Trust Board Meeting

Date and Time: Thursday 7 December 2017, 10:00 – 13:00
Venue: Hyde Park Room, 1st Floor, Lanesborough Wing

Time	Item	Subject and Lead	Action	Format
		FEEDBACK FROM BOARD WALKABOUT		
10:00		**Visits to Various Parts of the Tooting Site** *Board Members*	-	Oral
		OPENING ADMINISTRATION		
10:30	**1.1**	**Welcome and Apologies** *Chairman, Gillian Norton*	-	Oral
	1.2	**Declarations of Interest** *All*	-	Oral
	1.3	**Minutes of Meeting held on 09.11.17** *Chairman, Gillian Norton*	Approve	Paper
	1.4	**Action Log and Matters Arising** *All*	Review	Paper
	1.5	**CEO's Update** *Chief Executive, Jacqueline Totterdell*	Inform	Paper
		STRATEGY		
10:40	**2.1**	**Business Planning 2018/19** *Acting Director of Financial Performance & Planning, Tom Shearer*	Review	Paper
	2.2	**Trust Strategic Objectives** *Chief Executive, Jacqueline Totterdell*	Review	Paper
	2.3	**SW London Strategy STP Refresh** *Acting Medical Director, Andrew Rhodes*	Review	Paper
		QUALITY		
11:00	**3.1**	**Quality & Safety Committee Report including Quality Improvement Dashboard** *Chair of Committee, Sir Norman Williams*	Assure	Paper
		PERFORMANCE		
11.20	**4.1**	**Integrated Quality & Performance Report** *Executive Team*	Review	Paper
	4.2	**Elective Care Recovery Programme – Action Plan** *Chief Operating Officer, Ellis Pullinger*	Assure	Paper
	4.3	**Winter Plan** *Chief Operating Officer, Ellis Pullinger*	Assure	Paper
		FINANCE		
11.50	**5.1**	**Finance & Investment Committee Report** *Chair of Committee, Ann Beasley*	Assure	Paper
	5.2	**Month 7 Finance Report** *Acting Director of Financial Performance & Planning, Tom Shearer*	Assure	Paper
		Estates		
12:10	**6.1**	**PLACE Audit Action Plan** *Director of Estates & Facilities, Richard Hancock*	Assure	Paper
		GOVERNANCE		
12:20	**7.1**	**Audit Committee Report**	Assure	Paper

		Chair of Committee, Sarah Wilton		
	7.2	**Single Oversight Framework** *Director of Efficiency, Delivery & Transformation, James Friend* *Trust Secretary & Head of Corporate Governance, Fiona Barr*	Review	Paper
CLOSING ADMINISTRATION				
12.30	**8.1**	**Questions from the Public**	-	Oral
	8.2	**Any New Risks or Issues** *All*		-
	8.3	**Any Other Business** *Chairman*	-	-
	8.4	**Reflection on Meeting** *All*	-	Oral
12:40		**PATIENT STORY**		
Patricia Campbell, Flu Lead, will speak about the 2017-18 flu jab campaign followed by Nadine King, a patient, who will be supported by Sheila Horsman, Macmillan Support Worker and Carol Cuthbert, Carol Cuthbert, Macmillan Melanoma Clinical Nurse Specialist.				
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 25 January 2018

Trust Board
Purpose, Meetings and Membership

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.

Meetings in 2018-19 (Thursdays)									
25.01.18	22.02.18	29.03.18	26.04.18	31.05.18	28.06.18	26.07.18	30.08.18	27.09.18	25.10.18
29.11.18	20.11.18	20.12.18	31.01.19	28.02.19	28.03.19				

Membership and Those in Attendance		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive Officer	CEO
Ann Beasley	Non-Executive Director/Deputy Chairman	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director (St George's University Representative)	NED
Sir Norman Williams	Non-Executive Director/Senior Independent Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
In Attendance	**Designation**	**Abbreviation**
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Richard Hancock	Interim Director of Estates & Facilities	DE&F
Ellis Pullinger	Chief Operating Officer	COO
Mike Murphy	Quality Improvement Director – NHS Improvement	QID
Secretariat	**Designation**	**Abbreviation**
Fiona Barr	Corporate Secretary and Head of Corporate Governance	Trust Sec
Richard Coxon	Membership & Engagement Manager	MEM

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting
9 November 2017 – from 10:00, Hyde Park Room, 1st Floor, Lanesborough Wing

Name	Title	Initials
PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Chief Executive	CEO
Ann Beasley	Non-Executive Director	NED
Stephen Collier	Non-Executive Director	NED
Jenny Higham	Non-Executive Director	NED
Sir Norman Williams	Non-Executive Director	NED
Sarah Wilton	Non-Executive Director	NED
Tim Wright	Non-Executive Director	NED
Avey Bhatia	Chief Nurse and Director of Infection, Prevention & Control	CN
Andrew Grimshaw	Chief Finance Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
James Friend	Director of Delivery, Efficiency & Transformation	DDET
Richard Hancock	Interim Director of Estates & Facilities	DE&F
Ellis Pullinger	Chief Operating Officer	COO
APOLOGIES		
Mike Murphy	Quality Improvement Director - NHS Improvement	QID
SECRETARIAT		
Fiona Barr	Trust Secretary & Head of Corporate Governance	Trust Sec
Richard Coxon	Membership & Engagement Manager	MEM

Feedback from Board Walkabout

The Board members began by giving feedback from the departments visited which included: Wandle Annex; Gardeners; Day Surgery Unit; Surgery Pre-Assessment; Genetics; Communications Cell; Delivery Suite; Radiology; Phlebotomy; Endoscopy; Houtung Centre; Cardiac Cath Lab and Cardiac Investigation.

General observations included very positive staff who were keen to be involved in improving the areas where they work. Estates issues included insufficient storage space or space that was not being fully utilised. In the Pre-Operative Assessment Unit, the unsatisfactory drop off and collection of patients was highlighted again as well as the scope for a more efficient process. These were under review by Estates and the Surgical Division respectively. The SW Thames Regional Genetics service was found to be very innovative, worked well with pathology and managed a paperless office though in general the scientists did not feel well represented in the Trust. They did however invite the Board Members to get their DNA mapped as part of the 100k Genomes Project.

It was noted that some staff had experienced problems completing the Staff survey online or had not received any notification of it. The DHROD was aware and was investigating where the problem lay (eg in the Trust's firewall security or with Picker which was coordinating the survey) though advised that a quarter of Trust staff had so far completed the survey.

The Flu vaccination rate was currently at 69% and should be at 70% by the end of the day.

TB.09.11.17/51	**Board to be invited to be part of 100k Genomes Project and a visit organised to the service for interested Governors.** **LEAD: Director of Efficiency, Delivery & Transformation, James Friend and Associate Director of Communications, Chris Rolfe**

1. OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and advised the only apology was from Mike Murphy, the Quality Improvement Director from NHS Improvement.
Declarations of Interest	
1.2	Ann Beasley declared that she had just been appointed as Independent Financial Advisor to the ACAS Audit Committee but would not be a conflict of interest.
Minutes of Meeting held on 05.10.17	
1.3	The minutes of the meeting of 05.10.17 were agreed as a correct and accurate record.
Action Log and Matters Arising	
1.4	The Board noted that most actions on the Action Log were not yet due or had been closed because appropriate action had been taken outside the meeting. It was agreed that the Board Assurance Framework would come back to the Board in January. It was noted that the Quality Improvement Plan (QIP) information on workstreams would be complete and online before the next meeting.
TB.09.11.17/52	**Present a fully populated Board Assurance Framework to the Board in January 2018. LEAD: Chief Nurse, Avey Bhatia**
CEO's Report	
1.5	The CEO gave a brief report, advising that the performance of key services remains a particular challenge, especially the against the Four Hour Operating Standard. In September 90.03% of patients were seen within the Four Hour target and performance had deteriorated in October. To involve the whole Trust in the measures to address the Four Hour target, she explained that she had organised a Clinical Risk Summit on 21.11.17 to explore what improvements could be made to improve patient flow, including admission and discharge, and overall deliver a better service for patients. A large number of staff had been invited from the Divisions and individual services along with representatives from the Emergency Department and bed management teams. The NEDs welcomed the approach and asked to be invited to listen and participate. This was agreed.
TB.09.11.17/53	**Invite the NEDs to participate in the Clinical Risk Summit on 21.11.17. LEAD: Trust Secretary & Head of Corporate Governance, Fiona Barr**
1.6	She highlighted the current focus on quality improvement ahead of the mock Care Quality Commission (CQC) inspection, the launch of Quality Improvement Week at the end of November and the two day workshops with the Institute for Healthcare Improvement at the beginning of December. She would report on progress at the next meeting.
1.7	In closing, the CEO advised that Kevin Howell had been appointed as the new Director of Estates & Facilities and would start will start in post in January 2018. The Trust was advertising for a Director of Corporate Affairs with interviews taking place in the next few weeks. She would make a further announcement at the next meeting.
STRATEGY	
Trust Strategic Objectives	
2.1	The CEO introduced the paper which set out the Trust's Strategic Objectives which had been carefully drafted following internal discussions and presentation to various groups for

	feedback. They were presented for final review before they were launched.
2.2	The NEDs welcomed the work that had been done on the overarching objectives and the supporting deliverables but asked that an objective on strategy and partnership working be added and the objective on spending and saving re-drafted to give a greater sense of urgency. The DHROD also advised that he planned to add an objective on leadership and strengthen the wording on bullying and harassment to clarify that this would not be tolerated.
2.3	In terms of timing, the Board concurred that even though the new Strategy Director would be joining in January 2018, it was important to set out the strategic direction now for the benefit of staff and stakeholders. This would give an important framework from which the Trust could develop its organisational and clinical strategies and also on which the Board Assurance Framework could be built.
2.4	The new Strategic Objectives were agreed subject to changes noted in 2.2.
TB.09.11.17/54	**Strengthen the Strategic Objectives by adding objectives on strategy, partnership working and leadership, re-drafting the objective on spending and saving to give a greater sense of urgency and strengthening the wording on bullying and harassment.** **LEAD: Chief Executive Officer, Jacqueline Totterdell**
QUALITY	
Quality Committee Report	
3.1	Sir Norman Williams, Chair of the Quality Committee (QC) gave an update report from the meeting held on 26.10.17 and noted the following: i. The Committee undertook a "deep dive" review of the healthcare records workstream of the Quality Improvement Plan and noted continued risks in the availability and storage of healthcare records; it also discussed the importance of moving to electronic health records as soon as possible. ii. The Committee was briefed about the delivery of improvement actions arising from the s.29a and requested a paper to the November meeting on the electricity supply programme of work currently in progress to ensure safety requirements were being met. iii. The Committee received a new report which pulled together information about incidents, complaints, inquests and litigation. Further analysis would be conducted to map this data against location and service and would be presented to a future meeting.. A report on litigation against the Trust was also requested. The Committee noted a high number of incident reports in obstetrics but was assured that this was not unusual. Embedding a culture of learning from incidents and preventing recurrence is a key part of the Committee's duties and this new report represented a good start from which to review and strengthen these processes. In addition, the Committee considered the visibility of litigation and concurred that the Board should receive an annual report on litigation. iv. Two new cases of MRSA bacteraemia were reported along with a case of Legionella on which a full investigation as to the cause was currently in progress. Of the two MRSA cases, one appeared to have been acquired outside the hospital. The Committee requested an analysis of all three cases brought to the next meeting though received strong assurances that good infection control measures were in place at the Trust. v. The annual review of medication incidents and controlled drugs, presented by the Acting Chief Pharmacist, indicated that the number of incidents reported had increased by 21% though the level of harm had fallen - providing assurance that incidents were being identified and that learning from them leading to improvement had been achieved.

	vi. There had been two serious medication errors in recent months in the prescription of anti-coagulants and it was likely that the controls in the electronic prescribing system would have prevented these errors. The Committee was keen to see the full roll-out of electronic prescribing across the whole Trust as soon as possible. vii. The Committee received assurances on the review underway in the Cardiac Surgery team following a National Institute for Cardiovascular Outcomes Research (NICOR) alert with a fuller paper on a review into cardiac mortality at the next meeting. viii. Good progress was being made on tackling the backlog of elective care though performance – particularly against the Four Hour Operating Standard and Cancer targets – remained a challenge. A report on cancer patients waiting over 104 days for treatment would be taken to the next meeting.
3.6	He concluded by reporting that there was a lot of good work underway to support quality improvement.
PERFORMANCE	
Integrated Quality & Performance Report (IQPR)	
4.1	The DDET introduced the first part of the report and confirmed that the Four Hour Operating Standard had not been achieved in September (90.3%). There had been particularly high numbers of patients in the Emergency Department on certain days which had created a problem with overall flow through the hospital though steps were being taken to improve escalation. To reduce variability in performance, the weekly "Communications Cell" was reviewing the previous week's performance and sharing lessons learned/agreed actions to improve performance the following week and there was a daily forward look of staffing levels to ensure clinical staffing best matched time of attendances. Attention was also turning to ambulance handover processes to reduce delays in handover and use the SAFER bundle more consistently. Overall there was not a problem with bed occupancy and good links with local Councils was supporting the timely discharge of patients.
4.2	The CN & DIPC advised that no new patient Never Events were reported in September though there had been two events year to date; thirteen 13 Serious Incidents (SIs) had been declared in the month. There had been one case of hospital attributable Clostridium Difficile infection bringing the year to date total to nine cases against a threshold of 31, though there had been an improvement in CDiff rates over the past six months. The Trust was on the alert for seasonal Norovirus and planned to start reporting against Gram Negative Bacteria in line with new reporting requirements.
4.3	Latest Hospital Standardised Mortality Ratio (HSMR) data Trust showed mortality remained significantly better than expected and Summary Hospital Mortality Indicator (SHMI) was lower than expected when benchmarked against national comparators. The Trust was one of only 17 with lower than expected mortality rates and the Board received further assurance that the National Lung Cancer audit showed that the Trust had better mortality rates when compared with other trusts. This pointed to good learning from patient deaths which had received national recognition.
4.4	In September, six out of the eight Cancer standards were met with improvements in the performance of Breast Symptomatic and recovery plans in place for other modalities. 1.4% of patients had waited in excess of six weeks for a diagnostic procedure against a standard of 1%. Performance would worsen slightly from November as the Trust had recently identified that it had not been reporting on sleep studies and stress echo tests. However it was anticipated that the position would be recovered by the new calendar year.
4.6	The DHROD reported the Trust's vacancy rate had decreased along with use of agency which was at its lowest ever level. All trusts had signed up to pan London break glass ceiling and St George's was one of the few London trusts that had remained within it. The Board strongly encouraged the DHROD and the Executive to continue to hold the line.
4.7	The Board received the report.

Elective Care Recovery Programme (ERCP) – Action Plan	
4.8	The COO presented the report which was also been reported to the Quality Committee and Executive Management Team every month.
4.9	He explained that the ERCP had three key workstreams running in parallel across both hospital sites to treat patients; return to reporting patients on a referral to treatment pathway; and also on improvements in technology and training. Two further workstreams focused on elective care (Cancer and Diagnostics) and each workstream was underpinned by a need to provide clear communication to and engage with patients, GPs, staff and other stakeholders.
4.10	The COO talked through the programme structure and deliverables, noting that there was a good deal of work to do before the Trust could return to a position of reporting nationally. However this remained the intention. The plan to move to a new single, improved patient tracking list (which was vital to track patients on their clinical pathway) was on track to be delivered in December 2017 and good progress was being made to 'validate' patients on current patient tracking lists to understand who may require a further appointment with the Trust.
4.11	The Board welcomed the simplicity of how the information was presented - from which they could draw greater understanding and confidence in the steps being taken to treat the backlog of patients. The key change now was to move from a position of validating patients to actually treating them and for that additional capacity was needed. Additionally the DDET noted that the rate of 'did not attend' for outpatient appointments had dropped by 30%, which means 10,000 more patients turned up for their appointments. This would also have an impact on available capacity.
4.12	In receiving the report, the Board extended its thanks to the teams who were working on the ECR programme.
FINANCE	
Finance & Performance Committee Report	
5.1	Ann Beasley, Chair of the Finance & Performance Committee (FPC) was pleased to present the first written report to the Board from the Committee - which had been made possible by the rapid turnaround of the draft minutes.
5.2	She advised that between FPC and Quality both Committees were reviewing different elements of the IQPR in advance of its consideration at the Board. She felt that FPC was now taking a more proactive forward look at the Trust's financial position with a strong focus on forecasting rather just reviewing historical performance.
5.3	The Committee welcomed the improved position in regard to "green" Cost Improvement Programmes, as shown in the latest Finance Special Measures report, and it received a paper on debt recovery. This would be a regular paper given the scale of the debts owed to the Trust, a lot of which was aged. The Committee also approved two business cases the format and presentation of which were being improved by the Executive.
5.4	The Board received the report.
Month 6 Finance Report	
5.5	The CFO presented the Month 6 Finance Report which showed a cumulative deficit of £38.7m at the end of September, an adverse variance to plan of £2.8m. While this position was not in line with plan, it was consistent with the current forecast to NHS Improvement. The reduction in income was partially offset by an underspend in expenditure.
5.6	The Executive continued to work hard to improve the position and move as close to the year-end planned deficit of £45m as possible. There was close working with operational colleagues to ensure greater grip and control throughout the organisation on financial

	management; the CFO was seeking to inspire the same level of interest and engagement as with the quality agenda. The Executive noted some pressures in the position going into winter though the Board was advised there is some provision in the plan.
5.7	The Board noted a reduction in income from South West London Pathology (SWLP) and was advised that there had been a decline in the volume of the work. The reasons for this were under investigation though it was likely to be general reduction in demand rather than a shift to using other providers (though some private provision was already used within SWL).
5.8	The Board received the report noting the financial position.
ICT	
ICT Risk Review	
6.1	The CFO introduced this paper which set out how the Trust has recognised for a considerable length of time that the state of the ICT infrastructure, systems and operation posed a significant risk to the smooth and continuous running of the Trust. Late in 2016, several ICT risks were identified and recorded on the risk register, several were rated high risks but no individual risk had a score above 20. Consolidation of these risks had resulted in a heightened overall risk score.
6.2	The CFO explained that the ICT risks would be subject to a full risk assessment of each of the ICT components to identify the level of risk of each element. The controls, and assurance against those controls, would be evaluated and assessed and the risks re-scored. They would be presented back through the Board's Assuring Committee for ICT risk, the Finance & Performance Committee, as part of the Board Assurance Framework.
6.3	Tim Wright, NED with oversight for ICT, advised that the Board workshop planned for 14.11.17 would help the Board to better understand the current position with ICT and also the risk – from which it could make an informed decision about next steps and investments needed.
6.4	The Board supported the proposal to assess the risks associated with ICT as outlined in the paper.
WORKFORCE	
Quarterly Report of Compliance with the Fit & Proper Persons Regulations	
7.1	The DHROD introduced the report which noted that the Trust continued to be fully compliant with Regulation 5, Fit and Proper Persons (FFP) - Directors. Tim Wright, the most recently appointed NED, met all the FFP requirements before taking up his role and checks for incoming Directors Suzanne Marsello and Kevin Howell's FFP were in progress and they would not commence in role until these have been completed.
7.2	The Board was assured by the processes in place to conduct FFP.
GOVERNANCE	
Overview of New Board and Committee Arrangements from January 2018	
8.1	The Trust Sec introduced the paper which set out a revised Board and Committee structure following a governance report by the Trust's Internal Auditors, a detailed review of external governance by Deloitte and internal consideration of an appropriate Board and Committee structure by the Board.
8.2	The proposals were agreed in full save that the CEO clarified that there would not be Director reports to supplement the IQPR and the CEO's report.

CLOSING ADMINISTRATION	
Questions from Public	
9.1	Hazel Ingram, Patient Representative, gave an example of a friend of hers who had tried without success to change an appointment. Despite trying all through the day, she had been unsuccessful in reaching someone by telephone to change the booking. The COO agreed to look into this with the Central Booking team.
9.2	Nigel Brindley, Public Governor for Wandsworth, advised that he had spoken to patients who had been referred from Epsom & St Helier for treatment who had now decided that they only want to be treated at St George's. The Board agreed that sometimes the preferred place of care was not always the closest to a patient's home. The CEO also noted that the refreshed Sustainability and Transformation Plan had a focus on driving up standards across SWL and explained how she was working with other local CEOs to ensure that the most appropriate patients were referred to the Trust for treatment – and repatriate those whose care could be better managed by a more local provider.
9.3	It was noted that everyone could hear the proceedings clearly today.
New Risks or Issues and Any Other Business	
9.4	There were no new risks or issues and no items of any other business. In closing the meeting, the Chairman thanked everyone for their input and there was a shared view that the discussion had been good with everyone contributing effectively.
Patient Story	
The Chairman introduced Greta Adedeji, carer of her son Tajudeen (Taj), who had a learning disability and also Padraic Costello the Clinical Nurse Specialist for Learning Disabilities who had supported Greta and Taj.	
Greta started by saying how honoured she was to speak to the Board. Her daughter had died at the Trust and as a result she had bad memories and had not felt able to attend the hospital. When her son Taj was born, at another hospital, she was told he would have learning disabilities. He was cared for at different hospitals and had very good care from a consultant for five years until he retired. Greta herself needed treatment and was advised to get it from St George's in 2015. She had to force herself to come but once she had, her experience encouraged her to consider the Trust for Taj's care too. In 2016, Taj needed an operation which would require a stay in hospital and Padraic and the Learning Disabilities team exceeded expectations by organising a side room for Taj to ensure he felt safe and comfortable and explaining what the procedures were and what would happen. Greta felt so confident with Taj's care she even felt that she could leave him for a couple of days. Greta also explained that a hoist was moved from another department to enable Taj to get an X-Ray – though once this need had been identified everything was put in place for the next visit. Greta had nothing but praise for Padraic and the Learning Disabilities Team.	
Padraic spoke of how he and the Learning Disabilities Team had built up a relationship with Greta and Taj and worked in partnership with them to ensure Taj's needs were met. He explained that the Trust is a great advocate for Learning Disabilities and staff see the patient not the disability. He and his team members can support patients with Learning Disabilities and their carers by ensuring that reasonable adjustments are made - such as flexible visiting and using a 'Patient Passport' to avoid having to repeat the same details to different staff.	
Board members were very impressed to hear Greta's and Taj's story which was one of empowerment and brought to life the Trust's Strategic Objective to "treat the patient" by "treating the person". The Chairman thanked Greta and Padraic for attending and sharing their experiences with the Board.	

Date and Time of Next Meeting: Thursday 7 December 2017, from 10:00

Trust Board Action Tracker - 07.12.17

Action Ref	Theme	Action	Due	Revised Date	Lead	Commentary	Status
TB.06.07.17/35	**Fit & Proper Persons Regulations**	Provide a quarterly and annual report on compliance with the Fit & Proper Persons Regulation to the Board.	TB.22.02.18		DHROD	This was reviewed at the November Board meeting and this scheduled date for review is TB.22.02.18.	Ongoing
TB.06.07.17/36	**St George's Charity**	Schedule a meeting with between the Board and the Trustees of the St George's Charity every six months.	TB.25.01.18		Trust Sec	Not yet due.	Ongoing
TB.06.07.17/38	**Staff Engagement and E&D Statistics**	Regularly report on staff engagement and metrics on equality, diversity and inclusion in the workforce element of the IPR.	Q3 2017-18		DHROD	The format for reporting these additional workforce metrics was trialled at the WEC meeting in October 2017 and will be finalised at the WEC meeting in January 2018.	Proposed for Closure
TB.07.09.17/43	**Consultant Attribution**	Advise how consultant attribution is agreed and report this to the Quality Committee.	QSC.21.12.17		Acting MD & Nigel Kennea	As the agenda was very full with additional items to consider, this item was deferred to the December 2017 meeting of the Committee.	Open
TB.07.09.17/44	**Medical Revalidation**	Provide interim reports Medical Revalidation to the Workforce & Education Committee.	Q4 2017-18		Acting MD & Karen Daly	Medical revalidation is part of the WEC remit and when exactly it will fall in the annual cycle is currently under consideration and will be presented as part of the revised terms of reference and annual cycle to the next meeting (January 2018).	Open
TB.05.10.17/46	**All and New Harms**	Quality Committee to explore how further improvements can be made for all and new harms.	QC during Q3 2017-18		MD	Item transferred to Quality Committee forward plan.	Open
TB.05.10.17/47	**Emergency Prepardness, Resilience & Response**	Board to receive a further update on the Trust's compliance with core standards against its duties as a Category 1 responder following the review by NHS England.	TB.25.01.18		COO	No yet due.	Open
TB.05.10.17/49	**Corporate Risk Register**	Arrange a Board seminar on the Trust's IT programme and plans for IT investment	14.11.17		CFO/Trust Sec	Seminar took place on 14.11.17. Action closed.	Closed
TB.05.10.17/50	**Quality Improvement Plan**	Consider how to make the information underpinning the Quality Improvement Plan available to the public online.	Dec-17		CN	The dashboard measuring outcomes on the Qualilty Improvement Programme has been presented in the December Board papers and will be made available on the Trust's website and updated monthly (to show progress) once the format has been finalised.	Proposed for Closure
TB.09.11.17/51	**100K Genomes Project**	Board to be invited to be part of 100k Genomes Project and a visit to the Service organised for interested Governors.	Nov-17		DEDT/ADoC	Discussions underway with the Genomes team.	Open
TB.09.11.17/52	**Board Assurance Framework**	Present a fully populated Board Assurance Framework to the Board in January 2018.	TB.25.01.18		CN	Not yet due.	Open
TB.09.11.17/53	**Clinical Risk Summit**	Invite the NEDs to participate in the Clinical Risk Summit on 21.11.17.	ASAP		Trust Sec	Completed.	Proposed for closure.
TB.09.11.17/54	**Trust Objectives**	Strengthen the Strategic Objectives by adding objectives on strategy, partnership working and leadership, re-drafting the objective on spending and saving to give a greater sense of urgency and strengthening the wording on bullying and harassment.	ASAP		CEO	These changes were made and the revised strategic objectives are on the agenda.	Proposed for closure

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 December 2017	**Agenda No.**	1.5
Report Title:	Chief Executive Officer's Update		
Lead Director/ Manager:	Jacqueline Totterdell, CEO		
Report Author:	Chris Rolfe, Associate Director of Communications		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	Overview of the Trust activity since the last Board Meeting.		
Recommendation:	The Board to receive this report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led, Safe, Caring, Effective and Responsive		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	

Chief Executive Officer's Update
Trust Board, 7 December 2017

1. PURPOSE

1.1 To provide an update of activities of the Trusts activities since the last Board Meeting.

1.2 The past few weeks have been particularly busy at the Trust, and the pressure of meeting our quality, performance and financial challenges are clearly being felt by many staff — both clinical and non-clinical.

