016/17		
Lead Director/ Manager:	Margaret Pratt, Chief Financial Officer		
Report Author:	Michael Armour, Reporting Accountant		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	The Trust has reported an in-month deficit of £5.4m in November which is £5.2m worse than plan. Included in month is a Non Pay overspend (£2.8m), excess pay costs of £0.1m and below plan Income (£2.0m; mainly attributable to the STF (£1.5m) and RTT non-reporting penalty (£0.3m)). £0.4m of Pay, £0.2m Non Pay and £0.3m of Income in-month is cost unforeseen and outside of the control of the Trust. The YTD deficit is £47.7m. The Trust is currently assuming a £80.7m forecast deficit although this is subject to a full reforecast exercise with NHS Improvement in the coming weeks.		
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:	Executive Management Team Finance & Performance Committee	**Date**	21.11.16 24.11.16
Equality Impact Assessment:	N/A		
Appendices:	None		

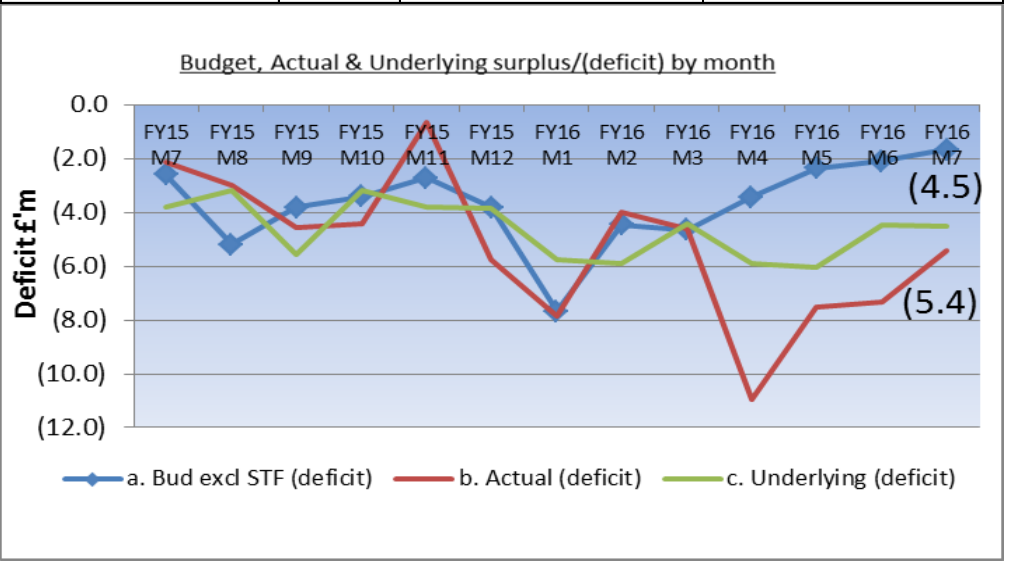
Summary Finance Report
Month 07 2016/17

Trust Board 1st December 2016

Contents

1. Financial Position for the month October 2016

Income & Expenditure	Annual Budget £'m	Current Month Budget £'m	Current Month Actual £'m	Current Month Variance £m	Year to Date (YTD) Budget £'m	Year to Date (YTD) Actual £'m	Year to Date (YTD) Variance £m
SLA Income	650.2	55.1	54.5	(0.6)	379.0	374.7	(4.3)
STF Income	17.6	1.5	0.0	(1.5)	10.3	0.0	(10.3)
Other Income	111.9	9.4	9.5	0.1	65.6	68.3	2.8
Overall Income	**779.8**	**65.9**	**63.9**	**(2.0)**	**454.9**	**443.0**	**(11.9)**
Pay	(487.9)	(40.8)	(40.9)	(0.1)	(283.6)	(287.9)	(4.3)
Non Pay	(274.0)	(22.4)	(25.2)	(2.8)	(166.9)	(182.0)	(15.2)
Overall Expenditure	(761.9)	(63.2)	(66.2)	(2.9)	(450.5)	(469.9)	(19.5)
EBITDA	17.9	2.7	(2.2)	(4.9)	4.4	(26.9)	(31.3)
Financing costs	(35.1)	(2.9)	(3.2)	(0.3)	(20.5)	(20.7)	(0.3)
Surplus/(deficit)	**(17.2)**	**(0.2)**	**(5.4)**	**(5.2)**	**(16.1)**	**(47.7)**	**(31.6)**
Memo: Below the Line Items	0.0	0.0	(0.9)	(0.9)	0.0	(9.7)	(9.7)



Commentary

- An in-month deficit of £5.4m is reported in October which is £5.2m worse than plan. The YTD deficit is £47.7m.
- **Forecast Outturn** a deficit of £80.7m is subject to a full reforecast exercise with NHS Improvement in the coming weeks.
- **Below the line** - £9.7m of cost year to date relate to items outside the Trust's initial plan regarding unforeseen, one off costs associated with areas such as the rectification of Estates & IT infrastructure, additional senior management support, lost income from the Junior Doctors' strike, Prior Year agency cost and the RTT penalty.
- **SLA income (not STF)** - £0.6m shortfall in month and £4.3m YTD. Business Case slippage in Neurosurgery (£2.8m YTD) and the impact of the RTT non-reporting penalty (£2.3m YTD) have impacted here. A dialogue with commissioners has commenced asking for reinvestment to support RTT recording and delivery.
- **STF Income –** There is an annual budget of £17.6m that the Trust is not expecting to receive this financial year.
- **Pay** - £0.1m overspent in month, and £4.3m YTD, as a result of spend on unbudgeted interim staff and divisional vacancies covered by bank & agency. The position has improved in-month as a result of the reduction of interim costs in overheads and physiotherapy agency. Internal control is being strengthened on agency booking.
- **Non pay**– £2.8m excess cost in month and £15.2m YTD, £12.3m (to date) of which is a consequence of non delivery of Trust CIP plans. The £2.7m can be attributed to drugs cost to deliver additional Commercial Pharmacy income.
- **The M7 underlying position (excl. STF)** is a deficit of £4.5m (£4.5m in M6). The M6&7 improvement from M5 is owing to additional working days supporting Elective & Outpatient activity, reduced divisional agency costs in M7 and other trend improvements in Non Pay. The deterioration since 15/16 is owing to higher: pay award & pension cost; spend on interims; soft FM costs; and costs of reactive maintenance.

