Trust Board Meeting

Date and Time: **Thursday 26 April 2018, 10:00 – 13:00**
Venue: **Hyde Park Room, 1st Floor, Lanesborough Wing**

Time	Item	Subject	Lead	Action	Format
FEEDBACK FROM BOARD WALKABOUT					
10:00	**A**	**Visits to various parts of the Tooting site**	**Board Members**	-	Oral
OPENING ADMINISTRATION					
10:30	**1.1**	**Welcome and apologies**	**Gillian Norton** Chairman	-	Oral
	1.2	**Declarations of interest**	All	-	Oral
	1.3	**Minutes of meeting held on 29 March 2018**	**Gillian Norton** Chairman	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
	1.5	**CEO's update**	**Jacqueline Totterdell** Chief Executive	Inform	Report
STRATEGY					
10:45	**2.1**	**Research update**	**Andrew Rhodes** Acting Medical Director	Discuss	Report
QUALITY					
10:55	**3.1**	**Quality & Safety Committee report**	**Sir Norman Williams** Committee Chair	Assure	Report
PERFORMANCE					
11:05	**4.1**	**Integrated Quality & Performance report**	**Executive Team**	Inform	Report
	4.2	**Elective Care Recovery Programme**	**Ellis Pullinger** Chief Operating Officer	Assure	Report
	4.3	**Emergency Care Performance**	**Ellis Pullinger** Chief Operating Officer	Approve	Report
FINANCE					
11:35	**5.1**	**Finance & Investment Committee report**	**Ann Beasley** Committee Chair	Assure	Report
	5.2	**2017-18 Outturn Finance report (March)**	**Andrew Grimshaw** Chief Financial Officer	Update	Report
	5.3	**Annual Plan 2018-19**	**Andrew Grimshaw** Chief Financial Officer **Suzanne Marsello** Director of Strategy	Approve	Paper
WORKFORCE					
12:00	**6.1**	**Workforce and Education Committee report**	**Stephen Collier** Committee Chair	Inform	Report
GOVERNANCE					
12:10	**7.1**	**Audit Committee report**	**Sarah Wilton** Committee Chair	Assure	Report
	7.2	**Board Assurance Framework**	**Avey Bhatia**	Assure	Report

Time	Item	Subject	Lead	Action	Format
			Chief Nurse & DIPC		
	7.3	**Interim Report on NHS Premises Assurance Model (PAM)**	**Kevin Howell** Director of Estates and Facilities	Assure	Report
	7.4	**St George's Hospital Charity: Quarterly report**	**Suzanne Marsello** Director of Strategy	Update	Report
CLOSING ADMINISTRATION					
12:35	**8.1**	**Questions from the public**	-	-	Oral
	8.2	**Any new risks or issues identified**	**All**	-	-
	8.3	**Any Other Business**	**All**	-	-
	8.4	**Reflection on meeting**	**All**	-	Oral
12:40	**VOLUNTEER STORY** Volunteer Angela Lodge, winner of the Volunteer of the Year award at the recent Staff Appreciation Awards, shares her experience with the Dementia and Delirium Team, accompanied by Moira Rowan, Dementia and Delirium Nurse.				
TBC					
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 of next meeting:

Thursday 31 May 2018, 10.00 – 13.00

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 In Attendance Attendees		
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 & Director of Infection, Prevention & Control	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
Kevin Howell	Director of Estates & Facilities	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Ellis Pullinger	Chief Operating Officer	COO
Mike Murphy	Quality Improvement Director – NHS Improvement	QID
Secretariat	**Designation**	**Abbreviation**
Shanaz Islam	Interim Assistant Trust Board Secretary	ATBS

St George's University Hospitals NHS
NHS Foundation Trust

Minutes of Trust Board Meeting

Thursday 29 March 2018, 10.00 – 13.00, 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
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 Financial Officer	CFO
Andrew Rhodes	Acting Medical Director	MD
IN ATTENDANCE		
Harbhajan Brar	Director of Human Resources & Organisational Development	DHROD
Kevin Howell	Director of Estates & Facilities	DEF
Stephen Jones	Director of Corporate Affairs	DCA
Suzanne Marsello	Director of Strategy	DS
Ellis Pullinger	Chief Operating Officer	COO
Mike Murphy	Quality Improvement Director, NHS Improvement	QID
APOLOGIES		
James Friend	Director of Delivery, Efficiency & Transformation	DDET
SECRETARIAT		
Shanaz Islam	Interim Assistant Trust Secretary (Minutes)	ATBS

Feedback from Board Walkabout

Members of the Board gave feedback on the departments visited, which included: Allingham Ward, McEntee Ward, William Drummond, Kent Ward, Ben Weir Ward, Caroline Ward, Pinckney Ward, Blue Sky Centre, Keate Unit, Florence Unit, General Intensive Care, Acute Adult Ambulatory Unit, Renal Dialysis Unit, and Champneys Unit.

General observations included evidence of strong infection control procedures across a number of the wards visited, pressures on workforce caused in part by vacancy rates and retention challenges, and specific concerns about estates and equipment. Allingham Ward had recently achieved silver in the ward accreditation programme as had Keate and Florence, both of which were now working towards gold accreditation. In McEntee, an infectious diseases ward, significant work had been undertaken in relation to antimicrobial stewardship. Good controls were in place to manage infections such as C.difficile. Ben Weir, a leading cardiac surgery ward, had also demonstrated strong performance in infection control and in the last quarter had recorded a 0% infection rate. The Blue Sky Centre, a new children and young people's ambulatory care service, had been established to provide urgent ambulatory care for children and was working well, taking paediatric patients and helping to ease the

pressures on the Emergency Department (ED). Although it could not yet take referrals directly from GPs, it was hoped that this could be put in place soon, which would further help the ED and be better for patients.

Workforce issues were raised during the visit to William Drummond, where the ward had a number of vacancies which were currently covered by temporary staff. Vacancy rates were also raised during the visits to Keate and Florence. On Pinckney, a paediatric infectious diseases and oncology ward, Board members heard that there had been challenges retaining nursing staff. This was, in part, a wider issue around the removal of nursing bursaries at national level but there was also a perception that neighbouring Trusts were more competitive on the level of salaries they offered. Appraisal rates on Keate and Florence had dropped slightly due to operational pressures. In the Acute Adult Ambulatory Unit the main concern was about recruiting additional Band 5 nurses. In relation to the feedback around pay, the DHROD agreed to look into reports of pay discrepancies to establish whether there was any substance to these. If so, these should need to be addressed but if not it would be important to dispel any inaccuracies.

Estates issues were reported in Pinckney Ward where some of the laminar flow equipment was not working in three of the rooms. The DEF said that these would be addressed. In General Intensive Care, various estates issues had been reported the resolution of which were linked to the development of the new clinical strategy. In Champneys inpatient ward, where acute dialysis takes place, there had been problems with water pressure. Ann Beasley noted the proliferation of red and white tape on the floors in a number of areas, particularly in Grosvenor Wing. The DEF acknowledged that plans had been in place to relay the floor in the corridor in Grosvenor Wing over the Easter bank holiday weekend but these plans had been postponed until the first May Bank Holiday weekend as the failure of a CT scanner meant the corridor from the Emergency Department was required for transporting patients to another scanner.

OPENING ADMINISTRATION	
Welcome and Apologies	
1.1	The Chairman opened the meeting and welcomed Stephen Jones, Director of Corporate Affairs, who had started in post on 5 March 2018. Apologies had been received from James Friend, Director of Delivery, Efficiency and Transformation.
Declarations of Interest	
1.2	Sir Norman Williams reminded the Board that he was chairing a review of gross negligence and manslaughter in healthcare for the Secretary of State for Health and Social Care.
Minutes of Meeting held on 22 February 2018	
1.3	The minutes of the meeting held on 22 February 2018 were agreed as an accurate record, subject to one amendment at section 3.1 where the reference to the Trust's performance against the 62 day cancer standard should have stated December rather than January.
Action Log and Matters Arising	
1.4	The Board noted that most of the actions were not yet due or had been closed because appropriate action had been taken outside the meeting. In relation to action TB. 06.07.17, it was agreed that St George's Hospital Charity should be invited to the May Trust Board.

	DHROD provided an update on Trust's compliance with the Fit and Proper Person (FPP) regulation. All directors now had the necessary clearance and the Trust was fully compliant. There had been an administrative delay in receiving the Disclosure and Barring Service (DBS) clearance for the incoming Director of Corporate Affairs. Following a discussion with the Non-Executive Directors, the Chairman had agreed that an exceptional exemption should be made to allow him to take up post as scheduled on 5 March. The CQC had been fully sighted on this ahead of the exemption being made and the DBS clearance had since been received. In light of the Trust's compliance with the FPP regulation, the Board discussed the frequency with which it should receive ongoing reports on the issue. The Chairman proposed that quarterly reporting should continue throughout 2018/19 until a full year of compliance had been achieved. Given previous concerns expressed by the CQC about the process, the Board agreed it was important to adopt a rigorous approach to compliance reporting. For the next FPP report in June, DHROD would also update the matrix to differentiate the roles for which specific professional qualifications and / or registration were required. **Action: TB 29.03.18/68: DHROD to bring quarterly reports on compliance with Fit and Proper Person Regulation in 2018/19 starting in June**
CEO's Update	
1.5	The Chief Executive reported that the Trust had faced a particularly challenging month. Demand for services had been exceptionally high, particularly in the Emergency Department, due in significant part to the adverse weather and on-going winter pressures. Although this had been a tough period for the Trust, it had brought out the best in staff, who had dealt with the pressures impressively. The Care Quality Commission (CQC) had carried out an unannounced inspection at the Trust in early March. Inspectors had looked at six core services across the St George's and Queen Mary sites namely: medicine, surgery, emergency care, diagnostics and outpatients, children and young people, and community inpatients. A Well-Led review would follow in mid-April and the Trust expected to receive the report covering both aspects of the inspection around three months after this. While the report would be eagerly anticipated, the focus of staff across the Trust was on delivering outstanding care to patients. The Trust was currently finalising its financial plans for 2018/19 and this would be discussed in more detail later in the Board meeting. The next financial year would be challenging as the Trust sought to reduce its deficit. All staff shared the responsibility to identify and make savings and this message had been widely communicated. The Trust had held its first Staff Appreciation Awards on 15 March, acknowledging the hard work and dedication of staff across the organisation. The event had been a real success and the intention was that this would become an annual event. The St George's Hospital Charity had supported the awards and the CEO thanked Martyn Willis, the outgoing Chief Executive of the Charity.
QUALITY	
2.1	**Quality and Safety Report**
	Sir Norman Williams, Chair of the Committee, reported on the meeting held on 22 March 2018. In recent months there had been real improvements in quality in several areas and 'green shoots' of recovery were now apparent. In terms of the specific items the Committee had considered, Sir Norman highlighted that:

	▪ The fundamentals of care, in particular hand hygiene, had improved significantly and compliance on hand hygiene was now 95%. The Trust's performance against its Duty of Candour obligations had also been very strong. ▪ The Committee had heard about the Trust's compliance with risk assessments for venous thromboembolism (VTE) and Sir Norman commended the work of staff in this area. There had been 15 cases of Hospital Acquired Thrombosis (HAT) in the year to date. Seven root cause analysis (RCA) investigations had been undertaken; none of these HATs were found to be preventable. However, 8 RCAs remained outstanding and the CN and MD agreed to support this work over the coming weeks. ▪ Performance in meeting the Four Hour Emergency Standard remained well below the required 95%; the Trust had achieved 83.5% in February. The 62 day cancer standard continued to be missed and the Committee would receive a report on this at its next meeting. ▪ The Quality Improvement Plan (QIP) dashboard was moving towards green. There had been fewer serious incidents and reporting had improved. However, there were some red indicators including in relation to patient flow and outpatients. ▪ Complaints remained a perennial problem and significant improvement was required. The Chairman asked what the plan was to improve in this area and the CN said that she would be taking a paper to the Committee in April outlining proposals for improvement. The Chairman noted that the Board would therefore expect the next report from the Committee to provide greater assurance on this. **Action: TB. 29.03.18/69 CN to bring substantive item on complaints to the April Quality and Safety Committee meeting** ▪ The Committee had received a presentation from the Medical Director of South West London Pathology (SWLP) on the new governance framework for SWLP which had been introduced in recent months. The Board agreed that SWLP should be invited to present at a Trust Board meeting in the coming months. **Action TB. 29.03.18/70 COO to invite SWLP to present to the Board in the coming months**
PERFORMANCE	
3.1	**Integrated Quality & Performance Report**
	The MD presented the report on behalf of the DDET, noting the significant operational pressures on the Trust throughout March. Infection control had been very good; there had been just 14 cases of C.difficile in the year-to-date compared with a threshold of 31 cases. The Trust's mortality rate remained among the best in the country. No never events had been recorded in February, though two had subsequently been recorded which would be discussed at the Board in April. The CN reported that the number of falls had increased the previous month but had since reduced and a tougher target of 5.0/5.5 falls per 1,000 bed days had been set from April. The Trust planned to build on its strong infection control performance by extending its focus to include MSSA, E-coli, surgical site infection, and pressure ulcers. The COO highlighted that the Trust's performance on the 62 day referral to treatment cancer standard continued to prove challenging, though the indicative performance figure for March had improved and currently stood at 85%. The number of on the day cancellations for non-clinical reasons had fallen in February and there had been improvements in percentage of patients rebooked within 28 days. Despite this, further progress was needed and new standard operating procedures had been put in place while

	greater emphasis was being placed on the booking and list planning processes. The DHROD reported that appraisal rates were not where they should be and recent operational pressures would likely exacerbate this. Supporting paperwork for appraisals continued to be a source of frustration to staff and an electronic solution was being developed. Significant progress had been achieved in reducing expenditure on agency staff. The Trust had set an ambitious target to reduce this further next year, with a cap set at £17m which was £6m below national target set by NHS Improvement. Ann Beasley commented that the report provided some good news, such as the improved performance in on the day cancellations, but performance in the Emergency Department remained a concern. Sir Norman Williams observed that appraisal rates for non-medical staff needed to improve and noted that the Workforce and Education Committee should consider this. He also asked what action was being taken to address sickness rates. DHROD explained that there had been an increase in focus on staff health and wellbeing and a physiotherapist had been appointed to help staff with musculoskeletal problems. In response to a question from Sir Norman, the CEO said she was wholly supportive of ensuring staff were treated promptly as a healthy workforce meant better and more timely care for patients. The format of reporting was also discussed. Ann Beasley commented that the Board needed to be able to get behind the figures and unpick the data. Tim Wright added that the summary slide should set out the previous month's figures so that Board members could see at a glance trends across the key indicators. The CEO reported that the intention was to move towards a balanced scorecard report in the coming months. Sarah Wilton welcomed this and suggested that the Board should have an opportunity to discuss its format. The Chairman proposed that a Board workshop should be held to explore this further. The CEO added that the Board may also wish to consider inviting Samantha Riley of Plot the Dot to the session as she had done considerable work on how to tell whether performance improvements were sustainable. **Action: TB 29.03.18/71 Schedule Board workshop to discuss the development of balance scorecard reporting**
3.2	**Elective Care Recovery Programme Update**
	The COO presented the report and highlighted developments including the progress of the independent review of cancer pathways at Queen Mary Hospital. The COO had considered the draft report of the independent review and there were no material issues of concern. The COO then outlined the training plan required to ensure effective management of the pathway by providing clinical and administrative teams with the knowledge, skills and competencies required to be able to confidently and accurately manage new referrals. A phase 1 refresher training programme on the Patient Tracking List (PTL) for administrative staff was in place. Phase 2 would target a wider pool of staff who were involved in entering elective care pathway data. Together, these steps would ensure that the data reported on the PTL was accurate. Stephen Collier asked about the status of the training and the COO responded that it was mandatory. Tim Wright enquired about how those providing the training had been trained and how the programme would raise standards and the COO offered to discuss this with him in more detail outside the meeting. It was noted that the Elective Care Recovery Programme would be discussed in more depth in Part 2. The Board noted the report.

