



OUTSTANDING CARE, EVERY TIME

OUR QUALITY IMPROVEMENT PLAN

SEPTEMBER 2017

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Executive Summary

Over one million patients in south west London and beyond rely on the hospital and community services we provide each year. With over 9,000 dedicated staff, we are the largest healthcare provider, major teaching hospital and tertiary care centre for south west London, Surrey and beyond.

We want to provide the best possible care for our patients. Our most recent full-scale Care Quality Commission (CQC) inspection in June 2016 showed we weren't doing this consistently, and their report (published in November 2016) marked the start of an improvement journey for all of us.

Since then, we have made a number of improvements – from modernising some of our operating theatres to stabilising our senior leadership team. However, we are now looking at our longer term ambitions as part of our quality improvement journey to become an outstanding Trust, recognised for the care we provide and the staff we develop.

Outstanding Care, Every Time

Our Quality Improvement Plan (QIP) reflects this renewed focus and puts the patient at the centre of everything we do. Our ambition is to provide Outstanding Care, Every Time for every single one of our patients, wherever they are treated.

Outstanding Care, Every Time means;

- Every patient receives safe and outstanding care
- The right patient is seen in the right place at the right time, every time
- Staff say "I'm proud to work at St George's"
- All staff – wherever they work – can shine and contribute to our future

Our Quality Improvement Plan is the start of an 18 month journey towards outstanding care. By delivering it, we will equip our staff with a long-term framework, methodology and passion for improving patient safety and quality. We will ensure that we embed a culture of excellence and always continue to look at how we can improve. The plan demonstrates a deep rooted desire running throughout the organisation to always find ways to make things better for our patients. We will ensure that as a Trust we make

the best of use of this commitment and that we remain enthusiastic and passionate about quality improvement throughout the delivery of the plan and in to the future.

We want to demonstrate that we offer highest standards of clinical services to our local community and beyond and that we remain true to our values to provide excellence across clinical care, education and research. Our staff know the services they run best, and they will drive our Quality Improvement Plan forward. The improvements we want to make – set out in this document - will be embedded into the culture of the organisation, and help us build the capacity and capability to improve as we go forward.

Our Quality Improvement Plan covers everything from end of life care, dementia care, outpatients, and emergency care as well as being more responsive to the findings of the NHS Friends and Family test – all with the aim of providing Outstanding Care, Every Time. The following pages provide an overview of the Quality Improvement Plan. They describe the background to the plan and how it has evolved over the past year.

The document includes the interventions we have taken in response to our most recent full CQC inspection in June 2016. It details how by bringing together people from all areas of the Trust who had different perspectives on what is needed to improve our services, we developed a long term plan and approach to quality improvement. A significant proportion of the document describes each of the improvement areas we are focussing on. The various elements of each project are summarised with their key metrics for success to monitor and track progress.

We are determined to deliver this plan, but we recognise and know we can't do this alone. We are already receiving welcome support to help us to make these improvements. We value the support of our stakeholders, our partner organisations and, critically, our staff and patients as we work together to deliver the necessary change.

This plan demonstrates our commitment and ambition to provide Outstanding Care, Every Time.

A message from Jacqueline Totterdell, Chief Executive

As Chief Executive, I see every day the positive impact we have on patients, and the communities we serve. This is down to the 9,000 staff who work across our hospital and many community services.

I joined the Trust in May 2017 and, whilst the challenges we face are immense, I am confident we have the skills and desire to make St George's great again – and ultimately put us in a position to deliver Outstanding Care, Every Time.

I have been struck by how much good-will there is locally, and amongst the communities we serve, for St George's to succeed. This includes our patients, but also the many partner organisations we work with – this inspires me, and re-emphasises the importance of delivering the improvements we want to make.

Of course, our ambition to provide Outstanding Care, Every Time will be difficult, and challenging – and I believe strongly that, however much progress we make, there will always be additional improvements we want to make.

Great organisations never think they have reached their goals – they always want to be better. This is the type of organisation I want us to be here at St George's.

This document represents our Quality Improvement Plan, but the real work to deliver Outstanding Care, Every Time must happen on the ground, in our hospitals and community services – and I am confident we are already making progress in this regard.

Thank you

Jacqueline Totterdell,

Chief Executive





Introduction & Background

Who is responsible for delivering our Quality Improvement Plan?

The Trust Board acknowledge the findings of the fullscale CQC inspection and are clear about the challenges the Trust faces to achieve significant improvement. The immediate challenges following the CQC's inspection in June 2016 fell into the following areas.

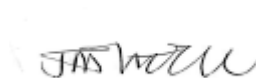
- Financial challenges
- Unstable leadership
- Weak governance and assurance processes
- Variable adherence to infection control procedures
- Low levels of mandatory training completion by staff
- Lack of formal mental capacity assessments
- Poor staff engagement
- Significant estates and IT challenges due to historical under-investment
- Failure to deliver access targets
- Lack of stakeholder confidence, and strategic direction
- Data quality

Since April 2017, key substantive appointments have been made to the Trust Board which has included the appointment of individuals with significant experience in leading a Trust through a substantial quality improvement journey. This includes the appointment of a new Chair and Chief Executive, with other substantive appointments made including a Chief Financial Officer, Chief Operational Officer, Director of Delivery, Efficiency and Transformation, and Director of Human Resources and Organisational Development.

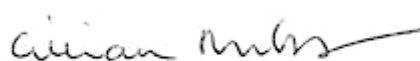
The Chief Executive is ultimately responsible for implementing the actions in this document. The Medical Director and the Chief Nurse and Director of Infection Prevention and Control provide the leadership for the Quality Improvement Plan. Individual improvement programmes have been developed and led by our staff - clinical, operational, and corporate services will work together to ensure we provide high quality care and improved patient experience.

The Trust is also working closely with NHS Improvement, through an Improvement Director who is supporting the Trust with the delivery of the Quality Improvement Plan.

Chair/Chief Executive Approval (on behalf of the Board)



Jacqueline Totterdell,
Chief Executive



Gillian Norton,
Chairman

Background to the Quality Improvement Plan

On 1 November 2016, the Care Quality Commission (CQC) published its inspection report for St George's following a visit to the Trust in June 2016. The CQC is the independent regulator of health and social care in England. The CQC's role is to ensure healthcare organisations like St George's provide people with safe, effective, compassionate, high quality care.

The CQC disappointingly found a number of significant issues that resulted in an overall rating of "Inadequate" for the services we provide:

- Both St George's Hospital and Queen Mary's Hospital, Roehampton (and the community services we provide) were rated as **Requires Improvement**. The Trust was rated as **Inadequate** for being safe and well-led, and **Requires Improvement** for being effective and responsive. The Trust was given a rating of **Good** for being caring
- The CQC also recommended St George's be placed in quality special measures, which meant the Trust was able to access support to help deliver the required improvements
- In addition, the CQC issued the Trust with a Section 29a Warning Notice. A Section 29a Warning Notice required the Trust to take immediate actions specifically to: provide safe and fit premises at St George's Hospital; obtain consent under the Mental Capacity Act; ensure good governance and ensure we meet the fit and proper person test regulation.
- We immediately began addressing the requirements within the Section 29a Warning Notice to improve the quality of our services. You can read how we responded and the changes we made on [page 11](#).

In May 2017 a focused inspection by the CQC has

shown some improvements at St George's. You can read a description of these on [page 14](#).

Our Quality Improvement Plan is not just a response to the Care Quality Commission's (CQC) Inspection report of November 2016. It also includes the actions that we feel are necessary to provide the communities we serve with safe, effective, compassionate and high quality care.