2. Analysis of cash movement M07 YTD

Source and application of funds - cash movement analysis:
M07 YTD and forecast vs Plan

	Actual vs Plan YTD			Based on forecast £80.7m deficit			
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*	*Plan Year £m*	*Forecast Outturn £m*	*Forecast VAR £m*	Notes based on forecast £80.7m deficit
Opening cash 01.04.16	7.4	7.4		*7.4*	*7.4*		
Income and expenditure deficit	-18.7	-47.7	***-28.9***	*-17.2*	*-80.7*	***-63.5***	
Depreciation	14.3	14.2	***-0.1***	*25.0*	*25.0*	***0.0***	
Interest payable	2.9	2.8	***-0.1***	*5.1*	*5.8*	***0.7***	
PDC dividend	3.6	3.6	***0.0***	*6.3*	*5.3*	***-1.0***	
Other non-cash items	-0.1	-0.1	***0.0***	*-0.2*	*-0.2*	***0.0***	
Operating deficit	**2.0**	**-27.1**	***-29.2***	**19.0**	**-44.8**	***-63.8***	
Change in stock	-0.2	-0.9	***-0.7***	*0.6*	*0.6*	***0.0***	
Change in debtors	-1.4	-17.4	***-16.0***	*2.0*	*-8.2*	***-10.2***	does not assume debt targets met
Change in creditors	3.0	29.6	***26.7***	*-5.5*	*4.5*	***10.0***	
Net change in working capital	1.4	11.4	***10.0***	-2.9	-3.1	**-0.2**	
Capital spend (excl leases)	-23.3	-12.5	***10.9***	*-33.4*	*-33.4*	***0.0***	The capital cash spend forecast is prudently reduced to £33.4 - equivalent to the baseline budget excluding emergecy capital - on the basis of the signifcant under spend at M07. This means no additional borrowing would be required to finance capital expenditure in year.
Interest paid	-2.8	-2.5	***0.2***	*-5.1*	*-5.6*	***-0.5***	
PDC dividend paid	-3.1	-3.1	***0.0***	*-6.3*	*-5.3*	***1.0***	
Other	-4.6	-3.8	***0.8***	*-8.0*	*-8.0*	***0.0***	
Investing activities	-33.8	-22.0	***11.9***	*-52.7*	*-52.2*	***0.5***	
WCF/ISF borrowing	26.2	40.1	***13.9***	*32.5*	*96.0*	***63.5***	The borrowing forecast now excludes emergency (unapproved) capital funding as the capital forecast is to spend the baseline budget only. Therefore all the additional borrowing is to finance the higher deficit. The borrowing total does not include the requested £20m cash headroom.
Closing cash 31.10.13 / 31.03.17	3.2	9.8	***6.6***	3.2	3.2	***0.0***	

Commentary

M07 YTD cash movement

- Of the I&E deficit of £47.7.m YTD, depreciation (£14.2m) does not impact cash. The accruals for PDC dividend and interest payable are added back for presentational purposes and the amounts paid for these expenses shown lower down. This generates a YTD cash operating deficit of £27.1m.
- The operating variance from plan of £29.2m in cash is directly attributable to the I&E deficit. Members will recall that the NHSI plan and Internal trust plan are phased differently
- The Trust has been able to offset the worsening operating deficit with better performance on working capital (+£10m) and cash under spend on capital (+£10m) delivering a combined cash and borrowing position ahead of plan.

Forecast outturn

- The forecast operating cash deficit of £44.8m results from a forecast deficit of £80.7m offset by depreciation of £25m.
- The total forecast borrowing requirement for the year would be £96m, £63.5m higher than plan. This includes £63.5m extra borrowing to finance the higher operating deficit. NB this borrowing total does not include emergency capital funding as the capital expenditure forecast assumes spend to the baseline budget only.

3. M7 Forecast

M7 Desired/Planned forecast
=
£34.8m Deficit

Straight-line forecast at M7
=
£81.7m Deficit

Straight-line forecast at M6 = £84.5m Deficit

Forecast submitted to NHSI at M7
=
£55.5m Deficit

- There has been dialogue with NHS Improvement over the last month regarding the year end forecast which has been a completed each month since Q1 reporting.
- The Trust is being held to account against its initial gross plan of a £34.8m deficit (£17.2m minus £17.6m STF), which assumes full achievement of the £42.7m CIP programme.
- A straight-line forecast of the month 7 position leads to an £81.7m deficit by year end: an improvement from September's projected £84.5m deficit.
- A forecast of £55.5m deficit was submitted at month 7, with a note stating the Trust's forecast had held at £80.7m (as notified to NHSI in M6). Owing to NHSI guidance, the Trust is unable formally to change its projected £55.5m deficit until Q3 reporting in January. Should the Trust wish to change the forecast outturn at that point, the governance document 'Appendix 2b' completed. Appendix 2b was shared with the Trust Board on 3rd November.
- NHSI has requested a full reforecast which will be reviewed by the Trust Board in early December. NHSI has an expectation that the Trust will continue to demonstrate the improvement in trend seen this month.
- Divisions, and the transformation team, continue to work on recovery actions to improve the Trust's current run rate, and address the significant deficit position each month.
- The implied exit run rate at M12 is expected to be a £3.2m deficit; however this is work in progress and may change on completion of the full reforecast exercise.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	1 December 2016	**Agenda No**	**4.1**
Report Title:	Response to NHS Improvement Enforcement Undertakings		
Lead Director/Manager:	Professor Simon Mackenzie		
Report Author:	Chief Executive Officer		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Assurance		
Executive Summary:	This paper sets out a high level action plan in response to the enforcement notice received by the Trust on 01.11.16 from NHS Improvement, sets out progress to date and proposes a forward reporting schedule to retain focus on the Enforcement Undertakings.		
Recommendation:	It is recommended that the Board receives: i. The Enforcement Undertakings Action Plan set out in Appendix 1 as assurance of the action is being taken to address the Enforcement Undertakings; ii. a regular update on progress against the Action Plan.		
Supports			
Trust Strategic Objective:	All four objectives: 1. Deliver our Transformation Programme enabling the Trust to meet its operational and financial targets. 2. Refresh the Trust's strategy, to develop a sustainable service model with a clear and consistent message. 3. Ensure the Trust has an unwavering focus on all measures of quality and safety, and patient experience. 4. Ensure we make the most of our buildings and estate and maximise efficiency through improving back office and corporate functions.		
CQC Theme:	All especially Safe, Well-led, Effective and Responsive		
Single Oversight Framework Theme:	All		
Implications			
Risk:	**BAF Risk 6:** Failing to deliver the financial plan. **BAF Risk 7:** Failing to provide safe, high quality and a satisfactory experience of care for service users. **BAF Risk 8:** Failing to achieve key performance targets mandated in the NHS Outcomes Framework and local contracts. **BAF Risk 9:** Failure to provide a suitable environment of care in all patient-facing areas and locations.		
Legal/Regulatory:	Enforcement Action under the Health & Social Care Act 2012		
Resources:	Under consideration		
Previously Considered by:	Executive Management Team		07.11.16
Equality Impact Assessment:	Will be considered as separate pieces of work are undertaken.		
Appendices:	**Appendix 1:** NHSI Enforcement Undertakings – St George's University Hospitals NHS Foundation Trust - Operational Plan		