1.3 Despite this, there is a clear will and desire to make St George's better - both for patients, and each other. I also believe there is strong organisational buy-in towards our ambition to provide Outstanding Care, Every Time.

1.4 At times, this can feel a long way from our grasp - however, I also see improvements day in, day out, and we need to remember this when times are hard and the end goal sometimes feels unachievable.

1.5 The key updates I want to provide this month are as follows:

2. LEADERSHIP UPDATE

2.1 Last week, we announced the appointment of Stephen Jones as our new Director of Corporate Affairs. Stephen will join us early next year from the General Medical Council, where he has been Chief of Staff and executive lead for corporate governance since 2014.

2.2 I am confident we have made an excellent appointment, and Stephen is clearly excited to be joining the team here at St George's. As Director of Corporate Affairs, Stephen will have overall responsibility for a broad portfolio, including governance, and will also oversee the Board Assurance Framework, which is something we absolutely must get right.

2.3 On the leadership front, I am also delighted that Matt Laundy has been appointed as our Clinical Chief Information Officer. As many of you will know, Matt is a Consultant Microbiologist and Clinical Director of Specialist Medicine at the Trust.

2.4 As CCIO, Matt will ensure the views of our clinicians are at the forefront of our future ICT Strategy - he has hit the ground running and, whilst there is a huge amount to do, his enthusiasm to get cracking and help deliver the changes we want to see is fantastic to see.

3. THE FUTURE OF ICT AT ST GEORGE'S

3.1 This brings me neatly to the future of ICT at St George's, and last month members of the Trust Board held a seminar on this very issue.

3.2 Our ICT problems are well documented. However, the purpose of the session in November was to ensure there is absolute clarity at Trust Board level on the current state of our ICT, and to ensure we are all sighted on any actions required to address the risks it presents; both short and medium term.

3.3 The session was useful for everyone involved, and the Trust Board has asked for further work to be undertaken following the November meeting. This work is well underway and will be completed in time for a follow-up seminar early in the New Year.

3.4 Following that, a detailed action plan to address any issues within the Trust's current ICT environment will be developed, and presented to the Trust Board in January.

4. MODERNISING OUR ESTATE

4.1 In addition to our ICT challenges, we are taking steps to tackle our estates problems, particularly on our St George's site.

4.2 Our estates team has recently launched a new Helpdesk, which we hope will give staff greater visibility with regard to how issues they've raised are being dealt with, and increase confidence that they will be dealt with quickly.

4.3 We are all aware of historical problems with legionella in our water system, and a recent confirmed case of legionella infection in a patient has caused us to increase the range and frequency of water testing we carry out.

4.4 The precautionary steps we introduced last year to reduce the risk of infection - including regular flushing of water outlets and removal of dead legs - also continue unabated. However, this remains a problem we need to manage and review on a regular basis.

5. QUALITY AND SAFETY INSPECTION

5.1 Since the last Trust Board meeting, we have also held a quality and safety inspection over two days in mid-November. As expected, the team of volunteer inspectors highlighted some positives, but also identified some areas where significant improvements are needed.

5.2 The inspection was on a relatively small scale, and based entirely at St George's - although we will be undertaking a similar exercise at Queen Mary's and across our community sites in the very near future.

5.3 We should be pleased that progress has been made in a number of areas – such as incident reporting. However, as I said in a message to staff last week, and at a face to face briefing session immediately after the inspection, it is important that no-one underestimates the scale of the challenge we still face.

5.4 Some of the problems the inspection team identified (such as out of date drugs) are simply not acceptable, and shows that we still need to get the basics right in a number of areas. For example, many staff are still not observing bare below the elbow in clinical areas - despite the fact this is standard practice across the NHS, and has been for some time.

5.5 A new uniform policy launching this month will stress again the importance of this, and the other basic steps staff are expected to take as an absolute minimum in their day to day roles.

5.6 So, despite some positives, we are still a long way from where we need to be - and I have stressed this in interactions with staff since.

6. WINTER PLANNING & PERFORMANCE AGAINST THE FOUR HOUR OPERATING STANDARD

6.1 We are now officially in winter, and we know from experience that there will be greater pressures on all the services we provide over the coming weeks and months - but particularly in the Emergency Department (ED) at St George's.

6.2 I have stressed repeatedly that performance against the four hour operating standard is not the ED's problem to solve - every speciality has a part to play. To this end, we held a summit this month to look at ways of solving the problem together - with fantastic engagement from the 100+ clinical leaders and managers in attendance.

6.3 Indeed, in the week that followed, we saw an immediate improvement in the response times for specialities coming to ED - which goes to show that many of problems we face in terms of patient flow within the hospital are absolutely within our gift to solve.

6.4 Of course, long term and sustainable improvements are what we need - and that is what we are all working towards. I am confident the opening of our new ambulatory care unit in the New Year will help improve flow, and the care we provide for our patients - which is the most important reason we need to start getting this right.

7. FLU VACCINE TAKE-UP AND STAFF SURVEY COMPLETION RATES

7.1 Finally, I would like to congratulate the many teams involved in making sure we improved flu vaccine and staff survey updates this year.

7.2 We will hear from our flu lead Pat Campbell today about the fantastic campaign she has orchestrated, although much of the success is down to her personal enthusiasm and commitment to the task in hand - indeed, I don't think there is a single member of staff who hasn't been approached by Pat when walking past the entrance to the Monckton Lecture Theatre!

7.3 Our staff survey response rates have also improved and, whilst they aren't as high as I would like, my hope is that by acting on the feedback we've received - and communicating this clearly - will see much greater response rates in the years to come.

8. RECOMMENDATION

8.1 To receive the report for information.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	30 November 2017	**Agenda No**	2.1
Report Title:	Business Planning 2018/19		
Lead Director/ Manager:	Andrew Grimshaw, Chief Financial Officer		
Report Author:	Tom Ellis, Head of Business Planning		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	St. George's, in common with most trusts, carries out an annual business planning process to identify the activity it will deliver, and from that the income and expenditure budgets required to undertake that activity. From this the final CIP target will also be identified, as well as service aspirations and proposed service developments for the coming year. This paper seeks to bring the Trust Board up to date on planning work undertaken so far, and the timetable for action over the coming months. It is important to note that Business planning guidance for 18/19 has yet to be received from NHSI Improvement. The trust is working to 17/18 planning guidance, and will amend requirements, plans or submissions to ensure that any changes instigated by NHSI are addressed.		
Recommendation:	Trust Board is asked to note or agree the following: 1. Note the work underway to develop a set of plans, at both trust and care group level, for 2018/19 2. Note the timetable and actions contained within, including key sign-off dates.		
Supports			
Trust Strategic Objective:	1. **High Quality Care**: To ensure consistently high quality care for patients by ensuring it is safe, effective and patient led. 2. **Teaching and Research**: To develop and maintain effective world class teaching and research through partnership with St George's, University of London. 3. **Modernising our buildings and internal systems:** To support clinical, teaching and workforce development through the modernisation of buildings and information systems. 4. **Valuing our staff:** To develop leadership that inspires staff and ensures they feel valued, and value the Trust as a place to deliver care. 5. **Financial sustainability:** To make the Trust financially sustainable with effective financial monitoring and reporting systems. 6. **Partnership working:** To meet the needs of our patients through joint working with commissioners and other partners to provide integrated and well-aligned services.		
CQC Theme:	1. **Safe**: you are protected from abuse and avoidable harm. 2. **Effective**: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence. 3. **Caring**: staff involve and treat you with compassion, kindness, dignity and respect. 4. **Responsive**: services are organised so that they meet your needs. 5. **Well-led:** the leadership, management and governance of the organisation		

	make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.		
Single Oversight Framework Theme:	▪ Quality of Care (safe, effective, caring, responsive) ▪ Finance and Use of Resources ▪ Operational Performance ▪ Strategic Change ▪ Leadership and Improvement Capability (well-led)		
Implications			
Risk:	Board Assurance Framework, SR5: Financial efficiency, forecasting and accountability is not seen as a priority for service managers or wider workforce; resulting in overspending, poor budgetary management which in turn may lead to poor service delivery and regulatory action.		
Legal/Regulatory:	The trust is required to submit to NHSI a comprehensive financial plan, and accompanying narrative plan, as part of its licence requirements.		
Resources:	Resources are in place to implement the process over the coming months, though it will require relevant staff to devote time and effort to delivering a workable plan		
Previously Considered by:	-	**Date:**	
Appendices:	▪ N/a		

St George's University Hospitals NHS
NHS Foundation Trust

Business Planning 2018/19 Progress Update

Chief Finance Officer

Trust Board 7 December 2017

Background

All organisations need to appropriately plan for future activity. St. George's carries out an annual business planning process to identify the activity it will deliver, and from that the income and expenditure budgets required to deliver that activity, as well as service aspirations and proposed service developments for 2018/19. From this any CIP target will also be identified, based on national efficiency requirements and action to close any residual deficit.

This paper seeks to provide an overview of the planning process, and bring the Trust Board up to date on work undertaken so far. It outline the actions required and associated timetable to deliver a Business Plan and Financial plan by 31/03/18. It is important to note that Business planning guidance for 18/19 has yet to be received from NHSI Improvement. The trust is working to 17/18 planning guidance, and will amend requirements, plans or submissions to ensure that any changes instigated by NHSI are addressed.

A review of the 2017/18 process was undertaken to identify both what worked well but more importantly what could be improved upon in the 2018/19 process. Some of the key outputs of these meetings were:

- There was a lack of connection between discussions about activity, and associated income, and the budget to deliver the activity
- The challenge meetings – too many of them, and too early in the process
- That income targets need to be kept under closer review, once agreed, to ensure the end of year outturn is reflective of the activity proposed for next year
- The process was too financially focussed, and did not give services the opportunity to outline their service development plans for the coming year
- That communications throughout the process needed further consideration
- The need to align job planning, business planning, and demand & capacity modelling.

The plan for 18/19 seeks to address all of these issues.

Work underway on business planning for 2018/19

Business planning for 2018/19 is underway. The oversight group, the Business Planning Operational Meeting (BPOM) meets weekly. This group oversees and will drive over the coming weeks and months, the process that will lead to an agreed set of plans and associated budgets for all services, clinical and corporate, within the trust.

Activity planning and SLA development – a first round of meetings have been held with all General Managers and HoFs, to discuss and come to some initial agreements around proposed activity for next year. There will be further meetings arranged to review again activity numbers and to ensure that activity linked to RTT recovery is appropriately factored into the SLA. Initial feedback shows that activity planned for 2018/19 is broadly in line with 17/18 forecast outturn +/- demographic growth uplifts. No service is currently predicting significant increases in activity for next year.

Bottom up budget setting – is underway, with draft pay budgets having been reviewed internally within Finance, and with divisional challenge sessions taking place between Friday 1st December, and Friday 8th December. Executive challenge sessions will take place following this, where divisions will present their proposed budgets. An output of this process will be to set correct pay budgets, ensuring required posts are funded, and also removing or challenging recurrently vacant posts.

Transformation and CIP opportunities are being developed, with each element of Trust expenditure being allocated to a work stream. A Head of Finance has been aligned to each work stream.

The above points were discussed at FPC on 29/11/17

The Care Group Plan

A draft Care Group Plan template has been developed. It is designed to deliver a number of outputs:

- Key service objectives for the coming year
- Help identify how well trust wide Transformation projects are known, understood and owned at a care group level
- Help identify if and how far the QIP, and the implications at a care group level, have percolated through the organisation
- Activity planned, and capacity available
- Support development of the trusts Workforce Plan to reflect current and future workforce requirements.

From the above, an opportunity to outline service development aspirations for the coming year, to feed into the revenue and capital investment process, managed currently through IDDG.

Crucially, it also asks the Care Groups to identify what support trust it might need to be able to deliver the plan – the plan should be a two way process that helps Care Groups access the support they need.

The Care Group Plan will be iterated twice, first at a high level by end of January 2018, and then in more detail, as activity and income/expenditure budgets are finalised, in March 2018.

An important point to note is the need to incorporate the Care Group Plan into the trusts performance management architecture in 2018/19, to ensure the plan becomes a living document and one that serves the care group, and the trust, through the year

Timeline for delivery

	Nov	Dec	Jan	Feb	Mar	Apr
Activity						
Income						
Capacity						
Expenditure						
Transformation and Efficiencies						
Workforce						
Capital						
Balance sheet and cash						
Finance & Investment Committee	Progress update	Progress update	Detailed overview	Detailed overview	Final position for sign off	Review if needed
Trust Board	Progress update	Progress update	Detailed overview (Part 2)	Detailed overview (Part 2)	Final position for sign off (part 1).	Review if needed
NHSI	Update on high level assumptions	Initial submission (TBC)	Update to FSM	Update to FSM	Core submission (FIMs template)	Possible FIMs refresh (if requested)

Key timeline and meetings – progress

(Items in green completed, items in amber noted as need to be booked).

Forum	Purpose	Nov	Dec	Jan	Feb	Mar
Trust Board Part 1	To approve Business Plan and Budget					Approve Plan
Trust Board Part 2	To review progress in the development of the Business Plan and the Budget	Standing agenda item	Standing agenda item	Standing agenda item	Standing agenda item	Standing agenda item
Council of Governors	Provide an opportunity to canvass members opinions about the Plan and feedback this to the Board of Directors for consideration prior to finalising the Plan		Initial presentation to Council		Review of Plans and underlying assumptions	Provide feedback to the Governors on final plan
Finance Committee	To review progress and seek assurance on assumptions and deliverables	Monthly	Monthly	Monthly	Monthly	Monthly
Trust Board Seminar	To provide opportunity for the Board to review the planning assumptions and to be kept informed of progress.		To review and test assumptions		To review and test assumptions	
EMT	To review progress and resolve issues where possible.	Review and challenge	Review and challenge	Review and challenge	Review and challenge	Approve for recommendation to Board
Financial Recovery Board	To provide a regular review point for consideration of the plan and in particular transformation and efficiency actions.	2 per month	2 per month	2 per month	2 per month	2 per month
Run Rate Grip meetings	Regular meeting in diary. Planning to become a standing item to help maintain pace and focus	2 per month	2 per month	2 per month	2 per month	2 per month
Divisional meetings	Regular challenge session, both within divisions to ensure ownership and identify issues for escalation. And challenge meetings with the exec team to support and resolve issues	At least monthly	At least monthly	At least monthly	At least monthly	At least monthly

Progress to date, next steps & recommendation

Progress to date and next steps

- Slide 6 shows the proposed plan and timetable for delivery of the narrative and financial plan to NHSI within the required timetable
- The actions outlined in that timetable, and elsewhere in this paper, are being implemented to that timetable, for example:
  - Bottom up budget setting is underway, with Divisional Challenge sessions to review pay budgets to take place week commencing 4th December.
  - First draft bottom up income, pay, and non-pay budgets to be consolidated by Care Group for review and challenge week commencing 4th December

Recommendation

The Trust Board is asked to note the following

1. The work underway to develop a set of plans, at both trust and care group level, for 2018/19
2. The timetable and actions including key sign-off dates.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 December 2017	**Agenda No.**	2.2
Report Title:	Trust Strategic Objectives		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Board reviewed the proposed six strategic objectives last month and following comments these have now been refined. The Objectives are set out in the attached poster Our Vision: Outstanding Care, Every Time. The six strategic objectives proposed are: • *Treat the patient, treat the person* • *Right care, right place, right time* • *Balance the books, invest in the future* • *Build a better St George's* • *Champion Team St George's* • *Develop tomorrow's treatments today*		
Recommendation:	To accept and agree the six strategic objectives set out above.		
Supports			
Trust Strategic Objective:	As above.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (Well-Led)		
Implications			
Risk:	There are no specific risks associated with this proposal. However, these objectives will be used to refine the Board Assurance Framework.		
Legal/Regulatory:	There are no legal or regulatory implications.		
Resources:	There are no direct resource implications, and the six objectives set out above summarise work just started, ongoing, and/or nearing completion.		
Previously Considered by:	Trust Board	**Date:**	09.11.17

OUR VISION: OUTSTANDING CARE, EVERY TIME | 2017-19

St George's University Hospitals NHS
NHS Foundation Trust

At St George's, our aim is to provide Outstanding Care, Every Time for all of our patients, wherever they are treated.

As part of this, we have agreed a set of organisational objectives – all of which are designed to improve care for patients, and the working lives of our staff.

We are confident these will give staff, patients, and our local and national stakeholders much greater clarity about where we are focussing our energies, and where we want to improve.

1 TREAT THE PATIENT, TREAT THE PERSON

- We will deliver the fundamentals of patient care to ensure our patients are kept safe and free of avoidable harm
- We will continue to improve the experience for patients and their loved ones at the end of their life
- We will ensure there is no decision without the patient's or carer's involvement, and that the patient's wishes are at the centre of their care
- We will recognise and manage deteriorating patients, and ensure staff support patients and their carers to make choices regarding their treatment
- We will ensure the safe and efficient storage and use of medicines, and continue to reduce the time patients wait for their medicines.

2 RIGHT CARE, RIGHT PLACE, RIGHT TIME

- We will improve the timeliness of emergency care for patients, and consistently meet the four hour emergency operating standard
- We will ensure we admit patients to the right ward or place of care first time, and ensure a positive experience for our patients
- We will align our people and clinical capacity to pathway demand, and ensure our patients are taken to the most appropriate environment for their assessment, treatment and care
- We will reduce cancellations of operations and make efficient use of our operating theatres
- We will offer patients greater choice about how they access our services, and ensure we match capacity to patient demand
- We will tackle our data quality and waiting list challenges, so ensuring patients are effectively tracked on our systems.

3 BALANCE THE BOOKS, INVEST IN OUR FUTURE

- In 2017/18, we will achieve the target deficit agreed with NHS Improvement
- We will continue to reduce our deficit, and aim to break-even in 2019
- We will deliver organisational efficiencies – from the way we buy drugs to how we use our clinical IT systems
- We will develop a financial model to help us identify and prioritise future investment requirements.

4 BUILD A BETTER ST GEORGE'S

- We will develop an organisational and clinical strategy that asserts St George's position as a provider of local and world-leading specialist services
- We will work with our partners and stakeholders to seek their views, so we address the challenges we face together
- We will improve our governance arrangements, as well as our everyday management systems (such as Agresso and ESR)
- We will modernise theatres and wards so they are better for patients and staff. We will also improve capacity in our ED, ITU and Critical Care Unit
- We will address our maintenance backlog to ensure fire, water, heating, electrical and ventilation safety
- We will continue to stabilise and improve our IT infrastructure
- We will work with St George's Hospital Charity to ensure money raised by fundraisers and donors is invested to improve care for patients and improve the working lives of our staff.

5 CHAMPION TEAM ST GEORGE'S

- We will improve staff engagement
- We will tackle bullying and harassment
- We will improve equality and diversity
- We will develop our leadership capability, and up-skill our managers
- We will develop a behaviour charter based on our values of being Excellent; Kind; Responsible; Respectful.

6 DEVELOP TOMORROW'S TREATMENTS TODAY

- We will work closely with St George's, University of London to train the healthcare professionals of the future
- We will embed research into clinical practice, to further foster a 'bench to bedside' culture within our organisation
- We will innovate, and ensure our patients have access to the latest treatments and surgical procedures
- We will use the latest technology to improve outcomes for patients, and make it easier for staff to provide care safely and effectively.

OUR QUALITY IMPROVEMENT PLAN

In October 2017, we launched our Quality Improvement Plan, which will play a key part in helping us deliver Outstanding Care, Every Time for our patients.

Our Quality Improvement Plan is made up of three improvement programmes, which are supported by two enabling programmes. They are:

IMPROVEMENT PROGRAMMES

Safe and Effective Care | Flow and Clinical Transformation | Quality and Risk

ENABLING PROGRAMMES

Estates and IT | Leadership and Engagement

Our Quality Improvement Plan is a major priority for the organisation, and successful delivery of the plan is closely linked with the strategic objectives set out in this document.

To find out more about our Quality Improvement Plan, log onto our website at www.stgeorges.nhs.uk

excellent kind responsible respectful

Meeting Title:	Trust Board		
Date:	7 December 2017	**Agenda No**	2.3
Report Title:	SW London STP strategy refresh document for discussion		
Lead Director/ Manager:	Professor Andrew Rhodes, Medical Director		
Report Author:	STP		
Freedom of Information Act (FOIA) Status:	Unrestricted		
Presented for:	Update		
Executive Summary:	Following a year of engaging with stakeholders and local people since the publication of the South West London STP in November 2016, this document presents a refreshed strategy for health and care in South West London. This discussion document reflects the feedback received over the last year, and presents a renewed focus and approach. **Local health and care plans** At a local level, Local Transformation Board partners will be continue to work together to develop "Local health and care plans" in each area. These will provide clear and detailed actions to the local challenges we have set out in the STP discussion document. These plans will be published in June 2018. The main points in the STP discussion document are: · **A local approach works best for planning health and care:** After listening to stakeholders, local people and communities, we believe a local approach works best. We have set up four local health and care partnerships in Croydon, Merton/Wandsworth, Kingston/Richmond and Sutton, to drive the improvement of services at local level. ● **We have strengthened the focus on prevention and keeping people well -** the greatest influences on our health and wellbeing are factors such as education, employment, housing, healthy habits in our communities and social connections. We want to strengthen the focus on reducing health inequalities, and keeping people healthy at home, both mentally and physically, by earlier support and care. Helping people stay well for longer, providing much more support at home when people need it, so they can live healthy and independent lives for as long as possible. ● **As part of our refreshed strategy, the South West London health and care partnership are coming together to champion children and young peoples' mental health and well-being as a shared health prevention priority.** With one in ten children aged 5-16 having a diagnosable mental health condition, and increasing levels of self-harm an issue across south west London, we will work with partners to raise awareness and		

	understanding of this important issue. We will also be talking to young people to help us understand what knowledge and support they need to strengthen their personal resilience, and to encourage them to seek the right advice and services. · **Commitment to a new way of working; it's about a partnership with the organisations who provide health and care for the local people**, with front-line staff working across our organisational boundaries, acting as one team, to give more rapid joined-up care. · **We have started the first phase of an evaluation of service quality across each of the four local areas**. We have begun with assessing six core services in hospitals. This is the start of a wider process to look at service quality in the other hospital services, GP and community and mental health services. Each of our Hospitals in south west London were asked to self-assess their services against an agreed set of clinical standards for south west London (these standards were agreed at the last meeting of the Clinical Senate). This self-assessment provides a clear position for these six hospital services for each of the south west London Hospital sites. With the exception of Epsom and St Helier NHS Trust, Hospital Trusts, south west London hospitals - Croydon Health Services NHS Hospital Trust, Kingston Hospital NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust - believe that taking this self-assessment into account, with their knowledge of their individual staffing, estates and operational issues and plans, that they are clinically sustainable in these six clinical services. Epsom and St Helier NHS Trust however, has indicated that it will be unable to deliver all of these acute services on a sustainable basis without a level of change to its clinical model. Local clinical commissioning groups for Merton, Sutton and Surrey Downs, now need to take this self-assessment, and the evidence provided by the Epsom and St Helier Trust NHS Trust about their future sustainability to scrutinize and test it. This will be a CCG-led process. **Progress** Over the coming months, the STP will be working with its partners to develop a local health and care plans for publication in June 2018. These plans will detail the actions to address local challenges that will be set out in the STP discussion document. We are working with local organisations and their communications colleagues across South West London to support clear and consistent communications around the publication of the STP discussion document.
Recommendation:	• The Trust Board is asked to be updated with regards the developments in the local STP and to feedback comments through the executive so that they can be incorporated into to developing strategy and vision going forwards.
Supports	
Trust Strategic	Data to help strengthen quality and safety work, as well as improve experience

Objective:	of bereaved families.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:			
Legal/Regulatory:			
Resources:	There are resource implications associated with these works that are being worked through and can be discussed with this paper.		
Previously Considered by:	N/A	**Date**	
Equality Impact Assessment:	N/A This is in line with the principles of the Accessible Information Standard		
Appendix:	https://www.swlccgs.nhs.uk/documents/south-west-london-health-and-care-partnership-discussion-document/		

Report to the Board from: Quality & Safety Committee

Committee Chair: Sir Norman Williams

Date of the Committee Meeting: 29.11.17

1.0 Matters for the Board's Attention

1.1 The Committee was updated on the quality improvement dashboard. This is now populated with baseline information and information for 2017/18; the associated trajectories were also presented. The Committee discussed that the purpose of this dashboard is to measure improvement, noting that similar indicators appear in the Integrated Quality and Performance Report. The Committee noted that the dashboard continues to develop and that some indicators are not yet fully populated. When the dashboard is finalised it will be published on the Trust's website. The draft dashboard and trajectories are attached to this report for information.