3.3	**NHS Improvement Emergency Care Site Visit**
	The Chairman opened the discussion on this item noting that while the paper set out a number of actions in response to the recent NHS Improvement (NHSI) site visit, the Board itself had previously requested a paper setting out the steps the Trust was taking to improve Emergency Department performance and this predated the visit from NHSI. The COO presented the report and explained that the Trust's performance against the Four Hour Emergency Care Standard was currently 87.57%, well below the national standard of 95%, and there was significant variability in daily performance. A 15-point plan to improve performance had been developed which would allow the Trust to achieve a 90% position against the Standard by Quarter 2. To achieve this, wider issues around bed occupancy and length of stay also needed to be addressed. However, the COO observed that the Trust would not be in a position to achieve the 95% Standard in 2018/19. Sir Norman Williams observed that the report did not present data on 12-hour trolley waits. The MD responded that there had been two recent 12-hour waits and root cause analysis had been undertaken following each case. Sir Norman also asked about performance in ensuring discharge of patients before 11 am and the COO explained that in February 16.6% of patients were discharged before 11 am, below the target of 30%. Sarah Wilton asked about the differences between Emergency Department performance as a whole and Paediatric ED performance, following her visit to the Blue Skies Centre that morning. In response, the COO said that data was available for inpatient paediatric ED performance and he would pick this up outside the meeting. Ann Beasley expressed reluctance to sign up for a target that was below the national 95% standard. Further assurance would be needed, along with sight of the detailed workings underlying the proposition, before she could agree to this. In summarising the discussion, the Chairman concluded that signing up to a 90% target was too significant a step for the Board to take on the basis of the information in front of it and it was also unclear whether this was a sufficiently ambitious target. The Non-Executive Directors in particular needed greater assurance, including sight of the key metrics, additional data and underlying assumptions. If the Board was to agree a target below the national standard, it would need assurance on what further actions would be required to meet the 95% standard within a reasonable timeframe. The Chairman asked that a further paper on emergency care performance be brought to the Board in April which provided additional detail on these points. The Board, however, noted the report and agreed the specific actions proposed in response to the recommendations following the NHSI site visit and the proposed governance structure for delivering the 15-point plan. **Action: TB. 29.03.18/ 72: COO to bring revised report on emergency care performance to the April Board meeting**
FINANCE	
4.1	**Finance and Investment Committee Report**
	Ann Beasley, Chair of the Committee, highlighted key issues from the report. At its meeting on 22 March, there had been a detailed discussion of the financial position and the Committee had noted that the year-end deficit was still forecast to be £53m, provided the

	£7m PSS funding from NHS England was delivered. The underlying run rate was not coming down as fast it needed to and this had to be addressed in 2018/19. The Trust had recently been informed it would receive additional capital funding that needed to be spent in the current financial year and was assured that plans were in place to ensure this was allocated appropriately. In terms of planning for next year, there had been some progress around identifying and firming-up CIPs but significant work remained. A Board workshop would be held on the 16 April 2018 to discuss the annual plan in more detail. The Committee had considered the risks on the Board Assurance Framework allocated to it under its terms of reference, but a review of the estates risks had not been possible due to an error in the paperwork. It was clear, however, that further work would be needed by the estates and facilities management team before the Committee could feel assured. Sarah Wilton expressed concern about the level of assurance the Board had received in relation to fire and water safety and said that the Board needed to know what steps were in place, for example in relation to water testing. The CEO noted that the Premises Assurance Model (PAM) had been scheduled to come to the Board for consideration in May, but in light of the discussion it may be better to bring an item on the key estates risks to the Board in April and schedule a Board workshop on the PAM in May. The PAM itself could then be developed in light of these discussions. The DEF explained that a report on water safety would come to the Quality and Safety Committee in April and this should help give the Committee and Board greater assurance. Jenny Higham also pointed that it was important to remember that the Trust and the University shared a site and that shared facilities should be discussed at the Joint Implementation Board. The Board noted the report. **Action: TB. 29.03.18/73 DEF to bring interim update on key estates risks to the April Board meeting and Board workshop to be scheduled in May to inform the development of the PAM**
4.2	**Chairman's Actions**
	The CFO summarised the actions taken by the Chairman under section 5.2 of the Trust's Standing Orders (SOs) on 7 March 2018. He explained that in the Trust needed to access a loan of £10m from NHS Improvement at short notice and that the SOs permitted the Chairman to enter such an agreement provided two Non-Executive Directors have been consulted in advance and agree with the action proposed. The Chairman had consulted Sarah Wilton and Ann Beasley, both of whom gave their approval. The Board noted the use of the delegated authority and the receipt of the £10m loan.
4.3	**Month 11 Financial Report**
	The CFO presented the report, explaining that the Trust was reporting a £57.1m year-to-date deficit at the end of month 11, which was adverse to plan by £10.2m, but expected to recover the position. The Trust had planned to deliver £36.6m of Cost Improvement Plan (CIP) measures by the end of February 2018. To date, £36.7m had been delivered, of which £12.4m was from income actions and £24.3m from expenditure reductions. The Trust's forecast outturn remained at £53m deficit at year end. The CFO expected this to be met, though this was subject to receipt of £7m in PSS funding. If this was not delivered it would impact on the year end deficit and this risk had been flagged to NHS Improvement. The Board noted the report.

WORKFORCE	
5.1	**NHS Workforce Race Equality Standard**
	In opening the discussion on this item, the Chairman expressed concern that the Workforce and Education Committee was not meeting frequently enough and that, as a result, important items such as the NHS Workforce Race Equality Standard (WRES) had not been considered by the Committee before coming to the Board. The DHROD reported that he and the Committee Chair, Stephen Collier, had discussed this and were in agreement that the Committee should meet at least six times a year, rather than quarterly as at present, with additional Committee workshops scheduled as necessary. This would be proposed at the next Committee meeting on 12 April. The Board agreed that this change in meeting frequency should be taken. **Action: TB. 29.03.18/74 Workforce and Education Committee to increase the frequency of its meetings to at least six times a year** The DHROD introduced the report, setting out an analysis of how the Trust compared at both a national and pan-London level for each of the nine WRES indicators. The report presented a stark and uncomfortable picture for the Trust. Compared with other London Acute Trusts, St George's was among those least likely to appoint BME staff from shortlisting. BME staff were also more likely to enter formal disciplinary processes. This was particularly concerning given that 42% of the Trust's workforce was from a minority ethnic background. While the Trust had made some minor improvements, it had a long way to go to address the issues of race equality. A new Workforce Diversity and Inclusion Lead had been appointed but had not yet started in post. The Board welcomed the appointment which would help introduce improvements. It also agreed that the appointee should present regularly to the Board so that Board members understood what needed to be done. The Board also expressed a desire to understand where an immediate impact could be made and agreed that an action plan for improving performance against the WRES was needed urgently. It was also noted that papers to the Board should consider equality implications explicitly. **Action: TB. 29.03.18/75 Workforce Diversity and Inclusion Lead to be invited to present to the Board on a regular basis and a clear action plan to be developed to improve the Trust's performance against the WRES**
5.2	**Gender Pay Gap**
	Stephen Collier, Chair of the Workforce and Education Committee, thanked Sion Pennant-Williams and the DHROD for the thoughtful and analytical report. The Trust had a gender pay gap of 13.94% mean and 2.11% median in favour of male employees. Although the Trust was in the upper quartile on gender fairness compared with other NHS providers, the Trust should take no comfort in this and action was needed to address the gap. Across the Trust's workforce as a whole, male employees were disproportionately represented in the lowest and the highest earnings quartiles. If the medical workforce was excluded from the results, the gender pay gap would be reversed and would favour female staff. The DHROD noted that the report was useful starting point and commented that the data would be used to drive change. The report also highlighted the distribution of Clinical Excellence Awards (CEA) and the MD mentioned that there had been 90 applications for the CEA of which 51% were female. This was significant given that the medical workforce was 44% female in composition. The Board approved the report subject to minor tweaks and the report to be released on the website before 31 March 2018.

5.3	**Update on Freedom to Speak Up**
	The DHROD introduced the report, which was intended to give the Board assurance that the Trust was compliant with its obligations. All NHS providers were required to appoint a Freedom to Speak Up (FTSU) Guardian. The Trust had appointed Karyn Richards-Wright to this role, and she was an important source of help to staff to ensure they could access confidential advice and raise concerns about patient safety. The Trust had also appointed two FTSU champions to support the function and there were plans to increase the number of these champions significantly. Sir Norman Williams welcomed the progress set out in the report but emphasised that this would require careful and on-going monitoring. The Chairman observed that the FTSU Case Review at North Lincolnshire and Goole NHS Foundation Trust, which was appended to the report, was troubling and it was important that St George's learned from this experience. The Board agreed that it was essential that staff across the Trust understood how to raise concerns. It also agreed that the Board should receive regular reports, via the Workforce and Education Committee, on this issue. **Action: TB. 29.03.18/ 76 Board to receive a report on Freedom to Speak Up following the next discussion of this issue at the Workforce & Education Committee and to receive regular reporting thereafter**
5.4	**NHS Staff Survey 2017**
	The DHROD gave an overview of the Trust's 2017 NHS Staff Survey results. In summary, the Trust had performed significantly better than in 2016. The response rate had increased from 40.6% in 2016 to 51.5% in 2017 and improvements had been recorded across 19 indicators. Three indicators had deteriorated. Overall, the scores were moving in the right direction but significant progress was necessary before the Trust was where it should be and the Trust should aim higher than simply to be 'among the pack'. In response, there would be a renewed focus on: addressing personal development, increasing organisational development interventions, and management development. Further work was also needed to address concerns around bullying and harassment, diversity and inclusion, and staff engagement. A detailed corporate action plan would be developed with input from the Staff Survey Action Plan Working Party. The Chairman welcomed the improvements but voiced concerns around feedback on bullying and harassment, where the Board needed to understand the steps that were being taken to address concerns. The DHROD explained that, as a first step, the plan was to set up focus groups so the Trust could better understand the views of staff. This would help to establish whether the right mechanisms were in place to support staff in raising concerns about bullying and harassment. Sarah Wilton asked whether the Board would have sight of the staff survey action plan. The DHROD also confirmed that the action plan would be considered by the Workforce and Education Committee and would come to the Board for discussion after that. **Action: TB. 29.03.18/ 77 Staff Survey action plan to come to the Board following consideration by the Workforce and Education Committee**
GOVERNANCE	
6.1	**Board Assurance Framework**
	The CN briefed the Board on the two key changes that had been made to the Board Assurance Framework (BAF) to take account of the feedback from the Board at its

	February meeting. Strategic Risk 1 had been revised to incorporate skill mix and new roles within the workforce. The risk appetite agreed at the previous meeting had also been updated. The Board agreed these changes.
CLOSING ADMINSTRATION	
7.1	**Questions from the Public**
	A member of the public asked the Board about the impact of significant new property developments in the area on demand for the Trust's services and the extent to which the Trust had a say over such developments. The Chairman reflected that this raised a broader issue about the operation of the planning system. The CEO added that only North East London was currently recording a growth in population. All other parts of the capital, including South West London, were either static or reducing. The DS commented that in the case of the Nine Elms development in Battersea, the local CCG had been involved in ensuring requirements around general practice were considered but it was not clear that the potential impact on secondary care had been taken into account. Nigel Brindley, a public governor from Wandsworth, asked the Board how the Trust engages with partners and other stakeholders across South West London. The discussion that morning had been somewhat introspective, perhaps naturally, but many of the issues facing the Trust required a wider system response and could not be addressed in isolation. The Chairman acknowledged that a substantive discussion about wider strategic issues, including engagement with partners across South West London, would be covered in Part 2 of the Board meeting, which governors were welcome to attend, but the point was well made and further consideration would be given to what could be brought to the public part of the meeting. The COO added that the Trust's 15-point plan for improving emergency care performance had been in light of broader engagement with partners including community providers and the CEO was a member of the Emergency Care Delivery Board for South West London which looked at broader system issues and solutions.
7.2	**Any new risks or issues**
	No new risks or issues were identified.
7.3	**Any Other Business**
	No items were raised.
7.4	**Reflection on meeting**
	The Chairman commented that the administration of the meeting had improved compared with previous Board meetings.
	Patient Story as young adult renal patient
	The Chairman welcomed Isaac, a renal patient at the Trust, and Marie-Louise Turner, a young adult worker who had supported Isaac during his treatment, and thanked them for agreeing to share their experiences with the Board. Isaac had been 17 years old when he was admitted to the Emergency Department with symptoms including vomiting and difficulty breathing and walking. Blood tests were taken and he was soon diagnosed with end stage

	renal failure. Isaac recalled that when he first attended the renal ward for dialysis it was striking that he was, by several decades, the youngest patient waiting for treatment. Other patients were often retired and attended with their partners whereas Isaac was in school and attended on his own. This made it hard to relate to the other patients. His consultant suggested Isaac attend a twilight shift where patients were relatively young. Isaac ultimately received a kidney transplant and was now at St George's University studying medicine. Reflecting on his experience, Isaac said that attending a clinic along with other patients of a similar age, who shared similar concerns and worries, had been very positive and had significantly improved his experience. Dialysis had been very challenging. While it was good that this was built around his study, it nonetheless meant that Isaac would complete his treatment at 10.30pm after 4.5 hours of dialysis and arrive home at around 11.30pm. Such a schedule was difficult given the need to be in class early the next morning. Marie-Louise pointed out that young adults with renal problems were a high risk group and were harder to engage. One study had found that approximately 40% of transplants in young adults failed during the first three years. Young adults were at a difficult stage in their lives. Many disengaged and their treatment suffered. Marie-Louise, whose role was supported through Kidney Care UK, provided psycho-social support for young adults. She supported patients by speaking to clinical staff on their behalf and arranging education sessions for the medical staff on the issues facing young adults. She had worked to ensure that all young adults receiving dialysis at the Trust had been brought together onto the twilight shift so that they could attend school without disruption and be together during their treatment. The impact of bringing together dialysis treatment for all young adult renal patients at the Trust was apparent. The Did Not Attend (DNA) rates among young adults for dialysis had previously been 20.8%, but following the changes introduced through the young adult workers this had fallen to 4.8% in 2015 and to 3.5% in 2016. In 2017, not a single young adult had missed a dialysis session. The impact was also apparent in terms of the reduction in inpatient bed days for renal patients, which had fallen from 18.5 days in 2014 to just 6.3 days in 2017. Overall, young adults had reported that their well-being had improved as had opportunities for effective peer support. Funding for the work provided by Marie-Louise remained a challenge but the effectiveness of the interventions was clear. The Board thanked Isaac and Marie-Louise for sharing their experiences.