Response to NHS Improvement Enforcement Undertakings
Trust Board, 01.12.16

1.0 PURPOSE

1.1 This paper sets out a high level action plan in response to the enforcement notice received by the Trust on 01.11.16 from NHS Improvement.

2.0 BACKGROUND

2.1 In advance of the publication of the Care Quality Commission's report on 01.11.16, the Chief Inspector for Hospitals wrote to NHS Improvement recommending that the Trust be put in Special Measures. NHS Improvement's Provider Regulation Committee (PRC) agreed to accept the recommendation and placed the Trust in Special Measures from 01.11.16. The Trust agreed a number of Enforcement Undertakings which are set out in Appendix 1.

3.0 ACTION PLAN

3.1 The Action Plan details the individual requirements within the Enforcement Undertakings as well as the Lead Director and how and when the requirement will be addressed.

3.2 The letter in response to Section 29A will be sent on 30.11.16 following internal review at the Trust's Quality Improvement Board and Quality Committee. The Quality Improvement Plan will also be submitted to NHS Improvement and the Care Quality Commission on 30.11.16; it is also included with papers for Board meeting on 01.12.16. In addition, the Board will also receive a briefing on Referral to Treatment at the 01.12.16.

3.3 The Board has a forward schedule to consider other matters within the Undertakings and progress against the Action Plan will form a regular part of Board business.

4.0 IMPLICATIONS

Risks

4.1 The risks associated with failure to deliver against the Enforcement Actions are already set out within the Board Assurance Framework, most notably:

i. **BAF Risk 6:** Failing to deliver the financial plan.
ii. **BAF Risk 7:** Failing to provide safe, high quality and a satisfactory experience of care for service users.
iii. **BAF Risk 8:** Failing to achieve key performance targets mandated in the NHS Outcomes Framework and local contracts.
iv. **BAF Risk 9:** Failure to provide a suitable environment of care in all patient-facing areas and locations.

Legal Regulatory

4.2 These are Enforcement Undertakings which NHS Improvement has accepted from the Trust pursuant to NHS Improvement's powers under section 106 of the Health and Social Care Act 2012.

Resources

4.3 The resource impact of delivering the requirements is under review.

5.0 RECOMMENDATION

5.1 It is recommended that the Board receives

i. the Action Plan set out in Appendix 1 as assurance of the action is being taken to address the Enforcement Undertakings;
ii. a regular update on progress against the Action Plan.

Author: **Fiona Barr, interim Corporate Secretary & Head of Corporate Governance**
Date: **25.11.16**

NHSI ENFORCEMENT UNDERTAKINGS – ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

OPERATIONAL PLAN

NHSI Ref	Requirement	Executive Responsible for Production	Format of Response	Review / Sign Off Mechanism	Target Date for Review / Sign Off	NHSI Submission Deadline	Submitted
2.1	Address the issues highlighted in the CQC Section 29A Warning Notice issued on 27 August 2016, by the dates advised by CQC.	DIRECTOR OF QUALITY GOVERNANCE	Letter of Assurance signed by Accounting Officer	Quality Improvement Board	24/11/2016	30/11/2016	PENDING
2.2.1 2.2.2 2.2.3	The Licensee (i) 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 CQC report.	DIRECTOR OF QUALITY GOVERNANCE	All 'must do' actions incorporated within the QIP by 30/11/2016 Actions assured at Quality Improvement Board. Verification by CQC re-inspection.	Quality Improvement Board	Monthly Review at Quality Improvement Board. Re-inspection date to be determined by CQC.	02/11/2017	PENDING
2.3	Finalise and submit to CQC and NHSI a plan setting out the steps which it will take to ensure compliance with its licence conditions relating to quality, and include key milestones it will need to achieve ("the Quality Improvement Plan").	DIRECTOR OF QUALITY GOVERNANCE	Delivery of QIP to CQC Inspectors, and NHSI engagement manager	Quality Improvement Board	24/11/2016	02/12/2016	PENDING

NHSI Ref	Requirement	Executive Responsible for Production	Format of Response Required	Review / Sign Off Mechanism	Target Date for Review / Sign Off	NHSI Submission Deadline	Submitted
3.2.1 3.2.2	Commission a governance review ("the governance review") consisting of: (i) A review of corporate governance, including board effectiveness, capacity and processes for appropriately escalating issues to the board; and (ii) A review of quality and clinical governance including the Licensee's performance against NHS Improvement's quality governance and assurance framework	COMPANY SECRETARY DIRECTOR OF QUALITY GOVERNANCE	(i) Letter of confirmation to NHSI setting out external advisor, Terms of Reference, scope and time frame agreed in advance with NHSI; and (ii) Independent report of the governance review; (iii) The Board's action plan in response to recommendations made	Board of Directors	To be agreed with NHSI	To be agreed with NHSI	PENDING
4.1.1	Develop and deliver (or demonstrate the Licensee can deliver): (i) An estates plan for the two years 2016/17 and 2017/18 ('Estates Recovery Plan') setting out a. how it addresses 'must do' actions within the CQC inspection report; b. the estimated capital and revenue impact of these plans; and c. the options appraisal used to identify the preferred approach.	DIRECTOR OF ESTATES & FACILITIES	Submission of Estates Recovery Plan to NHSI	Board of Directors	To be agreed with NHSI	To be agreed with NHSI	PENDING