Having managed the immediate issues, since May 2017 we have further developed and revised the Quality Improvement Plan. In order to safeguard the provision of safe and effective care for our patients as a matter of course, we needed to think beyond the day-to-day issues to ensure that we can deliver long term strategic improvements that will benefit our patients for years to come.

We have put safety at the heart of everything we do. We are strengthening our response to risk, reducing harm, building reliable systems and addressing the issues with our estate to support our staff to provide safe and effective care. We will involve patients in the design and delivery of our services so that we better understand what matters to them.

To give confidence to our stakeholders, staff and patients that we are making continued improvements, the Quality Improvement Plan is underpinned by improvement milestones and metrics to ensure that we can effectively track our progress.

Our plan involves fundamental improvements to services, structures and systems to ensure we deliver the immediate changes required and position the organisation to be able to respond to the demands of the future. The delivery of our Quality Improvement Plan will maintain and build on our recent progress to ensure our actions will lead to measurable improvements in the quality and safety of care for our patients.

CQC 2016 Rating

Below are the 2016 ratings for St George's Hospital, the Community Services and the overall rating for the Trust.

Summary and full CQC reports can be found on the CQC website: <https://www.cqc.org.uk/provider/RJ7>

Our ratings for St George's Hospital - Tooting

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Outstanding	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Requires improvement	Good
Community health services for children, young people and families	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Community health inpatient services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Community End of Life Care services	Requires improvement	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Overall Community	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Our ratings for St George's University Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Section 29a Improvement Warning Notice

In response to the S29a Warning Notice received in June 2016 the Trust prioritised actions against the following issues:

CQC S29a Compliance Issues	What we did
<ul style="list-style-type: none"> ■ Maintenance and refurbishment of Operating Theatres ■ Lack of capital investment in Lanesborough Wing, St James Wing and Paul Calvert Theatres ■ Thermoregulation Lanesborough Theatre 1 ■ Theatre air handling in units in St James Wing failing 	<ul style="list-style-type: none"> ■ Theatre Refurbishment Plan produced for schedule of work for 16 theatres. ■ Each set of theatres will take five months to complete. ■ St James Wing Theatre 3 and 4 completed ■ Two air handling units have been replaced. ■ Service and Maintenance Contract in place. ■ Paul Calvert Theatres (3) to commence September 2017 ■ St James Wing Theatre 7 to commence December 2017 ■ St James Wing Theatres 1 and 2 to commence April 2018 ■ Lanesborough Wing (Theatres 1, 2, and 3) to commence August 2018
<ul style="list-style-type: none"> ■ Repair of maternity staff room roof in Lanesborough Wing 	<ul style="list-style-type: none"> ■ Repairs have been completed
<ul style="list-style-type: none"> ■ Continued occupation of Wandle Unit after fire concerns identified 	<ul style="list-style-type: none"> ■ Building has been demolished
<ul style="list-style-type: none"> ■ Conclude renal unit patient moves from Buckland Ward, Knightsbridge Wing 	<ul style="list-style-type: none"> ■ Knightsbridge Wing decant and relocation programme completed. ■ Renal unit no longer provided on Buckland ward
<ul style="list-style-type: none"> ■ Assure fixed wire installation compliance across the St George's site 	<ul style="list-style-type: none"> ■ Fixed Wiring Testing Schedule in place
<ul style="list-style-type: none"> ■ Water safety management – Legionella contamination ■ Water safety management – Pseudomonas 	<ul style="list-style-type: none"> ■ Flushing compliance record in place and achieved 100% compliance
<ul style="list-style-type: none"> ■ Mental Capacity Act (MCA) Policy requires updating ■ Recording of MCA and Best Interest Decisions ■ Awareness amongst staff of care interventions that might constitute restraint – bed rails and use of mittens to prevent removal of nasogastric tubes 	<ul style="list-style-type: none"> ■ Updated the Mental Capacity Act Policy ■ MCA/ Deprivation of Liberty Safeguards training in place ■ Further MCA Audit completed in January 2017 ■ Project group established to focus on wards identified as a concern
<ul style="list-style-type: none"> ■ Fragmentation of Hospital and Community End of Life Care (EoLC) Teams 	<ul style="list-style-type: none"> ■ EoLC Strategy developed in partnership with key stakeholders ■ Joint working group and case discussion between services
<ul style="list-style-type: none"> ■ Risk Management process insufficient 	<ul style="list-style-type: none"> ■ Risk Management Policy updated ■ Good Governance Master Class training provided ■ Risk Management Committee forward plan and Terms of Reference (ToR) in place
<ul style="list-style-type: none"> ■ Timeliness of reporting and investigating Serious Incidents (SI), particularly in Surgery 	<ul style="list-style-type: none"> ■ Active Serious Incidents (SI) performance monitoring and update of policy
<ul style="list-style-type: none"> ■ Referral To Treatment (RTT) waiting list management 	<ul style="list-style-type: none"> ■ Clinical Harm Group established ■ Recovery Programme established including RTT
<ul style="list-style-type: none"> ■ Monitoring serial numbers for FP10 prescription pads, particularly in outpatient departments 	<ul style="list-style-type: none"> ■ Provision and monitoring processes amended ■ Audit results of the provision of FP10 prescription monitoring
<ul style="list-style-type: none"> ■ Radiographers administering contrast media without authorised Patient Group Directions (PGD) in place 	<ul style="list-style-type: none"> ■ Copies of all 16 applicable PGDs signed off
<ul style="list-style-type: none"> ■ Inadequate compliance with Fit & Proper Person Checks amongst Board members 	<ul style="list-style-type: none"> ■ "Fit and Proper Person" resolved for all Executive and Non-Executive Directors
<ul style="list-style-type: none"> ■ Workforce Race Equality Standards (WRES) 2015 published without presentation to the Board 	<ul style="list-style-type: none"> ■ WRES action plan presented to the Trust Board December 2016



CQC Inspection May 2017

In May 2017 the CQC undertook a focused inspection which showed improvements at the Trust. During the inspection the Trust was assessed as meeting the requirements of the Section 29a Warning Notice. The CQC findings include:

- The Trust had made significant progress with regards to addressing legionella risks in the water system
- There had been improvements in monitoring prescriptions and the risk of these going missing had been reduced
- Renal services had been relocated, so patients were no longer in an unsafe environment
- Operating theatres 5 and 6 had been refurbished since the previous inspection
- The water leaks to the maternity staff room had been resolved
- Governance around estates management had improved and annual reports were published for all services
- Serious Incidents were now being reported within internal and external Key Performance Indicator deadlines
- Mental Capacity Act and Deprivation of Liberty Safeguards training, understanding and application had improved
- There were mechanisms in place to ensure that staff delivering End of Life Care services in the acute hospitals and community services worked closely together
- The Trust was continuing to fail to meet the Fit and Proper Person Requirement regulation
- Systems and processes that operate effectively in accordance with good governance remain weak

Key CQC recommendations were that the Trust

- Must ensure the Trust has systems and processes that operate effectively in accordance with good governance
- Must strengthen governance and reporting arrangements, so as to provide the Board with increased oversight of Elective Care Recovery programme / RTT delivery
- Must continue to address the gaps in assurance with regards to estates maintenance
- Must ensure it meets the Fit and Proper Person Requirement regulation

What we have done to support the Quality Improvement Plan?