1.2 The Committee received a briefing from the Chief Nurse and Director for Infection Prevention and Control and the Infection Control Doctor and Consultant Microbiologist on an episode of probable hospital acquired legionella infection. Low counts were found from two outlets in the area where the patient was treated, the counts were in a range not usually considered to be significant. Action was taken immediately to ensure the area was safe with filters put in place across the unit. Investigation found a redundant thermostatic valve embedded in the wall of one outlet which may have contributed to the count detected, this has been removed and a review of all outlets in the Trust has been started. The Committee was also briefed on the recent detection of a high count of legionella from a single outlet; the high count was detected through the routine testing. The Committee noted that the controls had worked and that the detection of this high count had allowed immediate action to be taken to remove the risk. To ensure that other actions to mitigate the water safety risk are being delivered the Committee asked for a report from the Water Safety Committee on progress with the water safety action plan to come to its next meeting.

1.3 The Committee received a report entitled Safety Concerns in Cardiac Surgery presented by the Medical Director and prepared in consultation with the Associate Medical Director leading on mortality monitoring, the Divisional Chair for MedCard and the Clinical Director for Cardiac and Vascular Surgery. This had been triggered in response to a National Institute Cardiovascular Outcomes Research mortality alert. The review looked at key safety metrics to assess the safety of the service. The report concluded that the mortality signal was a concern but appeared to relate to historic practice, current mortality data does not suggest that the risk is higher than expected. There was a need however to closely monitor this service for all aspects of safety. The Committee noted the work being done to improve communication both within the team and between teams.

1.4 The Committee received a report on the delivery of the s29A Warning Notice and the 'must do' and 'should do' actions from the CQC inspection in June 2016. The majority of the 'must do' actions came within the s29A notice and have been delivered, the outstanding improvement actions are linked to long term programmes of work and are being delivered to plan. The Committee noted the feedback from the quality and safety reviews and the need to embed 'should do' actions in day to day working. The Committee asked the Executive to consider how to remind staff of their responsibility to comply with Trust policy and standards, a hierarchy of; consequence was discussed.

1.5 The Committee received a report from the Senior Responsible Officer for the dementia workstream of the quality improvement plan. The workstream has delivered the first of its objectives to introduce a dementia carer passport, this is now being used on five wards and uptake of the carer's survey has improved since it was linked to the Friends & Family Test questionnaire. Dementia training for staff has been taken up by 86% of staff and there are

now dementia champions on five wards. The next objective is to make it possible for carers to stay overnight on the ward. The Committee was told that if we achieve all the objectives of the work stream that we would be regarded as a dementia friendly hospital. The Committee congratulated the team on the improvements they have delivered for patients with dementia.

1.6 The report from the Patient Safety Quality Board was received.

1.7 The Committee reviewed the Integrated Quality and Performance Report. Response rates to FFT are low outside of inpatient areas leading to little assurance being provided by the good recommendation scores. A business case is being made to improve this by using text messaging. Complaints have increased but remain within control limits, Patient Advice and Liaison Service enquiries have fallen. PALS to be analysed to see if there is an issue that has been resolved that has driven the reduction in numbers, with PALS now open throughout the day it was expected that numbers would have increased.

1.8 The Committee received a report looking at patients treated on a cancer pathway who were more than 104 days from referral in quarter 2. All patients in this category have had a harm review and root cause investigation, no patients were assessed as coming to harm as a result of the delay. A number of the breaches happen because a patient chooses to be seen at a later time, work is being done with patient groups to understand how we can improve how patients access the service. Delays on the diagnostic pathway and late transfer from other providers also have an impact.

1.9 The Committee received the Patient Led Assessment of the Care Environment (PLACE) assessment report and action plan 2017. The PLACE assessment is an appraisal of the non-clinical aspects of healthcare settings; it covers cleanliness, food and hydration, privacy and dignity and the degree to which the premises support the needs of people with dementia or with a disability. The Committee was disappointed to hear that scores for the Trust were below the national average. The action plan to address all the issues identified was also presented.

2.0 Recommendation

2.1 To receive the update from the Quality & Safety Committee meeting on 29 November 2017 for information and assurance.

QIP Dashboard

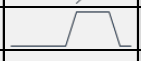
Figures subject to final validation

QUALITY IMPROVEMENT PROGRAMME DASHBOARD Oct-17 Outstanding Care, Every Time

Ref	Criteria	Baseline Actual 2016/17 (Various)	National / Aspirational Target	END Q1 2017/18 Actual	END Q2 2017/18 Actual	OCT 2017 Actual	2017/18 (QIP Yr 1) Target	2018/19 (QIP Yr 2) Target	12 Month Mean Value	SPC Control Limits	SPC Chart	12 Month Trend	CQC Ref	Date Target Delivered	RAG (Based Upon Latest Trajectory Data)
	FLOW & CLINICAL CARE														
FC1	ED 4 Hour Operating Standard	93.1%	95.0%	92.1%	90.0%	88.0%	95.0%	95.0%					R	May-18	✗
FC2	Ambulance handover times 15 Mins	51.8%	100.0%	51.9%	50.9%	35.0%	60.0%	93.3%					R	May-18	✗
FC3	Ambulance (All) handover times 30 Mins	96.0%	100.0%	96.5%	96.6%	97.0%	97.5%	100.0%					R	Apr-18	○
FC4	No. ED Referrals to Ambulatory Care	25	897	135	108	102	29	37					R	Mar-19	✗
FC5	AMU Occupancy rate @ 10am	TBC	80%	89%	93%	94%	7	10					R	Mar-19	✗
FC6	Outpatients Friends & Family Response Rate	1.0%	10.0%	1.0%	1.0%	1.0%	3.0%	10.0%					C	Mar-19	✗
FC7	Outpatient Friends & Family Test (+ive response)	83.3%	90.0%	96.6%	94.4%	96.3%	95.0%	95.0%					C	Oct-17	✓
FC8	Outpatient DNA Rate	14.2%	8.5%	10.4%	10.2%	10.5%	8.5%	8.0%					E	2019/20	✗
FC11	Theatres: IP On the Day Cancellations (all causes)	8.8%	5.0%	10.3%	9.6%	9.1%	5.0%	5.0%					E	Jul-18	✗
FC12	Patients With Pre-Op Assessment %	TBC	70.0%	71.0%	59.0%	65.0%	70.0%	70.0%					S	Jun-18	✗
FC13	WHO checklist compliance (Quarterly Clinical Audit)	TBC	100%	100.0%	100.0%	98.3%	100.0%	100.0%					S	Oct-17	○
FC14	Bed Occupancy (Midnight)	88.4%	90.0%	89.9%	91.7%	91.7%	90.0%	90.0%					S	Dec-17	○
FC15	Emergency Readmission Rate (CCG OIS)	10.3%	7.0%	9.7%	8.4%	6.2%	7.0%	7.0%					S	Oct-17	✓
FC17	SAFER Compliance	New TBC	TBC	_	_	_	0.0%	0.0%			New measure, awaiting data		S	N/A	
	SAFE & EFFECTIVE CARE														
SE1	Fall resulting in moderate or above harm / 1000 Bed Days	0.4	0	0.1	0.0	0.1	0.0	0.0					S	N/A	✗
SE2	No. Patient Falls / 1000 Bed Days	5.2	4.4	5.5	5.2	4.9	4.4	4.4					S	Oct-18	✗
SE4	VTE Risk Assessment Completed	97.6%	95.0%	96.3%	95.8%	92.2%	98.0%	98.0%					S	Oct-17	○
SE5	Number of avoidable Hospital Aquired Thrombosis /1000 Bed Days (Rolling 3 Month	4.6	0.0	0.1	0.1	_	0.0	0.0					S	N/A	✗
SE6	Avoidable Grade 3 & 4 Pressure Ulcers / 1000 Bed Days (Rolling 3 Month Average)	0.0	0.0	0.0	0.0	0.1	0.0	0.0					S	N/A	✗
SE7	Clostridium Difficile rate / 1000 Bed days (Rolling 3 Month Average)	0.1	0.0	0.0	0.0	0.0	0.0	0.0					S	Oct-17	✓
SE9	MRSA Bacteraemia rate / 1000 Bed days (Rolling 3 Month Average	0.0	0.0	0.1	0.0	0.1	0.0	0.0					S	N/A	✗
SE8	MSSA Bacteraemia rate / 1000 Bed days (Rolling 3 Month Average	0.0	0.0	0.0	0.0	0.0	0.0	0.0					S	N/A	✓
SE10	Infection Control Clinical MAST (staff training compliance)	TBC	85.0%	78.1%	78.1%	78.0%	85.0%	85.0%					WL	2019/20	✗
SE11	Hand Hygiene Audit compliance	95.0%	95.0%	95.4%	95.0%	92.1%	95.0%	95.0%					WL	Oct-17	○
SE12	%. of staff Completed Dementia Awareness Training	N/A	85.0%	_	_	86.0%	85.0%	85.0%					C	Oct-17	✓
SE13	Number of Dementia Surveys Completed / Month	5	20	_	6	4	12	20					E	Aug-18	✗
SE14	Friends & Family Dementia Survey Satisfaction Score (Patient and/or carer)	TBC	25% Over Baseline	_	_	_	0.0%	0.0%					C	N/A	
SE15	Number of Cardiac Arrests /1000 bed days (to become avoidable cardiac arrests)	0.8	25% Over Baseline	0.7	0.4	_	0.0	0.0					S	N/A	✗
SE16	Number of Cardiac Arrests 2222 Calls /1000 Inpatient Bed Days	0.1	25% Over Baseline	0.1	0.0	_	0.0	0.0					S	N/A	✓
SE17	% of patients in ED with sepsis receiving antibiotics within an hour	TBC	25% Over Baseline	_	_	_	0.0%	0.0%			Newly added measure and awaiting data		S	N/A	
SE18	TTO dispensed from the satellite unit within 1 hour	TBC	90.0%	75.0%	77.0%	78.0%	90.0%	90.0%			Newly added measure and awaiting data		E	N/A	
SE19	Hospital Standardised mortality rate (HSMR)	83.7	80.0	81.3	80.6	81.3	80.0	80.0					S	N/A	✓
SE20	% of Hospital Deaths With Structured Reviews	TBC	90.0%	83.0%	83.0%	87.0%	90.0%	90.0%					WL	N/A	✗
SE21	No. Of Hospital Deaths With 3+ Emergency Admissions in Last 90 Days of Life	4	25% Over Baseline	11	4	9	0	0					S	N/A	✗
	QUALITY & RISK														
QR1	Compliance with 25 working day complaint response for non-complex complaints	62.0%	95%	_	_	61.0%	95.0%	95.0%					WL	N/A	✗
QR2	Compliance with 40 working day complaint response for all amber complaints	0.0%	95%	_	_	_	95.0%	95.0%			Newly formed measured. Reporting from Dec 17		WL	N/A	
QR3	Compliance with 60 working day complaint response for all red complaints	0.0%	95%	_	_	_	95.0%	95.0%			Newly formed measured. Reporting from Jan 17		WL	N/A	
QR4	Complaints that require a second response	0.0%	<8%	11.0%	9.0%	2.0%	8.0%	8.0%					WL	N/A	✓
QR5	Duty of Candour completed for all incidents (as graded on Datix) at moderate harm and	0.0%	100.0%	97.0%	92.0%	_	100.0%	100.0%					WL	N/A	✗
QR6	Duty of Candour completed within 10 working days, for all incidents at moderate harm and above - (By March 2018)	0.0%	100%	69.0%	68.0%	_	100.0%	100.0%					WL	N/A	✗
QR7	Incidents reported – non clinical/1000 bed days	7	TBC National Upper Quartile	8	7	6	TBC National Upper	TBC National Upper					WL	Dec-17	✗
QR8	Incidents reported – clinical / 1000 bed days	44	TBC National Upper Quartile	41	40	39	TBC National Upper	TBC National Upper					WL	N/A	✗
QR9	Serious Incidents / 1000 days	14	90 per year	0	0.54	0	7	6					WL	N/A	✓
QR10	Open SI investigations >60 days	0	0	0	0	0	0	0					WL	N/A	✓
QR11	Never Events declared (By March 2018)	1	0	1	0	0	0	0					WL	N/A	✗

	ESTATES & FACILITIES														
EF1	% of Estate Used for Clinical Purposes	70.0%	62.5%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%				E		✓
EF2	Inpatient Wards (inc ED) Estates Issues Reporting At Morning Handover	0.0%	95.0%	TBC	TBC	TBC	95.0%	95.0%					E		
EF3	Acknowledgment of Estates Issues By Helpdesk Within 24 Hrs	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				E		✓
EF4	Initial Assessment of Logged Issues Within 24 Hrs	0.0%	<24 Hours	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				R		✓
EF5	Low Use Outlets Tracked & Flushed Routinely	89.0%	100.0%	89.0%	89.0%	95.0%	100.0%	100.0%	93.0%				S		✗
EF6	Valid Training Sessions Available Ensure Trained Fire Ward on Each Shift in Every	N/A	TBC	1742	1950	1950	TBC	TBC	1846				WL		✓

	IT														
IT1	Reduction in Number of Clinical & Organisational Incidents (where IT infrastructure is contributory factor)	0.0%	50% Reduction On Previous Year										S		
IT2	Reduction in Number of Medication Admin Errors Accountable to IT Failure	0.0%	50% Reduction On Previous Year										S		
IT3	Reduction in Number of Incidents Related to Failure to Identify Deteriorating Patients Due to IT Failure	0.0%	50% Reduction On Previous Year										S		

	LEADERSHIP														
L1	Number of Staff Undertaking Formal Leadership Development Programmes	TBC	200/Year	143	179	182	200	200					WL		○
L2	Delivery of Effective People Management Programme (Rolling 12 Months)	TBC	200/Year	23	0	0	200	200					WL		✗
L3	Trust Board Participation in Board Development Programme	TBC	100.0%	_	_	100.0%	100.0%	100.0%					WL		✓

	ENGAGEMENT														
E1	Improved NHS National Staff Survey Scores	3.7%	10% + Over Previous Year			TBC							WL		
E2	Staff Turnover	18.0%	<15%	18.0%	18.0%	18.0%	16.5%	15.0%					WL		✗
E3	Staff Survey Participation	40.4%	50.0%			60.0%							WL		✓

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Trust Board – 7 December 2017
Reporting period - October 2017

Excellence in specialist and community healthcare

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

October 2017

Daycase and Elective Surgery operations

Actual
4,486

Target 4,897

Discharges before 11am

Actual 12.8%

Target 30%

Four Hour Emergency Standard

Actual
88.0%

Target 95%

Whole Trust Inpatient Friends and Family Test

Actual
96%

Target
95%

Outpatient First Appointment

Actual 17,193

Target 18,178

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
71%

Target
83%

Activity Summary

St George's University Hospitals NHS
NHS Foundation Trust

The table below compares activity to previous months and quarters and against plan for the reporting period

		Activity compared to previous year			Activity against plan for month		Activity compared to previous year			Activity against plan YTD	
		Oct-16	Oct-17	Variance	Plan Oct-17	Variance	YTD 16/17	YTD 17/18	Variance	Plan YTD	Variance
ED	ED Attendances (Type 1)	14,011	14,160	1.06%	14,715	-3.77%	96,894	97,362	0.48%	101,578	-4.15%
Inpatient	Elective & Daycase	4,724	4,486	-5.04%	4,897	-8.39%	30,501	31,792	4.23%	32,157	-1.14%
	Non Elective	3,983	3,948	-0.88%	4,369	-9.64%	28,440	27,235	-4.24%	30,159	-9.70%
Outpatient	OP Attendances	54,653	53,570	-1.98%	54,589	-1.87%	379,014	372,524	-1.71%	366,291	1.70%

>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

Source: SLAM

Executive Summary – October 2017

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- One patient Never Event was declared in October. The Trust has reported three events year to date. There were five Serious Incidents declared in the month.
- In October the Trust reported four patients with hospital attributable Clostridium Difficile infection, which brings the trust year to date total to thirteen cases. The threshold for the year is 31.
- Two patients acquired an MRSA Bacteraemia in month, the trust total year to date is six against a ceiling of zero.
- Patient safety thermometer – the percentage of patients with harm free care (new harm) remains consistently better than the 95% threshold. [*The 'new harm' patient safety thermometer looks at harms acquired by patients while in hospital.*]

Clinical Effectiveness

- Mortality is lower than expected for our patient group when benchmarked against national comparators
- Maternity indicators continue to show expected performance. A recent report by the Royal College of Obstetricians and Gynaecologists on NHS maternity services across the country, showed our Maternity Unit achieving expected standards in all parameters, outperforming the national average for our emergency caesarean rate and episiotomy rate. The trust is also below the national average for babies born with brain damage. These excellent results are a testament to our caring and forward thinking maternity team.

Access and Responsiveness

- The Four Hour Operating Standard was not achieved in October reporting a performance of 87.97% of patients admitted, discharged or transferred within four hours of arrival. This was below the improvement trajectory agreed with NHS Improvement and a trust wide Delivery Risk Summit has now been held to identify and agree immediate actions for recovery.
- Seven out of eight cancer standards were met in October showing a significant improvement with 62 day standard to be confirmed on Monday 4th December,
- The trust achieved the 1% standard for access to Diagnostic tests.

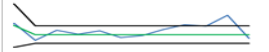
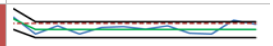
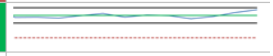
Patient Experience

- The Friends and Family Test (FFT) recommendation rate for inpatients was 96.5% and for Outpatients was 96.3% in October. This remains above threshold. Response rates are strong for inpatients and below standard for Outpatients. The recommendation score for inpatients provides reasonable assurance on the quality of patient experience. Given the low response rate for outpatients the assurance it provides on patient experience is weak.

Workforce

- Staff sickness remains above the trust target of 3%
- Non Medical appraisal rates have seen a decline in performance within the reporting period at 72.2%. Medical appraisal rates have increased to 80.7%, both remain below target.

Patient Safety

Indicator Description	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend (12 months)
Number of Never Events in Month	0	0	0	0	1	0	0	0	1	1	0	0	1	
Number of SIs where Medication is a significant factor	0	2	0	1	0	0	0	0	0	1	1	1	1	
Number of Serious Incidents	8 / mth	10	4	8	6	8	5	6	8	11	9	13	5	
Serious Incidents - per 1000 bed days	N/A	0.42	0.17	0.32	0.26	0.31	0.21	0.24	0.33	0.44	0.38	0.54	0.20	
Safety Thermometer - % of patients with harm free care (all harm)	95%	95.8%	93.7%	94.7%	93.7%	94.5%	94.6%	94.3%	94.7%	93.8%	93.8%	95.8%	94.9%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	97.7%	97.7%	97.6%	97.9%	98.2%	97.7%	98.0%	97.9%	97.5%	97.8%	98.3%	98.7%	
Percentage of patients who have a VTE risk assessment	95%	95.9%	95.9%	96.8%	96.5%	96.3%	95.3%	96.2%	96.3%	95.8%	95.7%	95.4%	TBC	
Number of Patient Falls	N/A	154	116	161	137	154	111	137	132	143	127	125	123	
Number of patient falls- per 1000 bed days	N/A	6.47	4.88	6.52	5.85	6.03	4.73	5.39	5.48	5.71	5.29	5.15	4.93	
Attributable Grade 2 Pressure Ulcers per 1000 bed days	N/A	0.42	0.80	0.53	1.20	0.78	0.72	0.28	1.16	0.92	0.63	0.74	0.20	
Number of Grade 3 & 4 Pressure Ulcers	N/A	0	1	3	2	3	2	1	0	1	1	2	0	
Attributable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00	0.00	0.04	0.12	0.09	0.12	0.09	0.04	0.00	0.04	0.04	0.08	0.00	
Number of overdue CAS Alerts	0	1	1	1	1	1	1	1	0	0	0	0	0	

Briefing

- One patient Never Event reported in October, occurring within the Delivery Suite. The Trust total is three year to date.
- The Trust declared 5 serious incidents in October 2017
- The falls rate is calculated to reflect the rate used in national audits and is shown above for the past 12 months. Using this rate we can benchmark ourselves against the rate of 6.6 falls per 1000 bed days that was found in acute hospital settings by the *National Audit of Inpatient Falls (2015), Royal College of Physicians.* Our falls rate has been lower than that found by the RCP for the past 12 months.

Actions: The never event investigation is in progress, immediate action was taken to ensure that LOCSIPs are being completed.

Infection Control

Indicator Description	Threshold	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend (12 months)
MRSA Incidences (in month)	0	0	0	0	1	0	2	0	2	0	0	0	2	
Cdiff Incidences (in month)	31	4	4	3	4	3	1	1	1	2	3	1	4	
MSSA	N/A	5	0	7	2	2	3	2	4	4	4	1	1	
E-Coli	N/A	3	2	6	3	11	4	2	5	9	6	8	6	

Briefing

- There were four patients reported who suffered with a hospital acquired Clostridium Difficile Infection in October.
- C Diff threshold for 2017/18 remains the same as the previous year at 31 cases. There have been thirteen cases year to date.
- Root cause analysis is undertaken for each case to ensure that any opportunities for learning are captured and appropriate actions taken to prevent similar avoidable infections in the future
- There were two patients who acquired an MRSA Bacteraemia in October. The Trust year to date total stands at 6.

Actions:

Root cause analysis is under way for the C diff incidences detected in October. Areas have been placed on a period of increased surveillance and audits with the support of the infection control team to ensure infection control practice are being completed.

Mortality and Readmissions

Indicator Description	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	84.1	84.1	84.1	83.3	82.5	83.5	81.3	81.3	79.7	81.1	80.6	81.3	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	84.2	82.4	82.4	81.1	79.2	80.1	78.2	78.2	81.3	77.4	77.2	77.5	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	92	86.7	86.7	86.8	84.0	86.0	83.5	83.0	76.0	81.8	81.2	82	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.9	0.88	0.88	0.88	0.86	0.86	0.86	0.84	0.84	0.84	0.84	TBC	
Emergency Readmissions within 30 days following non elective spell	TBC	9.3%	9.8%	8.9%	10.2%	9.3%	9.5%	9.7%	9.7%	8.9%	8.8%	8.4%	6.2%	

Briefing

- Latest HSMR data for the Trust shows mortality remains significantly better than expected for our patient group and SHMI lower than expected when benchmarked against national comparators.
- Readmission rates following a non elective spell is on a downward trend.

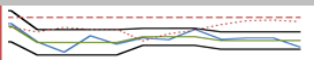
Maternity

- Maternity indicators continue to be monitored and reviewed by the Divisional Governance process

Indicator Description	Threshold	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend
C Section Rate - Emergency and Non Elective	28%	26.1%	28.4%	28.8%	29.6%	34.1%	29.9%	29.1%	24.6%	29.5%	24.9%	30.2%	29.7%	
Admission of full term babies to neo-natal care		1	2	2	7	2	11	2	16	21	20	15	10	

Actions: All term admissions to the Neo-natal Unit are reviewed to identify any avoidable causes by the Trust's governance midwife and consultant and discussed at monthly risk and morbidity meeting. Improved reporting on datix through the addition of subcategories to be in place to assist in thematic reviews. A review of local and national data is to be completed.

Emergency Flow

Indicator Description	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend
4 Hour Operating Standard	95%	93.50%	89.14%	86.63%	90.59%	89.09%	90.50%	89.68%	92.12%	89.76%	90.05%	90.03%	87.97%	
Patients Waiting in ED for over 12 hours following DTA	0	0	1	0	1	0	0	1	0	0	0	0	0	
Ambulance Turnaround - % under 15 minutes	100%	53.8%	49.9%	46.9%	52.4%	50.2%	46.0%	48.4%	51.9%	48.9%	50.5%	50.9%	49.9%	
Ambulance Turnaround - % under 15 minutes (London Average)	100%	43.2%	39.7%	38.9%	42.5%	43.4%	43.7%	45.3%	47.5%	46.4%	47.0%	46.5%	45.1%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	48	76	81	37	53	79	72	71	53	84	71	57	
Ambulance Turnaround - % under 30 minutes	100%	97.8%	96.6%	96.4%	98.1%	97.6%	96.1%	96.7%	96.5%	97.4%	96.0%	96.6%	97.4%	
Ambulance Turnaround - % under 30 minutes (London Average)	100%	90.1%	86.7%	85.4%	90.3%	90.7%	91.8%	92.3%	93.3%	93.2%	93.1%	92.2%	91.9%	
Ambulance Turnaround - number over 60 minutes	0	0	0	0	0	0	1	1	0	1	1	0	0	

Briefing

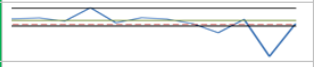
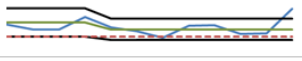
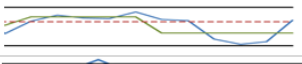
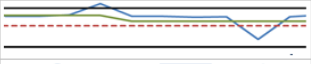
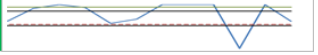
- The Four Hour Operating Standard was not achieved in October reporting a performance of 87.97%. This was also below the improvement trajectory agreed with NHSI.
- Ambulance turnaround performance has seen a stable trend with 30 minute handover performance increasing in the month of October within the Trust, and both 15 and 30 minute handover times remain higher than the London average.
- Much work is underway to further improve patient flow (expanding space for ambulatory care) and thus improve patient safety and experience and improve our ability to deliver performance.
- A four hour operating standard remedial action plan has been drafted covering the root causes of performance shortfalls to expectation.