NHSI Ref	Requirement	Executive Responsible for Production	Format of Response Required	Review / Sign Off Mechanism	Target Date for Review / Sign Off	NHSI Submission Deadline	Submitted
4.1.2	Develop and deliver (or demonstrate the Licensee can deliver) a five-year strategy and plan for estates longer term sustainability (together termed the 'Estates Strategy').	DIRECTOR OF ESTATES & FACILITIES	Submission of Estates Strategy	Board of Directors	31/03/2017	31/03/2017	PENDING
4.1.3.1 4.1.3.2	In relation to both the Estates Recovery Plan and Estates Strategy, the Licensee will consult with its commissioners and will ensure that the plans: (i) reflect accurately the views of its commissioners; and (ii) are aligned to the Sustainability and Transformation Plan (STP) for South West London	DIRECTOR OF ESTATES & FACILITIES	Letters of Assurance from Chief Officers of Wandsworth and Merton CCGs	Board of Directors	31/03/2017	31/03/2017	PENDING

NHSI Ref	Requirement	Executive Responsible for Production	Format of Response Required	Review / Sign Off Mechanism	Target Date for Review / Sign Off	NHSI Submission Deadline	Submitted
5.1 5.3.1 5.3.2 5.3.3 5.3.4 5.3.5 5.3.6 5.4	The Licensee will finalise and submit to NHSI an action plan to deal with the issues of RTT data quality raised by the CQC and previous diagnostic reports ("the Action Plan"). Specifically it is expected that the plan will: (i) consolidate the findings of previous reviews and identify plans to address these; (ii) include the Trust's current position regarding addressing RTT recovery; (iii) identify a clear approach to the validation of the historic incomplete pathways, pathways with unknown status and confirming the accuracy of RTT data held within the patient administration system(s) (PAS); (iv) validation and operational management of the inpatient/day case patient tracking list (PTL); (v) Management of all new referrals to include a review of the configuration of RTT function within PAS, to ensure accurate and complete recording of RTT status for new referrals. As well as delivering effective implementation of supporting operational processes; (vi) Appropriate plans to treat any patients waiting longer than constitutional standards; (vii) Review the exclusions applied to the PTL to ensure these are within business rules (viii) The RTT Action Plan will be agreed with stakeholders and include any actions that could be taken by key system partners to support the Licensee to deliver its immediate priorities	RTT PROJECT DIRECTOR	Submission of RTT action plan to NHSI. Plan signed off by NHSI.	RTT Project Board	30/11/2016	30/11/2016	COMPLETE 24/11/2016

NHSI Ref	Requirement	Executive Responsible for Production	Format of Response Required	Review / Sign Off Mechanism	Target Date for Review / Sign Off	NHSI Submission Deadline	Submitted
5.2	The Licensee will implement an effective clinical harm review process and associated governance	MEDICAL DIRECTOR	Independent audit of clinical harm review process	Quality Improvement Board	31/05/2017	01/06/2016	PENDING
5.5	The Licensee will agree with NHS Improvement the governance and oversight arrangements to support the implementation of [RTT] Action Plan	RTT PROJECT DIRECTOR	Letter confirming governance and oversight arrangements signed by Accounting Officer	Board of Directors	To be agreed with NHSI	To be agreed with NHSI	PENDING
5.6	The Licensee will identify the programme resources required to support the effective implementation of the [RTT] Action Plan. The 'Resourcing Plan" will be agreed with NHSI	RTT PROJECT DIRECTOR	Submission of RTT Resourcing Plan	Board of Directors	To be agreed with NHSI	To be agreed with NHSI	PENDING
5.7	Develop a data reporting strategy that will include PAS as a source of data	CHIEF OPERATING OFFICER	Submission of data reporting strategy	Board of Directors	To be agreed with NHSI	To be agreed with NHSI	PENDING
5.8	The Licensee will provide to NHS Improvement, should NHS Improvement so request, external assurance from a source and a scope to be agreed with NHS Improvement that it has implemented the recommendations and actions associated with the data quality review.	CHIEF OPERATING OFFICER	Subject to a request from NHSI.	N/A	N/A	N/A	NOT REQUESTED
5.9	Commit to resume reporting RTT at as early a date as possible	COMPANY SECRETARY	Letter of Assurance signed by Accounting Officer on behalf of the Board of Directors	Board of Directors	To be determined by the Board of Directors	To be agreed with NHSI	PENDING

NHSI Ref	Requirement	Executive Responsible for Production	Format of Response Required	Review / Sign Off Mechanism	Target Date for Review / Sign Off	NHSI Submission Deadline	Submitted
6.2 6.3	In respect of the QIP, Estates Recovery Plan, Estates Strategy, RTT Recovery Plan, RTT Data Reporting Strategy, the Licensee will ensure: (i) plans are modified if needed following input from NHS Improvement after it has received and considered the plans, such input from NHS Improvement to be provided before and/or after the commissioning and receipt of the assurance specified in 5.8 above; and (ii) the key parameters and detailed scope of the plans will be agreed with NHSI and will be updated by the Licensee as needed upon any subsequent review by NHSI.	To be allocated as required following receipt of NHSI requirements	Subject to a request from NHSI.	N/A	N/A	N/A	AS REQUIRED
6.4	In respect of the QIP, Estates Recovery Plan, Estates Strategy, RTT Recovery Plan, RTT Data Reporting Strategy, the Licensee will: (i) demonstrate it is able to deliver the plans described above including demonstrating it has sufficient capacity at both executive and other levels of management	COMPANY SECRETARY	To be incorporated into the scope and reported as part of the independent governance review	Board of Directors	To be agreed with NHSI	To be agreed with NHSI	PENDING