Date of next meeting: Thursday 26 April 2018 at 10:00

Trust Board Action Log - 29 March 2018 - Draft as of 16.04.2018

Action Ref	Theme	Action	Due	Lead	Commentary	Status
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.	31.05.2018	DCA	Charity to be invited to the May Trust Board meeting. Interim CEO available to attend.	PROPOSE FOR CLOSURE
TB.07.09.17/ 44	**Medical Revalidation**	Provide interim reports on Medical Revalidation to the Workforce & Education Committee.	26.04.2018	MD & Karen Daly	On next Workforce and Education Committee agenda. Annual report on revalidation to come to the Board in September.	PROPOSE FOR CLOSURE
TB. 07.12.17/ 54	**Trust Strategic Objectives**	Present a quarterly update on progress against the Trust's strategic objectives.	26.04.2018	DS	Discussion of Trust objectives deferred to May Board meeting. Quarterly reporting to begin in July 2018.	OPEN
TB. 22.02.18/ 67	**Fit & Proper Person Regulation (Matrix)**	DHROD to give consideration to updating the FPP matrix to clarify which roles require professional qualifications / registrations.	28.06.2018	DHROD		OPEN
TB 29.03.18/ 68	**Fit & Proper Person Regulation (Frequency of reporting to the Board)**	DHROD to bring quarterly reports on compliance with Fit and Proper Person Regulation in 2018/19, starting in June 2018	28.06.2018	DHROD	Quarterly reporting on compliance with FPP scheduled for June, September, December 2018 and March 2019.	OPEN
TB. 29.03.18/ 69	**Complaints**	CN to bring substantive item on complaints to the April Quality and Safety Committee meeting	26.04.2018	CN	Considered by Quality and Safety Committee on 19 April and the Committee's discussion is referenced in the Chair's report to April Board.	PROPOSE FOR CLOSURE
TB. 29.03.18/ 70	**South West London Pathology**	COO to invite SWLP to present to the Board in the coming months	28.06.2018	COO	Simon Brewer, Managing Director, scheduled to attend June Board meeting.	PROPOSE FOR CLOSURE
TB. 29.03.18/ 71	**Integrated Quality & Performance Report**	Plan Board workshop to discuss the development of balanced scorecard reporting	31.05.2018	DDET		OPEN
TB. 29.03.18/ 72	**Emergency care performance**	COO to bring revised report on emergency care performance to the April Board meeting	26.04.2018	COO		PROPOSE FOR CLOSURE
TB. 29.03.18/ 73	**Estates risks and the NHS Premesis Assurance Model**	DEF to bring interim update on key estates risks to the April Board meeting, and Board workshop to be scheduled in May to inform the development of the PAM	26.04.2018	DEF		PROPOSE FOR CLOSURE
TB. 29.03.18/ 74	**Workforce and Education Committee**	Workforce and Education Committee to increase frequency of its meetings to at least six times a year	26.04.2018	DHROD	Agreed at the April Workforce and Education Committee.	PROPOSE FOR CLOSURE
TB. 29.03.18/ 75	**Board assurance on equality issues**	Workforce Diversity and Inclusion Lead to be invited to present to the Board on a regular basis and a clear action plan to be developed to improve the Trust's performance against the WRES	31.05.2018	DHROD		OPEN

TB. 29.03.18/ 76	**Freedom to Speak Up**	Board to receive report on Freedom to Speak Up following the next after the next discussion of this issue at the Workforce & Education Committee and to receive regular reports thereafter	28.06.2018	DHROD	Added to the Board forward planner	OPEN
TB. 29.03.18/ 77	**NHS Staff Survey 2017**	Staff Survey action plan to come to the Board following consideration by the Workforce and Education Committee	28.06.2018	DHROD		OPEN

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Update**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

CHIEF EXECUTIVE OFFICER'S UPDATE

I want to begin my report to the Trust Board this month by referring to a fantastic event Gillian Norton, Chairman and I spoke at on Wednesday 18 April.

The event – a pan London student nurse congress, organised by Nikki Yun – attracted speakers from across the country. This included Janet Davies, Chief Executive of the Royal College of Nursing; Professor Oliver Shanley, Chief Nurse at NHS England (London); plus Jane Cummings, Chief Nursing Officer, who also has a professorship at St George's, University of London.

Both Gillian and I talked at the event about the fantastic contribution nurses make across our hospital and community services.

I began my own career as a paediatric nurse in Sheffield, and shared at the conference some of my own experiences as a trainee - including seeing the worst of the miners' strike, and being involved in the response to the Hillsborough tragedy.

My current job is very different to those early days, but I remember the joy of working for the first time as part of a team, as well as the privilege I felt (as a nurse) to look after people and their loved ones in their darkest hours.

We have some fantastic nurses at the Trust, and they should be celebrated, as should the many others – clinical and non-clinical – who keep our hospital and community services running night and day.

We have a unique chance to celebrate the contribution they make on 5 July, when St George's – and the rest of the health service – celebrates the 70th birthday of the NHS. We will be hosting a giant tea party on the day, plus a range of other initiatives - so watch this space !

Emergency care performance

Our focus remains on improving emergency care performance, which we know remains challenged. The key for me is that we deliver systemic change, rather than fire-fighting every day – which isn't sustainable and which, over time, can start to impact negatively on staff morale.

The introduction of our new ambulatory care units is starting to make a difference. This includes our new Blue Sky Centre for Children and Young People, which opened its doors for the first time last month. This is better for our patients – who get the expert care they need in a dedicated facility – but also reduces pressure on our ED, which still sees peaks in demand.

I have said many times that teams from across the organisation need to understand their role in improving patient flow – and this is something we are working to improve. In short, emergency care performance is not solely the Emergency Department's problem to solve.

Financial planning and CQC inspection

We will only deliver Outstanding Care, Every Time for our patients if we address our financial, operational and quality challenges in tandem, and not in isolation.

We are in a new financial year and it is positive that we ended the 2017/18 financial year in the position we expected to. However, we are still spending more money than we bring in – and reducing the monthly run-rate is an absolute priority for 2018/19. This is non-negotiable – we must reduce the deficit significantly this year, and this is something we are all going to have to wrestle with over the coming months.

I am confident we are making progress with our quality agenda. At the Trust Board in March, we discussed the positive steps we've taken in areas as diverse as hand hygiene and infection control, through to a reduction in serious incidents. This is great, although we welcome external scrutiny and the CQCs inspection team will offer another perspective on where we are doing well, and where we need to improve.

The CQC concluded their inspection this month, including the well-led component, and we await their final report later this summer.

Championing Team St George's

Finally, I want to briefly touch on the work we are doing with our staff in terms of the training and development opportunities open to them.

Our staff have told us many times that they want more development opportunities. We are putting a number of initiatives in place as a result, including working with the King's Fund to support development of our 250 senior leaders.

We are also continuing to engage with the Institute for Healthcare Improvement, who are helping 90 of our managers to learn new skills in a programme of activities planned for next month.

Our staff continue to do us proud, and it has been fantastic in recent weeks to see their many achievements of celebrated with a wider audience.

The work of our interventional radiology and maternity teams to save a woman and her unborn baby featured in the Evening Standard: and the same newspaper also wrote about the work of surgeon Darren Lui and colleagues, who fitted magnetic rods to the spine of young Harleigh Jackson who can now walk properly for the first time as a result.

Finally, we even have a gold medalist in our ranks! ENT surgeon Parag Patel won Gold and Bronze medals for shooting at the Commonwealth Games in Australia. What an amazing achievement, and another example of why I feel proud to be Chief Executive of St George's.

Jacqueline Totterdell
Chief Executive
April 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No**	**2.1**
Report Title:	**Research report**		
Lead Director/ Manager:	Professor Andrew Rhodes, Medical Director		
Report Author:	Dr Daniel Forton, Associate Medical Director for Research Mark Cranmer, Director of Joint Research and Enterprise Services (JRES)		
Presented for:	Discussion		
Executive Summary:	Research is an integral part of the Trust's strategy, as a large university hospital co-located and closely linked with a leading medical university. Research improves quality of care and the patient experience, and evidence shows that university hospitals have better patient outcomes, making it vital that research remains as a key strategic focus. In 2016/17, a total of 5,040 patients were recruited into 222 clinical trials at St George's, placing the Trust 20th out of 155 Acute NHS Trusts in England for clinical trial patient recruitment. Provisional patient recruitment for 17/18 shows a significant improvement to 6,300 patients, which is an excellent performance given the loss of research associated with the GUM clinic. Patient recruitment is projected to increase by more than 50% in 2018/19. With improving research management and delivery, there is an opportunity to focus on longer-term strategy. We wish to increase our academic clinical research and the scope and number of clinical trials, with the aim of giving every patient in the Trust the opportunity to participate in a clinical trial or research study. Working with St Georges' University of London (SGUL) we aim to develop our clinical academic research with a view to a successful bid for a National Institute for Health Research (NIHR) Biomedical Research Centre/Unit funding in the next round.		
Recommendation:	• Support the core strategic objective to 'Develop tomorrows treatments today' and to review the opportunities that an enhanced research portfolio would present. • Review this report of research activity and to agree the next steps proposed.		
Supports			

Trust Strategic Objective:	Develop tomorrows treatments today		
CQC Theme:	Safe, Effective, Well-led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	Defined in section 4		
Previously Considered by:	Medical Board Quality & Safety Committee	**Date**	
Equality Impact Assessment:	Low		
Appendices:	N/A		

1.0 PURPOSE

1.1 To provide the Board with an overview of the St. George's University Hospitals NHS Foundation Trust's (SGUH) research portfolio.

1.2 To suggest to the Board next steps that could be taken to improve both the profile of research at SGUH and also to increase the scope and number of trials recruited to.

2.0 BACKGROUND

2.1 SGUH has recently refreshed its vision together with its core strategic objectives, one of which is to 'Develop tomorrows treatments today.' This objective has a number of sub-headings that include:

- We will embed research into clinical practice to further foster a 'bench to bedside' culture within our organization.
- 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.

2.2 Research is an integral part of SGUH strategy, as a large university hospital co-located and closely linked with a leading medical university. Research improves quality of care and the patient experience, and evidence shows that university hospitals have better patient outcomes. World leading clinical services invariably have a strong academic backbone to i) enable recruitment and retention of the best staff and ii) to ensure a strong reputation, important for maintaining and growing market share. For these reasons, it is vital that research remains as a key strategic focus.

2.3 SGUH has around 200 research active consultants, 5,000 patients recruited annually to research projects and clinical trials, and, crucially, a close partnership with St George's, University of London (SGUL), with about 30 joint clinical academic appointments. This is a firm base on which to build, utilising our strengths to develop our research to where it should be for a leading university hospital. There is great scope to increase the number of clinical trials, particularly those we lead on, to enhance our research links with SGUL and to develop the research strengths of our clinicians.

2.4 **How NHS research works**

Research in the NHS comprises of a mix of clinical trials and projects. These range from observational studies of diseases and their management, through "first in man" trials that translate pre-clinical research from the bench to bedside, to large pre- and post- licensing clinical trials of medicines and devices.

Clinical research in the NHS is led (sponsored) by Universities, NHS organisations or commercially by pharmaceutical and medical device companies. All Trusts in England conduct research, and university hospitals like St George's will lead their own research studies as well as taking part in collaborative clinical research which is

sponsored by other universities/NHS Trusts or commercially. Most research that is considered to be of benefit to the NHS is adopted onto the National Institute for Health Research (NIHR) research portfolio, through a process of peer-review.

The funding for clinical research comprises of 1) direct funding of research costs from research funders (like charities and research councils) and commercial sponsors and 2) the funding of research support costs from the NIHR via the South London Comprehensive Research Network (SLCRN). The latter is based on historical rates of patient recruitment to portfolio adopted clinical trials and is competitively awarded in South London. It is paid to support the costs of delivering non-commercially funded research, such as research nurses and trial coordinators, research pharmacy and some R+D administrative functions. Sometimes, excess treatment costs for research studies are funded by clinical commissioners (CCGs and NHSE).

Current studies which St George's patients are participating in, include a trial to determine the optimal antibiotic treatment for childhood pneumonia, a trial of a drug to treat insomnia for Alzheimer's patients and the evaluation of a home blood pressure testing app for pregnant women, which recently won the 2017 Health Service Journal award for Improving Care with Technology.

2.5 **Current Research**

In 2016/17, a total of 5,040 patients were recruited into 222 clinical trials at St George's, placing SGUH 20th out of 155 Acute NHS Trusts in England for clinical trial patient recruitment. This number excludes a small number of patients recruited into trials which were not adopted by the National Institute for Health Research (NIHR), that is, those funded outside of a competitive funding process or funded by industry but not recognised by the NIHR. Provisional patient recruitment for 17/18 shows an improvement to 6,300 patients, which is an excellent performance given the loss of research associated with the GUM clinic. Patient recruitment is projected to increase by more than 50% in 2018/19.

Overall, the large majority of trials were led from outside SGUH, with only 16 trials led (sponsored) by St George's (recruiting 1016 patients), numbers which do not reflect our academic potential. The number of accruals to NIHR portfolio adopted studies determines the NIHR funding received from the SLCRN and SGUH therefore competes with neighbouring NHS Trusts, predominantly Guys and St Thomas's, Kings College Hospital and the Royal Marsden for a share of this funding allocation. Our relative performance has remained stable at approximately 11% of South London trial recruitment.