In May 2017, we revised our Quality Improvement Plan and how we supported it. Since then, we have undertaken the following activities to support this:

- Refreshed our internal inspection model in July 2017 to include Infection Control, Estates and Facilities and patient representatives. Two wards are inspected each week and an action report is produced with follow-up supportive action planning meetings
- Launched a real-time Quality Reporting system across the Trust. This system brings together quality and performance data for all wards and services in one place, to provide a more simplified and standardised overview of our clinical data
- Refreshed our unannounced Quality Audits in line with the new Quality Reporting system. Staff from Corporate Nursing, Infection Control, Estates and Facilities, Patient representatives, Medical staff and Therapies attended
- Introduced external Quality and Safety inspections led by staff from NHSI in collaboration with Trust staff. The first external inspection took place in June 2017 with a second scheduled for September 2017
- Engaged with the Institute of Health Improvement (IHI) to provide an independent assessment of the Trust's quality improvement culture, strategies, policies, and priorities. Based on the results, IHI will support the Trust using an agreed quality improvement methodology to adopt a comprehensive and effective quality improvement framework, for building capacity, capability and the cultural foundation to promote and sustain value-based healthcare and quality
- In addition to internal reviews and data, external data and quality sources will be used for benchmarking and quality improvement, for example Getting It Right First Time (GIRFT).

Our **Quality** **Improvement Plan** May 2017 onwards



Developing the Quality Improvement Plan

Our Quality Improvement Plan is a key driver for change, as are our Financial and Elective Care Recovery Programmes. Our Financial Recovery Programme focuses on cost improvement programmes, reducing our spend and becoming more efficient as a Trust, whilst the Elective Care Recovery Plan focuses on the important issues with our data quality, and the operational processes and technology we use to support this. These three programmes have been developed in parallel to ensure we address our quality, financial and performance challenges at the same time, rather than in isolation.

In addition to these major programmes, other key change programmes are in place which will have an impact on the quality of care we provide. One example is the Staff Engagement Programme which aims to improve the way we work with each other. This programme focuses on staff engagement, equality and inclusion and ensuring that we are exceeding the Workforce Race Equality Standard (WRES) requirements. It aims to ensure that we are able to respond appropriately and sensitively to diversity, including gender, race and ethnicity, disability, religion, sexuality, class and age – to recognise other factors that can influence staff, their behaviours and the quality of care they provide.

As described on [page 9](#) the design of our Quality Improvement Plan has evolved from an initial response to the Care Quality Commission's (CQC) Inspection report of November 2016, to now describe our long term vision to provide Outstanding, Care, Every Time.

Key to the development of the plan has been the involvement of our staff to identify the project areas for improvement. The projects they have identified will be delivered through a framework of three areas of major change, together with two enabling workstreams.

To ensure we can effectively monitor and track our performance, we have developed a governance structure (on [page 22](#)) for the Quality

Improvement Plan, which flows from the Terms of Reference reporting for each workstream through to Trust Board reporting. The framework and governance plan were developed by the Programme Management Office (PMO), with staff in conjunction with the Medical Director and Chief Nurse as the Executive leads for the Quality Improvement Programme, along with input from the workstream leads.

Each workstream within our Quality Improvement Plan has a Terms of Reference which details how work will be coordinated, prioritised, with outcomes, milestones and key performance indicators (KPI's). Milestones vary between short term, within the current year, and longer term, up to four years.

The Terms of Reference provide for communication of where the project is, where the project is heading, the timescales involved and the activities that need to be undertaken to allow the project to deliver. Each Terms of Reference details the concerns raised by the CQC during their 2016 inspection. For example, the Deteriorating Patient's Terms of Reference details that following the CQC findings in June 2016, it was recognised that improvements were required in respect to recognising and escalating deteriorating patients. The CQC found that there was an inconsistent approach on the wards to requesting advice and support for the deteriorating patient and that there was no critical care outreach team to review deteriorating patients at short notice. In response, the Terms of Reference detail and articulate the actions we have taken so far to mitigate this, what we want to achieve and what are our key change objectives for this project are in the future.

The Terms of Reference provide the project management method and control of projects. They include a detailed workstream governance plan, a programme organisation and structure, reporting arrangements, a workstream implementation plan and the required capital investment.

Each workstream has a clear set of activities and milestones for the lifecycle of the project. For example, an activity in the End of Life Care project is to provide more training to staff on how to discuss the last hours and days of life with a patient and their family. In both the Complaints Management and Theatres workstream, activities included holding workshops with staff to understand their views on how we improve the quality of service and care we provide.

The outcomes of the activities from each workstream are reviewed monthly at the Quality Delivery Board.

Each workstream has senior clinical leadership and is supported by a team structure who are described in the Terms of Reference. The workstream lead provides oversight on the linkages and dependencies between activities to ensure that the workstreams are not working independently of each other. They are the means of identifying the critical paths for linked activities such as the End of Life Care and Deteriorating Patients workstreams which both aim to ensure that our staff feel confident and have the skills, training and support to recognise when patients are deteriorating.

The latest developments for each project are overseen by the PMO and publicised on the quality area of the Trust intranet, with summary updates published to the Trust's website. The PMO has been resourced to support the QIP and regularly meets with the workstream and project leads to monitor achievements, milestones and KPIs.

The PMO support ensures that anything that might prevent a workstream from achieving its objectives is dealt with promptly and additional support is provided to the programme.

Ensuring that we work closely with and support our stakeholders and staff is critical to the delivery of the plan. With this in mind we will continue to develop our programme management and governance approach throughout our improvement journey.

Quality Improvement Plan

Delivery Framework

PROGRAMMES		WORKSTREAMS		PROJECTS			
SAFE & EFFECTIVE CARE	FUNDAMENTALS OF CARE	Risk Assessments	Infection Control	Consent	Patient Experience		
	END OF LIFE CARE	Strategy Implementation					
	DEMENTIA, MCA & DOLS	MCA Compliance	Use of Restraints	Carer Access			
	DETERIORATING PATIENT	Deteriorating Adult	Sepsis				
	MEDICINES OPTIMISATION	Handling of Medication	Expedite Discharges				
FLOW & CLINICAL TRANSFORMATION	UNPLANNED/ ADMITTED CARE	Front Door Streaming	ED processes	Ambulatory Care	Inpatients Processes	Discharge Processes	
	THEATRES	Theatre Environment	NATSSIPS	Efficiency			
	OUTPATIENTS	Environment	Efficiency				
	RTT	RTT programme					
QUALITY & RISK	FLOOR TO BOARD GOVERNANCE	Corporate Governance	Clinical Governance				
	COMPLAINTS MANAGEMENT	Improvements to Process and Quality	Thematic Reviews				
	LEARNING FROM INCIDENTS	Learning from staff groups	Thematic learning	Mapping and establish best practice			
	CLINICAL RECORDS	Access to records	Ward Records Storage				
ENABLERS	ESTATES & IT	ESTATES RECOVERY PLAN	Recovery Plan Delivery				
		IT STRATEGY	10 Year Plan Delivery	Infrastructure Innovations and Solutions			
	ENGAGEMENT & LEADERSHIP	LEADERSHIP & CULTURE	Institute for Health Improvement (IHI) programme				
		ENGAGEMENT	Staff Engagement				

How we will implement the Quality Improvement Plan

Our Quality Improvement Plan describes our vision to provide Outstanding Care, Every Time for each of our patients wherever they are treated. Outstanding Care, Every Time means:

- Every patient receives safe and outstanding care
- The right patient is seen in the right place at the right time, every time
- Staff say “I’m proud to work at St George’s”
- All staff - wherever they work - can shine and contribute to our future

The Quality Improvement Plan will be delivered through a framework of three areas of major change together with two quality improvement enabling workstreams.