Actions

- Trust Risk Summit on 4 hour operating performance chaired by the Chief Executive Officer held on 21/11/2017 with Executive members, Senior Managers, Clinical Care Group Leads identified and agreed a series of immediate remedial actions.
- The unplanned and admitted patient care programme led by divisional chair for Medicine and Cardiothoracic Division supported by clinicians throughout the Trust has been launched with the aim of providing patients with alternatives to emergency admission and of accelerating discharge to reduce overall bed occupancy.
- SAFER bundle is being rolled out to improve patient safety and remove non added value delays in the inpatient journey.
- Revised Trust Internal Professional Standards and Escalation policies have been launched
- Partnership working has been escalated to free inpatient capacity by lowering the number of patients awaiting continuing care elsewhere including repatriation to other Acute Hospitals

Delivery

Cancer

Indicator Description	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend (12 months)
Cancer 14 Day Standard	93%	85.7%	93.3%	87.9%	87.9%	86.0%	75.4%	76.6%	67.4%	80.3%	89.7%	93.98%	96.05%	
Cancer 14 Day Standard Breast Symptomatic	93%	94.8%	93.2%	94.0%	93.4%	87.2%	82.7%	84.1%	62.9%	86.9%	90.3%	98.2%	99.6%	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	96.0%	96.0%	95.1%	100.0%	94.6%	96.4%	95.9%	94.2%	90.9%	95.8%	82.4%	94.1%	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	98.4%	100.0%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	
Cancer 31 Day Diagnosis to Treatment	96%	96.9%	96.6%	96.4%	97.5%	96.7%	96.4%	96.4%	96.8%	96.9%	96.2%	96.2%	98.1%	
Cancer 62 Day Referral to Treatment Standard	85%	80.0%	85.2%	87.7%	86.6%	86.3%	89.0%	87.3%	85.4%	77.8%	75.6%	76.7%	85.5%	
Cancer 62 Day Referral to Treatment Screening	90%	92.7%	92.7%	93.0%	96.2%	92.6%	92.7%	92.4%	92.5%	86.1%	92.5%	93.0%	78.4%	
Cancer 62 Day Consultant Upgrade	85%	87.5%	97.1%	100.0%	97.7%	85.7%	88.9%	100.0%	100.0%	100.0%	66.7%	100.0%	87.5%	

Briefing

- The Trust has seen significant improvement against the eight cancer standards, provisionally achieving seven standards in the month of October with the final position for 62 days standard to be confirmed on Monday 4th December.
- The 14 day standard was achieved reporting 96.05%, above the national standard for a consecutive month. Increased leadership and management support given to Two Week Rule office has increased performance against both 7 day booking and contact with patients within 48 hours.
- 14 Day Breast Symptomatic also observed a significant increase reporting 99.6% (a total of 1 breach)
- The 62 day standard continued to below target reporting 76.7% for the month of September with 5 tumour groups below the 85% target, however when reporting internal performance only (with the exclusion of shared breaches due to late Inter Trust Transfers) the Trust are at 82%. Provisional data shows that October has achieved national standard.

	62 day wait for first treatment - GP referral to treatment (before and after reallocation)		
Sep-17	Target: **85%**	Actual (before reallocation): **76.6%**	Actual (after reallocation): **82%**

- The number of patients waiting greater than 62 days on the patient tracking list (PTL) has seen a significant reduction as well as a reduction in those patients waiting more than 104 days.

Actions

- Increased leadership and management support given to Two Week Wait office. Additional staff from central booking office provided to help clear backlog. .
- To increase number of patients treated in October and November to help achieve recovery within 62 day performance

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Brain	93%	100.0%	85.7%	100.0%	66.7%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%
Breast	93%	96.1%	95.1%	93.0%	96.1%	89.9%	92.3%	88.7%	84.7%	69.5%	76.4%	93.4%	94.1%
Childrens	93%	100.0%	55.6%	100.0%	100.0%	100.0%	90.0%	66.7%	80.0%	66.7%	80.0%	100.0%	100.0%
Gynaecology	93%	89.8%	93.0%	95.7%	76.0%	75.4%	87.1%	64.6%	66.7%	75.6%	93.4%	90.4%	91.1%
Haematology	93%	95.2%	90.9%	100.0%	100.0%	100.0%	95.8%	76.2%	96.9%	76.9%	95.7%	100.0%	100.0%
Head & Neck	93%	95.4%	96.3%	95.9%	98.4%	97.4%	97.9%	90.9%	84.9%	82.4%	88.0%	82.4%	90.6%
Lower Gastrointestinal	93%	94.4%	93.6%	98.3%	95.7%	95.7%	90.5%	75.1%	90.7%	44.4%	60.0%	73.9%	94.6%
Lung	93%	97.9%	94.9%	100.0%	98.2%	100.0%	100.0%	96.2%	91.1%	91.2%	95.6%	100.0%	94.1%
Skin	93%	86.3%	59.8%	79.4%	67.1%	67.7%	57.4%	29.4%	48.1%	26.9%	74.3%	96.6%	93.4%
Upper Gastrointestinal	93%	100.0%	98.6%	96.6%	87.8%	95.3%	94.2%	88.8%	96.1%	93.8%	97.6%	98.8%	98.8%
Urology	93%	95.8%	96.3%	96.9%	98.1%	95.0%	98.4%	96.1%	90.1%	82.3%	93.8%	97.0%	96.4%

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Brain	85%	100.0%	100.0%	-	-	-	100.0%	50.0%	-	0.0%	100.0%	0.0%	100.0%
Breast	85%	100.0%	100.0%	86.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	91.7%
Childrens	85%	-	-	-	-	100.0%	-	-	-	-	-	0.0%	-
Gynaecology	85%	100.0%	80.0%	92.3%	100.0%	100.0%	50.0%	100.0%	90.9%	100.0%	61.5%	100.0%	50.0%
Haematology	85%	100.0%	100.0%	70.0%	80.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%
Head & Neck	85%	85.7%	50.0%	100.0%	63.6%	72.7%	75.0%	58.3%	85.7%	46.2%	66.7%	71.4%	87.5%
Lower Gastrointestinal	85%	83.3%	66.7%	93.3%	76.5%	66.7%	71.4%	-	62.5%	100.0%	60.0%	100.0%	66.7%
Lung	85%	69.6%	68.8%	66.7%	80.0%	78.6%	73.7%	85.7%	85.7%	64.3%	41.7%	47.4%	72.2%
Skin	85%	92.3%	80.0%	100.0%	100.0%	95.5%	100.0%	93.3%	96.4%	95.7%	100.0%	76.5%	93.8%
Upper Gastrointestinal	85%	66.7%	85.7%	100.0%	50.0%	11.1%	100.0%	100.0%	100.0%	100.0%	100.0%	77.8%	0.0%
Urology	85%	93.5%	72.7%	70.4%	85.2%	87.9%	83.9%	90.0%	67.9%	81.8%	63.0%	64.3%	77.4%

Diagnostics

Indicator Description	Threshold	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend
6 Week Diagnostic Performance	1%	0.7%	2.2%	5.1%	2.8%	2.9%	4.1%	3.3%	2.6%	2.7%	2.0%	1.4%	0.3%	
6 Week Diagnostic Breaches	N/A	50	151	372	219	222	313	248	197	190	158	102	21	
6 Week Diagnostic Waiting List Size	N/A	6,878	6,906	7,358	7,871	7,678	7,559	7,443	7,584	6,989	7,766	7,243	7,136	

Indicator Description	Threshold	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend
MRI	1%	1.1%	1.7%	9.6%	4.3%	3.3%	2.6%	1.1%	0.6%	0.8%	0.2%	0.1%	0.0%	
CT	1%	0.0%	0.1%	0.6%	0.0%	0.7%	1.5%	0.5%	0.2%	0.2%	0.3%	1.2%	0.3%	
Non Obstetric Ultrasound	1%	0.1%	1.0%	3.0%	1.9%	3.0%	4.0%	2.5%	0.3%	1.1%	0.9%	0.0%	0.0%	
Barium Enema	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Dexa Scan	1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Audiology Assessments	1%	0.0%	0.0%	0.0%	4.5%	2.5%	6.5%	10.1%	11.3%	4.6%	5.7%	4.5%	0.0%	
Echocardiography	1%	0.0%	0.0%	0.1%	0.1%	0.3%	1.2%	9.4%	2.0%	3.0%	0.3%	0.3%	0.3%	
Electrophysiology	1%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	75.0%	75.0%	100.0%	0.0%	100.0%	
Peripheral Neorophys	1%	2.6%	0.4%	0.5%	0.0%	0.5%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	
Sleep Studies	1%													
Urodynamics	1%	80.0%	15.4%	0.0%	52.6%	55.0%	65.5%	75.6%	64.4%	64.2%	50.6%	37.0%	16.7%	
Colonoscopy	1%	1.4%	3.6%	20.2%	5.7%	8.7%	5.7%	4.7%	0.5%	1.8%	0.0%	0.4%	1.1%	
Flexi Sigmoidoscopy	1%	0.0%	10.5%	20.8%	12.0%	8.4%	6.7%	0.0%	1.1%	4.9%	0.7%	1.5%	0.0%	
Cystoscopy	1%	10.6%	28.3%	14.4%	9.9%	2.6%	15.0%	11.5%	24.4%	14.0%	12.3%	14.7%	4.0%	
Gastroscopy	1%	0.9%	7.2%	10.1%	3.2%	4.5%	12.7%	10.0%	9.2%	11.2%	6.7%	0.8%	0.0%	

Briefing: In October the Trust achieved the national 6 week diagnostic standard reporting 0.3% of our patients were waiting greater than 6 weeks for a diagnostic procedure against a standard of 1% with a total of 21 breaches, reducing by 79% compared to September. Patients waiting beyond 6 weeks are mainly within Cystoscopy and Urodynamics.

Actions

- Urodynamics – additional clinics to clear backlog and provide additional ongoing capacity
- Endoscopy –additional capacity provided through waiting list initiatives. Recruitment ongoing to staff 2 additional rooms. Recentralisation of management at the QMH site and offering STG capacity to help recover position.
- The Trust will be reporting sleep studies and stress echo tests from November 2017. NHS Improvement are aware of this position.

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Trend
Number of on the Day Cancellations		103	60	104	91	63	58	72	64	84	54	49	
Number of on the Day cancellations re-booked within 28 Days		88	45	92	89	56	54	70	54	70	43	43	
% of Patients re-booked within 28 Days	100%	85.4%	75.0%	88.5%	97.8%	88.9%	93.1%	97.2%	84.4%	83.3%	79.6%	87.8%	

Briefing

- The number of patient procedures cancelled on the day has remained in line with previous months however a spike was seen in July. Of the 187 patients cancelled in Quarter 2, 83.4% (156 patients) were rebooked within 28 days.
- When compared with our peers, St George's has a high number of reportable on the day cancelled operations and services are working to improve this across all areas. The top three reasons for last minute cancelled operations are: 1. lack of theatre time, 2. an emergency case taking priority, 3. bed unavailability. These three reasons account for approximately 67% of last minute cancellations.

Actions

- Daily theatre briefing to confirm all theatres started on time.
- Daily monitoring and forward planning of HDU bed requirements to prevent cancellations due to lack of HDU beds.
- A theatre transformation programme has commenced, aiming to increase the number of patients treated in each theatre session. Focus is on three key areas: 1. Locking down of fully booked lists 2 weeks in advance. 2. Increasing Pre-operative attendance to reduce cancellations. 3. First patient to the anaesthetic room by 8.30 to start on time.
- Improvement is being measured via a series of metrics with agreed targets

Patient Experience

Patient Voice

Indicator Description	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend
Emergency Department FFT - % positive responses	90%	84.4%	82.3%	85.0%	86.3%	82.8%	85.2%	83.0%	85.2%	83.9%	85.9%	83.5%	86.4%	
Inpatient FFT - % positive responses	95%	97.5%	95.9%	96.2%	96.9%	96.7%	95.8%	97.3%	96.0%	96.6%	96.8%	96.5%	96.5%	
Maternity FFT - Antenatal - % positive responses	90%	No Responses				100%		85.7%	100.0%	100.0%	100.0%	100.0%		
Maternity FFT - Delivery - % positive responses	90%	100%	87.0%	89.0%	93.0%	97.0%	88.2%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	
Maternity FFT - Postnatal Ward - % positive responses	90%	95.0%	95.0%	95.0%	93.0%	90.0%	94.1%	97.9%	95.4%	87.1%	96.4%	100.0%	92.6%	
Maternity FFT - Postnatal Community Care - % positive response	90%	100%	100%	100%	100.0%	100%	100%	100%	100%	100%	98%	100%	100%	
Community FFT - % positive responses	90%	96.5%	94.7%	96.6%	96.2%	93.0%	93.0%	97.6%	96.3%	94.5%	98.3%	94.1%	98.9%	
Outpatient FFT - % positive responses	90%	94.9%	92.3%	94.8%	91.7%	88.1%	92.6%	95.6%	96.6%	94.2%	96.2%	94.4%	96.3%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints		92	56	85	73	79	63	76	75	61	99	80	89	

- ED Friends and Family Test (FFT) – The score has increased in October reporting 86.4% meaning that the percentage of patients recommending the service has increased slightly. Performance has remained stable and compared to our London peers our response rate is one of the best in London.
- Maternity FFT – The score for maternity care are above local threshold and work to increase the number of patients responding continues, Significant improvements were made with the percentage of patients responding increasing by 22.41% in July and August and after a drop in September has seen the response rate increase again above internal target.
- The number of complaints have increased slightly in October reporting 89 patient complaints.

Actions: The ED management team are reviewing the results from the FFT survey for the last quarter to determine any further themes for improvement, an example being the review of staffing model to ensure response nurses are available to support high volume periods and minimise delays for patients. Complaints and PALS: Reporting against the new timeframes for complaint responses will start in January 2018 and is part of a programme of work on improving complaints management in the Quality Improvement Plan (QIP). The downward trend in PALS contacts will be analysed to see if this is a reduction in a particular type of contact e.g. way finding queries. PALS started opening during lunch hours in September, it was expected that enquires would increase.

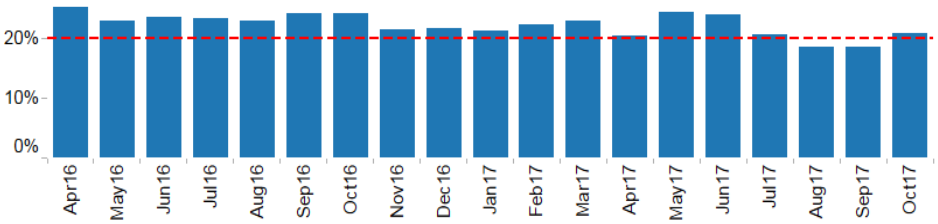
Patient Voice

CARING – Friends and Family Test

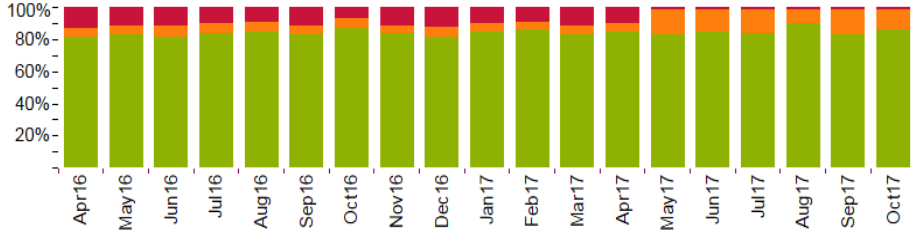
Target ¢ MetricMeasure | Percentage Recommended | Neutral | Percentage Not Recommended

A&E Friends & Family Response Rate

Target: 20% Sep 17: 18.7% Oct 17: 20.9% Movement: ▲2.2%

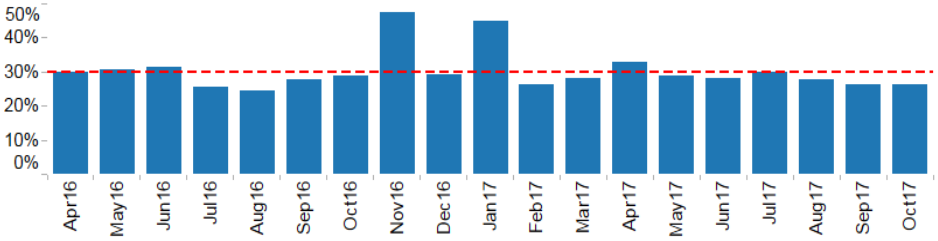


A&E Friends & Family Recommend Rate
The expected target is 90%

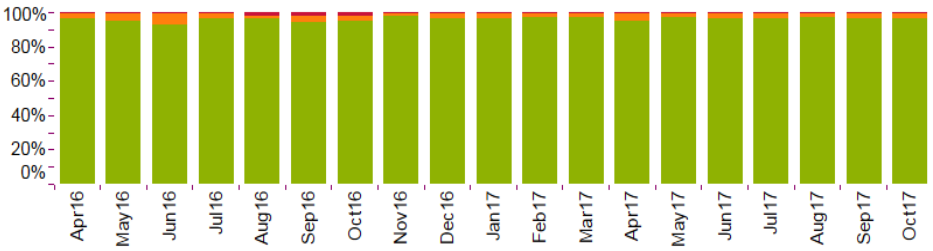


IP Friends & Family Response Rate

Target: 30% Sep 17: 26.1% Oct 17: 26.1% Movement: ▲0.0%

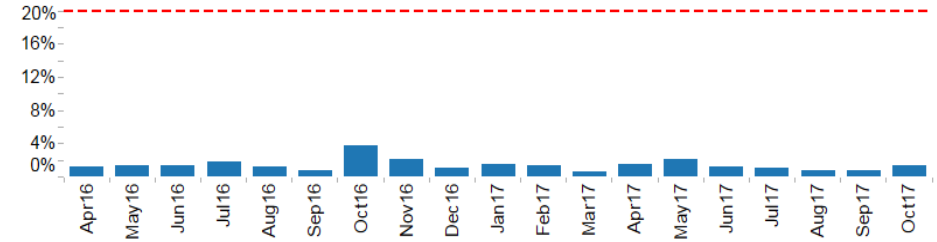


IP Friends & Family Recommend Rate
The expected target is 95%

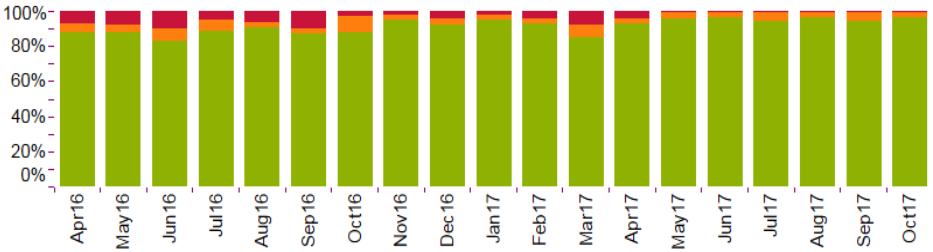


OP Friends & Family Response Rate

Target: 20% Sep 17: 0.7% Oct 17: 1.3% Movement: ▲0.6%



OP Friends & Family Recommend Rate
The expected target is 90%

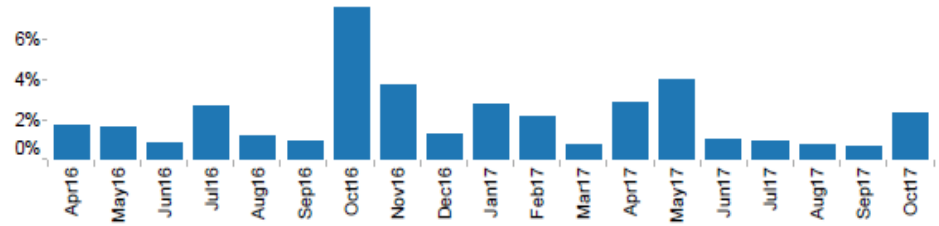


Patient Experience

Patient Voice

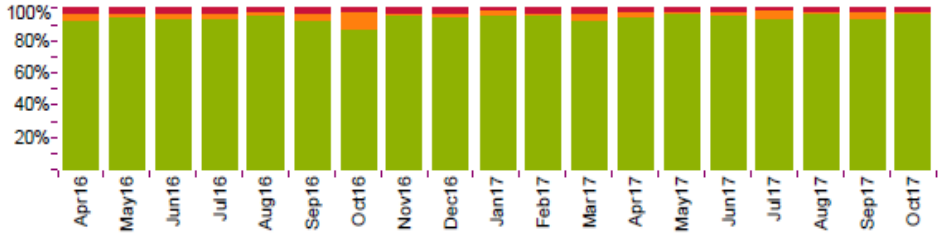
Community Friends & Family Response Rate

Target: 20% Sep 17: 0.6% Oct 17: 2.4% Movement: ▲1.8%



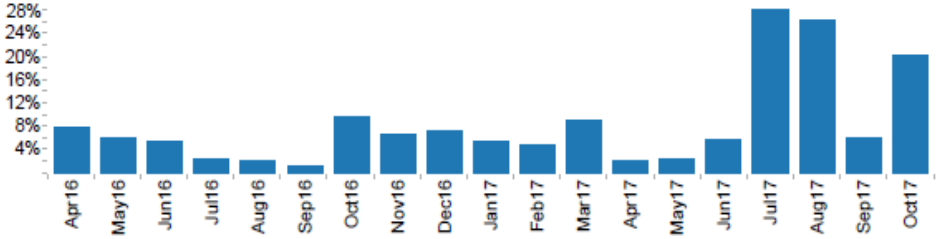
Community Friends & Family Recommend Rate

The expected target is 90%



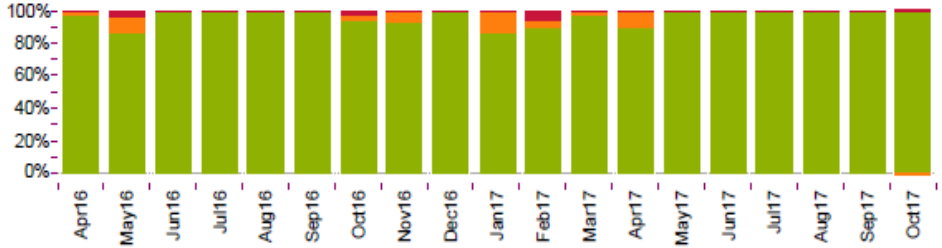
Maternity (Birth) Friends & Family Response Rate

Target: 20% Sep 17: 5.9% Oct 17: 20.2% Movement: ▲14.3%

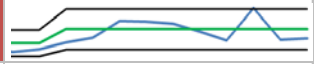
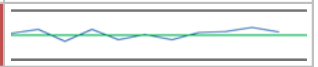
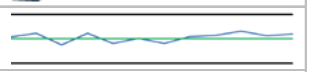
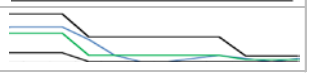


Maternity (Birth) Friends & Family Recommend Rate

The expected target is 90%



Workforce

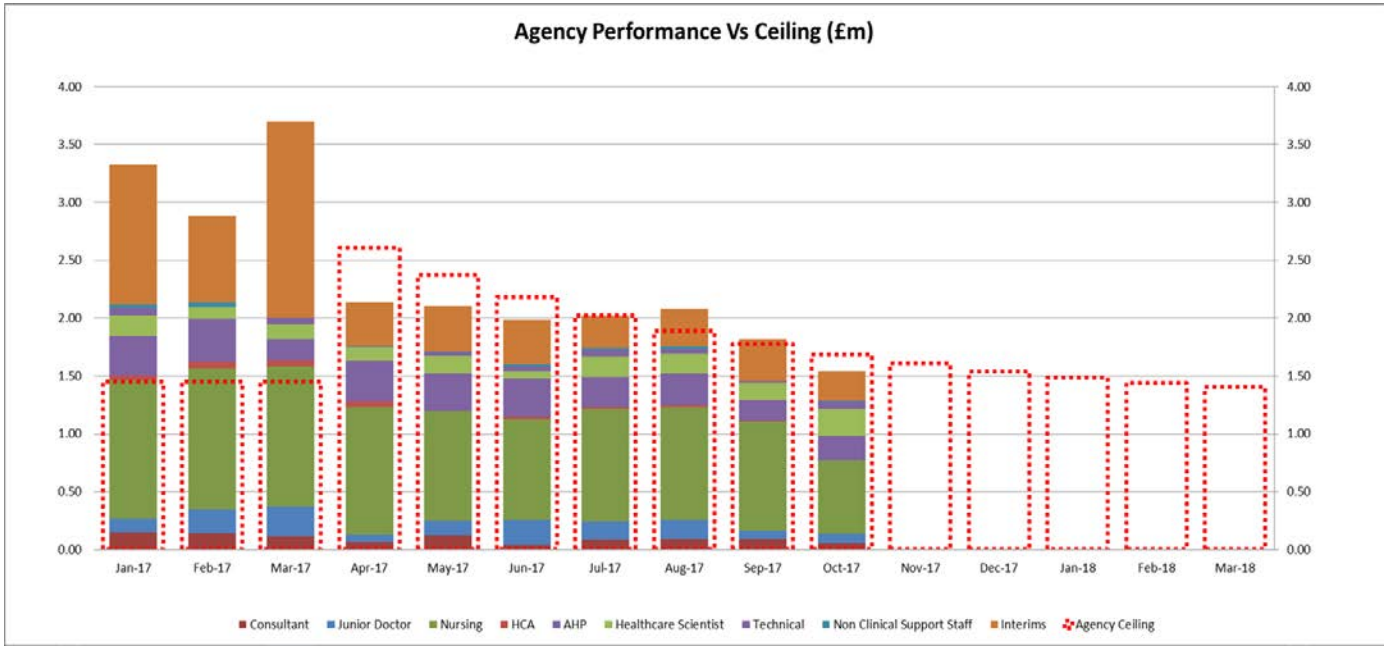
Indicator Description	Target	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Trend
Trust Level Sickness Rate	3%	3.8%	3.7%	4.2%	3.8%	3.3%	3.2%	3.4%	3.4%	3.6%	3.7%	3.6%	3.4%	
Trust Vacancy Rate	10%	14.7%	15.3%	15.1%	15.1%	15.4%	16.3%	17.0%	17.1%	16.1%	16.5%	14.8%	16.1%	
Trust Turnover Rate* Excludes Junior Doctors	10%	18.0%	18.1%	18.4%	18.5%	19.1%	19.1%	19.1%	18.8%	18.4%	19.6%	18.5%	18.5%	
Total Funded Establishment		9,788.42	9,804.22	9,856.56	9,834.97	9,798.10	9,784.10	9,924.93	9,947.77	9,878.79	9,855.40	9,794.00	9,808.00	
IPR Appraisal Rate - Medical Staff	90%	80.5%	76.0%	79.2%	81.3%	77.3%	82.4%	82.0%	74.2%	84.8%	79.0%	74.0%	80.7%	
IPR Appraisal Rate - Non Medical Staff	90%	65.6%	64.1%	67.5%	70.4%	72.8%	80.3%	78.2%	76.1%	76.1%	75.1%	79.4%	72.2%	
% of Staff who have completed MAST training (in the last 12 months)		80.0%	79.7%	81.9%	85.0%	85.0%	85.9%	87.0%	87.0%	86.0%	86.0%	85.0%	86.0%	
Ward Staffing Unfilled Duty Hours	10%	5.7%	6.2%	4.6%	6.2%	4.8%	5.5%	4.8%	5.8%	5.9%	6.5%	5.9%	6.1%	
Safe Staffing Alerts	0	11	11	11	7	2	0	0	1	2	1	0	1	

Briefing

- Funded Establishment increased by 14 WTE to 9,808 WTE in October
- Vacancy Rate increased from 14.8% to 16.1%
- Sickness has remained above 3% target reporting 3.4% in October
- Mandatory and Statutory Training figures for October were recorded at 86%
- Appraisal rates remain below target, both Medical and Non Medical. Non medical appraisal rate decreased by 7.2% in October with performance of 72.2%
- Percentage of Staff vaccinated was 75.4% as at the 21st November 2017

Workforce

Agency Use



Briefing

- The Trust's annual agency spend target set by NHSI is £24.5m. There is an internal annual agency target of £22.0m. For October, the monthly target set was £1.68m.
- Total agency cost in October was £1.54m or 3.9% of the total pay costs. From M1-6 2017/18, the average agency cost was 5.0% of total pay costs.
- Agency cost decreased by £0.28m compared to September. In 2017/18 YTD, the Trust has performed better than the planned target by £0.89m.
- In October, there have mainly been decreases in Nursing (£0.30m) and Interims (£0.11m). The former reflects the transfer of some community.
- The biggest area of overspend was in Healthcare Scientist, which breached the target by £0.17m.
- These figures are compared to the internal target of £22.0m.