NHSI Ref	Requirement	Executive Responsible for Production	Format of Response Required	Review / Sign Off Mechanism	Target Date for Review / Sign Off	NHSI Submission Deadline	Submitted
6.5	In respect of the QIP, Estates Recovery Plan, Estates Strategy, RTT Recovery Plan, RTT Data Reporting Strategy, the Licensee will: (i) keep the plans and their delivery under review	COMPANY SECRETARY	Incorporated into Board Cycle of Business, reported at each formal meeting of the Board until such time as NHSI deem this unnecessary. Submission of Letter of Assurance signed by Accounting Officer on behalf of the Board	Board of Directors	01/12/2016	N/A	AS REQUESTED BY NHSI
6.6	In respect of the QIP, Estates Recovery Plan, Estates Strategy, RTT Recovery Plan, RTT Data Reporting Strategy, the Licensee will: (i) develop and agree with NHSI Key Performance Indicators (KPIs) to assess the impact of the plans described above	DIRECTOR OF QUALITY GOVERNANCE DIRECTOR OF ESTATES & FACILITIES CHIEF OPERATING OFFICER CHIEF EXECUTIVE	Submission of performance reports	Board of Directors	To be agreed with NHSI	To be agreed with NHSI	PENDING
6.7 6.7.1 6.7.2	The Licensee will consult and agree with NHS Improvement: (i) the appointment and scope of any key advisers in relation to the plans described in 6.4, 6.5 above; and (ii) executive capacity to support the delivery of the plans described in 6.4, 6.5 above, including key executive	COMPANY SECRETARY	The appointment of advisers in relation to QIP, Estates and RTT plans are subject to NHSI consultation and agreement. The appointment of executives is subject to NHSI consultation and agreement	To be agreed with NHSI	To be agreed with NHSI	To be agreed with NHSI	AS REQUIRED

	appointments						
NHSI Ref	Requirement	Executive Responsible for Production	Format of Response Required	Review / Sign Off Mechanism	Target Date for Review / Sign Off	NHSI Submission Deadline	Submitted
7.1 7.2.1 7.2.2	Implement sufficient programme management and governance to enable delivery of these undertakings. Such programme management and governance arrangements must enable the Board to: (i) obtain clear oversight over the process in delivering these undertakings; (ii) obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and (iii) hold individuals to account for the delivery of the undertakings	CHIEF EXECUTIVE	Letter of Assurance, signed by Accounting Officer and endorsed by Audit Committee on the Board's behalf, confirming sufficient and effective PMO and governance to deliver these undertakings	31/02/17	31/02/17	To be agreed with NHSI	PENDING

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	01.12.16	**Agenda No**	**4.2**
Report Title:	Corporate Risk Report		
Lead Director/ Manager:	Paul Moore, Director of Quality Governance		
Report Author:	Paul Moore, Director of Quality Governance		
Freedom of Information Act (FOIA) Status:	Unrestricted Restricted		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	1) Core operational risk exposure has been grouped under the following risk areas: • Timely Access to Clinical Services/Patient Harm • Insufficient Resilience/Unstable Critical IT/Estates Infrastructure • Unsustainable Financial Position • Inadequate Governance/Reputation Loss 2) Proceedings of the Risk Management Committee		
Recommendation:	• The Board are invited to satisfy itself that the current level of risk exposure is tolerable or acceptable and also satisfy themselves that the risk is under sufficient control; • The Board are invited to consider and advise on any further mitigating action required to achieve control; and • To consider whether any modification is needed to the Board's risk appetite in light of current risk exposure and act accordingly		
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 Risk Assessment Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective		
Legal/Regulatory:	Covers issues included in the Care Quality Commission		
Resources:	There are no specific resource implications		
Previously Considered by:	Executive Directors	**Date**	18.11.16
Equality Impact Assessment:	N/A		
Appendices:	A. Risk Grading Matrix / Risk Escalation Arrangements (illustrated) B. Figure 1: Core Operational Risk Drivers – Nov 2016 C. Figure 2: Emergent Risk Horizon Scan – Nov 2016 D. Figure 3: Interpreting the Risk Horizon Full Corporate Risk Register is available in the reading room for reference		

Corporate Risk Report
Trust Board 01.12.16

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 November 2016

2.2 The CRR continues to be rebuilt and reassessed accordingly. This work remains ongoing at time of report. This follows:

(i) a simplification and rationalisation of the arrangements for risk management and escalation;
(ii) consideration and acceptance by the Board in August of a range of proposals to enhance governance and risk; and
(iii) a decision to accelerate the migration of risk registers at divisional and corporate levels into a single electronic database within Datix.

2.3 Training is being rolled out to support and assist risk register gatekeepers at divisional and corporate levels. This will allow efficient analysis, better oversight and enhanced risk escalation arrangements. Until this work is concluded, caution is advised when interpreting the CRR.

2.4 The CRR may change as further analysis, challenge and development of the risk profile progresses.

3.0 PROPOSAL OR ISSUE OR ANALYSIS OR OPTIONS APPRAISAL

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 Risk Assessment Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective. Figure 1 illustrates using a driver diagram the primary cause, effect and potential impact of core operational risks currently on the CRR. The Board remains exposed to extreme risk in the following areas:

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

3.2 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 identified for inclusion in the BAF are as follows (in no particular order):

- **Corporate strategy not aligned to commissioning intentions or anticipated regulatory changes** (i.e. the Trust, CCGs or regulators are moving in different directions - one of the causes might be that commissioning intentions are not known to the Trust, or a lack of clarity regarding corporate strategy, other potential causes might include conflict, competition or poor stakeholder relations)
- **Exposure to local and specialist commissioner affordability** (this is currently subject to further review)
- **Loss of influence within and across the local health economy** (one of the potential causes might be inadequate stakeholder relationships)
- **Addressing demand for care** (on the assumption that demand for services will continue to grow and supply-side resources continue to be stretched)
- **Future supply, recruitment and retention of the workforce** (thereby affecting staffing levels, quality, safety and operational compliance)
- **Failure to retain critical community contracts** (one of the causes might be poor quality/performance/outcomes, or inadequate stakeholder relationships)
- **Expanding deficit and non-delivery of the financial plan** (to incorporate the combined effects of income volatility, liquidity and CIP delivery)
- **Poor or insufficient quality governance** (i.e. poor standards of care, unintended consequences of CIP, poor risk management, non-compliance with CQC)
- **Insufficient performance against contracts and KPIs** (to incorporate applicable KPIs in the NHS Outcomes Framework)
- **Poor service user experience** (inadequate user satisfaction with services for example, this has subsequently been incorporated with the quality governance vector)
- **Failure to deliver the estate improvement or backlog maintenance**
- **Prolonged and unrecoverable critical IT system down time**.