1) Safe and Effective Care - to consistently deliver the fundamentals of patient care and ensure that improvements we make are sustained in the long term.

The projects within the Safe and Effective Care workstream are designed to ensure that we get the basics right for all of our patients and we further develop our patient care to be outstanding, every time. All Quality Improvement Plan workstreams impact the Safe and Care Effective Care programme and the quality of care we provide. The Estates workstream, for example, has a short-term strategy to stabilise and improve our estate and that equipment used must be clean, secure, suitable, maintained and used properly – which has a direct impact on the quality care we provide.

Ensuring we provide the fundamental standards of care make up a significant portion of the day-to-day activities at the Trust. There is an

existing quality governance structure in place to ensure we provide safe and effective care. As part of the quality improvement journey, we are aligning this to our Quality Improvement Plan and dedicating a workstream to reviewing the effectiveness of this and further improving our quality governance. We have also aligned the Quality Delivery Board and the Financial Recovery Board which is described in more detail on [page 22](#).

Alongside the Quality Improvement Plan we measure how safe and effective our care is in a number of ways. These include audit programmes, ward safety huddles, multidisciplinary audits, ward conversations, inspections, safety walkabouts, back to the floor meetings and Board visits. We have developed a quality dashboard for each clinical area so we can identify where we need to improve to our performance. In October 2017 we will begin a Ward Accreditation Programme to recognise the achievements of our staff and wards.

Although we gather feedback from our individual patients through the Friend and Family Test and localised patient surveys, we will be improving the way we engage with our patients and use their feedback to drive improvement.

On [page 26](#) you can see the workstreams and projects that make up the Safe and Effective Care programme.

2) Flow and Clinical Transformation - we will make the process and operational changes to improve the flow of patients along their care pathway, from arrival through to discharge.

Many of our staff are involved in the Trust-wide Flow & Clinical Transformation programme as part of their day-to-day work, in particular with

initiatives such as pre-11am discharge, and the outpatients and theatres programmes.

The Flow and Clinical Transformation programme is addressing how effectively a patient moves along their care pathway from arrival to discharge. How a patient flows through the hospital affects all of our staff. The effective flow of patients means that patients who are coming for planned care as well as those who come to us for emergency care will have a better quality experience through being able to access their treatment in a timely way. Through the programme we aim to reduce waiting times, cancellations and clear the patient backlogs. To drive our ambition for quality we aim to improve the patient experience from the moment they come into our services until they leave. We will ensure they receive the right information, are booked efficiently in advance, have safe and effective care and are discharged as soon as safely possible.

Ensuring that we make the operational changes to improve patient flow and make the most efficient use of our resources also helps to improve the Trust's financial position. For this reason the Flow & Clinical Transformation workstream is governed by and reports in to both the Quality Delivery Board and the Financial Recovery Board.

On [page 33](#) you can see the workstreams and projects that make up the Flow & Clinical Transformation programme.

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

A significant part of this workstream is designed to improve how we learn as an organisation when things don't go how we expected them to.

For our patients, our aim is to avoid preventable harm. Should patients be harmed, we want to make sure that we are open and honest and that as an organisation we learn from these events to stop them from happening again. We

also want to ensure that our patients receive high quality feedback and a timely response to their complaints.

For our staff our aim is to provide a safe environment and promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events, and feel empowered to make the changes necessary to avoid them happening in the future. We aim to ensure a consistent feedback loop for staff to learn from the incidents and complaints.

We aim to ensure we have good quality governance processes such as at ward handover times, ward rounds, National Early Warnings System (NEWS) recognition, record keeping and storage, infection control procedures, identifying and recording end-of-life care needs, and recording do not attempt resuscitate (DNAR) decisions. A key part of this programme is to ensure we work within all clinical guidelines and the use of national clinical guidelines is evident throughout our services.

On [page 41](#) you can see the workstreams and projects that make up the Quality and Risk programme.

These are supported by two quality improvement enabling programmes:

- 4) Estates & IT - improve our systems and environment so that we are making what's right for patients the easiest thing for staff to do.**
- 5) Leadership and Engagement - ensure our current and future leaders are supported and developed to deliver high quality, compassionate care, and that we engage with our staff who know our services best.**

How we will implement the Quality Improvement Plan - Governance arrangements

We have developed a governance structure for our Quality Improvement Programme which is aligned to the Trust's Financial Recovery Programme. This had oversight and external scrutiny at Trust level by NHS Improvement. Each workstream has developed a Terms of Reference and is held accountable through the Quality Delivery Board which ultimately reports to the Board via the Finance and Quality Delivery Board as detailed in the diagram on [page 23](#).

Responsibilities of programme Lead

- The programme lead for each programme is responsible for ensuring that the identified outcomes, Key Performance Indicators (KPI's) and actions identified by the programme / workstream are agreed and delivered
- The programme lead will be allocated responsibility for overseeing the implementation and impact of each of the workstreams associated to their programme
- The programme lead will provide both support and challenge to the workstream Senior Responsible Officers (SROs) at the relevant governance meeting if concerns are identified, or the delivery of actions are delayed to meet the stated outcomes. Programme SROs will be requested to identify mitigating actions to bring the delivery back on track.

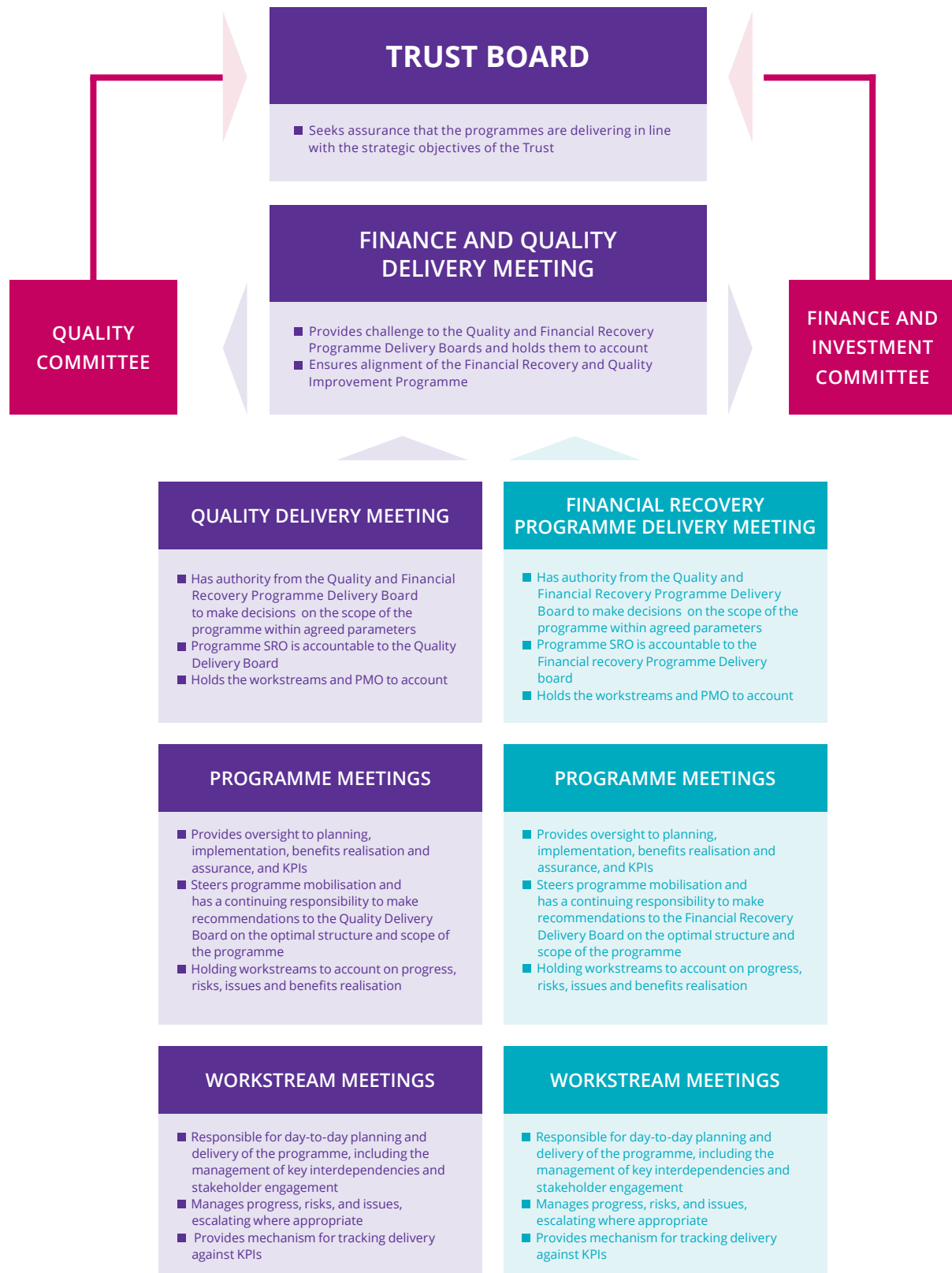
Responsibilities of Divisional Leads/ Trust Leads/ Staff with actions