3.0 RESEARCH STRENGTHS

3.1 A review was recently undertaken by Joint Research and Enterprise Services (JRES) to map research activity and strengths across the Trust. A proportion of clinical research is undertaken with or by SGUL employed principal investigators (PIs) so we sought to understand the relative contribution of SGUH and SGUL employed PIs. The review examined the scientific impact of research from our PI's using the *h*-index, an author level metric that measures the impact of publications through

citation by others. We also examined the activity across care groups by measuring the number of clinical trials each PI had led, together with patient recruitment data. In addition, and as a separate measure of research activity, we calculated the number of PhD/MD (Res) postgraduate students the PIs had supervised in the last three years. Finally, in relation to research income, we examined grant and commercial trial income over the last three years.

All PIs known to the JREO were included in the analysis. In addition, all consultants were asked if they wished to be included. Data were derived from Web of Science and JREO records. The data outputs are based on information held by the JREO and are *unlikely* to be complete. The results should be interpreted as a broad analysis of the relative research activity across the Trust rather than a definitive ranking of individual PI and care group performance because different opportunities, infrastructure and support exist across the organisation.

3.2 *h*-index

The *h*-index gives an indication of the number of publications and their impact, defined where *h* is the number of publications each of which have been cited at least *h* times. It is a measure of academic impact but is also heavily influenced by age, historical achievements and an individual's collaborating networks, since not all cited publications are necessarily led by the researcher.

The 30 PIs with the highest *h*-indices in SGUH and SGUL were identified. The median (range) *h*-index was 20 (15-46) for the top 30 SGUH PIs and 30 (9-109) for the top SGUL PIs.

The data allow identification of individuals with significant research outputs (not shown). SGUL's strengths are predictably in areas within the established research institutes and groups (Population Health, Cardiology, Clinical Infection, Neurosciences, and Vascular). SGUH strengths are complimentary but also include Obstetrics and Gynaecology, ICU, Genetics, Lymphoedema, Trauma and Orthopaedics, Rheumatology, Gastroenterology and Hepatology, Chest Medicine and Oncology.

The *h*-index data do not reflect current areas of activity and future impacts. Notable areas of *expanding* NHS research activity and grant applications include Trauma and Orthopaedics (Ms Caroline Hing) and Reproductive Medicine (Ms Asma Khalil).

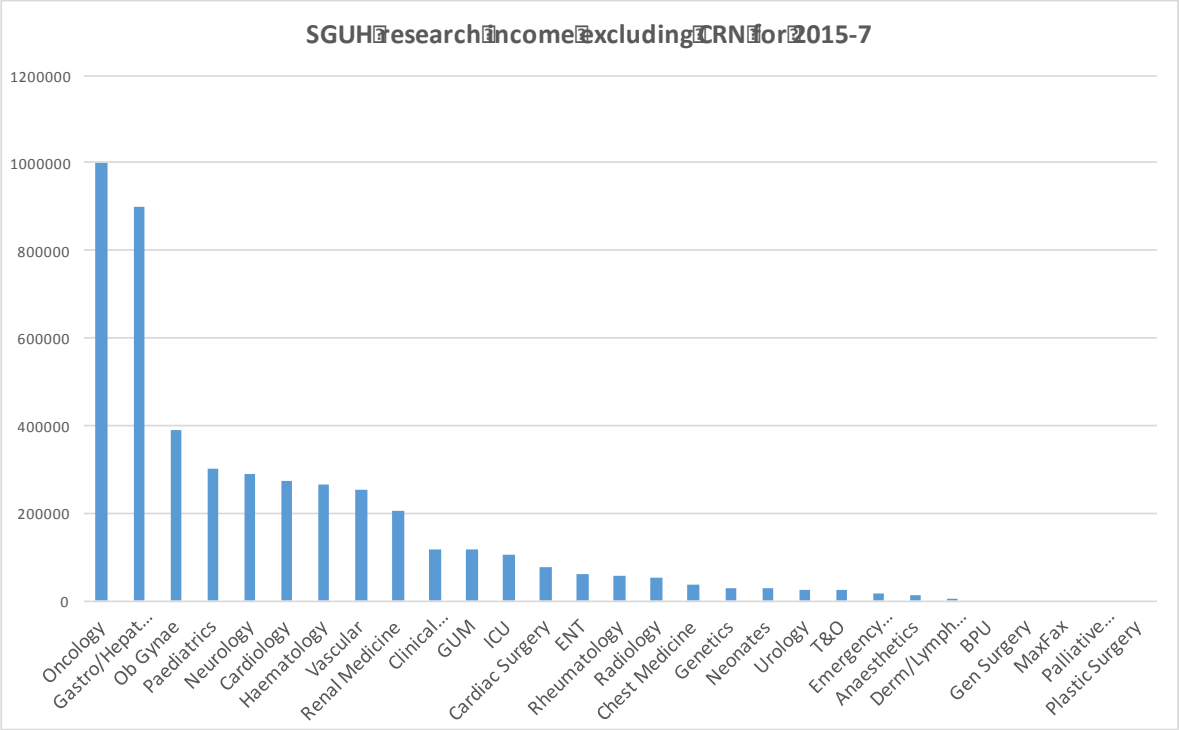
3.3 Clinical research activity

Clinical trials at SGUH range from phase I first in man studies (Vaccine Institute, Hepatology) through to phase IV post-licensing and observational studies. These may be grant funded, academic, NIHR-adopted trials or pharmaceutical company sponsored trials of new medications or devices. Our PIs work with both academic partners and industry. Clinical trial activity across SGUH and SGUL in the last three years was analysed by PI (not shown). The busiest specialities were Gastroenterology and Hepatology (35 trials), Obstetrics and Gynaecology (33), Clinical Genetics (43), Oncology (35), Neurology (40) and Paediatric Infection (27).

3.4 Research income

Research delivery is funded through the SLCRN allocation, grants and income from commercial sponsors. SGUH income for the last three years by care group is shown below.

Figure 1 SGUH by income for the last three years



3.5 Figure 2 shows a plot of average PI h-index versus care group trial activity. The balloon sizes are proportional to the number of active PIs. Vascular surgery, Clinical Infection and Dermatology and Lymphoedema have high research impact but few clinical trial opportunities at SGUH. Gastroenterology and Hepatology, Neurology and Paediatrics have high levels of trials activity, though lesser impact. Cardiology, Oncology, Obstetrics and Genetics have high levels of trial activity and impact. Gastroenterology and Hepatology, Vascular Surgery and Dermatology and Lymphoedema achieve their activity or impact with relatively fewer PIs.

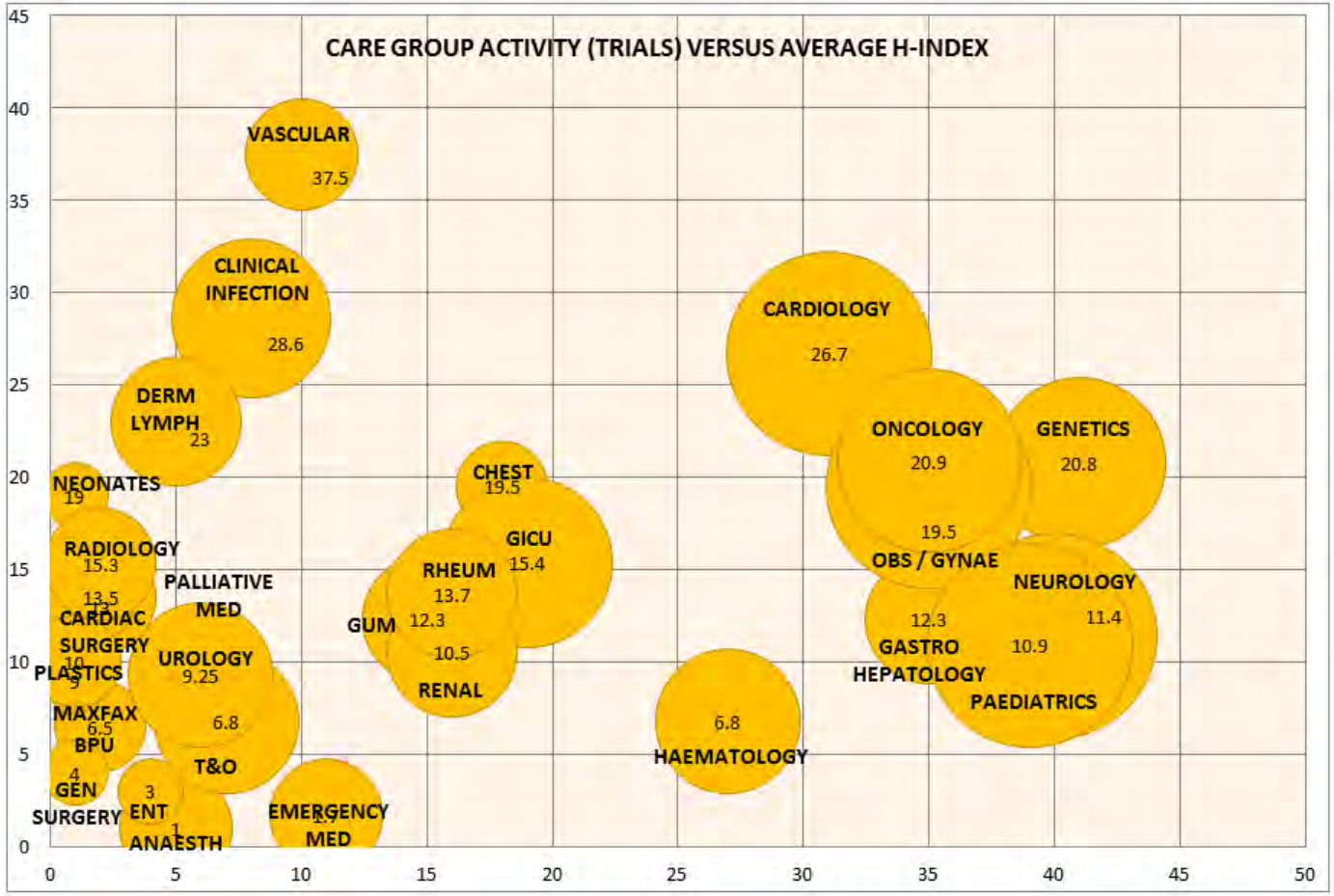


Figure 2 Plot of average PI h-index in each care group versus the number of clinical trials in the last three years. Balloon areas are proportional to the number of PIs, generating this activity

3.6 Research degree supervision

Postgraduate research degree (PhD and MD) supervision is undertaken by both SGUL and SGUH staff. Cardiology and Cardiac Surgery host the highest number of postgraduate students followed by Vascular Surgery, Chest Medicine, Oncology, Obstetrics and Gynaecology and Clinical Infection. SGUL staff account for the busiest postgraduate degree supervisors but notable SGUH supervisors include Prof Jahangiri (Cardiac Surgery, 22 students over 3 years), Prof Thilaganathan (Obstetrics and Gynaecology, 10), Prof Loftus (Vascular Surgery, 9), Dr Anderson (Cardiology, 7), Prof Mortimer (Lymphoedema, 6) and Dr R Sharma (Cardiology, 6).

4.0 RESEARCH MANAGEMENT AND DELIVERY

4.1 Joint Research and Enterprise Services

Joint Research and Enterprise Services (JRES) provides research and enterprise management and facilitation for both St George's Trust and SGUL, ensuring a joined up and integrated service for clinicians, academics and external stakeholders.

JRES has been re-organised into three sections in 2017, with the appointment of the Director, Mark Cranmer: Research Governance & Delivery, Research Funding and Enterprise & Innovation, each led by a Head of Section. The JRES' remit is broad and includes research governance, clinical trial set up, supporting clinical trial delivery, facilitating new research opportunities, costing research, contract negotiation, research finance, research strategy, technology transfer and consultancy.

Under new senior management, numerous improvements are underway in all areas of the JRES, with work on processes, systems, communications and compliance, together with adopting a more strategic approach to facilitate research and enterprise. The processes around clinical trial set up inside and outside the JRES are being enhanced and simplified, which together with better use of the Edge Research Management System is starting to decrease clinical trial set up time, crucial to trial recruitment targets and (publically available) NIHR metrics. Research grant application processes are being professionalised, to increase research funding success.

A key element of JRES improvements is communication, both internal and external. As well as website development, external links, such as with the South London Clinical Research Network (SLCRN) and pharmaceutical companies, are being enhanced, and there is great emphasis on improving the support to clinicians and academics.

4.2 Research Nursing and Support

The model for research delivery at St George's is to support a research delivery workforce (research nurses and clinical trial assistants), organised into teams covering specific research areas (like Oncology, Reproductive Health and Stroke) and also a Clinical Research Facility (CRF) that provides multi-speciality support to clinical trials. This model facilitates teams to support clinical groups with critical mass,

whilst also providing a CRF team who can give multi-speciality support to all areas and provide a flexible and responsive service. Research delivery is also a function of the JRES, who support the facilitation of trials and undertake both strategic and day-to-day budget management.

Under the overall leadership of the Head of Research Nursing, there is a total clinical research delivery workforce of around 80 FTE. We are currently looking at how we can better professionalise the research delivery workforce, looking at training, support and recruitment, how we can be flexible and ensure that roles and management responsibilities are clear.

The CRF is both a facility and a core team of 12 research nurses and clinical trials assistants. The facility is a space on the Ground Floor of Jenner Wing, containing several treatment rooms and a specimen laboratory, which are there to support St George's Trust and SGUL clinical trials (these facilities can be used whether or not the CRF core team is providing nurse/admin help). As well as patient space, the CRF contains desk space for research delivery staff, both the CRF core team and others. The CRF core team support clinical trials, with priority being given where the CRF support will make the biggest difference, which is often in areas that do not have dedicated teams.

The CRF is currently looking at how space use can be optimised and the desk and patient space be best used to facilitate clinical trials. The permission and adoption process for using the CRF core team and facilities is being improved, to provide a streamlined, customer-friendly approach, which will help to improve trial set up times and enhance clinical trial recruitment.

4.3 Finance

Clinical research at St George's is funded mainly by the NIHR (via the SLCRN) and industry sponsors. In 2016/17, St George's received £2.4M from the SLCRN, which is allocated based on patient recruitment in NIHR portfolio-adopted studies over the previous two years. That year, £1.7M was received from industry sponsors to conduct clinical trials. In addition, £0.7M was received from other sources, mainly grant funding. There is no net direct contribution to research management or delivery staff from St George's Trust; all staff and other research costs are met from external funding, although there is a contribution of approximately 26 programmed activities, allocated to research active consultants as part of the job-planning framework, who act as principle investigators on NIHR adopted studies or as primary PhD/MD (Res) supervisors.