Meeting Title:	Trust Board		
Date:	7 December 2017	**Agenda No.**	4.2
Report Title:	Elective Care Recovery Programme Update		
Lead Director/ Manager:	Ellis Pullinger Chief Operating Officer		
Report Author:	Barry Mulholland Elective Care Recovery Programme Director		
Executive Summary:	**Cancer** • Good progress being made on the operational milestones within the plan at SGH and work is underway to further enhance the Infoflex system. • On plan for achievement of compliance in November. **Diagnostics** • Progress is continuing at pace and numerous milestones are now completed and delivered ahead of schedule • Much more control and grip in place on a weekly basis through a confirm and challenge approach. • On plan for achievement of compliance in December. **Treating Patients** **Cohort A (patients waiting greater than or equal to 40 weeks wait as at 01/09/17):** • Significant progress being made to reduce the numbers from the original baseline. On track to be completed as per plan by 31st December 2017. **Cohort B (patients with a 52-week breach date between 25/11/17 and 31/03/18)** • Significant progress being made to reduce the numbers from the original baseline. On track to be completed as per plan by 31st March 2018. **Return to Reporting** • Specification for the RTT incomplete PTL including Direct access and the Planned PTL Specification for first cut is complete. • The Plan has been revised to ensure all resources are focused on delivering the RTT incomplete and Planned PTL by the 22/12 **Training** • Work continues to understand and subsequently refine and reinforce the BAU Training approach as appropriate. IClip Refresher Training will be incorporated into the BAU training moving forward. E Learning and		

	RTT specific training rollout scheduled for January 2018. **NEXT STEPS** • New PTLs launching in December – booking from PTLs will be a focus moving forward • Implementation of maximum waiting cap for new outpatients – working to bring this cap down week on week • Continual focus on longest wait patients • Increased emphasis on specialty capacity plans • Contacting Phase 1 validation outputs in December and January that have the potential to need appointment as a result of Phase 1 validation • Increased focus on error prevention – implementation of new Data Quality dashboard • Continuation of progress with outcome form completion
Risks:	1. Planning and delivery of robust capacity plans 2. SOP development to ensure front line staff are working to agreed rules 3. Training resource to train staff on the right way to process patients [SOP's] and RTT knowledge through e-learning packages. 4. Delayed Cerner implementation at QMH

Programme Level Highlight Reports - Tooting

Cancer – Progress Against Milestones

Overall Project RAG		14 Day GP referral (93%)	93.98%	31 Day Treatment (96%)	96.2%	62 Day referral (85%)	76.7%

Workstream	RAG	Executive Summary
Operational		CIMS have provided a summary of work and quotation to address the required tumour type pathways, in addition to the Cerner/Infoflex data feed issues. Baseline SOPs and PTL assurance meetings have been arranged. Cancer pathway performance has been revised in order to increase productivity and highlight early escalation/intervention as required when delays in patient pathways occur.
QMH		Currently mobilising an external review to identify key areas of focus to address pathway issues for patients. This is an ongoing piece of work, which the operational team are responsible for overseeing.
Data Feed & Reporting		This work will not commence until early 2018.

Diagnostics – Progress Against Milestones

Project RAG		Key KPI	Breach numbers continue to decrease and are 87% lower than the position reported in mid August.

Executive Summary

- Progress is continuing at pace and numerous milestones are now completed and delivered ahead of schedule
- Recovery plan in place for Sleep studies and stress echo which is on target to complete as per trajectory
- Increased focus on endoscopy for the next 8 weeks with other actions now being completed
- Beyond the above the ECRP Project plan was revised on the 02/11/2017 and the main next step is to scope what is feasible and sensible (in liaison with the Manager of Information) regarding the improvement of recording diagnostic procedures by enabling recording with an OPECS code before the end of Nov 2017

Treating Patients – Progress Against Milestones

Project RAG	

Workstream	RAG	Executive Summary
Backlog and Waiting List management		**Cohort A** (patients waiting greater than or equal to 40 weeks wait as at 01/09/17.) • Significant progress being made to reduce the numbers from the original baseline. On track to be completed as per plan by 31st December 2017. **Cohort B** (patients with a 52 week breach date between 25/11/17 and 31/03/18) • Significant progress being made to reduce the numbers from the original baseline. On track to be completed as per plan by 31st March 2018.
Harm Reviews		**Phase 1** – Historical patients identified by Cymbio that have been lost to follow up/Cancer and RTT 52 Week Breaches • No significant harm identified to date from the programme. **Phase 2** – remaining historical patients identified by Cymbio that have been lost to follow up/Planned activity (104 days) and RTT 52 Week Breaches • SOP has been drafted and presented at Clinical Harm Review Panel 20/11/17 and in future performance on this criteria will only be reported to the ECR Programme

Return to Reporting – Progress Against Milestones

Project RAG	

Workstream	RAG	Executive Summary
PTL Creation		Specification for the RTT incomplete PTL including Direct access and the Planned PTL Specification for first cut is complete. The Plan has been revised to ensure all resources are focused on delivering the RTT incomplete and Planned PTL by the 22/12
Historic Validation		Workstream on schedule with the level of historic validation above the baseline trajectory Joint meetings between the Trust and Cymbio are taking place and there is a collaborative approach
BAU Validation		Completed Cohort B and on schedule to deliver against high-level plan Focus for next two weeks in on panned waiting list and unknown clock starts in order to support other Workstreams

Training – Progress Against Milestones

Project RAG	

Workstream	RAG	Executive Summary
SOP Rollout		A Paper outlining the SOP resource requirements and proposal for the purchasing of a SOP database is with the Executive team for endorsement and sign off. The SOP plan has been revised following an appreciation of the challenges to refine and rollout a SOP across the Trust. The focus now prior to 2018 is to implement the guide for Registration into CBS
CDOF Rollout		45% of all Care Groups are live with the new CDOF and significant performance improvement has been seen in Phase 1 Care Groups to date. However 20% of the clinicians in Phase 1 specialities and 83% of clinicians in Phase 2a specialities still require formal training. Performance target is 98%. Phase 1 all care groups KPI (>=) to 92% - Phase 2a KPI (>=) 85%. Trust overall KPI for reporting period 79% (Trust Target is 83%)
Training Plan		Work continues to understand and subsequently refine and reinforce the BAU Training approach as appropriate. IClip Refresher Training will be incorporated into the BAU training moving forward. E Learning and RTT specific training rollout scheduled for January 2018.
Error Prevention		Original Error Prevention approach was focused on SOP development and delivery to support operational teams and reduce errors. The approach has now matured and further to SOP rollout also defines and measures a number of KPIs which will permit the team to monitor a number of high impact errors with a supporting training approach to retrain the departments and users who consistently enter errors into the system. This approach will be monitored and adjusted as appropriate through the measurement of the newly defined KPIs over the next 2 months to ensure maximum benefit is being achieved from the limited training resource

Programme Level Highlight Reports – QMH

Treating Patients – Progress Against Milestones

Overall Project RAG	

Workstream	RAG	Executive Summary
Business Rhythm		As of 30/10/2017, no patients had waited over 10 weeks for receipt of a letter. This has been maintained to-date.
Harm Reviews		Implementing a re-worked clinical harm dashboard is on hold until the full-time arrival of Harm Lead. Harm Lead will be overseeing the implementation of this work at SGH. It is QMH's intention to replicate an identical approach.
Capacity and Demand		The majority of capacity and demand work will not commence until 2018. Progress is being made around agreeing the approach to managing long wait patients, which remains the chief goal for the rest of 2017.
Outsourcing		It is yet to be decided whether outsourcing will be a necessary course of action for the QMH site.

Return to Reporting – Progress Against Milestones

Overall Project RAG	

Workstream	RAG	Executive Summary
PTL Creation		A recovery plan meeting took place on 15th November in order to address delays around the Live Feed. This has outlined an approach to bring back plans in line with overall delivery targets.
Historic Validation		Phase 1 validation has been completed, Phase 2 validation has commenced. Overall, good progress is being made.
BAU Validation		A re-profiling of the validation cohorts for BAU has been undertaken, which should have greater impact on externally reported waiting lists.

Training – Progress Against Milestones

Project RAG	

Workstream	RAG	Executive Summary
SOP Rollout		There have been some delays in the completion of 3 SOPs. Additional support is now in place to deliver this, but a two week delay in completion was submitted through the change control request process to extend to Mid-November. All missed milestones are near completion, and therefore no significant concerns exist.

Programme Risks

Key Risks			
Risk / Cause / Impact	**RAG Score**	**Owner**	**Mitigating action/s**
Embedding key SOPs across SGH and QMH **Risk**: There is a risk that the validation burden could continue to increase until key SOPs are embedded into the organisation at the earliest opportunity to mitigate some of the causes of the cohorts which require validation **Cause**: Incorrect entries into Cerner **Impact**: An increase in the time for the Trust to return to National Reporting and the requirement of a significantly sized validation team. Patients also at risk of getting 'lost' in the system without appropriate standardised management and tracking increasing long waiting patients and risk of harm.	16	Ellis Pullinger	**Controls in place**: Strong communications on the need and consequences. Lessons learnt from the outset **Actions**: • 'How to guide' being developed to address requirement in short term • The requirement to a secure competent SOP lead for Programme made a top priority (Paper now produced which requires endorsement to agree funding) • Error Prevention workstream pursuing a targeted, data driven approach to 'support' and retrain' those that are consistently making the largest amount of errors – this will be monitored by refined workstream KPIs
Significant gaps and high % of non substantive filled roles in Programme Resource **Risk**: There is a risk that areas which require significant momentum in SOP development and Trg will be limited due to current resource Gaps. Furthermore currently there is an overreliance on interim non substantive staff to fill key Programme roles which is a concern for the medium/long term success of the Programme **Cause**: Underinvestment in key positions within Trust **Impact**: Limited progress will be made in key areas and the NHSI imposed deadlines will become increasingly unachievable	16	Ellis Pullinger	**Controls in place**: Project Resources are working to priorities across the Programme Plan **Actions:** • SOP lead requires appointing ASAP • Trg Lead requires appointing ASAP • Continue to appoint Trust employees to take ownership and responsibility for delivery where appropriate and available to set the Programme up for long term success
The correct use of Cerner and the delay in the rollout of Cerner at QMH **Risk**: There is a risk of staff not knowing how to use Cerner appropriately and furthermore the delay in the rollout of Cerner at QMH **Cause**: Lack of appropriate training, culture of acceptance with bad habits and the lack of appropriate guides (SOPS) for staff which are compounded by the prolonged delays surrounding approval for Cerner in QMH **Impact**: The delayed rollout of Cerner at QMH will reduce the Trust's ability to strategically develop the site with other services and will limit the overall success of this Programme and the Trusts aspirations to return to National Reporting	15	Shiren Patel	**Controls in place**: Strong project management and robust plans to tackle the use and rollout of Cerner as well as appropriate Trust resources made available as part of the implementation phase. **Actions**: • Engagement form the Executive team with NHSI to ensure the funding is approved for Cerner at QMH as a matter of priority (Milestone for funding approval currently missed) • 'How to guides' SOPs and revising the training approach to ensure the correct use of Cerner is incorporated into BAU training as a Programme priority and resourced appropriately • Approval of training proposal by Executive team to secure resource uplift
Risk: There is a risk that patients may be subject to harm if Consultants do not complete the outcome functionality appropriately **Cause**: patient outcome is not recorded and therefore tracked and monitored appropriately **Impact**: Patients maybe subject to harm and furthermore this creates incomplete data and erodes confidence in PTLs which in turn impacts the overall progress towards returning to National Reporting	12	Andy Rhodes	**Actions:** • CDOF rollout, training and support to users across the Trust • **Clinician engagement and training to be discussed with AR to drive improvement in Clinician training % and subsequent form completion** • The move to Electronic Outcomes as a priority for the Trust
Programme link with Operations and limited capacity **Risk**: There is a risk that the Programme is not linked in with Operations which will severely limit Programme success **Cause**: The Governance structure is not fully established for all to understand who should attend the Programme meetings to link the operational teams in with the ECRP. Furthermore the Trusts Clinical Directorates are not currently fully engaged in the Programme aims and challenges **Impact**: This lack of engagement could result in a lack of ownership and understanding of the entirety of the backlog problem, which will hamper the ability to increase the run rate to realise full recovery	↑ 10	Ellis Pullinger	**Controls in place**: Engagement by Programme Leadership and Executives **Actions:** • Outline Governance communicated to all DDOs to facilitate understanding of what operational rep can best represent them at weekly meetings as required • Invites for all meetings revised to ensure appropriate representation to develop understanding and drive ownership • Access Committee meeting established to further foster and improve the link between the Programme and Operations
Identification of patients at risk of potential harm **Risk**: There is a risk that patients maybe subject to potential harm due to the current pathway challenges **Cause**: 'Dirty' PTL, non standardised processes and the incorrect use of Cerner **Impact:** Patients at potential risk of avoidable harm	↓ 10	Andy Rhodes	**Controls in place**: Enhanced waiting list management, validation and review of all patients within current defined criteria **Actions**: • Harm review criteria under review • Creation of new PTL • Introduction of CDOF and SOPs as well as revising BAU staff training

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 December 2017	**Agenda No.**	4.3
Report Title:	Winter Plan		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Brendan Mc Dermott, Head of Operations		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify) (select using highlight)		
Executive Summary:	This paper provides a highlight report on St. George's preparedness for winter 2017.18. Included are: 1. The updated Trust escalation action cards 2. Full Capacity Protocol 3. Operations Centre - Standard Operating Procedure The full / detailed winter preparedness plan can be found in the reading room on Boardpad.		
Recommendation:	Approve plans outlined for Winter Preparedness 2017-18.		
Supports			
Trust Strategic Objective:	Right care, right place, right time.		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Leadership and Improvement Capability (well-led)		
Implications			
Risk:	Our processes for admitting, reviewing, treating, discharging and following up both elective and non-elective patients on their pathway are not timely or robust, resulting in poor, delayed or missed treatment.		
Legal/Regulatory:	Compliance with the Health & Social care Act 2018 and CQC Registration Regulations.		
Resources:	N/A		
Previously Considered by:	EMT -13.11.2017 & 27.11.2017	**Date:**	07.12.2017
Appendices:	The full / detailed plan can be found in the reading room on Boardpad.		

Winter Preparedness

1.0 PURPOSE

The Trust has developed a detailed surge capacity management plan including cold weather plan for 2017.18. This was approved by EMT on 13.11.2017 and 27.11.2017

The purpose of this document is to outline the current and proposed changes to capacity and patients pathways as well as changes to escalation plans to ensure St. Georges is fully prepared to continue to deliver quality services throughout winter 2017.18

This paper is a summary document of the detailed winter preparedness plan which can be found in the reading room on Boardpad.

2.0 CONTEXT

2.1 It is recognised that there is an increase in emergency admissions and length of stay during winter. The Trust plan is developed to ensure we can meet this increased demand and continue to deliver quality services and without impacting on planned (elective) services.

The plan is developed with the local surge hub to ensure a system-wide approach.

3.0 Escalation Plans

3.1 Surge Capacity & Escalation: The trust has a well-tested Standard Operating Procedure for day–to-day operations. This has been further updated to include detailed escalation at differing levels with actions for the management of surges in demand.

The escalation cards have been updated to include triggers that describe escalation at different levels (both Emergency Department & bed capacity). Additionally, the escalation cards have detailed actions required by individuals / roles at certain levels of escalation, particularly at RED and BLACK escalation. It is recognised that certain actions impact on clinician time and may require changes to daily routine / job plan to ensure the Trust return to Amber / Green status early. Implementation may be at short notice.

Black escalation has been updated to include the 'Full Capacity Protocol'. This aim is that we have a plan where risk is shared across the organisation and we can maintain to operate a safe Emergency Department (ED).

There have no changes to all other escalation plans, previously discussed (Delayed Transfers of Care, Repatriations, and Critical Care).

There is no plan for the use of escalation beds during winter. There is no suitable area in St. Georges where further beds can be opened at short notice.

3.2 Delayed Transfers of Care (DTOCs): The Trust has developed a detailed escalation plan for the management of DTOCs. It clearly outlines roles & responsibilities of certain staff members at delayed days 2, 3, 4 and 5. A twice weekly meeting with Wandsworth and Merton Social Services meeting will continue throughout winter.

3.3 Repatriations: St. Georges has an agreed protocol for all hospitals in South West London that patients referred will be repatriated to their local hospital within 48 hrs. For Stroke mimic patients this is 24hrs. The escalation process has been updated and clearly outlines roles and responsibilities at days 1, 2 and 3.

3.4 Critical Care: A detailed escalation plan for critical care has been developed by the clinicians. There is no plan to 'Treat & Transfer'. All surges will be managed in-house.

4.0 Division of MedCard

4.1 Bed Capacity

The aim of St George's winter plan is to ensure that internal processes and wider systems are resilient and fit for purpose to meet the anticipated level of demand whilst maintaining optimal patient safety.

A detailed demand and capacity review has been completed based on 2016.17 elective and non-elective activity. This has been adjusted for a 92% and 95% bed occupancy. The overall result suggests that by Q4 Acute Medicine and Senior Health will have a bed capacity gap of 15 beds (92% occupancy), taking into account mitigating actions outlined below. This result is based on St. George's current bed base and does not assume any further bed reductions. Additionally, there is no assumed increase in elective activity to recover the RTT position.

The division have agreed a number of mitigating action which are summarised below.

Bed gap	Plan	By when	Remaining gap
35	12 beds from surgery	Immediate and complete	-23
	Open closed beds in Allingham ward (2 beds)	Friday 24th November	-21
	CHS brokerage (5 beds)	December 11th 2017	-16
	SAFER roll out across all wards (estimated) discharge/LOS (5 beds)	Complete by 11th December	-11
	Further release of surgery beds (16)	2nd January 2018	+5
	AAA opening (further 6 beds)	February 2018	

4.2 Ambulatory Care: The Ambulatory Care Unit based on the Acute Medical Unit (AMU) operates across 7 days a week from 09.00 to 21.00 hours Monday to Friday and from 10.00 to 18.00 Saturday and Sunday. The unit has dedicated Consultant cover on weekdays and is Nurse Practitioner-led with support from the on-call Medical team on a weekend.

The service is open to direct referrals from GPs in addition to the Emergency Department. There is a CQUIN in place for 2017/18 to increase the proportion of referrals to Ambulatory Care from the Emergency Department. Both services have been engaging with staff to deliver this.

There are agreed capital plans to expand the Ambulatory Care Unit based at the entrance of the Acute Medical Unit on the Ground Floor, St James' Wing, to enable the introduction of a best-practice 'process' approach to the delivery of ambulatory care, as opposed to a pathway specific model. The development is supported by £980k central funding from the Department of Health. It is planned to have this in place by February / March 2018, subject to the enabling moves and decant of the existing Ambulatory Care Unit taking place within the required timeframes.

The development will enable all medical patients to be seen in an ambulatory care setting where clinically appropriate, ensuring rapid access to diagnostics and treatment and avoiding an acute admission where possible.

The building works started on 27.11.2017

The Ambulatory Care Unit will not be utilised as an escalation area.

4.3 Care Home Select – Discharge Processes

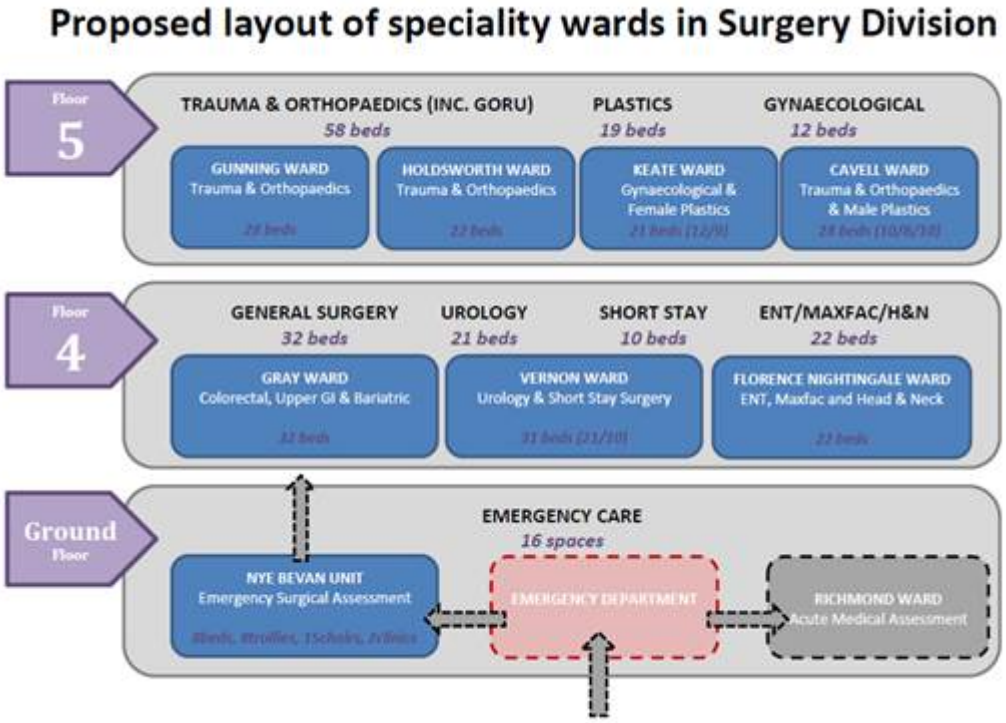
To contribute to risk mitigation for the winter period and enable patient flow, the Trust has purchased specialist discharge services from Care Home Select (CHS) for up to 20 patients per month who have typically complex package of care and home placement needs. CHS will serve as an enabler to help navigate specific patients through the discharge process which is expected to positively generate the equivalent bed day savings of up to 150 bed days/month (up to 5 beds) when fully mobilised from 11th December 2017.

5.0 Div. of Surgery & Neurosciences

5.1 The Division is rolling out, at pace, SAFER with a plan to provide Medicine with additional beds in January 2018, without impacting on the RTT programme

5.2 Wards.

The division have agreed a reconfiguration of wards per speciality as below:



6.0 Division of Women's & Children's

6.1 Paediatric Ambulatory Care

There is a capital plan to develop a Children's Ambulatory Care Unit on the 5th floor Lanesborough wing, co-located with paediatric inpatients. This will provide sharing of skilled staff, management by paediatric and children's nursing senior staff and maintain the flow of patients from and to inpatient wards if needed.

The service will care for and treat all children and young people up to their 18th birthday who are referred to paediatric medicine with urgent care needs; either from a local GP, from another community healthcare professional or from ED. Pathways will be developed to guide clinicians as to patients that may be acceptable for ambulatory care. Space to develop the unit has been identified by the children's directorate. The current planned opening date is December 2017. The CAU will be open for 12 hours a day between 10am and 10pm, to address peak times for paediatric attendances to urgent care.

The Children's Ambulatory Unit SHOULD not be used as an escalation area.

7.0 Community Services:

The patient pathway from St. Georges to QMH has been agreed and the plan is that QMH will operate at 98% occupancy daily.