- The Quality Improvement Plan is monitored on a regular basis by Divisional Leads and programme leads to ensure it remains on track, pro-actively identifying slippage and mitigating actions to rectify as soon as possible.

Responsibilities of the central Programme Management Office (PMO) team

- The central PMO team provides support to the Divisions / programme Leads to ensure that the Quality Improvement Plan is co-ordinated appropriately.

How we will implement the Quality Improvement Plan - Governance structure





Safe & Effective Care

The Safe and Effective Care Improvement programme has five workstreams predominantly focusing on delivering the fundamentals of patient care and ensuring that improvements we make are sustained in the long term.

The following pages provide a summary of the detailed workstream plans that underpin the Safe and Effective Care programme.

SAFE & EFFECTIVE CARE

WORKSTREAMS

FUNDAMENTALS
OF CARE

END OF LIFE
CARE

DEMENTIA, MCA
& DOLS

DETERIORATING
PATIENT

MEDICINES
OPTIMISATION

PROJECTS

Risk
Assessments

Strategy
Implementation

MCA
Compliance

Deteriorating
Adult

Handling of
Medication

Infection
Control

Use of
Restraints

Sepsis

Expedite
Discharges

Consent

Carer Access

Patient
Experience

Fundamentals of Care

Aim: To consistently deliver the fundamentals of patient care to ensure our patients are kept safe and free of avoidable harm.

We will:

- Ensure patients receive safe care and are not put at risk of avoidable harm
- Ensure all premises and equipment used is clean, secure, suitable, maintained and used properly
- Deliver quality improvements with a focus on Harm Free Care to prevent patients across our services from harm, including pressure ulcers, falls, hospital-acquired infections and Venous Thromboembolism (VTE).

How we will achieve this:

Infection control

- Provide accurate information and reporting on identified infections and hand hygiene variants
- Undertake focused audits on four wards per month to achieve perfect hand hygiene outcomes of 95% compliance
- Improve the accuracy of the hand hygiene audit through quarterly cross-divisional audits
- Ensure that Aseptic Non-Touch Technique (ANTT) competences are being met
- Ensure prompt identification and isolation of patients with an infection to reduce risk of transmitting infection to other people.

Harm Free Care

- Increase the number of VTE, pressure ulcers, falls, environment, nutrition and risk assessments

- Ensure robust governance and processes are in place to proactively manage risk assessments

Further work will be completed as part of this workstream to identify MSSA, E Coli cases, consent and patient experience. Once a baseline can be identified a threshold/target will become an indicator for this workstream.

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

Indicator	Successful when we achieve
Hand Hygiene Audit compliance	95%
Fall resulting in moderate or above harm	0
VTE risk assessment completed	85%
Grade 3 & 4 pressure ulcers	0
Avoidable VTE events	0
Infection Control Mandatory and Statutory training (MAST) compliance	85%
Staff completed ANTT competences	95%
Clostridium difficile cases reported (yearly target)	31
MRSA bacteraemia reported	0
Harm Free Care to patients	95%

End of Life Care

Aim: Continue to improve the experience for patients and their loved ones at the end of their life.

We will:

- Improve End of Life Care (EoLC) for patients and their families across the Trust by focusing on the recommendations outlined within 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020'
- Engage and work with staff across all wards and departments by implementing our new EoLC Strategy
- Enhance quality of life for people with long term conditions
- Ensure that people have a positive experience of (health) care
- Ensure the care people receive, reaching the end of their life, is aligned to their needs and preferences
- Reduce unscheduled care hospital admissions leading to death in hospital (where death in hospital is against the patient's stated preference)
- Improve the co-ordination of EoLC between providers such as care homes and the community.

How we will achieve this:

- Patients who are nearing the end of their life (last year of life) will be offered the opportunity to engage in Advance Care Planning in response to their changing needs and preferences with the opportunity to discuss, develop and review a personalised care plan for current and future treatment. Those at the end of their life will receive holistic and comprehensive assessments to deliver the right care to them in the last days and hours of life.

- Promote the use of Advance Care Planning to enable patients to state their EoLC wishes and ensure they are adhered to
- Improve the care for patients in their last year of life and ensure they have the opportunity to plan their care along with those close to them
- Change the perception of "Death is failure" to "A good death is a successful care outcome"
- Ensure health and social care professionals have access to a framework of appropriate and high quality training and education.

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

Indicator	Successful when we achieve
Relatives/carers who responded to the bereavement survey who rated overall care as good or excellent	100%
Complaints relating to EoLC themes for patients in our care	0
Serious incidents relating to EoLC themes for patients in our care	0

Dementia, Mental Capacity Act & Deprivation of Liberty Safeguards

Aim: Ensure there is no decision without the patient's or carer's involvement and the patient's wishes and values are at the centre of their care and treatment.

We will:

- Improve our compliance with Mental Capacity Act Assessment (MCAA)
- Improve the safe, effective and appropriate use of restraints (e.g. bed rails) throughout the Trust
- Improve carer access for patients with dementia
- Be recognised as a dementia friendly hospital

How we will achieve this:

- Avoid inappropriate use of restraints through training and education
- Improve compliance with dementia carers' survey to obtain better feedback from this important group of service users
- Work with wards to roll out dementia carers passports and facilitate overnight stays by carers
- Ensure staff have access to and complete dementia awareness training
- Increase use of the Butterfly Scheme
- Develop a dementia and delirium scorecard to monitor performance at Divisional level to drive continuous improvement

- Further work will be completed as part of this workstream to identify the number of patients that could potentially be on the Butterfly Scheme. Once a baseline can be identified a threshold/target for participation will become an indicator for this workstream.