3.3 Proceedings of the Risk Management Committee

The Risk Management Committee met on 18th November 2016 to review the corporate risk register and to review in more details reportable risk in: (i) South West London Pathology and (ii) Turnaround.

- Confirmed and agreed that IT represents the biggest risk facing the organisation at the present time;
- Agreed to add EWS as a risk in its own right to the CRR. This is being taken forward by the Medical Director.
- Bed rails and the withdrawal of IDDGs decision to fund a bed replacement plan over a 17 year timeframe. Point prevalence audit of every bed to be undertaken on 13th December which will inform a revised bid to IDDG.
- It was acknowledged that the need to better describe the nature of the risk associated with the use of information upon which the Board and the Executive can evaluate performance and make decisions as part of the CRR
- It was agreed, now that the CRR was stable and seen as credible, to undertake deep dives into the control frameworks at the next meeting for (i) IT risk; (ii) Data Quality; (iii) management capacity and capability; and (iv) colleague engagement
- Reviewed the South West London Pathology (SWLP) risk profile and it was agreed that this required further development in light of the challenges made to develop a better understanding of risks facing SWLP and a concern that impact scores may have been under-estimated in some cases.
- The turnaround risk register was not accepted as a valid record and it was agreed to review and revisit this at the next meeting to be held in December.

4.0 IMPLICATIONS

Risks

4.1 These risks could have a direct bearing on requirements within NHSI's Risk Assessment Framework, ongoing CQC Registration or the achievement of Trust policies, aims and objectives should the mitigation plans be ineffective

Legal Regulatory

4.2 Covers issues included in the Care Quality Commission

Resources

4.3 There are no specific resource implications

5.0 NEXT STEPS OR TIMELINE

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

6.0 RECOMMENDATION

6.1 The Board are invited to satisfy itself that the current level of risk exposure is tolerable or acceptable and also satisfy themselves that the risk is under sufficient control;

6.2 The Board are invited to consider and advise on any further mitigating action required to achieve control; and

6.3 To consider whether any modification is needed to the Board's risk appetite in light of current risk exposure and act accordingly

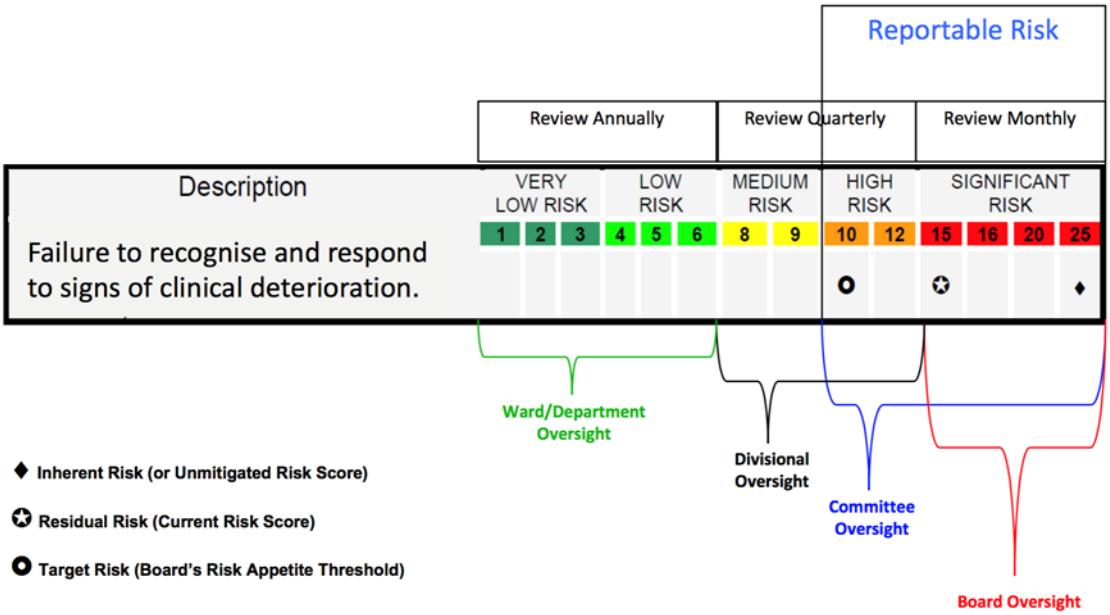
Author: **Paul Moore**
Date: **25.11.16**

APPENDIX [A]

[Risk Grading Matrix]

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

[Risk Escalation Arrangement (illuystrated)]