8.0 Cold weather & Flu vaccination programme:

8.1 Flu Vaccination:

The Flu vaccination campaign runs every year, this year from late September through to March. The trust managed to achieve 72.7% front line clinical staff vaccinated last year (the target being 75%) which was above the national average (PHE reported 63.2% of all frontline HCWs (from all trusts) with direct patient care reported to have received the 2016 to 2017 seasonal influenza vaccine in England).

To date (23.11.2017) the Trust had achieved 75.9%. Our aim is 80%

8.2 Cold Weather Alerts

Public Health England maintain the Cold Weather Plan for the UK on behalf of the UK Government. Every year the Met Office is commissioned to provide a cold weather alerting system that allows forecasting of weather conditions and triggers for the levels of 'action' required as the weather becomes more unsettled and colder. These alerts include a response for the Health sector. The levels range from Winter preparedness and action (Level 1) to 'alert and readiness', (level 2) severe weather 'action' (Level 3) to Major Incident – Emergency response (Government intervention level 4).

St Georges receives these alerts direct from the Met Office (via the Emergency Planning Liaison officer) and from the Commissioning Support Unit when they anticipate there may need to be a response from acute and community providers. These alerts are dissemination by the EPLO or Head of Operations on receipt of alert, with advice on actions for service areas and communications to staff and patients required.

The detail of the Cold Weather Alerts and planned actions are included in the Cold Weather plan, published on the Trust intranet when finalised.

9.0 Risks

The Trust has requested system-wide support from Primary Care, NHS111, Ambulances Services, Social Care and community services. Merton Local Authority have confirmed plans for increased capacity in Social Care (reablement services by 20%). It is yet to be confirmed what plans other organisations have in place and how they will contribute to St. George's delivery. A further system-wide planning workshop with all partners has been organised by the CSU for 27th November.

The Trust is currently updating the Demand & Capacity Model.

- Lack of clinician support to fully implement the 'Full Capacity Protocol'.
- Delivery of ambulatory care development within timescale and with sufficient resources to enable implementation of 'process' model to maximise admission avoidance in Q4.
- Requirement for system wide engagement in implementing discharge to assess models.
- Insufficient staff to provide cover for escalation beds identified as a result of internal bed reconfiguration.

10.0 Resources

10**.1 Financial.** There is no additional financial resource available for winter 2017.18

The development and implementation of the new Ambulatory Care unit is estimated to cost £980K (Capital).

11.0 RECOMMENDATION

Agree

Author: Brendan Mc Dermott
Date: 01.12.2017

Report to the Board from: Finance and Investment Committee

Committee Chair: Ann Beasley

Date of Committee Meeting: 29 November 2017

1.0 Matters for the Board's Attention

1.1 The Committee met for the first time with its new remit following the Governance Review and accordingly agreed in principle its new terms of reference. There are still some issues to resolve around its core role, for example the extent of the requirement for reporting performance and activity given the potential overlap with Quality & Safety Committee and whether the Committee has a role in estates and information technology beyond capital planning. Committee members agreed to reflect on these issues outside of the meeting with the aim of finalising the terms of reference at the next meeting.

1.2 There was a discussion on the risks allocated to the Committee as part of the Board Assurance Framework but this needed to have had broader prior engagement from the finance community to be most productive. It was agreed that such engagement would happen within the next two weeks following the meeting, drawing on the expertise of the NEDs where appropriate, in order to ensure a full discussion at the Committee's next meeting.

1.3 On performance and activity, the Committee noted how busy Emergency Department (ED) had been and discussed the measures in train to improve performance against the four hour standard. A recent risk summit on ED had been well attended demonstrating the commitment of staff throughout the hospital to improve ED performance. The Committee welcomed the improvement against the Cancer standards and thanked the COO and Consultant teams for their efforts.

1.4 On workforce issues, the Committee welcomed news that at that stage 77% of staff had had their flu jabs, the improved response rate on the staff survey, albeit still under 50% and the continued focus on reducing the use of agency staff.

1.5 The Committee had a further discussion on whether additional activity would materialise within Neurosurgery and was assured that some extra activity would start in January but noted that this issue needed to remain under review.

1.6 The Committee considered the monthly finance report based on data up to the end of October and the forecast for Income and Expenditure until the end of the year. Members reflected that whilst the forecast was unchanged from last month, it remained both challenging to achieve and still in excess of the deficit target agreed with NHS Improvement. Members took some assurance from the robust challenge process that is being undertaken to ensure grip.

1.7 On business and financial planning for 2018/19, the Committee welcomed the more rigorous approach this year and looked forward to being able to agree budgets before the start of the next financial year.

1.8. The Committee ratified a business case for investing in ambulatory care which should, once implemented, be part of the solution to improving ED performance.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance and Investment Committee on 29 November 2017 for information and assurance.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 December 2017	**Agenda No.**	5.2
Report Title:	Finance Report Month 07 (October 2017)		
Lead Director/ Manager:	Andrew Grimshaw, Chief Finance Officer		
Report Author:	Andrew Grimshaw, Chief Finance Officer		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	The Trust is reporting a deficit of £41.9m at the end of the October, an adverse variance to plan of £4.8m. While this position is not in line with plan, it is consistent with the current forecast reported to NHS Improvement. Within the position, income is adverse to plan with this being partly offset by expenditure underspends. The Executive Team continue to work to improve the position and move as close to the year-end planned deficit of £45m as possible. The current forecast is £53m deficit.		
Recommendation:	The Board is asked to receive the update and confirm agreement on next steps.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-led.		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	Board Assurance Framework, SR5: Financial efficiency, forecasting and accountability is not seen as a priority for service managers or wider workforce; resulting in overspending, poor budgetary management which in turn may lead to poor service delivery and regulatory action.		
Legal/Regulatory	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence.		
Resources:			
Previously Considered by:	Finance & Performance Committee	**Date:**	29.11.17
Appendices:	Month 7 Finance Report		

St George's University Hospitals NHS
NHS Foundation Trust

Financial Report Month 7 (October 2017)

Chief Finance Officer

7th December 2017

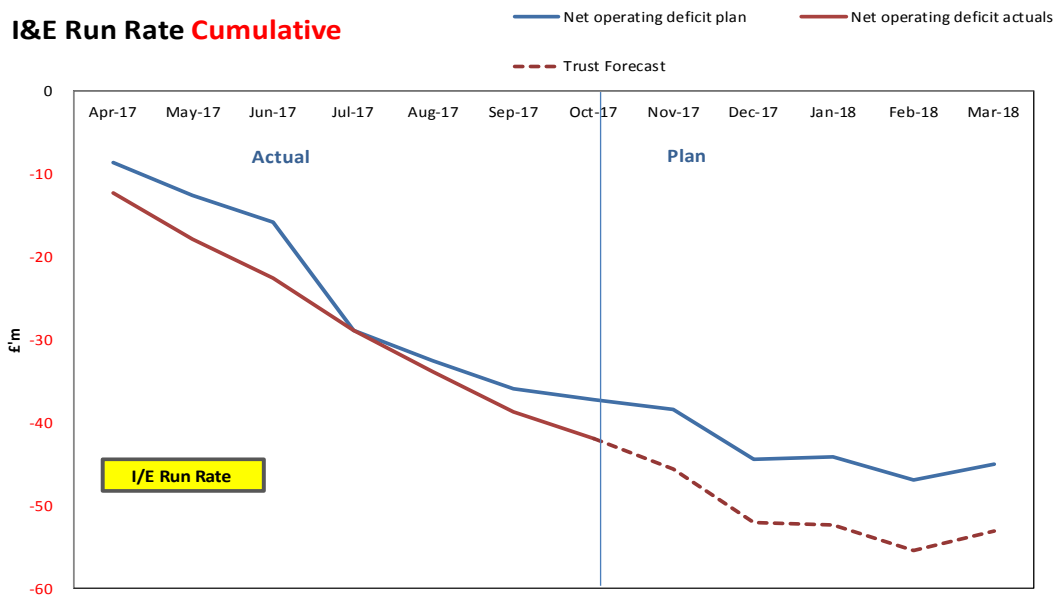
Executive Summary – Month 07 (October)

St George's University Hospitals NHS
NHS Foundation Trust

Area	Key issues	Current month (YTD)	Previous month (YTD)
Target deficit	The trust is reporting a deficit of £41.9m at the end of the October, an adverse variance to plan of £4.8m. However, the over delivery of CIPs totalling £3.0m is supporting this position. If these CIPs were excluded, the underlying position would be £7.8m adverse to plan. Within the position income is adverse to plan, with this being partly offset by Pay expenditure underspend.	£4.8m Adv to plan	£2.8m Adv to plan
Income	Income is being reported at £9.2m adverse to plan year to date, with an adverse movement in month of £0.5m. Included within the month 7 results are £0.5m of income relating to prior periods. There is lower than planned income of £5.0m in Elective and Non Elective of £0.6m YTD. Exclusions income is lower by £3.2m, but is offset by reduced expenditure. Non-SLA income is also under plan by £2.5m as well, although £1.5m of this is offset in SWLP.	£9.2m Adv to plan	£8.7m Adv to plan
Expenditure	Expenditure is £4.0m favourable to plan at month 7, £1.7m adverse in month. The majority of the favourable position is in pay, £6.7m YTD with underspends seen in Nursing, Non Clinical and ST&T categories. Non-pay is £2.7m overspent, and the main drivers being IT MSA costs, RTA bad debt and the impact of the removal of tendered community services.	£4.0m Fav to plan	£5.7m Fav to plan
CIP	The Trust planned to deliver £14.3m of CIPs by the end of October. To date, £17.3m of CIPs have been delivered; £6.3m of income actions and £11.0m of expenditure reductions. As noted above, the over delivery of CIPs is supporting the trust's bottom line. If these were excluded then the overall favourable variance from the planned deficit would move to a £7.8m adverse position.	£3.0m Fav to plan	£3.8m Fav to plan
Capital	Capital expenditure of £25.7m has been incurred year to date. This is £0.9m below plan YTD. The capital budget has been formulated on the expectation that the Trust will secure further DH capital funding of approx £8.4m to finance extensive investment in the IT infrastructure. Despite an independent audit recommending approval of £8.4m of this bid, the Trust has not received approval from NHSI. Therefore the Trust is in the process of undertaking a re-forecasting and re-prioritisation exercise to ensure the minimum level of IT capital investment required this year may be accommodated within the original capital budget. The capital budget for 2017/18 has been increased from £45.3m to £46.2m for the capital project which will be financed by a loan from Moorfields NHS Foundation Trust.	£0.9m Fav to plan	£0.1m Fav to plan
Cash	At the end of Month 7, the Trust's cash balance was £10.5m, which is better than plan by £7.5m. The Trust has received £9.6m more borrowing in November and has requested a further approx. £6.1m for December to finance the on-going deficit. These borrowings are subject to an interest rate of 6% for the amounts drawn up to October and 3.5% for the amount drawn in November (owing to the Trust meeting the in-month financial forecast in October).	£7.5m Fav to plan	£2.6m Fav to plan
Financial Risk Rating-Use of Resources (UOR)	At the end of October, the Trust's UOR score was: Capital service cover rating: Plan – 4; Actual – 4 Liquidity rating: Plan – 4; Actual – 4 I&E margin rating: Plan – 4; Actual – 4 Distance from financial plan: Plan – n/a; Actual – 3 Agency rating: Plan – 1; Actual – 1	Overall score 4	Overall score 4

1. Month 7 Financial Performance

L2 Cat	L3 Cat	M7 Budget (£m)	M7 Actual (£m)	M7 Variance (£m)	M7 Variance %	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	YTD Variance %	Full Year Budget (£m)
Income	SLA Income	58.28	57.96	(0.32)	(0.5%)	392.34	385.65	(6.68)	(1.7%)	675.55
	Other Income	9.67	9.51	(0.16)	(1.6%)	67.70	65.21	(2.49)	(3.7%)	116.24
Income Total		67.95	67.47	(0.48)	(0.7%)	460.04	450.86	(9.18)	(2.0%)	791.79
Expenditure	Pay	(40.29)	(39.73)	0.56	1.4%	(289.70)	(282.99)	6.71	2.3%	(487.80)
	Non Pay	(26.04)	(28.29)	(2.24)	(8.6%)	(187.66)	(190.37)	(2.71)	(1.4%)	(314.98)
Expenditure Total		(66.33)	(68.02)	(1.68)	(2.5%)	(477.36)	(473.36)	4.00	0.8%	(802.77)
Post Ebitda		(2.83)	(2.68)	0.16	5.5%	(19.84)	(19.44)	0.40	2.0%	(34.02)
Grand Total		(1.22)	(3.22)	(2.00)	(164.6%)	(37.16)	(41.93)	(4.77)	(12.8%)	(45.00)



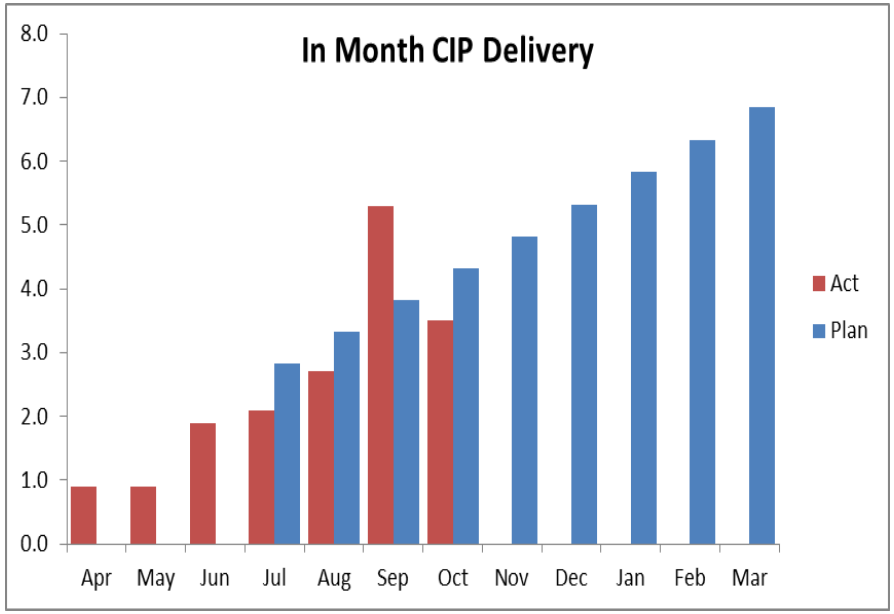
Trust Overview

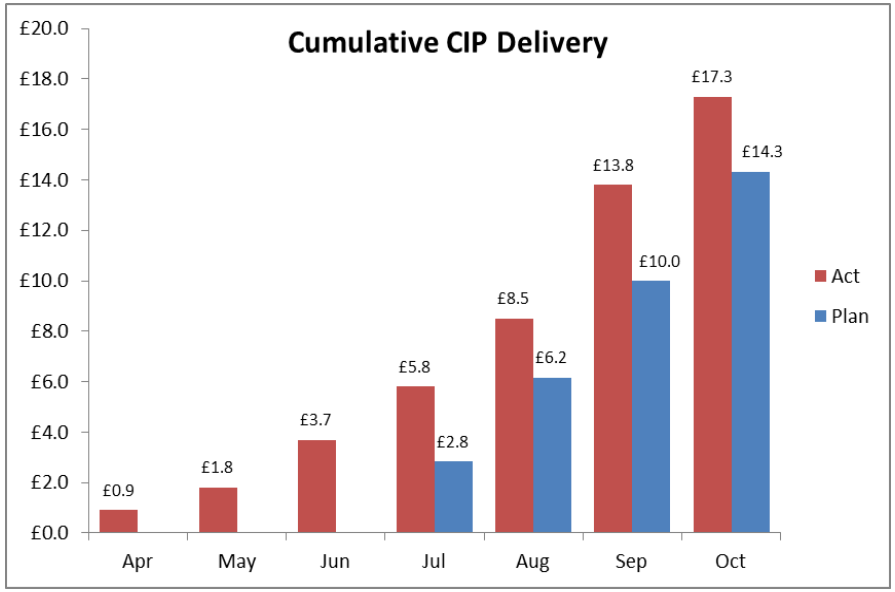
- Overall the Trust is reporting a deficit of £41.9m at the end of Month 07, an adverse variance to plan of £4.8m.
- **Income** is £9.2m adverse to plan. £4.0m of the under recovery of income is directly offset with underspends in expenditure (SLA Pass-through £3.0m, South West London Pathology £1.0m).
- **SLA Income** is £6.7m under plan, owing to shortfalls of £3.0m on pass-through, £5.0m in Elective and £0.6m in Non Elective offset by £1.1m over performance in Outpatients, Beddays and A&E. A £0.5m prior period SLA income catch-up in month is mainly volume (£0.5m). A £1.8m re-categorisation of RTT challenges to non-pay in M7 is impacting the in-month position (underlying income is £1.8m lower than reported).
- **Other income** under plan by £2.5m; the key drivers are Diagnostics (£1.0m) which is directly offset in SLA income and non-pay, lower than planned private patients income (£0.9m), and an under-performance on direct access pathology income.
- **Pay** is £6.7m favourable, with all major staff groups underspending with the exception of medical pay.
- **Non-pay** is £2.7m overspent, due to expenditure on the ECRP project that was budgeted within income (challenges) (£1.8m), as well as higher than planned spend in IT and Estates (£0.9m) which is forecast to come back within budget by year end. The ECRP cost re-categorisation is reflected in M7.
- **CIP delivery** of £17.3m is £3.0m ahead of plan. If this were excluded from the reported position then the overall position would show an adverse variance to plan of £7.8m. This indicates there is overall pressure in the Trusts baseline financial position at month 07, with the primary driver lower than planned income recovery.

Forecast to year end

- Current working deficit forecast at M7 is a deficit of £53m, and further challenges remain.

2. Month 7 CIP Performance





CIP Overview

- At the end of Month 7, the Trust is reporting the cumulative delivery of £17.3m of savings from Cost Improvement Programmes (CIPs)
- £3.5m of savings were reported in October compared to an average of £2.3m per month in the first six months of the year. As highlighted last month the additional savings reported in September related to the confirmation of a number of schemes, which although within run rate in previous months, where reported as CIPs for the first time

NB - In the revised financial plan CIPs are not planned to deliver during Q1 meaning the value of the CIPs 'ahead of plan' is favourably supporting the Trust's reported bottom line. This is the reason the two graphs on the left do not show any planned delivery (blue bars) in the first three months. It is also important to note that in the revised financial plan the full year CIP target is shown as £43.5m in the graphs and variances as CIP Contingency of £3.5m is used to offset the total value.

Actions

- The Trust requires CIP plans which deliver £47.0m of savings in 2017/18 and an on going 'Pipeline' of schemes in development for 2018/19
- As reported at November's FSM meeting £45.1m of the Trust's schemes have been rated 'Green'. To provide assurance that the CIP plans will deliver the required level of savings the Trust needs to progress a further £1.9m of CIP plans to 'Green' . It is also critical that the existing Green schemes deliver their planned savings in line with expectations to support the achievement of the year end financial position
- The Trust needs to identify and implement additional recovery actions necessary so that it can deliver its forecast year end deficit of £53m. Further CIP plans and/or financial controls will be required to mitigate any shortfall or additional in-year pressures

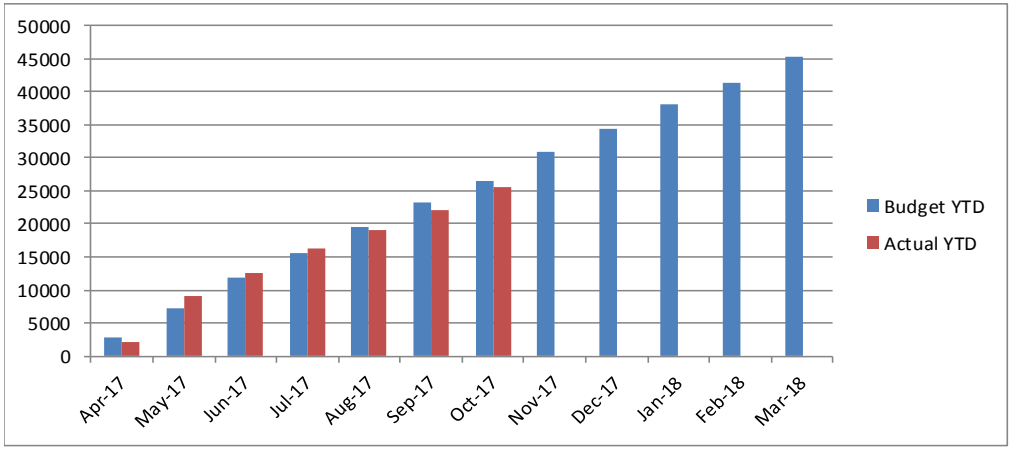
3. Month 7 Capital Programme

Capital expenditure summary M07 2017/18

Spend category	2017/18 Budget** £000	M07 YTD Budget £000	M07 YTD actual £000	*M07 YTD Variance*
Energy Perform Contract	**5,555**	**5,555**	**5,418**	*137*
Infra Renewal	**10,492**	**5,345**	**3,231**	*2,114*
Med Eqpt	**3,194**	**2,744**	**2,721**	*23*
Major Projs	**22,069**	**9,178**	**6,300**	*2,878*
IMT	**2,567**	**2,568**	**6,730**	*-4,162*
Other	**601**	**388**	**1,155**	*-767*
SWL PATH	**684**	**217**	**114**	*103*
Contingency	**1,096**	**537**	**0**	*537*
Total	**46,258**	**26,532**	**25,669**	***863***

Annual budget increased by £0.975m re: Moorfields loan-financed project approved by the board in October.

Capital prog. 2017/18 - budget & actual expenditure - cumulative



- The capital budget for 2017/18 has been increased from £45.3m to £46.2m for the capital project which will be financed by a loan from Moorfields NHS Foundation Trust recently approved by the board.
- Capital expenditure in October was £3.6m and M07 YTD expenditure is £25.6m giving rise to an under spend of £0.9m YTD.
- The capital budget was formulated at the beginning of the year on the basis the Trust would secure DH capital of £8.4m to finance investment in IT infrastructure. Despite an independent audit recommending approval of this bid, the Trust has not received approval from NHSI.
- Therefore the Trust has now completed a re-forecasting and re-prioritisation exercise to ensure the minimum level of IT capital investment required this year may still be accommodated within the existing budget. This exercise involved identifying expenditure in other categories which may be rescheduled to next year. The M07 forecast outturn is £45.3m against the updated budget of £46.3m i.e. a forecast UNDER spend of £1m (c/f M04: £7m, M05: £4.7m M06: £2.1m).
- Accordingly the restriction on the procurement of approved medical equipment purchases put in place while the Trust was completing the re-forecasting exercise has been partially lifted.

4. Month 7 YTD Analysis of Cash Movement

Source and application of funds - cash movement analysis: 2017/18 outturn vs Plan

		Actual M07 vs Plan M07	
	Plan YTD £m	Actual YTD £m	*Actual YTD VAR £m*
Cash balance 01.04.17	5.0	6.0	*1.0*
Income and expenditure deficit	-37.9	-42.6	*-4.8*
Depreciation	15.8	13.8	*-2.0*
Interest payable	4.5	4.5	*0.0*
PDC dividend	2.0	1.9	*-0.1*
Other non-cash items	-0.1	-0.1	*0.0*
Operating deficit	**-15.7**	**-22.6**	-6.9
Change in stock	-0.2	-0.7	*-0.6*
Change in debtors	-12.6	6.7	*19.3*
Change in creditors	12.1	5.2	*-6.9*
Net change in working capital	-0.7	11.2	11.8
Capital spend (excl leases)	-27.8	-24.7	*3.1*
Interest paid	-3.8	-3.8	*0.0*
PDC dividend paid	-1.7	-1.7	*0.0*
Other	-0.2	-0.2	*0.0*
Investing activities	-33.4	-30.3	3.1
WCF borrowing	36.7	34.5	*-2.2*
Capital loans	16.2	16.2	*0.0*
Loan/finance lease repayments	-5.1	-4.5	*0.6*
Cash balance 31.10.17	**3.0**	**10.5**	*7.5*

M07 YTD cash movement

- The cumulative M07 I&E deficit is £42.6m – £4.8m worse than plan.
- Within the I&E deficit of £42.6m, depreciation (£13.8m) does not impact cash. The charges for interest payable (£4.5m) and PDC dividend (£1.9m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £22.6m.
- The operating variance from plan of £6.9m in cash is in part attributable to the lower depreciation charge.
- Working capital performed overall- £11.8m better than plan. The correspondence in relation to late supplier payments appears to have increased over the last month. The root causes are being investigated with a view to implementing sustainable improvements to processes in order to ameliorate the situation.
- The Trust borrowed approx.£4.5m from working capital facilities in M07 and has borrowed £34.5m YTD which is £2.2m less than plan. The Trust has received £9.6m more borrowing in November and has requested a further approx. £6.1m for December to finance the on-going deficit. These borrowings are subject to an interest rate of 6% for the amounts drawn up to October and 3.5% for the amount drawn in November (owing to the Trust meeting the in-month financial forecast in October).
- The Trust has drawn down its £16.2m capital loan in full to finance expenditure on the NHSI-financed capital projects per the successful bid made last year.