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

Indicator	Successful when we achieve
MCA audit compliance (St George's Hospital)	100%
MCA audit compliance (Queen Mary's Hospital)	100%
Staff completed dementia awareness training	85%
Carers who would like to stay overnight with patient, who actually stayed beside the patient	100%
Carers passports issued per month	15 per month
Dementia carers survey completed	20 per month

Deteriorating Patient

Aim: Recognise and manage the deteriorating patient and ensure staff support patients and carers to make a choice regarding their treatment

We will:

- Put in robust processes to effectively identify patients who are at risk of and/or are deteriorating
- Ensure staff are confident and competent in knowing how and when to escalate deteriorating patients in a timely manner
- Support staff working with patients and carers to make a choice regarding their treatment in line with DNACPR (Do not attempt CPR resuscitation) and end of life guidance as appropriate

How we will achieve this:

- Increase awareness and local ownership of the associated risks with a deteriorating patient in every ward
- Embed inpatient care and deteriorating adult care into the governance of every speciality care group
- Improve EWS (Early Warning Score, which supports the recognition of deteriorating patients) monitoring and escalation compliance
- Monitor mortality and incidents and feedback locally
- Achieve 100% SAFER (a standardised way of managing patient flow through hospital) compliance on the wards
- Set individual escalation and End of Life Care plans for every patient admitted to the hospital

- Ensure patients who are nearing the end of their life will receive holistic, comprehensive assessments in response to their changing needs and preferences with the opportunity to discuss, develop and review a personalised care plan for current and future treatment

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

Indicator	Successful when we achieve
In hospital (All) Cardiac Arrest Rate/1000 admissions	50% reduction by April '18 from baseline of 14 (April 17)
Increase in compliance with appropriate response to EWS	85%
Blue light sepsis assessment and antibiotics in ED within one hour	85%

Medicines Optimisation

Aim: To ensure the safe and efficient storage and use of medicine and to continue to reduce the time a patient waits for their medicines.

We will:

- Ensure safe and secure handling of medicines focusing on room and fridge temperature monitoring solutions for medicines.
- Continue to improve discharge medication turnaround times for patients to improve the patient experience and patient flow through the Trust.

How we will achieve this:

- Ensure 80% of pharmacy staff resource is utilised for clinically focused patient-facing medicines optimisation and increase the number of prescribing and transcribing pharmacists
- Increase satellite dispensing pharmacies from three to four at St George's Hospital to ensure that patients receive their medication quicker than by dispensing from the central pharmacy
- Continue to reduce the turnaround time for patients receiving their discharge medications to support patient flow
- Increase the use of an external partner to provide monitored dosage systems to prevent delayed discharge

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

Indicator	Successful when we achieve
Pharmacists actively prescribing	80%
Medication to take out (TTOs) dispensed in satellite dispensing units	90%
TTOs completed in less than 60 minutes in satellite dispensing units	90%
Monitored Dosage System dispensed by external partners	90%
Time taken to resolve Frequent High Temperatures in Clinical Areas (FHTCA)	6 weeks



Flow & Clinical Transformation

The Flow and Clinical Transformation programme has four workstreams predominantly focusing on ensuring we make the process and operational changes to improve the flow of patients along their care pathway, from arrival through to discharge.

The following pages provide a summary of the detailed workstream plans that underpin the Flow and Clinical Transformation programme.

FLOW & CLINICAL TRANSFORMATION

WORKSTREAMS

UNPLANNED/
ADMITTED CARE

THEATRES

OUTPATIENTS

REFERRAL TO
TREATMENT
(RTT)

PROJECTS

Front Door
Streaming

Theatre
Environment

Environment

RTT programme

ED processes

NATSSIPS

Efficiency

Ambulatory
Care

Efficiency

Inpatients
Processes

Discharge
Processes

Unplanned and Admitted care

Aim: Improve the timeliness of emergency care for patients and consistently meet the A&E four-hour operating standard. Ensure that we admit patients to the right ward or place of care first time and ensure a positive patient experience. Align our people and clinical capacity to pathway demand and ensure our patients go to the most appropriate environment for their assessment, treatment, and care.

We will:

- Revise processes whereby patients on arrival receive the most appropriate environment for their assessment – in the hospital or out of hospital.
- Create a paper-free Emergency Department to enable our clinicians to focus their time on patient needs.
- Develop a systematic approach and physical space whereby adult and paediatric patient treatment needs can be on an ambulatory basis whenever possible as an alternative to admission.
- Enable direct and timely access to diagnostic tests and scans.
- Admit patients to the most appropriate environment for the patient's expected length of stay, with an early assessment and treatment plan toward discharge.
- Improve patient tracking systems electronically so that any task delays are rapidly identified and resolved and that every day every patient moves towards going home.
- Enable and institute consistent daily ward rounds and effective communication for every patient.
- Actively identify and resolve any internal or external constraints to discharge from the first day of stay.
- Develop boundary-less flow to minimise length of stay for patients requiring ongoing treatment or care, and create the flexibility within hospital to maintain a steady state during periods of increased demand.

How we will achieve this:

- More engagement and involvement of patients, front line staff, and partner organisations.
- Improve the transfer of care from the acute setting into community settings.
- Establish underlying principles to reduce variation, improve reliability, increase consistency and increase responsiveness to problems in patient flow.
- Comprehensive analytic assessment of bed capacity, Length of Stay (LoS) performance versus peer Trusts, attainment and ward discharge metrics.
- Review of bed capacity and demand model.
- Implement the SAFER care bundle across all wards with consistent monitoring, as well as hospital at night and seven-day hospital initiatives.
- New processes within A&E to enable decisions for streaming patients to the appropriate care environment.
- New discharge processes, including discharge to assess and trusted assessor to ensure discharge focuses on individual patient needs.
- Integration of the discharge system with improved coordination of the expertise, skills, and capacity of colleagues internal and external to the Trust.

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

Indicator	Successful when we achieve
A&E 4 hour operating standard	95%
Ambulance handover time 15min	100%
% of patients assessed within 15 min of arrival at A&E	100%
% of Daily discharges by 11am	40%
Bed Occupancy	92.5%
% of wards using SAFER	90% (staged)
Patient Experience (FFT)	95%

Theatres

Aim: To reduce cancellation of operations and make efficient use of our operating theatres.

We will:

- Co-ordinate operational, quality and financial improvement initiatives into one programme of work
- Increase theatre productivity
- Reduce cancellations on the day of surgery.

How we will achieve this:

We will improve our theatres efficiency, environment and outcomes through improvements in:

- Booking, admissions and staff/patient scheduling
- Pre-operative assessment
- Handling admissions via the Surgical Assessment Lounge (SAL)
- Preparing theatres to ensure they are ready to go without late starts
- Other areas of focus will be identified and indicators developed as part of the workstream activities.

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

Indicator	Successful when we achieve
Number of Serious Incidents / Never events	0
WHO checklist compliance	100%
Hand hygiene audit	95%
Increasing elective and day case activity	15% in target specialities
Increase pre-admission appointment attendees	20%
Local anaesthetics only lists	6 per week
Waiting list initiative reduction per year	300

Outpatients

Aim: To offer patients greater choice in how they access our services and ensure we match our capacity to patient demand.