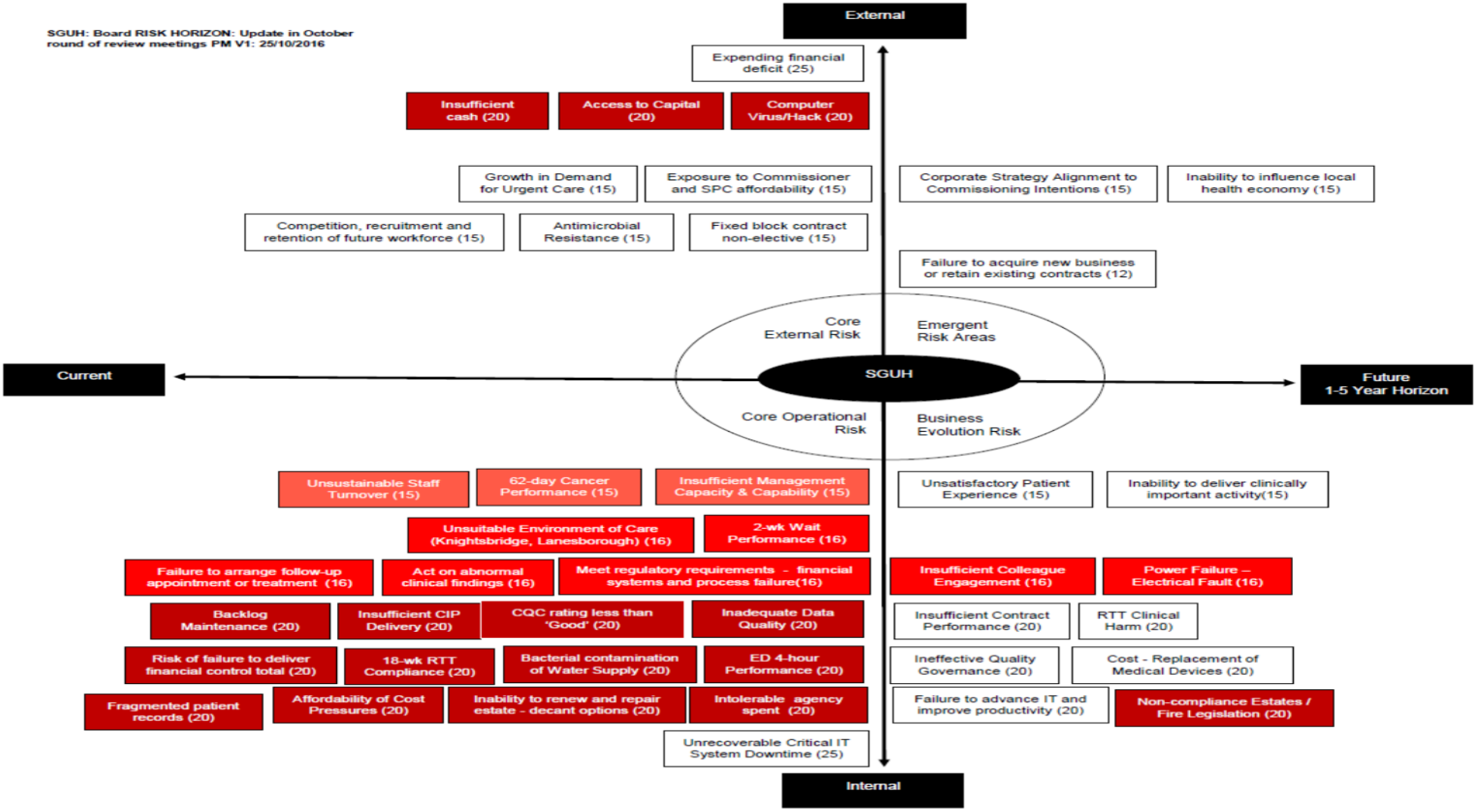


APPENDIX [B]

[Figure 1: Core Operational Risk Drivers – Nov 2016]

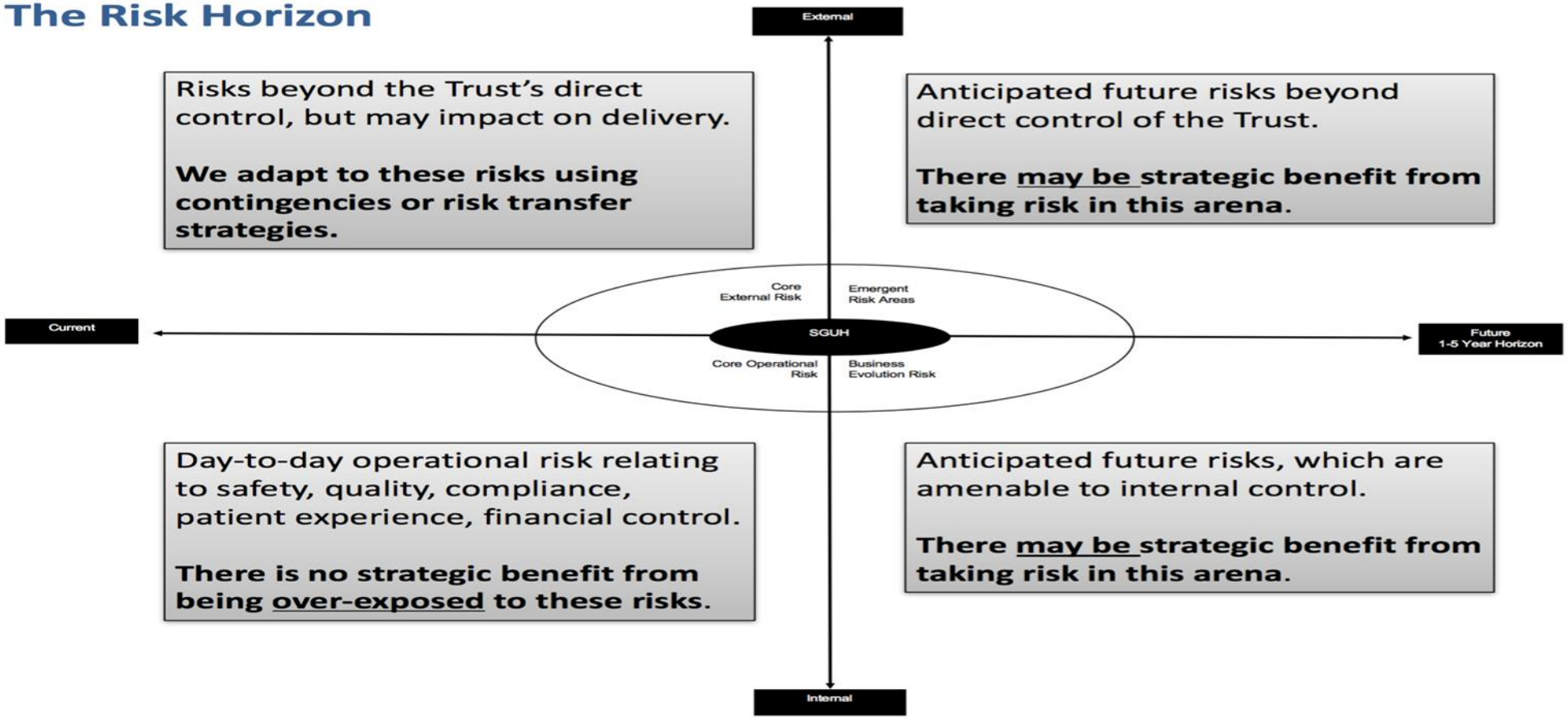
PRIMARY CAUSE	RATING	IN MONTH CHANGES	EFFECT	POTENTIAL IMPACT 16/17
Increasing 18-Week RTT backlog with potential for clinical harm	20	⇔	Timely Access to Clinical Services / Patient Harm	Continuity of Clinical Services Material Breach of Licence Conditions Integrity of CQC Certificate of Registration
Below target 2-week wait performance	16	⇔		
Below target 62-day cancer performance	15	⇔		
Failure to arrange follow-up appointments or treatments (where clinically required)	16	⇔		
Below target ED 4-hour performance	20	⇔		
Unsuitable environment of care (Renal Unit, Lanesborough OPD) – risk of premises closure, prosecution, fire	16	⇔	Insufficient Resilience / Unstable critical IT and Estates Infrastructure	
Potential unplanned closure of premises / non-compliance with estates or Fire legislation	20	⇔		
Bacterial contamination of water supply (Legionella, Pseudomonas)	20	⇔		
Inability to address backlog maintenance requirements	20	⇔		
IT storage: unrecoverable IT system downtime (affecting critical clinical, web and email systems)	25	⇔		
Vulnerability to computer virus or attack	20	⇔		
Inability to renew and repair clinical areas due to high bed occupancy and no decant options	20	⇔		
Power failure – electrical fault	16	⇔		
Insufficient CIP delivery in 2016/17	20	⇔	Unsustainable Financial Position in 2016/17 and beyond	
Insufficient cash to meet payment demand	20	⇔		
Lack of access to capital to address in-year IT, Estates and equipment replacement cost pressures	20	⇔		
Inability to control agency staffing and associated staffing costs	20	⇔		
Risk of failure to deliver the financial control total	20	⇔		
Inability to meet regulatory requirements due to financial system and process failure	16	⇔		
CQC rating less than 'Good' – insufficient safety, effectiveness, caring, responsiveness or not well-led	20	⇔	Inadequate Governance / Reputation Loss	
Failure to recognise, communicate and act on abnormal clinical findings	16	⇔		
Ongoing exposure to high numbers of serious incidents and never events	12	↓		
Fragmented electronic and manual patient records	20	⇔		
Unsustainable levels of staff turnover	15	⇔		
Insufficient management capacity or capability to deliver turnaround programme	15	⇔		
Failure to secure colleague engagement	16	⇔		
Inadequate data quality, completeness or consistency	20	⇔		
↑ = Risk Increase; ↓ = Risk reduced; ⇔ = No change from previous report to Board				