5.0 OPPORTUNITIES AND STRATEGY

5.1 With improving research management and delivery, there is an opportunity to focus on longer-term strategy. We wish to increase the scope and number of clinical trials and our academic clinical research, with the aim of giving every patient in the Trust the opportunity to participate in a clinical trial or research study. Working with SGUL we aim to develop our clinical academic research with a view to getting NIHR Biomedical Research Centre/Unit funding in the next round.

5.2 **Enhancing clinical academic research**

Whilst St George's has a significant clinical trial portfolio, the majority of these, around 90%, are 'hosted' studies led from outside St George's, either sponsored by industry or by other NHS Trusts or universities. There are currently only 9 interventional drug trials led by St George's consultants, mainly those who are jointly appointed with SGUL. Increasing SGUH-led clinical research and developing our consultants in research and academia are important priorities that will enhance our research, patient outcomes and reputation. Working closely with SGUL will be key to identify key individuals within and outside the organisations to support and attract respectively, in order to grow St George's led research.

5.3 **Increasing the scope and number of clinical trials**

As well as growing SGUH-led research, there is much scope to increase our 'hosted' clinical trials, crucial both to giving our patients more opportunity to participate in clinical trials and to maintain and increase our SLCRN and industry funding, which underpins the research delivery workforce and research management.

6.0 NEXT STEPS

6.1 There are a number of steps proposed to enhance clinical academic research, which apply to both medical and non-medical staff (e.g. nurses and therapists):

1. A strategic approach with SGUL to making joint clinical academic appointments in areas of aligned academic and clinical interest. SGUH may choose to invest strategically in funding SGUL clinical academics through a process that involves care group support.
2. In terms of recruiting high-calibre staff, there should be a more active consideration of the academic component to each new role, including all consultants and selected non-medical staff
3. In order to retain academically successful staff, contracted sessions for research activity should be considered, in order to provide time and support to progress academically, lead clinical trials and win research grant funding. This could be funded as part of NHS job plans or as contracted sessions with SGUL, with appropriate academic promotion. The latter could support SGUL's REF submission, subject to contractual change. Funding should be made available to support successful clinical researchers over and above the limited research sPAs in the job planning framework, which currently supports research delivery rather than development e.g. grant writing.
4. Engagement with St George's consultants who are interested in research; an event is planned in 2018 chaired jointly at a senior level by SGUH and SGUL which will help to inform our priority areas.
5. Short term provision of funding for academic sessions for consultants to develop research, building on the recent Wellcome Trust funded programme which funded six consultants (and had 22 applicants). St George's Charity may be a source of funding to progress this further.
6. Setting up more Clinical Academic Groups (CAGs), which are joint University-Trust groupings, working to grow and facilitate research and education, building

and extending the CAG model set up two years' ago in Cardiology and subsequently in Neurosciences and Clinical Infection.

7. Working together with St George's Charity to ensure that charitable funding is aligned to SGUH/SGUL priorities and supports infrastructure, rather than whole projects.
8. Inputting into SGUL's research strategy and in particular its upcoming external academic review of research, with closer formal and informal links e.g. the monthly clinical research agenda item at SGUL's Senior Management Team meeting and Trust representation at the SGUL Research Strategy Committee, both currently attended by the AMD for Research.
9. Improving 'on the ground' communication between SGUH and SGUL, so it is clearer how academics and clinicians can work more together.

6.2 There are a number of steps proposed to increase the scope and number of clinical trials:

1. Improvements in research management and delivery, such as decreasing study set up time, active horizon scanning and facilitation of new trials (especially high recruiting trials), simplifying the JREO and CRF processes and providing a better service for clinicians and sponsors.

2. Proactive and positive engagement with industry to build links and make St George's a preferred site for industry-sponsored clinical trials, transforming a reputation for poor research management in recent years which has deterred sponsors.

3. Ensuring that the research delivery workforce is optimally placed to support clinical trials, with the SLCRN funding allocation focussed on the areas with both the highest performance and the highest potential.

7.0 RECOMMENDATIONS

7.1 The Board is asked to support the core strategic objective to 'Develop tomorrows treatments today' and to review the opportunities that an enhanced research portfolio would present.

7.2 The Board is asked to review this report of research activity and to agree the next steps proposed.

Dr Daniel Forton
Associate Medical Director for Research

Mark Cranmer
Director of Joint Research and Enterprise Services (JRES)
April 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No**	**3.1**
Report Title:	**Quality and Safety Committee report**		
Lead Director/ Manager:	Sir Norman Williams, Chairman of the Quality and Safety Committee		
Report Author:	Sir Norman Williams, Chairman of the Quality and Safety Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 19 April 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	N/A		
CQC Theme:	All CQC domains		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Quality and Safety Committee Report – April 2018

Matters for the Board's attention

The Quality and Safety Committee met on Thursday 19 April 2018 and agreed to bring the following matters to the Board's attention:

1. **Quality Improvement Plan (QIP) dashboard**
   The Committee received the QIP dashboard which provided an overview of the Key Performance Indicators against the CQC domains and each core service. The Committee noted that for some indicators the data source has not been identified and that these gaps needed to be addressed. Consideration was being given to how best to present the data to the Committee going forward in order for it to be provided the assurance levels it needed. For the next report there will be a narrative to support the data. The Committee noted that the self-assessment against the CQC fundamental standards was last carried out in December 2017 and on this outpatients is identified as inadequate. The Committee agreed that the Trust should undertake a further self-assessment within the next two months, to provide assurance that compliance is improving.

2. **Integrated Quality and Performance report**
   The Committee noted that there had been a total of four confirmed cases of MRSA at the Trust in 2017/18. It also heard that there had been changes to the reporting process for MRSA which meant that there would no longer be recourse to arbitration in cases of suspected MRSA. There had been two cases of C.difficile in March, with 16 cases in total recorded for 2017/18 as a whole. This was positive and well below the threshold of 31 cases; in 2018/19, that threshold would be lowered to 30 cases. At national level, there was likely to be an increased focus on gram negative infections. The Committee expressed concern that patient voice indicators for the Emergency Department had fallen over the past three months. It also noted the very low response rates on the Friends and Family Test from outpatients. In terms of workforce, the Committee observed that unfilled duty hours in ward staffing showed a steady upward trend across the year. While this remained below the threshold, it needed to come down and the Board may wish to explore this further. The Committee noted that this would be monitored closely for any impact on quality, with an expectation that these are reduced and key areas of concerned addressed.

3. **Clinical harms report**
   The Committee received a report on patients currently on a cancer pathway in excess of 100 days, and the learning from root cause analysis that had been undertaken. The Committee heard that there were 4 patients treated in excess of 100 days in October, 7 in November, none in December, and 4 at the end of January. The majority of these were the result of delays in their pathways at other providers. Formal harm reviews had been carried out, each of which had concluded that the patient concerned had not suffered serious harm as a result of the delay in treatment. While positive, the Committee noted that this did not provide assurance as to underlying effect of the delay on patient outcomes, though recognised this was difficult to assess.

4. **QIP deep dive: Unplanned / Admitted Patient Care (UAPC) Programme**
   The Committee received an update on the UAPC programme. It welcomed the achievements to date, including the launch of Ambulatory Assessment Area, and noted the key priorities of the programme for 2018/19. The Committee was assured by the plans underway but noted the need to maintain momentum and progress.

5. Complaints management

The Chief Nurse and Director of Infection Prevention and Control presented an action plan for improving the Trust's performance in managing complaints, which had long been an area of concern for the Committee and Trust Board. The Committee agreed that performance in timeliness of handling complaints was not acceptable and significant improvements were required. It noted the plan and the intention that the Trust Executive Committee would receive reports on complaints at every meeting. The Committee considered the plan a good step forward and looked forward to seeing improvements in performance. But it also noted the effectiveness of the plan was hard to judge at this stage and that the key was its impact over the coming months. The Committee would monitor progress closely.

6. Water quality safety report

The Committee received an interim report on water quality safety from the Director of Estates and Facilities. This acknowledged the substantial operational effort to maintain safe services through reactive actions. However, it also highlighted significant gaps in the management and associated processes which undermined the successful operation of the water quality management regime. Previous assurances given to the Board, based on reports from external engineering firms, were being reassessed following more detailed surveys and the publication of a detailed report by the new authorised engineers. Changes were being made to governance structures to provide greater oversight and assurance and a number of operational changes were planned. The Director of Estates and Facilities explained that while the situation was not where he would want it to be there was a relentless focus on ensuring patients were protected.

7. Review of Q3-Q4 2017/18 – Medication incident and Controlled Drugs

A report on medication related incidents for Q3 and Q4 2017/18 was presented to the Committee by the Chief Pharmacist. A total of 894 such incidents had been recorded, of which 49 (5.5%) involved harm. Two serious incidents had been reported and one never event. The Committee noted that the Trust had a high level of reporting medication incidents compared with national figures and that this is regarded as a good indicator of an open and transparent culture. Of all incidents reported by the Trust, the latest figures from the National Reporting and Learning Service showed that medication incidents accounted for 15.6%, in comparison to 10.7% for other organisations. Medication was the second most common incident type reported. The Committee heard that there had been some delays with medicine administration in relation to offender healthcare at HMP Wandsworth. Noting this, the Committee asked for a broader report on the quality of care provided by the Trust at the prison in the coming months.

8. Quality Report

The Committee considered a draft of the Annual Quality Report which was in the process of being finalised ahead of incorporation into the Annual Report and Accounts 2017/18. The Committee reviewed and agreed the designated quality priority areas for the year ahead. It heard that the format of the report was highly prescribed and that the draft, while still a work in progress, followed the requirements set out by NHS Improvement. The Council of Governors had selected a quality measure – the percentage of patient safety incidents resulting in severe harm or death – which would be used by the auditor in their review of the quality of data supporting the 2017-18 indicators in the document. In response to a question from the local HealthWatch, it was confirmed that all stakeholders would receive a draft of the report on 20 April and there was a four-week period to provide feedback and statements. The Annual Report needed to be submitted to NHS Improvement on 29 May. As this was before the next Quality and Safety Committee, it had previously been agreed that the full draft Annual Report, including the Quality Report, would be circulated to all Board members for comment on 9 May.

9. Board Assurance Framework

The Committee considered the strategic risks allocated to it in its terms of reference (SR2, SR3, SR4 and SR15). The Committee agreed the risk and assurance ratings.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	Agenda No.	**4.1**
Report Title:	**Integrated Quality and Performance report**		
Lead Director/ Manager:	James Friend, Director of Delivery, Efficiency and Transformation		
Report Author:	Kaye Glover, Performance Development Manager Emma Hedges, Divisional Performance Manager		
Presented for:	Inform		
Executive Summary:	This report consolidates the latest management information and improvement actions across our quality, patient access, performance and workforce objectives. The Trust is performing positively against a number of indicators, however existing challenges continue in particular: Four Hour Operating Standard, 62 Day Cancer Access Standards and operations cancelled by the hospital for non-clinical reasons. The Trust has maintained compliance against the Diagnostic access target and continues to manage the use of agency workforce.		
Recommendation:	The Board is requested to note the report		
Supports			
Trust Strategic Objective:	Treat the patient, Treat the person Right care, Right place, Right time		
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led		
Single Oversight Framework Theme:	Quality of Care, Operational Performance		
Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal / Regulatory:	The Trust remains in Quality Special Measures based on the assessment of the Regulator NHS Improvement		
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Previously Considered by:	Finance & Investment Committee	**Date:**	19 April 2018
Appendices:	Integrated Quality and Performance Report		

excellent
kind
responsible
respectful

St George's University Hospitals NHS
NHS Foundation Trust

Integrated Quality & Performance Report for Trust Board

Meeting Date – 26 April 2018
Reporting period – March 2018

Excellence in specialist and community healthcare

St George's University Hospitals NHS
NHS Foundation Trust

HOW ARE WE DOING?

March 2018

Daycase and Elective Surgery operations

Actual
4,428

Target 4,897

Discharges before 11am

Actual 16.4%

Target 30%

Four Hour Emergency Standard

Actual
81.62%

Target 95%

Better data, safer patients

Outpatients appointments with RTT outcome recorded

Actual
86.45%

Target
83%

Whole Trust Inpatient Friends and Family Test

Actual
97%

Target
95%

Outpatient First Appointment

Actual 16,373

Target 18,178

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	
		Mar-17	Mar-18	Variance	Plan Mar-18	Variance	YTD 16/17	YTD 17/18	Variance	Plan YTD	Variance
ED	ED Attendances	14,011	13,774	-1.69%	14,715	-6.39%	163,506	164,510	0.61%	173,252	-5.05%
Inpatient	Elective & Daycase	4,705	4,428	-5.89%	4,897	-9.58%	52,159	54,135	3.79%	55,113	-1.77%
	Non Elective	4,096	4,298	4.93%	4,369	-1.63%	48,279	46,916	-2.82%	51,440	-8.79%
Outpatient	OP Attendances	55,727	51,146	-8.22%	54,691	-6.48%	646,181	634,265	-1.84%	623,658	1.70%

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

Source: SLAM

Executive Summary – March 2018

St George's University Hospitals NHS
NHS Foundation Trust

Patient Safety

- Two Never Events were reported in March, taking the Trust total to five events for the year. There were five Serious Incidents declared in the month, a total of 74 for the year.
- The Trust reported two patients with hospital attributable Clostridium Difficile infection in March. The number of cases were sixteen for the year.
- No patients acquired an MRSA Bacteraemia in month, the trust total for the year was four against a ceiling of zero.
- The number of falls per 1,000 bed days increased in March, to 6.05 compared to 5.32 in February.

Clinical Effectiveness

- The Trust's mortality rates show a small improvement this month and remains in the lower than expected category and shows that we are 17% lower than expected from typical hospitals and practice in this country.
- Maternity indicators continue to show expected levels of performance.

Access and Responsiveness

- Elective and Day case activity shows a 5.89% decrease compared to the same period last year.
- The Four Hour Operating Standard was not achieved in March reporting a performance of 81.62% of patients admitted, discharged or transferred within four hours of arrival. This is below February's performance and the improvement trajectory agreed with NHS Improvement who have visited the Trust and agreed a 15 point action plan which the trust is currently implementing.
- The Trust achieved five out of eight cancer standards in the month of February, continuing to achieve 14 day standard however the 62 day standard continues to see varied performance and remains challenged.
- The Trust remains compliant against the 6 week Diagnostic Access standard in March reporting 0.2% of our patients waiting greater than six weeks for a diagnostic procedure.