5. Balance Sheet as at Month 7 2017/18

St George's University Hospitals NHS
NHS Foundation Trust

Balance sheet OCTOBER 2017

	Mar-17 Audited £000	Oct-17 Plan £000	Oct-17 Actual £000	*YTD Variance £000*	**Explanations of balance sheet variances**
Fixed assets	335,834	346,728	347,858	*-1,130*	Lower depreciation charge than plan
Stock	6,575	6,745	7,303	*-558*	Main targets agreed to reduce adverse YTD variance by year end
Debtors	101,837	114,398	95,113	*19,285*	Overdue debt reduced in M07 due to credit notes for 16/17 challenges
Cash	6,022	3,000	10,555	*-7,555*	Higher opening cash than plan and better performance on working capital
Creditors	-118,305	-129,355	-123,492	*-5,863*	Higher levels of creditor payments in M07.
Capital creditors	-5,284	-2,284	-6,050	*3,766*	Timing of capital payments has increased capital creditors at M07
PDC div creditor	0	-345	-276	*-69*	
Int payable creditor	-259	-1,025	-993	*-32*	
Provisions< 1 year	-335	-335	-335	*0*	
Borrowings< 1 year	-55,206	-57,069	-56,812	*-258*	Lower drawdowns - higher opening cash bal & better working capital performance
Net current assets/-liabilities	**-64,955**	**-66,270**	**-74,986**	*8,716*	
Provisions> 1 year	-988	-778	-760	*-18*	
Borrowings> 1 year	-164,524	-212,178	-209,383	*-2,795*	Lower drawdowns - higher opening cash bal & better working capital performance
Long-term liabilities	**-165,512**	**-212,956**	**-210,143**	*-2,813*	
Net assets	**105,367**	**67,502**	**62,729**	*4,773*	
Taxpayer's equity					
Public Dividend Capital	129,956	129,956	129,956	*0*	
Retained Earnings	-114,843	-152,708	-157,429	*4,721*	Higher I&E deficit than plan
Revaluation Reserve	89,103	89,103	89,051	*52*	
Other reserves	1,150	1,150	1,150	*0*	
Total taxpayer's equity	**105,367**	**67,502**	**62,729**	*4,773*	

6. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M7 YTD)	Actual (M7 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	3
Agency rating	1	1

Basis of the scoring mechanism

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

- 1 represents the best score, with 4 being the worst.
- At the end of October, the Trust had planned to deliver a score of 4 in "capital service cover rating", "liquidity rating" and "I&E margin rating", and 1 in "agency rating".
- The Trust has scored as expected in these 4 categories, with the first 3 owing to adverse cash and I&E performance.
- The "agency rating" score of 1 is due to improved control and recruitment plans to reduce agency spend within the cap. Furthermore, interim spend has reduced significantly this year due to the IT MSA, with costs now being reflected in non-pay.
- The distance from plan score of 3 is based on being £4.8m away from plan at M7.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	Trust Board		
Date:	7 December 2017	**Agenda No**	6.1
Report Title:	Results from the Patient Led Assessment of the Care Environment (PLACE) 2017 for St. George's Hospital and Queen Mary's Hospital sites		
Lead Director/ Manager:	Richard Hancock – Director of Estates & Facilities		
Report Author:	Mary Prior – General Manager Facilities		
Presented for:	Assurance Discussion Update		
Executive Summary:	The paper is presented to the Trust Board to notify of the PLACE 2017 scores and summarises the key findings and plans to address any failings found in the assessment.		
Recommendation:	To receive report and action plan.		
Supports			
Trust Strategic Objective:	We develop an organisational culture that is routed in our values and behaviours.		
CQC Theme:	**CQC Regulations 15: Premises and Equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15**The intention of this regulation is to make sure that the premises where care and treatment are delivered are clean, suitable for the intended purpose, maintained and where required, appropriately located, and that the equipment that is used to deliver care and treatment is clean, suitable for the intended purpose, maintained, stored securely and used properly		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	Establishing a positive, supportive culture which is allied to accountability for delivery is not seen as a priority, with the result that our organisational culture is either negative/punitive or does not foster accountability amongst our workforce.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Executive Management Team Quality Committee	**Date**	27.11.17 29.11.17
Appendices:	Action Plan		

Patient-Led Assessments of the Care Environment (PLACE) Programme 2017

What is a PLACE Inspection?

PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The team must include a minimum of 50 per cent patient assessors.

PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

The Importance of the PLACE Inspections

PLACE aims to promote the principles established by the NHS Constitution that focus on areas that matter to patients, families and carers:

- Putting patients first
- Active feedback from the public, patients and staff
- Adhering to basics of quality care
- Ensuring services are provided in a clean and safe environment that is fit for purpose

Comments from the PLACE Lead and Patient Ambassador SGH Leslie Robertson

"The PLACE system is such that it is patient led in partnership with Facilities and Corporate Nursing. The PLACE team is experienced having worked together for approximately 10 years. We are very lucky to have a very dedicated group of patients that have been part of our assessment teams for a number of years – this does allow the teams to check on progress and also pick up any recurring areas of concern. This year the main areas of concern on the St. George's hospital site were the poor environment of toilets and bathrooms across the older parts of the estate – it is clear that the estates department have started refurbishment work in some areas but this needs to be escalated to the Board to agree that a full programme that can be delivered to upgrade all these areas"

Over 25% of the St Georges Hospital services were assessed including wards, outpatients, internal and external areas and the emergency department. All Trust services at Queen Mary's were assessed by another team.

Food and Hydration were assessed on each site.

The assessments were undertaken by Facilities staff, Corporate Nursing and our patient representatives. External validators were present. Scores were not received until September 2017 NHS Digital.

The Assessments Areas

The St Georges Hospital assessments took place on 27 and 28 April 2017. Those at Queen Mary's Hospital took place on 5 May 2017. Both of the site inspections at SGH and QMH were unannounced inspections. On an annual basis there are areas that must be assessed and these are mandatory. The other areas are chosen on a rational basis and must cover 25% of the site. Areas assessed were:

- Communal areas – Mandatory
- External areas - Mandatory
- Organisational questions on food - Mandatory
- Organisational questions on facilities - Mandatory
- Accident and Emergency - Mandatory
- Departure Lounge

Wards

- Thomas Young Ward
- Amyand Ward
- Caesar Hawkins Ward
- Florence Nightingale Ward
- Nye Bevan Unit
- Jungle Ward
- Trevor Howell Ward
- William Drummond Ward
- Belgrave Ward
- GICU
- Cheselden Ward
- Gordon Smith Ward
- Champneys Ward
- Nicholls Ward
- Ruth Myles Unit
- Allingham Ward
- Trevor Howell Day Unit
- Brodie Ward

Outpatient Areas

- Hand Unit
- Dental Unit
- St James OPD
- Clinic B – Lanesborough Wing OPD
- Fetal Medicine Unit
- Blood Test - Lanesborough Wing OPD
- Cardiac OPD

Food Service

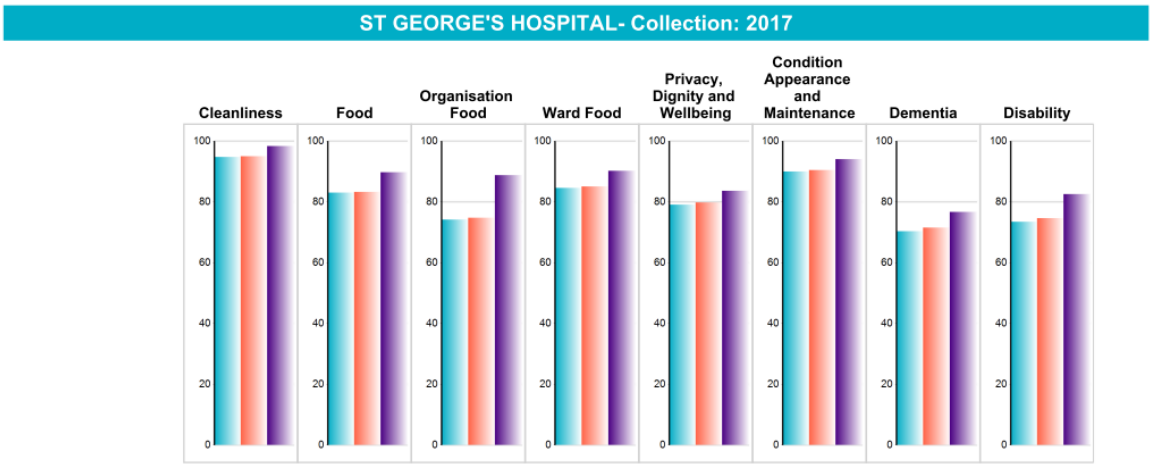
- Benjamin Weir Ward Food Service
- Amyand Ward Food Service
- Nicholls Ward Food Service
- William Drummond Ward Food Service
- Jungle Ward Food Service

The Queen Mary's Hospital assessment covered the following areas:

- A & E/Minor Injuries – Mandatory
- All outpatient areas
- Gwynne Halford Ward
- Mary Seacole Ward

Scores

St George's Hospital



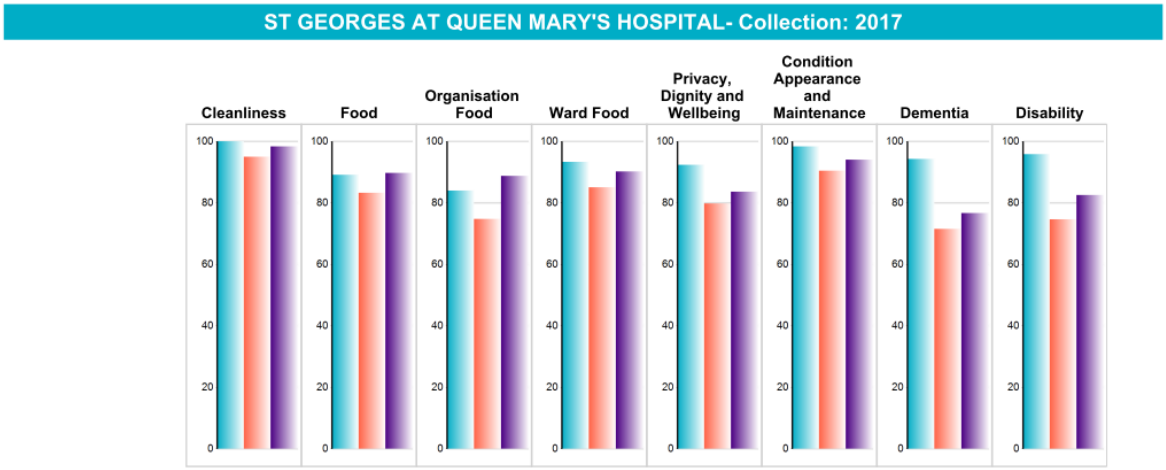
	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	6035.0000	610.5711	86.5124	524.0587	598.9999	2562.0000	924.0756	658.5882
Available Score (Actual)	6370.0000	735.9156	116.5880	619.3276	758.0000	2848.0000	1314.8571	896.3697
Site Score	94.74%	82.97%	74.20%	84.62%	79.02%	89.96%	70.28%	73.47%
Organisation Average	95.02%	83.30%	74.73%	85.09%	79.74%	90.41%	71.56%	74.67%
National Average	98.38%	89.68%	88.80%	90.19%	83.68%	94.02%	76.71%	82.56%

Results are provided for the following domains:-

(negative = lower than national average; positive = higher that national average)

St Georges Hospital	Site Score %	National Average %	Variance %
Cleanliness	94.74	98.38	-3.64
Food	82.97	89.68	-6.71
Organisation Food	74.20	88.80	-14.6
Ward Food	84.62	90.19	-5.57
Privacy, Dignity & Wellbeing	79.02	83.68	-4.66
Condition, Appearance and Maintenance	89.96	94.02	-4.06
Dementia	70.28	76.71	-6.43
Disability	73.47	82.56	-9.09

Services at Queen Mary's Hospital



Queen Mary's Hospital	Site Score %	National Average %	Variance %
Cleanliness	100	98.38	1.62
Food	89.18	89.68	-0.5
Organisation Food	84.02	88.80	-4.78
Ward Food	93.39	90.19	3.2
Privacy, Dignity & Wellbeing	92.38	83.68	8.7
Condition, Appearance and Maintenance	98.40	94.02	4.38
Dementia	94.25	76.71	17.54
Disability	95.89	82.56	13.33

Next Steps - Key areas of exception where improvement and action is required:

There is a detailed exception file that includes all areas that did not pass. This is available to view on the L Drive/PLACE folder.

There is an action plan in place which will be shared with the Matrons and all relevant staff. This will be monitored via the Matrons Environmental Action Team (MEAT). Immediate actions were put in place after the assessments and verbal feedback was provided to staff within the area on the day of the assessment. There are actions that will require funding which will need to be requested and approved via the usual Trust governance processes.

Areas of concern – main themes:

Cleanliness (*the cleanliness domain covers patient equipment, also bathrooms, showers, furniture, floors and fixtures and fittings)*	The cleaning results were reduced from previous years as a result of a high number of failings as follows: 1. Dust found on hard to reach areas behind patient beds. 2. Amyand Ward, Cardiac OPD and the Departure Lounge received a high number of low scores in cleaning areas which affected the Trust average. 3. Internal glazing across a high number of wards and OPD had lots of cellotape and markings. 4. Lots of clutter preventing access for cleaners to clean.
Food & Ward Food *(Includes taste, texture, temperature, choice of food, 24 hour availability, meal times and access to menus)*	The assessment scored highly for food tasting and quality and all the patient representatives were impressed with this area. The areas of concern relates to 1. The food service on the ward as this varied in terms of support from nursing staff. 2. At the time of the assessment there wasn't 24 hour access to catering services for visitors and carers. 3. Not all wards displayed the menus for patients to choose their meal. 4. Scores were also lowered due to the lack of separate day rooms for patients to eat away from the bedside.
Organisation Food	1. Did not have 24/7 access to food services for families, carers and guardians. 2. Lack of toast available. 3. Lack of juice and soup options at beginning of meal service. 4. Soup and Sandwich option not available. 5. Lack of review of packaging options.
Privacy, Dignity & Wellbeing *(includes provision of outdoor and recreational area, changing and waiting facilities, access to TV/radios, it also includes the practicality of male and female services e.g sleeping, bathrooms, private space and appropriately dressed)*	The scores were reduced as the Trust: 1. Wards are not designed so that no patient needs to pass through an area of the opposite sex in order to access toilets, bathrooms or to leave the ward. 2. Not all wards have a separate treatment room. 3. Not all patients had access to lockable storage.

Condition, Appearance and Maintenance *(includes various aspects of the general environment including décor, condition of fixtures and fittings, general tidiness, lighting, access to car parking, waste management and the external appearance of buildings/grounds)*	There were low levels of scores in a high number of areas assessed. Main themes were: **1. The toilets and bathrooms across the wards and outpatient areas are in urgent need of refurbishment.** 2. Lack of storage across wards. 3. Untidiness in busy OPD areas especially the Hand Unit and Clinic B in Lanesborough Wing OPD.
Dementia Friendly environment *(focuses on flooring, décor and signage availability of handrails)*	There is no area that fully meets the standards required for dementia patients. Heberden Ward day room and Dalby Ward are being refurbished to meet the standards of a dementia friendly environment.
Disability *includes wheelchair access, hearing loops, visual announcements)*	The scoring for disability has been introduced in 2016. The scoring was low for this area as: 1. The majority of wards and OPD do not have hearing loops or visual announcements 2. Door signs are on walls and not on doors. 3. Signage height need changing 4. Access from car parks to buildings entrances is not fully compliant for disabled access.

Action Plans

There is a detailed action plan in place. The following summarises actions planned for 2017/18 to address the main areas of failings.

1. The cleanliness failings have been actioned and continue to be monitored as part of the national standards monitoring for areas under the cleaning contract. Subsequent audits have shown improvement.
2. The estates team have commenced the refurbishment of Allingham Ward Kitchen, bathrooms and showers in Emergency Department, Freddie Hewitt Ward and Amyand Wards. Anti-ligature works in Freddie Hewitt. New sanitation was installed in Maxillofacial and Dental Day Surgery Unit.
3. Flooring to be replaced in main communal corridors in Grosvenor Wing.
4. Public toilets in Grosvenor Wing will be refurbished.
5. 24/7 food provision is now available in 1st Floor St James Wing.

6. Menu review is in progress to review options and will be launched in late November 2017 following consultation with the Dietetic team. Food tastings have taken place. The Dietitians are also providing training on the food service and the importance of nursing involvement in this.
7. Dump the Junk to de-clutter the wards and OPD areas took place in September 2017 and planning is taking place for December and January.
8. Dalby Ward has been closed for a full refurbishment and this will then be used as a decant ward moving forward for future ward redevelopments (subject to funding being agreed). Refurbishment commenced on 6 November 2017.
9. Costs for hearing loops and visual announcements at each reception will be obtained and funding will be sought from the Hospital Charity.
10. A full access audit is being commissioned for the St George's Hospital site. This will check all buildings for compliance against the Equality Act 2010 and will estimate costs to rectify any failings.
11. Since April 2017 the Corporate Nursing Team has been undertaking a system of Internal Quality Inspections across the wards. The Quality inspections framework is a multi-professional approach to providing assurance of the care provided and will also include estates and facilities services. The audits ensure any concerns/issues are identified and actions taken.

Information Governance

PLACE data will be published as Official Statistics and in particular be shared with the following organizations:

Care Quality Commission

Department of Health

NHS Commissioning

Clinical Commissioning Groups (when requested)

National Audit Office (when requested)

The Health and Social Care Information Centre (Clinical Quality Indicators)

The full set of assessment guidance and scoring forms are available from the NHS Digital website as per the link below:

http://www.digital.nhs.uk

St George's University Hospitals NHS
NHS Foundation Trust

Report to the Board from: Audit Committee

Committee Chair: Sarah Wilton

Date of Committee Meeting: 15 November 2017

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

Action Tracker

1. The Committee is very pleased to be able to report that the Internal Audit recommendations tracker now contains no overdue items. This compares to over 280 outstanding recommendations in April 2016 when TIAA's contract commenced. We had asked that the Executive should address the action tracker robustly with at least quarterly oversight from Executive Management Team (EMT), and that deadlines for completing these recommendations should only be put back by agreement with the Chief Executive Officer. We note that this position is now much more satisfactory. The Committee also proposed that it might be helpful for intermediate action milestones to be agreed for actions not due for a longer period.

2.

Internal Audit

3. The Audit Committee received final reports for five 2017/18 Internal Audit Reports, of which one (Cross Trust Recruitment) was an operational and not assurance review. Disappointingly, three completed 2017/18 Internal Audit Reports were reported with limited assurance: Estates and Facilities, ICT Disaster Recovery and Patient Records, with only one (SWL Pathology) providing reasonable assurance. The Committee reviewed the recommendations made in these audits and sought and received positive assurance from the relevant executive in attendance at the meeting that the recommendations made have been, or are being, addressed within the agreed timescale.

4. The Committee noted that some management responses to audit recommendations could be improved to ensure they address the recommendation being made, with any challenge to or disagreement with a recommendation being addressed prior to the report being concluded and submitted to the Audit Committee. The Chief Finance Officer agreed to take this forward with the Head of Internal Audit.

5. The Audit Committee agreed to review for approval the revised Internal Audit Plan 2018/19 proposals, following detailed EMT review and Board approval of the Board Assurance Framework, at its next meeting.

External Audit

6. The report from the auditors setting out matters identified in the course of their year end audit was again noted: there has been slippage but most agreed actions have now been completed. The required Disaster Recovery plan for financial systems is due for completion by the end of November and will then be reviewed by the Finance and Investment Committee.

7. The Committee was assured by the Director of Financial Operations that good progress was being made on the agreed programme for selecting the Trust's external auditor for 2018/19 onwards and that the required timeline, enabling Audit Committee's External Audit Working Group recommendation for approval by the Council of Governors on 6 December 2017, would be met.

Counter Fraud

8. The progress on several cases was discussed and noted: three are of particular concern and were discussed in detail. Counter Fraud are completing urgent reviews with Procurement and HR leads to ensure that gaps in controls are closed; staff involved have been disciplined.

9. The Committee is still not adequately assured that the learning from completed cases is being appropriately disseminated so that the risk of similar frauds occurring can be reduced. It was agreed that Counter Fraud will liaise with the Communications team to agree how awareness across the Trust can be improved, and also that a regular quarterly report on Counter Fraud will be presented to EMT.

Whistleblowing

10. The Director of HR and OD (DHROD) reported that work is underway to align, and relaunch through the Communications team, a number of policies relating to whistleblowing and the 'Freedom to Speak up Guardian' to ensure that staff are fully aware of which policy to use.

Procurement, Project Compliance, Breaches and Waivers, Aged Debt

11. The Committee noted that while some progress has been made in all these areas, there is considerable concern that the level of breaches and waivers continues to be too high. The Committee will review this again in January, together with a detailed written report on project compliance across payroll, purchasing and other financial procedures across the Trust.

12. Salary overpayments remain high, although the Committee was assured by the Executive that these are on track to reduce by over 20% in year. However the Committee expressed concern at the high cumulative balance of unrecoverable overpayments. Further analysis was requested of the causes of salary overpayment and the action being taken to prevent overpayments together with the actions being taken to reduce the balance of unrecovered salary overpayments.

Recommendation

13. The Board is recommended to receive the report from the Audit Committee on 15 November 2017 for information and assurance.

Author: Sarah Wilton, Chair of Audit Committee
Date: November 2017

St George's University Hospitals NHS
NHS Foundation Trust

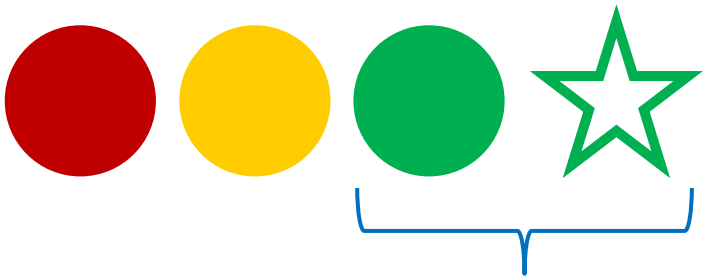
Meeting Title:	Trust Board		
Date:	Thursday 7 December	**Agenda No.**	7.2
Report Title:	NHS Improvement Single Oversight Framework		
Lead Director/ Manager:	James Friend, Director of Delivery, Efficiency & Transformation		
Report Author:	James Friend, Director of Delivery, Efficiency & Transformation		
Presented for:	Approval Decision Ratification Assurance Discussion Update Steer Review Other (specify)		
Executive Summary:	NHS Improvement has evolved the Single Oversight Framework (SOF) that applies to all NHS trust providers in England. The presentation from NHS Improvement sets out the changes in each domain and highlights what has remained the same. It is planned to review each line to ensure that the Trust reporting accommodates the evolved requirements of the SOF. Additions to reporting are envisaged to be included in the Integrated Quality & Performance Report. The SOF maintains the segmentation approach and there is no direct implication for the specific segmentation of the trust for Finance or Quality domains through this evolution. This is presented for the Board's information only at this stage. In preparation for the review of the Well Led Framework, the Executive is undertaking an internal review of compliance with Key Line of Enquiry number 6 (Is appropriate and accurate information being effectively processed, challenged and acted on?) and this will be presented to the Board in January 2018.		
Recommendation:	The Board is asked to note this report, in the context of future Trust Board development activity.		
Supports			
Trust Strategic Objective:	All Objectives		
CQC Theme:	All Themes		
Single Oversight Framework Theme:	All Themes		
Implications			
Risk:	The trust must evolve its reporting to ensure that it mitigates the risk of future regulatory intervention through the application of the segmental approach based on regulator review of trust submitted performance information.		
Legal/Regulatory:	Evolution of the relationship with and regulation by NHS Improvement as the Trust's Regulator.		
Resources:	Not applicable until full assessment has been completed. Head of Information Management is leading this assessment within the existing resource.		
Previously Considered by:	Not applicable	**Date:**	
Appendices:	1. NHSI Single Oversight Framework 2. NHS Providers Briefing		

NHS Improvement

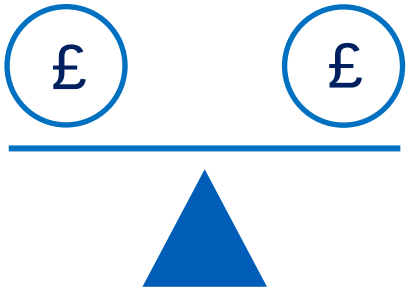
Single Oversight Framework update: an overview

November 2017

NHS Improvement's aims



Help providers gain and maintain '**good**' or '**outstanding**' ratings from CQC