We will:

- Ensure patients have access to high quality outpatient care when they require it and have full access to virtual or other types of extended outpatient care
- Ensure waiting times are reduced to deliver constitutional standards and improve experience and outcomes for patients
- Review and improve the appointment booking system, putting an effective system in place where patients are booked into the right clinics and have the right information for their appointment
- Offer patients greater choice in how they access acute specialists with alternatives to face-to-face appointments
- Ensure that patients have easy access to the hospital to check appointment enquiries through phone and email systems and that DNA (did not attend) rates for appointments are reduced to acceptable levels

How we will achieve this:

- Work with patients, services, Clinical Commissioning Groups (CCGs) and other providers to create sustainability in key services
- Migrate to electronic referral in line with NHS standards in parallel with extended advice and guidance access so that referring clinicians are alerted to potentially more appropriate assessment and treatment environments for their patients

- Standardise outpatient pathways across the Trust by utilising technology appropriately to reduce administrative inefficiency and ensure all activity is recorded and reported to commissioners

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

Indicator	Successful when we achieve
Outpatient Friends & Family Test	95%
First attendances per month	17196
Follow up attendances per month	29937
Advice and guidance activity per month (CQUIN)	100%
E-referral usage per month (CQUIN)	100%
Clinic appointment with eDM record	73%
Patients who Did Not Attend (DNAs) their appointment rates	5%

Referral to Treatment

In January 2016, we became concerned about the quality and robustness of our data reporting, particularly for referral to treatment (RTT) metrics.

An external review of our RTT data and patient tracking systems last year identified a number of serious issues with our operational processes and technology that posed significant risks to the quality of care and patient safety, and flaws with our reporting processes at St George's Hospital (Tooting).

A subsequent review carried out in April 2017 identified similar problems at Queen Mary's Hospital in Roehampton.

In real terms, this means that many patients are waiting longer than they should for treatment. We are also unable to confirm, at this stage, how long some patients have been waiting for treatment.

It is clear that our systems and processes have fallen far below the high standards we judge acceptable. However, we have a new leadership team in place, and our priority is to deliver a robust and long-standing solution for our patients, and the communities we serve.

Patient safety is our number one priority

Due to the problems highlighted above, we suspended national reporting of our RTT data in June 2016. We won't recommence reporting until we have full confidence that the information we are providing is reliable.

We have established an Elective Care Recovery Programme, which reports to the Trust Board on a monthly basis.

The programme is designed to review and validate existing electronic patient records, so as to ensure patients aren't waiting longer than they should for treatment.

It is also establishing an effective patient tracking system for the future, meaning the treatment plans for new patients referred to both St George's and Queen Mary's are tracked and monitored effectively.

A key part of our improvement journey

Due to the size and scale of the challenge we face in this area, the Elective Care Recovery Programme is being run as a separate project separate to the immediate scope of our Quality Improvement Plan.

However, delivering safe and effective patient tracking systems for the Trust – and addressing the historical problems we have identified – is a key part of our improvement journey.

As a result, the Elective Care Recovery Programme and our Quality Improvement Plan, will remain closely linked, and both are key to our wider recovery as an organisation.



Quality & Risk

The Quality and Risk Improvement programme has four workstreams predominantly focusing on how we handle risk effectively throughout the organisation through effective systems and processes that are used and understood by our staff.

The following pages provide a summary of the detailed workstream plans that underpin the Quality and Risk programme.

QUALITY & RISK

WORKSTREAMS

FLOOR TO
BOARD
GOVERNANCE

COMPLAINTS
MANAGEMENT

LEARNING FROM
INCIDENTS

CLINICAL
RECORDS

PROJECTS

Corporate
Governance

Improvements to
process and quality

Learning from
staff groups

Access to
records

Clinical
Governance

Thematic reviews

Thematic
learning

Ward records
storage

Mapping and
establish best practice

Floor to Board Governance

Aim: To handle risk throughout the organisation through effective systems and processes that are used and understood by our staff. To ensure that information is provided to our Board to assure them we are operating effectively and our patients and staff are being well cared for.

We will:

- Ensure that we maintain focus on strong integrated governance and leadership across quality, finance and operations, and this stays in line with the changing environment
- Ensure we are able to identify and mitigate against risks in the organisation and that the organisation has line of sight of risks which may be barriers to achieving its key objectives.

How we will achieve this:

- Use the CQC Well-Led framework to ensure we are meeting our regulatory requirements
- Undertake an independent review of our corporate governance function
- Develop action plans to improve control RAG ratings and ensure the appropriate governance measures are in place to learn from incidents and complaints
- Continue to monitor compliance with the risk management policy
- Review all risk register controls and RAG ratings
- Update the training on how to RAG rate controls within our risk and issues process system DATIX.

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

Indicator	Successful when we achieve
Risks without green controls	0
Risks with no controls	0
Moderate/high/extreme risks	< 6% per month
Moderate/high/extreme risks with overdue actions	0
Moderate/high/extreme risks with no actions	0

Complaints Management

Aim: To ensure complaints are responded to in a timely manner, investigated thoroughly and that we learn from complaints so that the same type of incident doesn't happen again.

We will:

- Ensure there is a focus on the quality of engagement with the complainant to support resolution of issues or concerns as soon as possible
- Identify a way to process complaints that improves quality and effectively responds within agreed timeframes
- Be a learning organisation – responsive to our patients concerns and understanding how successful we are by asking our complainants about their experience of making a complaint through a new Complaints Satisfaction Survey
- Reduce future complaints by improving how we act on lessons learnt.

How we will achieve this:

- Review our current processes and use learning from other organisations to understand what 'good' looks like to ensure we develop the best approach to handling complaints
- Identify other forums for complaint resolutions such as informal face-to-face meeting and telephone contacts to ensure that we are responding to the patient needs
- Develop a robust communication and development campaign to ensure that customer service is embedded into our day-to-day activities with staff willing and confident to support individual complainants

- Develop divisional action plan trackers to ensure that all actions are followed through and for more complex or serious complaints actively engage and involve our patients to demonstrate we are improving services.

- Design a Complaints Satisfaction Survey to be in place by December 2017.

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

Indicator	Successful when we achieve
Compliance within 25 working days complaint response for green complaints	95%
Compliance with 40 working day complaint response for all amber complaints	95%
Compliance with 60 working day complaint response for all red complaints	95%
Complaints that require a second response	<8%
Complaints upheld by the Parliamentary and Health Service Ombudsmen (PHSO)	0

Learning from Incidents

Aim: To ensure that learning from incidents is implemented properly throughout the Trust, so as to reduce the risk of repeat occurrences of any issues identified.

We will:

- For our patients, our aim is to avoid preventable harm. Should patients be harmed, we want to make sure that we are open and honest and that as an organisation we learn from these events to stop them from happening again
- For our staff, our aim is to provide a safe environment and promote a culture where all our staff are confident to report incidents and have the skills to investigate and learn from events and feel empowered to make changes necessary to avoid them happening in the future.
- Ensure that we address the human factors – environmental, organisational and the individual characteristics – which influence behaviour at work and the care our staff provide.

How we will achieve this:

- Review current practice and establish minimum standards for low and high level incident reporting and distribution, with improved communication to staff
- Ensure learning is embedded from actions resulting from incident investigations. We will evidence how effective this is through, ward safety huddles, inspections, safety walkabouts, back to the floor meetings and Board visits
- Survey staff to assess to what extent learning from incidents has been embedded
- Improve analysis of incidents to allow for thematic analysis and identification of recurrent themes

- Improve learning from low level incident reporting
- Enhance incident reporting usage and feedback
- Identify learning needs for specific staff groups and develop tailored approach.

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

Indicator	Successful when we achieve
Duty of Candour completed for all incidents (as graded on Datix) at moderate harm and above	100%
Duty of Candour completed within 10 working	100%
Incidents reported – non clinical	2200/year
Incidents reported – clinical	12,300/year
Serious Incidents declared	90/year
Serious Incidents investigations >60 days	0
Never Events declared	0
Staff who provide an informed response to the learning from incidents survey	95%

Clinical Records

Aim: To ensure patient care is not impacted by storage, completion or accessibility of clinical records. To ensure that staff meet the quality standards so we are able to support safe and effective care.