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



APPENDIX [D]

[Figure 3: Interpreting the Risk Horizon]



St George's University Hospitals NHS
NHS Foundation Trust

REPORT TO THE TRUST BOARD November *2016*

Paper Title:	Report to the Board from Audit Committee: 10 November 2016
Sponsoring Director:	Sarah Wilton, Non-executive Director
Author:	Sarah Wilton, Non-executive Director
Purpose: *The purpose of bringing the report to the board*	To provide the Board with a summary of the proceedings from the last Audit Committee
Action required by the board: *What is required of the board – e.g. to note, to approve…?*	To note the update
Document previously considered by: *Name of the committee which has previously considered this paper / proposals*	N/A

Summary:

Enclosed are the key messages and draft minutes from the Audit Committee meeting held on 10 November 2016. The Board are asked to note the proceedings.

Key risks identified:
Risks are detailed within the report.

Related Corporate Objective: *Reference to corporate objective that this paper refers to.*	All Corporate Objectives.
Related CQC Standard: *Reference to CQC standard that this paper refers to.*	N/A

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

No specific groups of patients or community will be affected by the initiatives detailed in the report. Where there may be an impact on patients then consultation will be managed as part of that specific programme.

REPORT TO THE BOARD FROM THE AUDIT COMMITTEE MEETING ON 10 NOVEMBER 2016

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

1. Despite considerable progress having been made, driven by our newly appointed internal audit firm TIAA, in confirming that actions arising from the previous auditors' Internal Audits have been or are being progressed by the Trust, there remain 26 overdue actions mostly in relation to estates and SWLP. All Priority 1 actions, however, are now complete. We stressed the importance of implementing all these outstanding actions, together with any outstanding actions arising from the Internal Audits completed since April 2016 by TIAA, and requested that the Executive address this action tracker robustly with regular oversight from EMT, to be led by the Director of Quality Governance and the Director of Finance.

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

2. The Audit Committee received an Internal Audit Report on the Agency Spend Cap which received only limited assurance. The Committee was very concerned, particularly given the materiality and significance of this issue, that although the draft report was submitted to management in June 2016, responses from management were not provided to TIAA until October 2016. The principal assurance gaps identified as needing urgent remedial action are set out below and the Committee urged the executive to ensure that the agreed actions are now urgently gripped and implemented:

   a. Agency usage data reported to the board is incomplete and does not reflect total usage as figures are limited to e-rostering systems
   b. There are no invoice checks being undertaken on the rates being charged and testing found some suppliers were charging above the agreed agency rates
   c. Variances were found between the weekly cap breach reports submitted to NHSI and reports presented to the Board
   d. Work to identify agency invoices processed with no booking reference is ongoing with no completion date

3. We received an Internal Audit Report on Data Quality of Key Performance Indicators for A&E reporting, which gave only limited assurance. The principal assurance gaps identified as needing urgent remedial action are:

   a. The Trust does not have documented procedures to support the A&E wait data validation processes. The use of CAS (used by most trusts for recording stop time) is unclear with widely differing levels of data being recorded and storage being erratic
   b. Material changes to action plans are being made without associated annotated explanations
   c. LAS is not providing the Trust with validated handover data.

4. We received from Internal Audit an operational review of the E-prescribing Medicines Management project which concluded that the Board has not prioritised this project, which has failed to realise its intended objectives and savings.

5. In an earlier private meeting with the External Auditors, and at the Committee meeting, significant concerns were expressed by the executives present with the competence and financial knowledge and experience of certain members of the Finance team. The Committee encouraged the DFO to address this long recognised issue, which caused delays and significant problems with the 2015/2016 External Audit, to ensure that there is no similar recurrence this year and that the Trust's financial reporting standards and effectiveness are robustly and quickly improved.

6. In response to an earlier Committee query, the Committee noted with concern the high level (c£3.5m pa) of cash and cheques currently received and handled across the Trust. The recommendation to move to a card/electronic-based system was welcomed and agreed.

7. The Committee is required to receive and consider information on SFI waivers. It received a extensive list of SFI waivers currently under review for agreement or otherwise, which appears to suggest that the Trust's current SFI procedures and processes are not working effectively. It noted that this issue has not yet been adequately addressed and asked for a full update from the relevant executives at its next meeting.

8. The Committee and relevant executives had held a private meeting with Counter Fraud before the Committee meeting to review progress and next steps on one confidential case. This followed the Committee's concern at its September meeting that investigations appeared to be proceeding very slowly.

Sarah Wilton
Non-Executive Director
November 2016