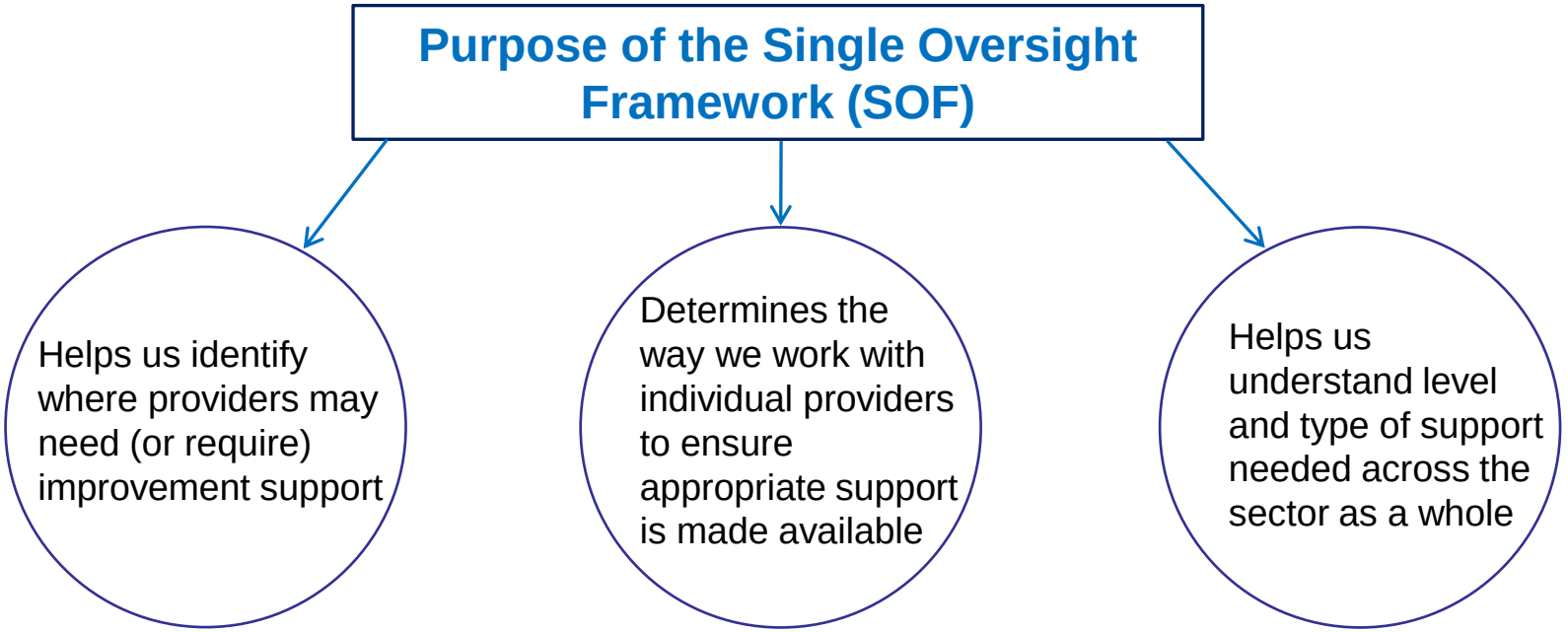


Help the sector achieve aggregate **financial balance**

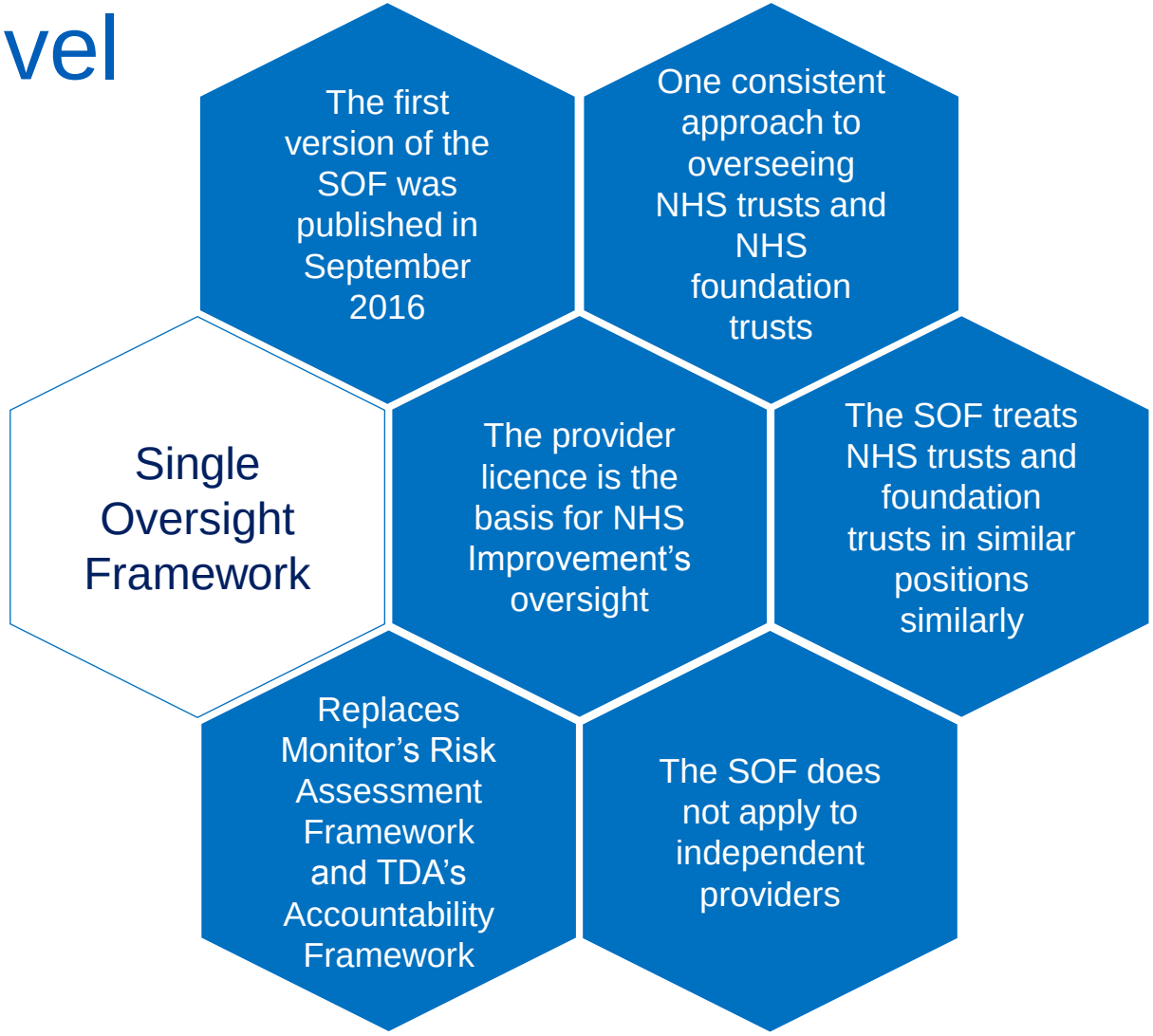
Reduce the number of providers in **special measures for quality**

Help providers **meet NHS Constitution standards** and other national priorities for performance improvement

Purpose of the Single Oversight Framework



Single Oversight Framework at a high level



Single Oversight Framework five themes

- NHS Improvement's 2020 objectives set out our overarching aims for the provider sector across five themes.

- The Single Oversight Framework monitors providers' performance and considers their support needs under these five themes.

Quality of care

Finance and use of resources

Operational performance

Strategic change

Leadership and improvement capability

Monitoring performance under the SOF

- Quality
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability

We monitor and gather insights about providers' performance across the five themes and use the information we collect to identify where they may need support

SOF data and insights

SOF data principles

- Reduce data collection burden
- Use nationally collected data
- Use evaluated and tested metrics

Collection and review of data

- **Ongoing in-year** eg A&E 4-hour waits
- **Annual** eg annual plans, staff surveys
- **Exception** eg events that trigger concern

Support needs and segment descriptions

NHS Improvement

Description of support needs

Segment 1	Segment 2	Segment 3	Segment 4
• No actual support needs identified • Maximum autonomy and lowest level of oversight. • Expectation that provider will support providers in other segments	• Support needed in one or more of the five themes • Not in breach of licence (or equivalent for NHS trusts); • NHS Improvement considers formal action is not needed	• Significant support needs • Actual or suspected breach of the licence (or equivalent for NHS trusts • Not in special measures	• Actual or suspected breach of its licence (or equivalent for NHS trusts) • Very serious/complex issues that mean it is in special measures
Maximum autonomy	Targeted support	Mandated support	Special measures

Level of support provided

Universal	**Universal** **+ Targeted** support as agreed with the provider to address issues identified and help move the provider to segment 1	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to address specific issues and help move the provider to segment 2 or 1	**Universal** **Targeted** **+ Mandated** support as determined by NHS Improvement to minimise the time the provider is in special measures

Triggers of potential support

Quality	• CQC rating - 'inadequate' or 'requires improvement' overall rating or in any of the individual key lines of enquiries (KLOEs) • CQC warning notices • Any other material concerns identified through CQC's monitoring process, eg civil or criminal cases raised or whistleblower information • Concerns arising from trends in our quality indicators
Finance and use of resources	• Poor levels of overall financial performance such as a monthly finance score of 4 or 3 • A Use of Resources rating of 'inadequate' or 'requires improvement' • Any other material concerns about a provider's finances or use of resources arising from intelligence gathered by or provided to NHS Improvement
Operational performance	• Failure to meet any operational performance standard for at least two consecutive months • Other factors (eg a significant deterioration in a single month) which indicate we need to get involved before two months have elapsed • Any other material concerns about a provider's operational performance arising from intelligence gathered by or provided to NHS Improvement
Strategic change	• Material concerns about a provider's delivery against the local transformation agenda including (where relevant) participation in new care models health and social care devolution plans
Leadership	• CQC 'inadequate' or 'requires improvement' assessment against 'well-led' • Material concerns about a provider's leadership and improvement capability, arising from third party reports, developmental well-led reviews or other relevant sources

NHS Improvement's oversight cycle

NHS Improvement

Monitoring

Review core set of data from all providers:

- weekly /monthly/ quarterly frequency depending on information source

Providers with critical issues may be monitored more frequently

Focus is on actual performance and, where possible, early warning

Identifying support needs

Is the monitoring data triggering any concerns in any of the five themes?
If so:

- consider the evidence (via existing knowledge and/or informal/formal investigation)
- assess the issues the provider is facing – how serious and complex are they; does the provider have a good understanding and clear plan to resolve them?

Focus is on identifying whether a provider has any support needs, and if so what type, level and intensity of support is required

Support decision and segmentation

Take decision on level of support need as:

- **universal** tools only – as no actual support needs identified
- **targeted** support - offered to address specific areas, for providers to accept voluntarily
- **mandated** support for significant concerns
- **mandated** support for providers in special measures

Place providers in the relevant segment and communicate decision

Focus is on confirming the proposed level of support and assigning the provider to a segment accordingly

Support activity

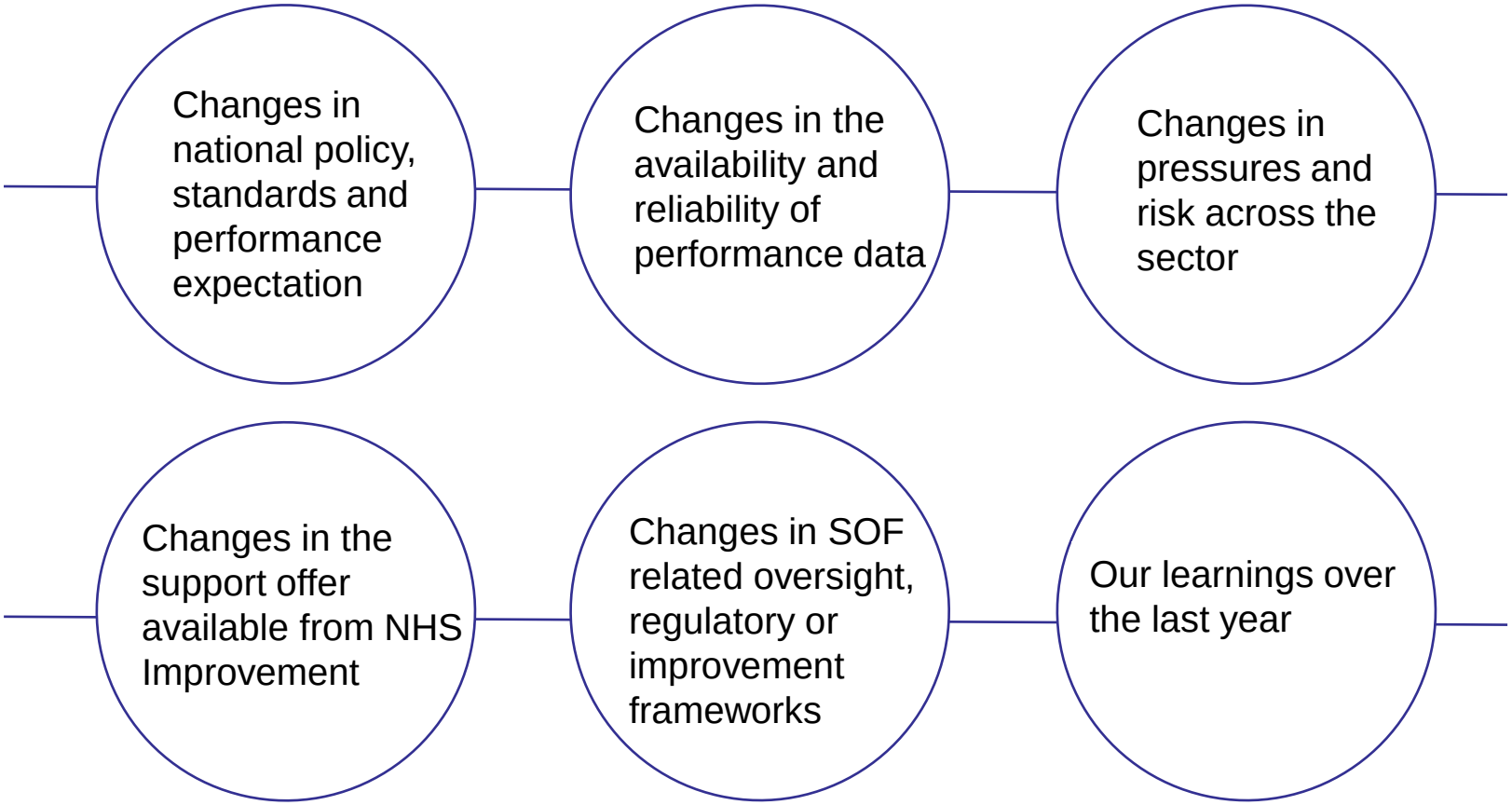
Where a support need is identified, consider what we know about:

- the background to the issue
- actions taken to date
- plans prepared/ delivered
- provider capability

Develop a package of support in consultation with the provider. This may include facilitating direct support from NHS Improvement, signposting to resources of other partners, or arranging peer support from other providers

Focus is on co-ordinating a tailored support package relevant and proportionate to a provider's circumstances

Why we have made changes



SOF changes

What we have changed

- Improved the structure and presentation – clarified processes /definitions; corrected discrepancies
- A few changes to the information/metrics we use to assess providers' performance under each theme
- A few changes to the indicators that trigger consideration of a potential support need

What we did not change

- The underlying framework, ie the five key themes, approach to monitoring, identifying and responding to support needs and provider segmentation

Key SOF clarifications

- The relationship between triggers and segmentation – a trigger indicates a potential support need; further investigation is needed to determine whether is an actual support need
- Operational performance standards – we will only use absolute performance against the national standard as a trigger; we will not use trajectories
- UoR assessments − provided an overview of the new UoR assessments which aim to understand how effectively trusts are using their resources to provide high quality, efficient and sustainable care for patients
- NHS Improvement's support offer – provided an overview of support offer
- SOF metrics – updated the SOF appendices to detail which metrics NHS Improvement uses to assess provider performance; how these metrics are defined and calculated; the frequency of data publication; and a link to the data source.
- Future updates to the SOF – align future updates of the SOF with the national planning cycle; the next scheduled refresh will therefore be for 2019/20

Changes to the SOF metrics

NHS Improvement

Quality

+ Added

- *E. coli bacteraemia bloodstream infection (BSI)*
- *Meticillin-sensitive staphylococcus aureus (MSSA)*

- Removed

- *Aggressive cost reduction plans metric*;
- *Hospital Standardised Mortality Ratio – Weekend (DFI)*

Finance and use of resources

+ Added

- Reference to new Use of Resources (UoR) framework, with explanation of how UoR assessments will be used under the SOF
- We will use the UoR report/rating alongside the finance score to inform our consideration of the provider's support needs

~ Amended

- Replaced the existing term SOF 'finance and use of resources score' with 'finance score' to make a clear distinction between this and the new UoR ratings; no change to any of the metrics or underlying calculations

Changes to the SOF metrics (2)

Operational performance

+ Added

- *Dementia assessment and referral standards (Acute)*
- *Reducing inappropriate adult mental health out-of-area placements (MH)*

- Removed

- *Patients requiring acute care who received a gatekeeping assessment* (MH)
- *Emergency readmissions* (Acute)

~ Amended

- *Data Quality Maturity Index (DQMI) - Mental Health Services Data Set Data Score* – replaces previous standards for submitting 'priority' and 'identifier' metrics to MHSDS
- For operational performance standards, we will use performance against the absolute national standards as a trigger, not performance against STF trajectories

Leadership

+ Added

- Reference NHS Improvement and CQC's new, fully joint well-led framework and guidance on how providers should carry out developmental reviews of their leadership and governance as part of their own continuous improvement.

Strategic change

+ Added

We will review the assessment of system-wide leadership in relevant sustainability and transformation partnership (STP) ratings when considering providers' performance under this theme.

13 November 2017

on the day BRIEFING

NHS Providers

NHS IMPROVEMENT SINGLE OVERSIGHT FRAMEWORK UPDATE RESPONSE – ON THE DAY BRIEFING

Today NHS Improvement (NHSI) has published the updated Single Oversight Framework (SOF) and its response to a recent feedback exercise on updates to the SOF. NHS Providers submitted a response to the exercise, which was informed by feedback from members and can be found on our website. This briefing summarises the specific metric changes under each SOF theme, followed by a summary of the feedback from respondents and NHSI's response, where this has been provided.

If you have any questions about this briefing or our work on regulation more generally please contact Ella Jackson, policy advisor (regulation), Ella.Jackson@nhsproviders.org

SUMMARY OF CHANGES TO THE SINGLE OVERSIGHT FRAMEWORK

The first version of the single oversight framework (SOF) was published in September 2016. In light of recent developments and to reflect learning from the framework's first year of operation, NHSI conducted this feedback exercise on making some changes to the SOF, including:

- Changes to improve the structure and presentation of the document, updating the introductory sections and summarising key information more succinctly
- Introducing a separate section outlining the five key themes of the SOF and summarising under each theme what would trigger consideration of a support need
- Changes to some of the metrics that NHSI uses to assess providers' performance under the SOF themes and the indications that trigger consideration of a potential support need (including removing some metrics and adding new ones). Of note is the addition of a new standard on the reduction of inappropriate adult mental health out-of-area placements as standard for mental health providers
- Making clear under all themes that in addition to specific triggers, other material concerns arising from intelligence gathered by or provided to NHSI could trigger consideration of a support need
- Making explicit that providers are expected to notify NHSI of significant actual or prospective changes in performance or risk outside routine monitoring.

NHSI did not propose any changes to the underlying framework itself – i.e. there will be no changes to the five themes, NHSI's approach to monitoring, how support needs are identified, and how providers are segmented.

During NHSI's feedback exercise we welcomed the changes to improve the structure, format and presentation of the SOF document which is now clearer and easier to read. However we have highlighted

the need for further clarity and detail around NHSI's support offer and the decision-making process around segmentation. We also highlighted concerns around some of the additional metrics being proposed, particularly around the mental health out of area placements. Although we support the ambition to reduce inappropriate adult mental health out of area placements, which is in line with the policy priorities of the Five year forward view for mental health, this new metric is likely to be a cause for concern and contention for providers that are not yet part of a new mental health care model which gives them control over the commissioning budget.

Overall we are pleased to see that NHSI is delivering on its commitment to review the SOF, but would encourage NHSI to establish a regular review of the SOF and to evaluate its impact, in the same way that Monitor undertook a yearly consultation on its risk assessment framework. We also note more broadly that it continues to be difficult to separate the framework from the wider policy context, continued financial pressure and the reality of greater grip and control from the centre. In addition to this, given the current direction of travel of Sustainability and Transformation Partnerships (STPs) and Accountable Care Systems (ACSs), NHSI will need to continue to work closely with providers and other national bodies to ensure the new framework develops alongside STPs and ACSs, as well as the development of new models of care, and the emerging organisational structures needed to support these new approaches.

CHANGES BY THEME

Please find below an overview of the metric changes under each SOF theme.

Quality of care		
Added	*Removed*	*Amended*
E.coli bacteraemia bloodstream infection (BSI) rates to quality indicators	Aggressive cost reduction plans metric from list of quality indicators	
Medticillin-sensitive Staphylococcus aureus (MSSA) rates to quality indicators	Hospital standardised mortality ratio-weekend (DFI) from list of quality indicators for acute providers	
	Emergency readmission rates from list of quality indicators for acute providers	
		Change to triggers of potential support needs regarding quality of care: CQC rating of 'inadequate' or 'requires improvement' in overall rating, or against any of the safe, effective, caring or responsive key questions.
Finance and use of resources		
Added	*Removed*	*Amended*
Reference to the new Use of Resources (UoR) framework, with		

explanation of how UoR assessments will be used under the SOF		
'Finance and use of resources score' is re-labelled as 'finance score'		
Operational performance		
Added	*Removed*	*Amended*
Dementia assessment and referral standards for acute providers	Patients requiring acute care who received a gatekeeping assessment as standard for mental health providers	Where relevant, NHSI will use performance against the national standard rather than the Sustainability and Transformation Fund (STF) trajectories as the trigger of potential support needs in relation to operational performance standards
Reduction of inappropriate adult mental health out-of-area placements as standard for mental health providers		Ambulance response time standards (updated to reflect the new standards, indicators and measures that have been introduced for ambulance providers through the Ambulance Response Programme)
Data Quality Maturity Index (DQMI) – Mental Health Services Data Set (MHSDS) Data score replaces previous standards for submitting 'priority' and 'identifier' metrics to MHSDS		
Strategic change		
Added	*Removed*	*Amended*
NHSI will review the assessment of system-wide leadership in relevant sustainability and transformation partnership (STP) ratings when considering providers' performance under this theme.		
Leadership and improvement capability		
Added	*Removed*	*Amended*
Reference to NHS Improvement and CQC's new, fully joint well-led framework and guidance on developmental reviews		

SUMMARY OF FEEDBACK AND NHSI RESPONSE

Quality of care

Feedback: Concerns were raised in response to the original proposal to move to using only the overall CQC rating as the main trigger to consider potential support needs under the quality of care theme. We recognised the rationale behind the proposed change to the CQC rating trigger under the quality of care theme from an 'inadequate' or 'requires improvement' rating against any of the safe, effective, caring or responsive key questions to a rating of 'inadequate' or 'requires improvement' in an overall rating. However, we urged NHSI to ensure there is a clear understanding of what sits underneath the overall rating so that support is tailored appropriately to individual providers

NHSI response: The SOF has reverted to listing ratings of 'inadequate' or 'requires improvement' in both the overall CQC rating and those for the individual themes acting as triggers to consider a potential support need under the quality of care theme.

Finances and use of resources

Feedback: Respondents to the feedback exercise felt NHSI's proposals clearly explained how the new UoR assessments will inform SOF monitoring and its assessment of providers' support needs under the finance and use of resources theme. We welcomed the re-labelling of the previous 'finance and use of resources score' as 'finance score' to reduce potential for confusion with the Use of resources assessment ratings. Requests for clarity on the UoR assessment process were made by respondents and some also suggested that the UoR key lines of enquiry (KLOE) would require further development for mental health services. We believe that NHSI should have revisited how UoR aligns with the financial special measures regime.

NHSI response: NHSI and CQC have now published the UoR assessment framework, summary of responses to the consultation on the assessment framework, and a brief guide for acute non-specialist trusts on UoR assessments. Currently, the availability and quality of productivity metrics for non-acute trusts are not sufficient to support a robust UoR assessment. NHSI is undertaking a programme of work to understand the productivity of community, mental health and ambulance trusts. The emerging metrics and benchmarking in these areas will be available to providers via the Model Hospital portal, in due course.

Operational performance

Feedback: We raised concerns that including both the STF trajectories and absolute performance as triggers around A&E performance was confusing. Respondents also suggested that reporting against STF trajectories should apply to other relevant operational performance indicators, in addition to A&E. There was a request for clarity on when formal monitoring of performance under the new ambulance response targets will start, and around how delayed transfers of care (DToCs) will be measured.

Some respondents noted that only a few metrics apply to community trusts and that the SOF could better reflect the requirements on mental health, community and ambulance sectors. Specific concerns were raised about the indicators and standards use to measure the performance of mental health providers,

including data quality; the requirement for local interpretation within the national definition; urban/rural population differences; the extent to which reducing out-of-area placements is within the control of providers, and how locally agreed trajectories for this metric will be agreed.

NHSI response: Consideration of support needs should be based on absolute performance. Failure to meet any of the absolute national standards - including A&E waiting times - for more than two months will trigger consideration of a provider's support needs. Where providers have an agreed trajectory for improvement toward any national standard, progress against this will be taken into account when determining whether they have an actual underlying support need. However, as all providers are expected to meet national standards, it is appropriate to consider what support may be required if performance consistently falls below this level.

There will be a transition period until April 2018 to allow all providers to implement the new ambulance response targets requirements. During this period providers will be expected to demonstrate progress towards full implementation of the new standards, following an agreed plan and trajectory. From April 2018, failure to meet the standards will trigger consideration of a provider's support needs in this area. NHSI will consider introducing DToCs as an indicator or standard in future updates of the SOF.

The out-of-area indicator is already a key indicator for clinical commissioning groups (CCGs) and addressing this issue requires a joined-up approach. The Department of Health has published guidance on what counts as an adult acute out-of-area placement. STP mental health leads, supported by NHS England and NHSI regional teams, are developing STP and provider-level baselines and trajectories for eliminating out-of-area placements.

Strategic change

While NHSI is developing its work on the governance and oversight of STPs and accountable care systems, we believe further work is necessary to clarify how NHSI intends to measure the contribution of individual providers to local systems as currently the strategic change theme is underdeveloped.

Use of information beyond routine monitoring

Feedback: Respondents made requests for clarity on what may be considered 'other material concerns' arising from intelligence gathered by or made available to NHSI. Clarity was also sought on when providers are expected to notify NHSI of significant actual or prospective changes in performance or risk outside routine monitoring. We also urged NHSI to adopt a formal consultation approach where any changes to the SOF are proposed, in a similar way to Monitor's approach when it proposed changes to its risk assessment framework.

NHSI response: It is not possible to specify what would suggest new, material concerns in each case, as such information would be considered in the context of NHSI's wider knowledge of the provider and its circumstances. However any such information should be discussed openly with the provider to determine its relevance and significance. Examples of the types of circumstances where NHSI would expect providers to notify it of significant actual or prospective changes in performance or risk outside routine monitoring have been provided in the updated SOF.

Contact: Ella Jackson, Policy Advisor (Regulation) ella.jackson@nhsproviders.org