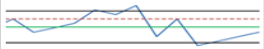
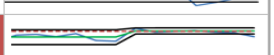
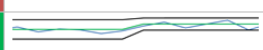
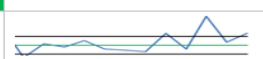
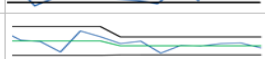
Patient Experience

- The Friends and Family Test (FFT) recommendation rate for both inpatients and outpatients was over 96% in March. This remains above threshold. Response rates are strong for inpatients but below expectations 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 less significant. This is being addressed by the outpatient transformation team as part of the Quality Improvement Programme.

Workforce

- Staff sickness remains above the trust target of 3% for the month of March reporting 3.6%
- Non Medical appraisal rates have seen a further decline in performance within the reporting period at 66%. Medical appraisal rates have decreased to 77%, both remain below target. A remedial action plan will be required.

Patient Safety

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend (12 months)
Number of Never Events in Month	0	0	0	1	1	0	0	1	0	0	0	0	2	
Number of SIs where Medication is a significant factor	0	0	0	0	1	1	1	0	0	0	0	0	1	
Number of Serious Incidents	8 / mth	5	6	7	10	9	11	4	8	2	3	4	5	
Serious Incidents - per 1000 bed days	N/A	0.21	0.24	0.29	0.40	0.38	0.45	0.16	0.32	0.08	0.12	0.18	0.19	
Safety Thermometer - % of patients with harm free care (all harm)	95%	94.6%	94.3%	94.7%	93.8%	93.8%	95.7%	94.9%	95.0%	95.1%	94.9%	94.8%	94.3%	
Safety Thermometer - % of patients with harm free care (new harm)	95%	97.7%	98.0%	97.9%	97.5%	97.8%	98.3%	98.7%	98.1%	98.5%	98.9%	97.9%	98.5%	
Percentage of patients who have a VTE risk assessment	95%	95.3%	96.2%	96.3%	95.8%	95.7%	95.4%	96.1%	96.4%	96.0%	95.4%	96.3%	96.0%	
Number of Patient Falls	N/A	111	137	131	143	127	125	122	157	127	189	140	157	
Number of patient falls- per 1000 bed days	N/A	4.73	5.39	5.43	5.71	5.29	5.15	4.89	6.23	5.17	7.49	6.15	6.05	
Attributable Grade 2 Pressure Ulcers per 1000 bed days	N/A	0.72	0.28	1.16	0.92	0.63	0.74	0.28	0.64	0.53	0.63	0.57	0.46	
Number of Grade 3 & 4 Pressure Ulcers	N/A	2	1	0	1	1	2	0	0	0	0	0	0	
Attributable Grade 3 & 4 Pressure Ulcers per 1000 bed days	0.00	0.09	0.04	0.00	0.04	0.04	0.08	0.00	0.00	0.00	0.00	0.00	0.00	
Number of overdue CAS Alerts	0	1	1	0	0	0	0	0	0	0	0	0	0	

Briefing

- Two Never Events were reported in March, with the Trust total at five for the year.
- The Trust declared five serious incidents in March 2018. A total of 74 serious incidents were reported for the year, 19 fewer incidents than the year previous.
- The number of falls reported in March increased from 140 in February to 157 in March as the month was longer. The rate of 6.05 per 1,000 bed days is an improvement. Of the falls reported 133 resulted in No Harm. The trust saw a 1.3% reduction in the number of falls in the year falling from 1,688 in 2016/17 to 1,666 in 2017/18.

Actions: All falls are looked at individually to identify themes. The Falls co-ordinator is revising the falls risk assessment tool in collaboration with the Falls Group so that it reflects national requirements.

St George's University Hospitals NHS
NHS Foundation Trust

Infection Control

Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend (12 months)
MRSA Incidences (in month)	0	2	0	2	0	0	0	0	0	0	0	0	0	
Cdiff Incidences (in month)	31	1	1	1	2	3	1	4	0	0	0	1	2	
MSSA	N/A	3	2	4	4	4	1	1	2	3	0	3	1	
E-Coli	N/A	4	2	5	9	6	8	6	2	5	5	5	5	

Briefing

- There were two patients reported to have suffered with a hospital acquired Clostridium Difficile Infection in March, this occurred on Pinckney and Allingham wards. The first patient is a child who was identified as colonised and reported in February, a further specimen was tested in March and as the child continues to be colonised this is reported as a further incident of Cdiff infection. There is no evidence of any acquisition (based on ribotypes) from any other patients and no other evidence of any lapse in care. The second incident is being investigated.
- C Diff threshold for 2017/18 remains the same as the previous year at 31 cases. There have been sixteen cases year to date.
- No reported cases of MRSA Bacteraemia in March. The Trust year to date total stands at 4.

- Actions: The area concerned has been put on a Period of Increased Surveillance and Assurance (PISA) for hand hygiene

Mortality and Readmissions

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
Hospital Standardised Mortality Ratio (HSMR)	<=100	82.5	83.5	81.3	82.9	79.7	81.1	80.6	81.3	81.4	82.2	80.8	81.1	
Hospital Standardised Mortality Ratio Weekday Emergency	<=100	79.2	80.1	78.2	78.9	76.4	77.4	77.2	77.5	76.6	77	77.1	76.8	
Hospital Standardised Mortality Ratio Weekend Emergency	<=100	84.2	86.0	83.5	85.4	81.3	81.8	81.2	82	83.8	84.1	83.7	86.7	
Summary Hospital Mortality Indicator (SHMI)	<=100	0.86	0.86	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.84	0.83	
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	TBC	9.5%	9.7%	9.7%	8.9%	9.0%	9.7%	10.2%	9.20%	9.38%	8.85%	9.0%		

Briefing

- Our SHMI data for the last reporting period (Oct-16 – Sept 17) remains statically lower than expected. The data shows that our mortality rate is lower then expected from typical hospitals and practice in this country.
- Readmission rates following a non-elective spell observed a slight increase in the month of March, reporting 9.0% of patients that were re-admitted to hospital within 30 days of discharge.

Maternity

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

Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
C Section Rate - Emergency and Non Elective	28%	29.9%	29.1%	24.6%	29.5%	24.9%	30.2%	29.7%	31.9%	25.4%	23.6%	23.1%	26.9%	
Admission of full term babies to neo-natal care		11	2	16	21	20	15	10	16	6	11	7	4	

Briefing: 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 incident reporting through the addition of subcategories to assist thematic reviews. Admissions to the Neo-natal Unit have decreased and intervention is beginning to result in a reduction.

Mortality

Deaths following time in hospital, England, October 2016 – September 2017

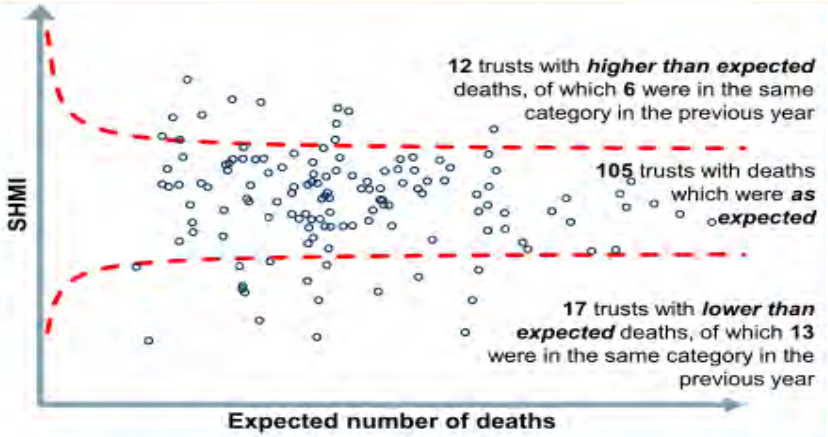
Quarterly statistics: Published 22nd March 2018

NHS Digital

This publication compares the actual number of deaths following time in hospital with the expected number of deaths, using the Summary Hospital-level Mortality Indicator (SHMI).

The expected number of deaths is estimated using the characteristics of the patients treated; age, sex, method of admission, current and underlying medical condition(s). It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

Between October 2016 and September 2017, there were approximately 8.9 million discharges, from which 293,000 deaths were recorded either while in hospital or within 30 days of discharge for the 134 hospital trusts covered. This includes deaths from other causes as well as deaths related to the reason for the hospital admission.



The 12 trusts with a ***higher than expected*** number of deaths were:

- **Blackpool Teaching Hospitals NHS FT**
- **Dorset County Hospital NHS FT**
- Isle of Wight NHS Trust
- James Paget University Hospitals NHS FT
- Northern Lincolnshire and Goole NHS FT
- **South Tyneside NHS FT**
- **Southend University Hospital NHS FT**
- Southport and Ormskirk Hospital NHS Trust
- The Royal Wolverhampton NHS Trust
- United Lincolnshire Hospitals NHS Trust
- **Wrightington, Wigan and Leigh NHS FT**
- **Wye Valley NHS Trust**

The 17 trusts with a ***lower than expected*** number of deaths were:

- **Cambridge University Hospitals NHS FT**
- **Chelsea and Westminster Hospital NHS FT**
- Croydon Health Services NHS Trust
- **Guy's and St Thomas' NHS FT ****
- **Homerton University Hospital NHS FT**
- **Imperial College Healthcare NHS Trust**
- **Kingston Hospital NHS FT**
- **London North West University Healthcare NHS Trust**
- North Middlesex University Hospital NHS Trust
- **Poole Hospital NHS FT**
- Royal Free London NHS FT
- Royal Surrey County Hospital NHS FT
- **St George's University Hospitals NHS FT**
- **Torbay and South Devon NHS FT**
- **University College London Hospitals NHS FT**
- **West Suffolk NHS FT**
- **Whittington Health NHS Trust**

Trusts in **bold** were also in the same category in the same period in the previous year. 'FT' means 'Foundation Trust'.
** Results for this trust are based on incomplete data and should be interpreted with caution.

The SHMI was developed in response to the public inquiry into the Mid Staffordshire NHS Foundation Trust.

It is used along with other information to inform the decision making of trusts, regulators and commissioning organisations.

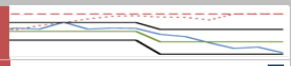
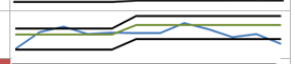
The SHMI is not a measure of quality of care. A *higher/lower than expected* number of deaths should not immediately be interpreted as indicating poor/good performance and instead should be viewed as a '**smoke alarm**' which requires further investigation.

The SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts by their SHMI.

See the full release at http://digital.nhs.uk/pubs/shmioct16sep17

Responsible Statistician: Chris Dew
Tel: 0300 303 5678
Email: enquiries@nhsdigital.nhs.uk

Emergency Flow

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
4 Hour Operating Standard	95%	90.5%	89.7%	92.1%	89.8%	90.1%	90.0%	88.0%	87.2%	85.0%	83.0%	83.5%	81.6%	
Patients Waiting in ED for over 12 hours following DTA	0	0	1	0	0	0	0	0	1	0	0	0	2	
Time to Treatment (number of patients seen within 60 minutes)		53.0%	52.3%	58.8%	56.0%	56.2%	54.1%	54.2%	54.2%	54.1%	51.7%	52.2%	52.6%	
Admitted patients with a length of stay 7 Days or Greater		264	310	326	305	309	307	307	336	318	296	304	277	
Ambulance Turnaround - % under 15 minutes	100%	46.0%	48.4%	51.9%	48.9%	51.8%	50.9%	49.9%	49.0%	44.3%	41.0%	42.2%	41.0%	
Ambulance Turnaround - % under 15 minutes (London Average)	100%	43.7%	45.3%	47.5%	46.4%	47.0%	46.5%	45.1%	46.1%	42.1%	41.4%	42.2%	41.1%	
Ambulance Turnaround - number of patients not handed over within 30 minutes	0	79	72	71	53	84	71	57	82	112	180	135	105	
Ambulance Turnaround - % under 30 minutes	100%	96.1%	96.7%	96.5%	97.4%	96.0%	96.6%	97.4%	96.2%	94.8%	91.3%	93.2%	94.5%	
Ambulance Turnaround - % under 30 minutes (London Average)	100%	91.8%	92.3%	93.3%	93.2%	93.1%	92.2%	91.9%	91.7%	91.6%	86.7%	87.4%	87.5%	
Ambulance Turnaround - number over 60 minutes	0	1	1	0	1	1	0	0	0	2	3	3	10	

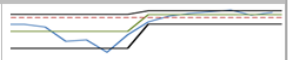
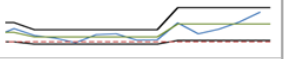
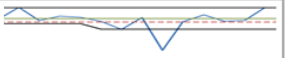
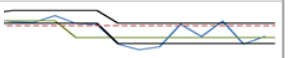
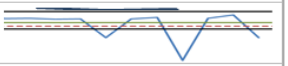
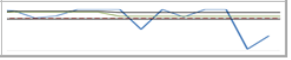
Briefing

- The Four Hour Operating Standard in March was 81.62% which falls below both the national target and the improvement trajectory agreed with NHSI.
- There was an increase in the number of ED attendances in March with 478 (Type1 and 3) attendances compared to 465 in February. The trust also saw an increase in the number of Ambulance attendances, from 3,028 to 3,244 in March .
- The trust completed both its largest Day of Care audit review (783 patients) and a combined Multi Agency Discharge Event (MADE) event (covering 14 wards). 25% of patients 'did not meet the criteria' of requiring an acute hospital bed with the MADE top 5 delay causes being: repatriations (19 on the day), senior review , social work , care home and waiting AHP.
- Key improvements seen include time to treatment and Four Hour Operating Standard for admitted patients
- Enhanced adult and children's ambulatory services launched

Actions

- The Trust Executive Committee has agreed a 15 point remedial action plan covering the emergency and non-elective pathway from arrival to discharge. The plan includes aspects of leadership, grip and control together with some short term process improvements to facilitate consistent delivery. The four key metrics, as recommended by the national Emergency Care Improvement Programme, are being tracked: ambulance handover, time to treatment, Four Hour Operating Standard (admitted and discharged patients) and stranded patients (Length of Stay over 7 and 21 days)
- The next key transformational change will be the release of emergency department clinical administrative task time through the implementation of a 'PaperLite' digital working environment. Further estates enhancements are also underway
- Effective system working continues.