We will:

- Protect our patients by ensuring that records relating to the care and treatment for each patient are kept securely and are an accurate and complete record
- Ensure records are accessible to authorised staff in order that they may deliver, to people, care and treatment in a way that meets their needs and keeps them safe.

How we will achieve this:

- Identify areas of non-compliance for clinical record storage and barriers to compliance
- Review capacity of corporate secure record storage facilities
- Review the audit process for clinical records to improve the quality of clinical records
- Hold workshops with junior doctors and matrons to identify barriers to creating accurate notes
- Identify training needs for clinical groups and identify feedback forums to support learning
- Agree national and local quality standards so we can track our performance
- Develop action plan for remedial action at area level to enable compliance

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

Indicator	Successful when we achieve
Number of outpatient appointments where clinical notes are not available	300
Notes not securely stored on wards	<50
Clinical records quality of meeting national standards	98%



Enablers:

Estates & IT and Leadership & Engagement

The Estates and IT programme has two workstreams predominantly focusing on how to improve our systems and environment so that we are making what's right for patients the easiest thing for staff to do.

The Leadership and Engagement programme has two workstreams designed to ensure that our current and future leaders are developed to deliver high quality, compassionate care, and we ensure our staff are at the centre of the changes we are making.

The following pages provide a summary of the detailed workstream plans that underpin the Estates and IT programme and the Leadership and Engagement programme.



Enablers Programme: Estates

Aim: Our short-term strategy is one of stabilisation and improving our estate to get the basics right so that our environment makes outstanding care possible. In the longer term, we will transform our estate through the delivery of new estates infrastructure that has improved capacity, reliability and compliance to underpin the Trust's clinical vision and strategy.

We will:

- Continue to stabilise our estate, to restore the Trust's performance and reputation as a university hospital providing excellence in both local healthcare and specialised services. This is our short-term strategy to improve our estates to get the basics right
- Improve the environment for staff and patients
- Ensure the Estates team provide a responsive service and addresses concerns by clinical staff

How we will achieve this:

- Vacate and demolish buildings that are no longer suitable for purpose, to create space for service improvement
- Modernise our theatres and wards in line with the clinical service needs
- Work through our backlog maintenance, fire, water, heating and ventilation safety; resolving our highest risks first
- Address our electrical compliance through the replacement and upgrade of our electrical infrastructure
- Improve capacity of our Emergency Department, ITU and Critical Care Unit
- Relaunch a more efficient and responsive Helpdesk.

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

Indicator	Successful when we achieve
In line with the Carter Recommendations to ensure that 62.5% of the trust estate is used for clinical purposes	62.5%
All inpatient wards including ED at morning handover to report estates issues and log to the estates helpdesk for example; dishwasher blockage, medicines cabinets secure	95%
Acknowledgment by estates of all logged issues via estates helpdesk	100%
Initial assessment of logged issue by estates department	24hrs
Low use outlets are tracked and all are flushed routinely	100%
Valid training sessions available to ensure trained fire warden on each shift in every area	2 per week

Enablers Programme: IT

Aim: To provide the right infrastructure to support clinical and management systems for our staff to provide modern services to our patients and to accurate record activity.

We will:

- Improve patient experience and reduce harm by enabling and supporting the Financial Recovery Programme
- Reducing cost by supporting the Trust's Cost Improvement Programme (CIP)
- Improve Trust staff experience of using IT
- Improve the timeliness and availability of data to support clinical and administrative decision making.

How we will achieve this:

- Invest in technology including infrastructure, clinical and corporate systems, and training of staff
- Define and publish a range of IT metrics that demonstrate stability, responsiveness and consistency
- Invest in the informatics service
- Further work will be progressed as part of this workstream on the service desk function. Once a baseline can be identified a threshold/target will become an indicator for this workstream.

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

Indicator	Successful when we achieve
A reduction in the number of clinical & organisational incidents recorded where IT infrastructure is a contributory factor	50% reduction on 16/17 data
A reduction in the number of medication administration errors accountable to IT failure	50% reduction on 16/17 data
A reduction in the number incidents related to failure to identify deteriorating patients accountable to IT failure	50% reduction on 16/17 data
Carry out an annual ICT staff satisfaction survey	October 2017
Create an IT Service desk dashboard of IT Key Performance Indicators (KPIs)	November 2017

Enablers Programme: Leadership

Aim: To ensure our current and future leaders are supported and developed to deliver high quality, compassionate care aligned to the needs of the populations we serve, in a cost-effective manner.

We will:

- Create the right conditions and environment in which staff will enable the Trust to deliver a continuously improving culture
- Develop the critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills
- Embed cultural and leadership behaviours that lead to higher quality care cultures amongst all staff in the organisation.

How we will achieve this:

- Use the NHS Healthcare Leadership Model as our leadership framework for the Trust
- Develop our existing leaders with a key focus on developing the four critical capabilities of compassionate, inclusive leadership; improvement skills; talent management and system leadership skills
- Give our leaders time and space to lead service transformation/quality improvement, and find ways to bring their staff along with them
- Evaluate and measure the return on investment in leadership development skills to ensure we use the resources available in the most cost effective way.

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

Indicator	Successful when we achieve
Set up and commence delivery of a leadership / management development centre	Nov 2017
Number of identified staff participating in formal leadership development programmes	200 staff participants per year
Delivery of effective people management programme	200 staff participants per year
Members of the Trust Board participating in Board development programme	100%

Enablers Programme: Engagement

Aim: Ensure our staff are at the centre of the changes we are making and incorporate their views in to everything we do.

We will:

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

How we will achieve this:

- Run a Quality Improvement Week in November 2017
- Support programme managers to run localised engagement activities within their services
- Deliver the staff engagement plan, so we can improve these three key areas:
 - Improve staff engagement
 - Address bullying harassment
 - Improve equality and diversity
- Local Quality Improvement Plan awareness and understanding events/meetings with toolkit produced by communications team.

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

Indicator	Successful when we achieve
Improved NHS National Staff Survey scores	10% improvement on previous years scores
Friends and Family Test (FFT) scores	95% recommend
Staff turnover	≤15%
Executive "Big Conversations"	4 by Nov 2017
Staff survey participation	60%



How we will communicate our
Quality Improvement Plan
achievements

Communications

The programme will require us to utilise existing communications channels and open new bespoke communications and engagement channels, including workshops, seminars, and drop in sessions.



If you have any questions about this plan or would like to comment or make a suggestion regarding its implementation, please contact: Avey Bhatia, Chief Nurse and Director of Infection Prevention & Control: avey.bhatia@stgeorges.nhs.uk, Elizabeth Palmer, Director of Quality Governance: elizabeth.palmer@stgeorges.nhs.uk, or contact the Communications Department: communications@stgeorges.nhs.uk



Contact us

Giving to George's

As well as making a donation there are lots of ways you can get involved with the St George's Hospital Charity. To find out more speak to the Giving to George's team.

Telephone: **0208725 4917**

Email: giving@stgeorges.nhs.uk

Web: www.stgeorghospitalcharity.org.uk

Volunteer

Our volunteers perform a number of varied roles, from manning information desks, general housekeeping, administration and helping patients find their way around. If you would like to volunteer at any St George's, University Hospitals NHS Foundation Trust sites, contact the voluntary services team.

Telephone: **020 8725 1452**

Email: zoe.holmes@stgeorges.nhs.uk

Request a printed copy

Contact the communications team if you would like a printed copy of the Quality Improvement Plan.

Telephone: **020 8725 5151**

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