Cancer

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	No of Patients	Trend (12 months)
Cancer 14 Day Standard	93%	75.4%	76.6%	67.4%	80.3%	89.7%	93.98%	96.05%	97.25%	98.51%	94.76%	96.70%	1,068	
Cancer 14 Day Standard Breast Symptomatic	93%	82.7%	84.1%	62.9%	86.9%	90.3%	98.2%	99.6%	98.0%	97.3%	95.9%	96.5%	199	
Cancer 31 Day Diagnosis to Treatment	96%	96.4%	96.4%	96.8%	96.9%	96.2%	96.2%	98.1%	96.9%	97.4%	98.2%	99.3%	140	
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	96.4%	95.9%	94.2%	90.9%	95.8%	82.4%	94.1%	96.9%	94.3%	94.6%	100.0%	36	
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98	
Cancer 62 Day Referral to Treatment Standard	85%	89.0%	87.3%	85.4%	77.8%	75.6%	76.7%	85.5%	80.8%	86.8%	77.8%	80.8%	49.5	
Cancer 62 Day Referral to Treatment Screening	90%	92.7%	92.4%	92.5%	86.1%	92.5%	93.0%	78.4%	92.7%	93.9%	86.1%	89.1%	23	
Cancer 62 Day Consultant Upgrade	85%	88.9%	100.0%	100.0%	100.0%	66.7%	100.0%	87.5%	100.0%	100.0%	33.3%	55.6%	4.5	

Briefing

- The Trust continues to achieve performance against the 14 day standard, reporting 96.7%, ensuring our patients are seen within 14 days of referral.
- Cancer 62 day Standard referral to treatment continues to be challenged with varied performance reporting 80.8% in February. A total of 9.5 patients were treated beyond target this included reasons of referrals being received late in the pathway from other providers, pathway management delays, complex pathways and patient choice.

	62 Day wait for First Treaatment- GP referral to treatment (actual and internal performance)		
	Target	Actual Performance	Internal Performance
Sep-17	85%	76.70%	82%
Oct-17	85%	85.50%	100%
Nov-17	85%	80.80%	90%
Dec-17	85%	86.80%	97%
Jan-18	85%	77.80%	79%
Feb-18	85%	80.80%	84.60%

- There is a continued focus on improving internal processes and a current action plan as part of the Elective Care Recovery Programme is in place.
- The Trust are looking at a number of patient pathways to improve waiting times and quicker access to diagnostics and treatment.
- This year there will be improved reporting within 62 day standard where the waiting times national database will record breaches that occur between each provider, the National reallocation policy will go live from July 2018.
- No Cancer patients have been cancelled due to bed unavailability during February or March

Cancer

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	No of Patients
Brain	93%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	7
Breast	93%	88.7%	84.7%	69.5%	76.4%	93.4%	94.1%	97.4%	98.4%	98.2%	96.0%	96.5%	197
Childrens	93%	66.7%	80.0%	66.7%	80.0%	100.0%	100.0%	100.0%	71.4%	100.0%	87.5%	100.0%	5
Gynaecology	93%	64.6%	66.7%	75.6%	93.4%	90.4%	91.1%	90.8%	95.0%	97.6%	98.0%	96.8%	93
Haematology	93%	76.2%	96.9%	76.9%	95.7%	100.0%	100.0%	96.8%	100.0%	94.7%	91.7%	100.0%	23
Head & Neck	93%	90.9%	84.9%	82.4%	88.0%	82.4%	90.6%	99.1%	99.4%	98.4%	100.0%	97.6%	127
Lower Gastrointestinal	93%	75.1%	90.7%	44.4%	60.0%	73.9%	94.6%	97.4%	97.7%	99.3%	95.2%	100.0%	171
Lung	93%	96.2%	91.1%	91.2%	95.6%	100.0%	94.1%	97.7%	100.0%	100.0%	92.3%	100.0%	30
Skin	93%	29.4%	48.1%	26.9%	74.3%	96.6%	93.4%	95.0%	95.5%	97.9%	92.7%	94.8%	250
Upper Gastrointestinal	93%	88.8%	96.1%	93.8%	97.6%	98.8%	98.8%	98.5%	99.0%	100.0%	89.0%	97.3%	75
Urology	93%	96.1%	90.1%	82.3%	93.8%	97.0%	96.4%	93.3%	97.1%	98.9%	95.0%	95.1%	90

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	No of Patients
Brain	85%	50.0%	-	0.0%	100.0%	0.0%	100.0%	-	100.0%	-	-	-	0
Breast	85%	100.0%	100.0%	100.0%	87.5%	100.0%	91.7%	100.0%	95.2%	100.0%	71.4%	100.0%	4.5
Childrens	85%	-	-	-	-	0.0%	-	-	-	-	-	-	0
Gynaecology	85%	100.0%	90.9%	100.0%	61.5%	100.0%	50.0%	83.3%	75.0%	67.0%	80.0%	77.8%	4.5
Haematology	85%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	-	100.0%	88.9%	83.3%	6
Head & Neck	85%	58.3%	85.7%	46.2%	66.7%	71.4%	87.5%	78.6%	81.8%	71.0%	100.0%	83.3%	3
Lower Gastrointestinal	85%	-	62.5%	100.0%	60.0%	100.0%	66.7%	100.0%	80.0%	100.0%	100.0%	75.0%	4
Lung	85%	85.7%	85.7%	64.3%	41.7%	47.4%	72.2%	72.7%	41.2%	33.0%	90.9%	57.1%	3.5
Skin	85%	93.3%	96.4%	95.7%	100.0%	76.5%	93.8%	90.9%	91.7%	93.0%	86.7%	100.0%	8
Sarcoma	85%	-	-	-	-	-	-	-	-	-	-	100.0%	0.5
Upper Gastrointestinal	85%	100.0%	100.0%	100.0%	100.0%	77.8%	0.0%	100.0%	84.0%	100.0%	33.3%	57.1%	3.5
Urology	85%	90.0%	67.9%	81.8%	63.0%	64.3%	77.4%	100.0%	72.7%	91.0%	60.7%	70.0%	12

Diagnostics

Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
6 Week Diagnostic Performance	1%	4.1%	3.3%	2.2%	2.7%	2.0%	1.4%	0.3%	1.9%	0.1%	0.1%	0.0%	0.2%	
6 Week Diagnostic Breaches	N/A	312	248	173	190	154	98	22	143	6	10	3	17	
6 Week Diagnostic Waiting List Size	N/A	7,550	7,442	7,843	6,988	7,751	7,184	7,072	7,534	6,440	6,884	7,232	7,075	

Indicator Description	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
MRI	1%	2.6%	1.1%	0.6%	0.8%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	
CT	1%	1.5%	0.5%	0.2%	0.2%	0.3%	1.2%	0.3%	0.1%	0.0%	0.1%	0.0%	0.3%	
Non Obstetric Ultrasound	1%	4.0%	2.5%	0.3%	1.1%	0.9%	0.0%	0.0%	0.0%	0.1%	0.1%	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%	6.5%	10.1%	11.3%	4.6%	5.7%	4.5%	0.0%	17.4%	0.0%	0.0%	0.0%	0.0%	
Echocardiography	1%	1.2%	9.4%	2.0%	3.0%	0.3%	0.3%	0.3%	0.8%	0.0%	0.0%	0.0%	0.0%	
Electrophysiology	1%	0.0%	0.0%	75.0%	75.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
Peripheral Neurophysiology	1%	0.0%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.3%	0.9%	0.0%	0.4%	
Sleep Studies	1%								26.8%	0.0%	0.0%	0.4%	0.6%	
Urodynamics	1%	65.5%	75.6%	64.4%	64.2%	50.6%	37.0%	16.7%	6.7%	0.0%	0.0%	0.0%	9.1%	
Colonoscopy	1%	5.7%	4.7%	0.5%	1.8%	0.0%	0.4%	1.1%	0.0%	0.0%	0.0%	0.6%	0.7%	
Flexi Sigmoidoscopy	1%	6.7%	0.0%	1.1%	4.9%	0.7%	1.5%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	
Cystoscopy	1%	15.0%	11.5%	24.4%	14.0%	12.3%	14.7%	4.0%	1.8%	1.5%	2.8%	0.7%	0.0%	
Gastroscopy	1%	12.7%	10.0%	9.2%	11.2%	6.7%	0.8%	0.0%	0.8%	0.4%	0.0%	0.0%	1.8%	

Briefing:

The Trust has continued to achieve performance in March reporting a total of seventeen patients waiting longer than 6 weeks, 0.2% of the total waiting list. Compliance has been achieved in all modalities with the exception of Urodynamics (4 patients) and Gastroscopy (5 patients).

Action The diagnostic waiting list will continue to be monitored as part of the Trust's weekly challenge meeting to ensure that the standard is maintained in all areas

St George's University Hospitals NHS
NHS Foundation Trust

On the Day Cancellations for Non-Clinical Reasons

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
Number of on the Day Cancellations		58	72	64	84	54	49	52	86	100	94	55	86	
Number of on the Day cancellations re-booked within 28 Days		54	70	54	70	43	43	34	76	67	76	48	76	
% of Patients re-booked within 28 Days	100%	93.1%	97.2%	84.4%	83.3%	79.6%	87.8%	65.4%	88.4%	67.0%	80.9%	87.3%	88.4%	

Briefing

- The table above shows that the number of patient procedures cancelled on the day has increased. March saw a significant shift observing an increase in the number of on the day cancelled operations for non clinical reasons .
- In March 86 patients were cancelled for non clinical reasons on the day of their procedure and 88.4% of these patients were re-booked within 28 days. Operations were cancelled due to bed unavailability, where an emergency case taking priority and lack of theatre time.

Actions

- Improving the Pre Operative Assessment (PAO) Process and the availability of more high risk capacity for POA
- Introducing a call to every patient before surgery to check that they are Ready, Fit and able to attend.
- At times of high non elective activity the elective patients are reviewed and their bed requirements in advance of the day of surgery
- Standard operating procedures have been introduced and a greater focus is being placed onto the booking process and list planning processes.

Outpatient Productivity

First Attendances (average per working day)

Division	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
C&W, Diagnostics, Therapies	134	136	141	133	128	141	139	132	126	137	129	116	
Medicine and Cardiovascular	244	279	261	263	243	255	251	262	223	262	259	254	
Surgery and Neurosciences	384	403	389	377	358	388	417	413	362	391	379	385	
Grand Total	762	818	790	773	730	785	806	808	711	790	767	755	

Follow Up Attendances (average per working day)

Division	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
C&W, Diagnostics, Therapies	137	145	137	137	130	147	151	159	142	163	160	131	
Medicine and Cardiovascular	868	867	842	821	801	821	808	805	754	850	817	811	
Surgery and Neurosciences	587	624	590	540	527	569	577	583	536	594	563	551	
Grand Total	1,592	1,636	1,569	1,498	1,458	1,537	1,536	1,547	1,432	1,606	1,540	1,493	

First and Follow Up DNA Rates (by month)

DNA Rate	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
C&W, Diagnostics, Therapies	9.9%	10.3%	10.2%	10.4%	11.1%	10.0%	10.1%	10.6%	11.6%	10.7%	11.3%	12.0%	
Medicine and Cardiovascular	10.7%	10.8%	10.8%	10.2%	10.6%	10.6%	11.5%	10.7%	11.6%	12.1%	12.0%	11.8%	
Surgery and Neurosciences	9.1%	9.9%	10.0%	9.7%	9.7%	9.6%	9.5%	9.5%	9.7%	10.1%	10.1%	10.2%	
Grand Total	**9.9%**	**10.4%**	**10.3%**	**10.2%**	**10.5%**	**10.1%**	**10.4%**	**10.3%**	**11.0%**	**11.1%**	**11.2%**	**11.3%**	

Briefing

- Across the three main divisions, daily First Outpatient attendances averaged 755 compared to 767 in February a reduction of 1.6% (12 patients)
- Follow-up attendances fell by 9.2% (52 patients) from 1,540 to 1,493 in March.
- Did Not Attend rates have fluctuated over the last twelve months.

Actions:

- Implementation of Netcall (telephony system) to contact patients to confirm clinic attendance and reduce Did not attend rates

Patient Experience

Patient Voice

Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
Emergency Department FFT - % positive responses	90%	85.2%	83.0%	85.2%	83.9%	85.9%	83.5%	86.4%	84.1%	86.5%	82.2%	81.0%	81.4%	
Inpatient FFT - % positive responses	95%	95.8%	97.3%	96.0%	96.6%	96.8%	96.5%	96.5%	95.7%	95.6%	94.7%	96.0%	96.3%	
Maternity FFT - Antenatal - % positive responses	90%		85.7%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	95.8%	
Maternity FFT - Delivery - % positive responses	90%	88.2%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.4%	
Maternity FFT - Postnatal Ward - % positive responses	90%	94.1%	97.9%	95.4%	87.1%	96.4%	100.0%	92.6%	96.0%	100.0%	99.0%	90.4%	100.0%	
Maternity FFT - Postnatal Community Care - % positive response	90%	100%	100%	100%	100%	98%	100%	100%	91.6%		100.0%	100.0%	100.0%	
Community FFT - % positive responses	90%	93.0%	97.6%	96.3%	94.5%	98.3%	94.1%	98.9%	95.7%	96.5%	99.2%	93.3%	98.3%	
Outpatient FFT - % positive responses	90%	92.6%	95.6%	96.6%	94.2%	96.2%	94.4%	96.3%	94.3%	98.2%	97.6%	96.1%	98.4%	
Mixed Sex Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	
Complaints Received		63	76	75	61	99	80	96	78	69	85	82	97	
PALS Received		299	299	234	268	170	203	185	298	262	283	234	257	

Briefing

- ED Friends and Family Test (FFT) – The score has increased slightly in March reporting 81.4%, however the percentage of patients recommending the service in March remains lower than those achieved in year.
- Maternity FFT – The score for maternity care are above local threshold and work continues to improve on the number of patients responding.
- The number of complaints received in the month of March were 97 compared to 82 in February. All complaints are now assessed for complexity when they arrive and given a response time of 25, 40 or 60 working days, the Trust is now able to report on the response times for all categories of complaints. For 25 day complaints received in February 61% were responded to within 25 working days against the target of 85%. For 40 day complaints received in January 64% were responded to within 40 working days. For 60 day complaints received in January 100% were responded to within 60 working days

Actions: A complaints handling improvement plan to address the timeliness and quality of complaint responses and which considers different models for handling complaints has been implemented and there is now executive focus on the 10 longest outstanding complaints to understand themes and issues. A review of the classification of complaints between Green and Amber categories is underway to ensure accurate reflection of the complexities. Complaints and PALS: An action plan to improve complaints management, particularly responsiveness, is underway

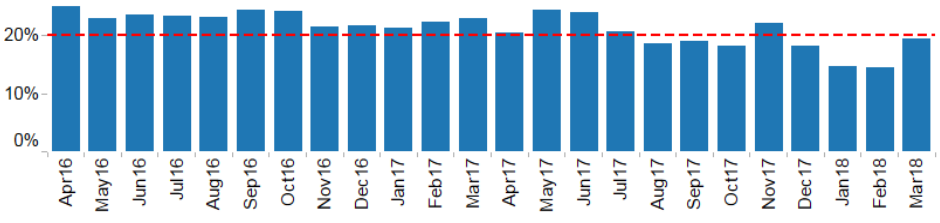
Patient Voice

CARING – Friends and Family Test

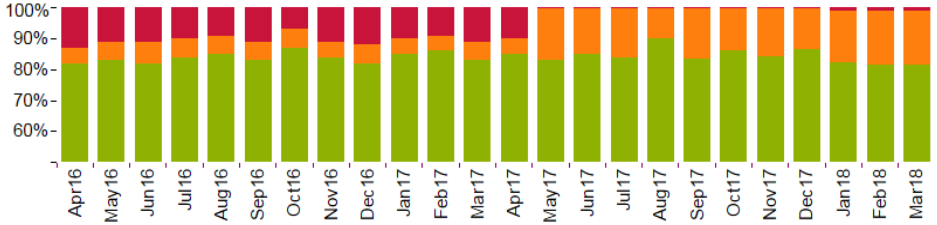
Target ¢ MetricMeasure | Percentage Recommended | Neutral | Percentage Not Recommended

A&E Friends & Family Response Rate

Target: 20% Feb 18: 14.40% Mar 18: 19.52% Movement: ▲5.12%

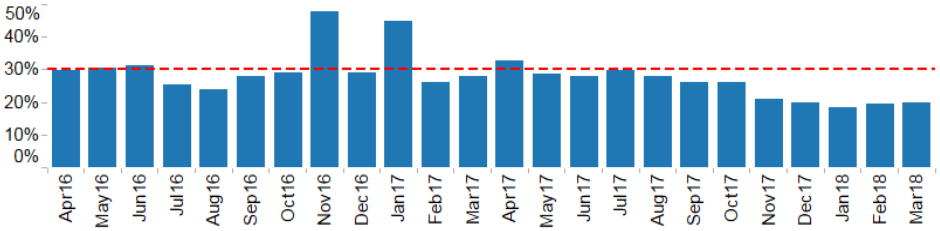


A&E Friends & Family Recommend Rate
The expected target is 90%

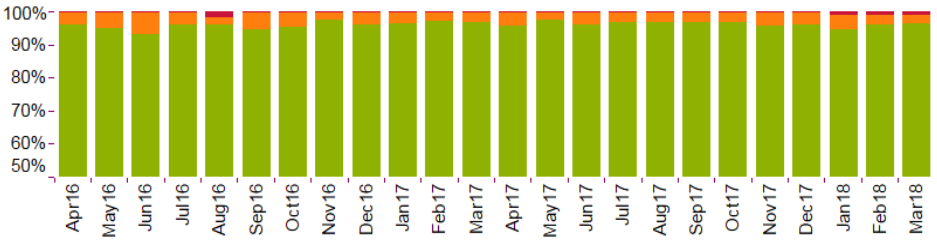


IP Friends & Family Response Rate

Target: 30% Feb 18: 19.70% Mar 18: 19.70% Movement: ▸0.00%

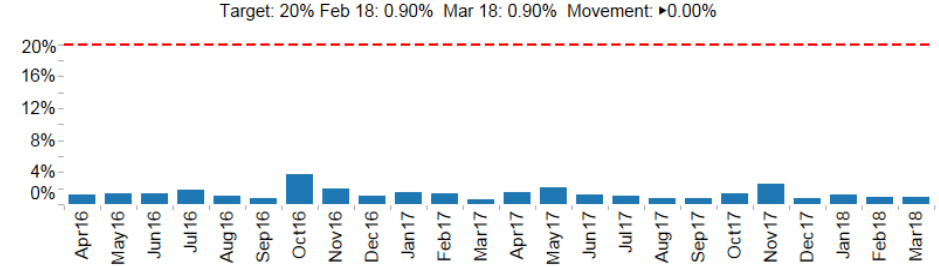


IP Friends & Family Recommend Rate
The expected target is 95%

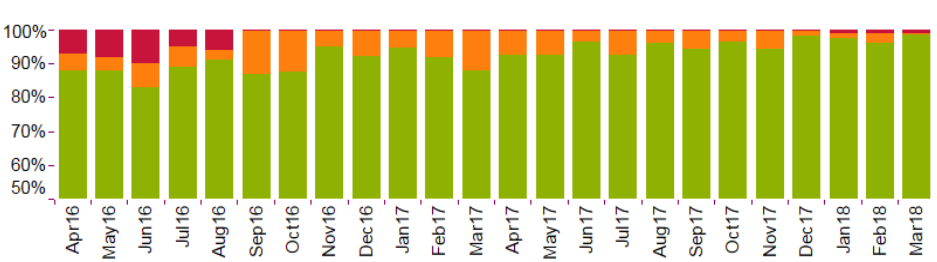


OP Friends & Family Response Rate

Target: 20% Feb 18: 0.90% Mar 18: 0.90% Movement: ▸0.00%



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



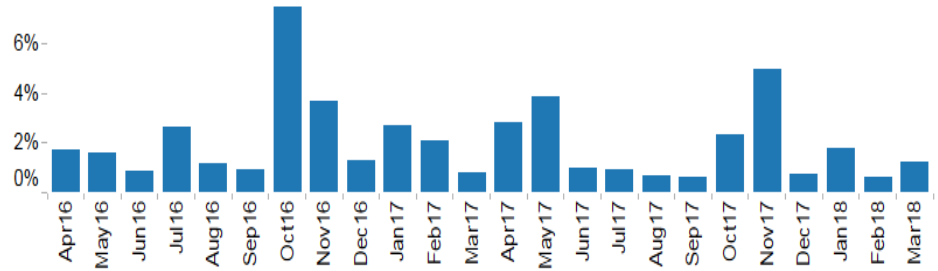
Patient Voice

CARING – Friends and Family Test

--- Target ¢ MetricMeasure Percentage Recommended Neutral Percentage Not Recommended

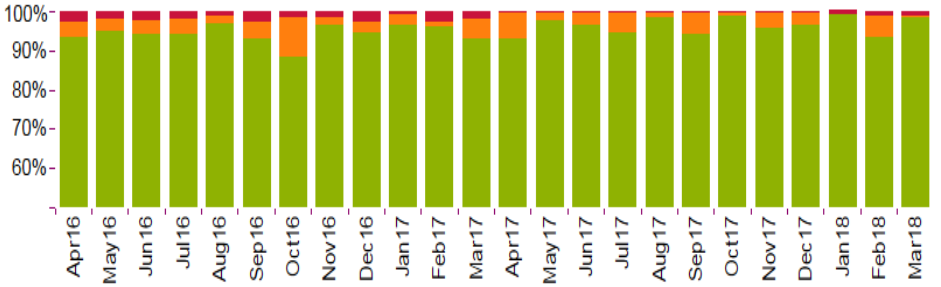
Community Friends & Family Response Rate

Target: 20% Feb 18: 0.60% Mar 18: 1.25% Movement: ▲0.65%



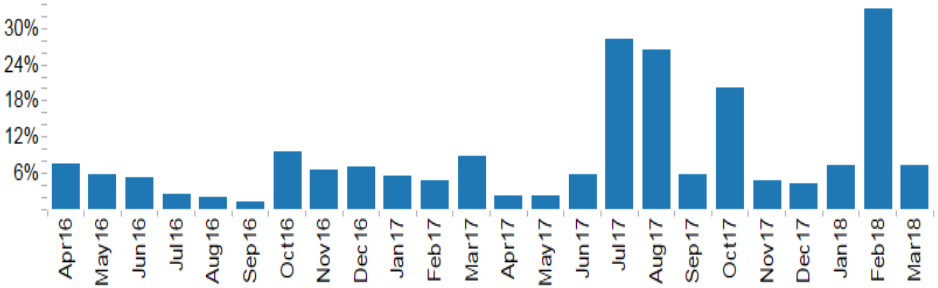
Community Friends & Family Recommend Rate

The expected target is 90%



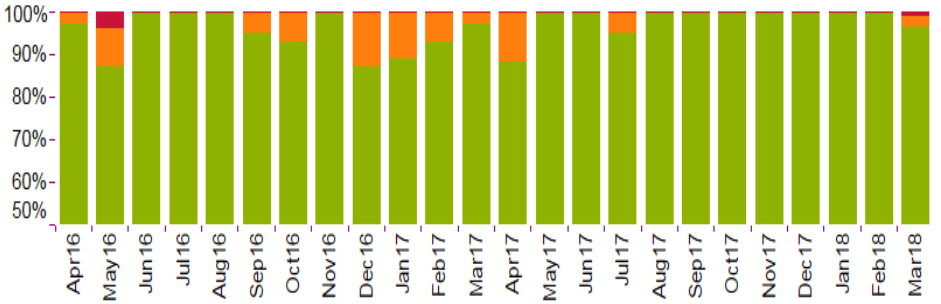
Maternity (Birth) Friends & Family Response Rate

Target: 20% Feb 18: 33.30% Mar 18: 7.41% Movement: ▼-25.89%



Maternity (Birth) Friends & Family Recommend Rate

The expected target is 90%



Workforce

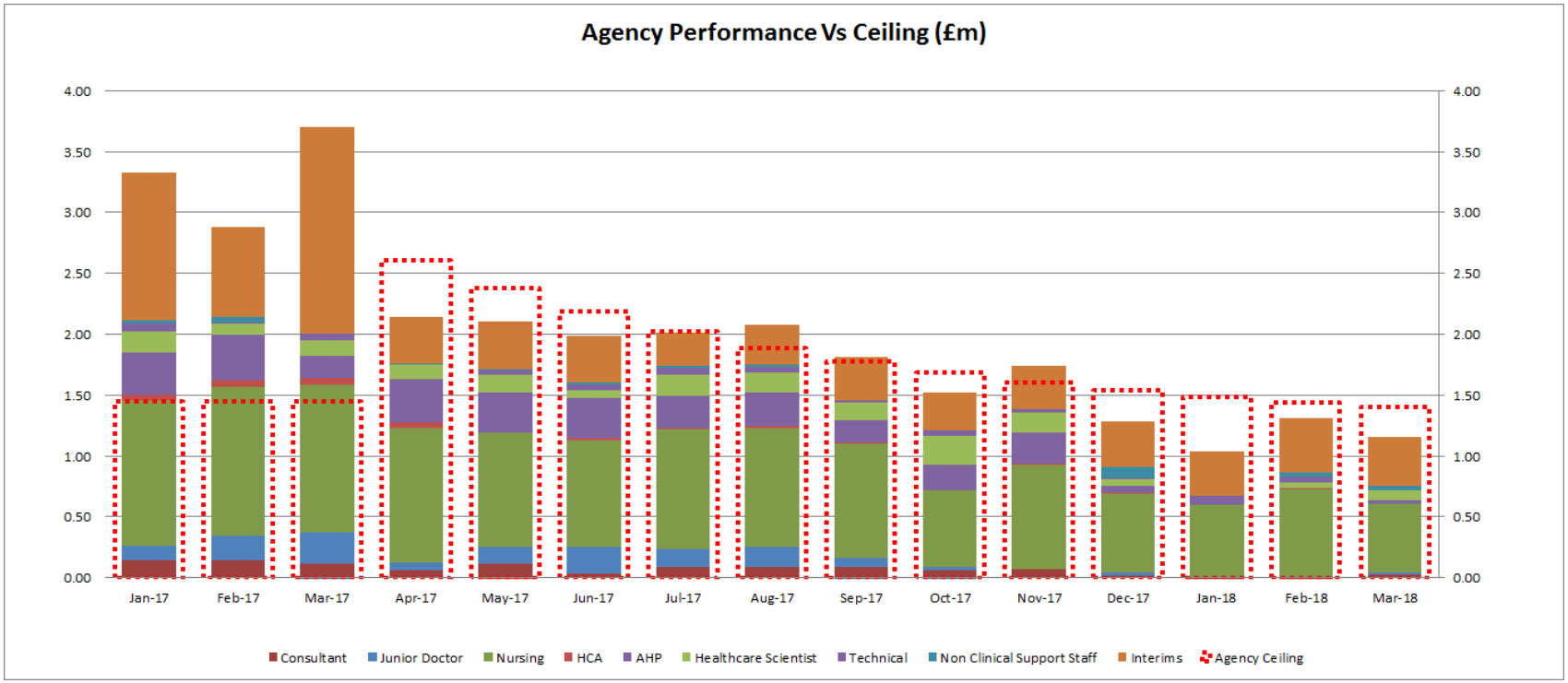
Indicator Description	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Trend
Trust Level Sickness Rate	3%	3.2%	3.4%	3.4%	3.6%	3.7%	3.6%	3.4%	3.8%	3.6%	4.1%	4.0%	3.6%	
Trust Vacancy Rate	10%	16.3%	17.0%	17.1%	16.1%	16.5%	14.8%	16.1%	12.7%	13.0%	13.4%	13.5%	13.3%	
Trust Turnover Rate* Excludes Junior Doctors	10%	19.1%	19.1%	18.8%	18.4%	19.6%	18.5%	18.5%	18.3%	18.4%	17.9%	17.6%	17.2%	
Total Funded Establishment		9,784.10	9,924.93	9,947.77	9,878.79	9,855.40	9,794.00	9,808.00	9,470.02	9,474.19	9,514.51	9,540.06	9,497.37	
IPR Appraisal Rate - Medical Staff	90%	82.4%	82.0%	74.2%	84.8%	79.0%	74.0%	80.7%	80.0%	78.9%	79.6%	76.9%	72.2%	
IPR Appraisal Rate - Non Medical Staff	90%	80.3%	78.2%	76.1%	76.1%	75.1%	79.4%	73.5%	70.2%	70.2%	67.2%	65.9%	61.6%	
% of Staff who have completed MAST training (in the last 12 months)		86%	87%	87%	86%	86%	85%	86%	87%	86%	87%	87%	87%	
Ward Staffing Unfilled Duty Hours	10%	5.5%	4.8%	5.8%	5.9%	6.5%	5.9%	6.1%	6.6%	7.8%	7.7%	7.9%	8.9%	
Safe Staffing Alerts	0	0	0	1	2	1	0	1	2	2	4	1	1	

Briefing

- Funded Establishment fell compared to the previous month reporting 9,497.37 WTE in March, a reduction of 2.93% from April 2017 as a result of the changes to the Community Division.
- Vacancy Rate fell by 0.2% reporting 13.3% in month.
- Sickness was above the 3% target reporting 3.6% in March.
- Mandatory and Statutory Training figures for March were recorded at 87%
- Appraisal rates for both Medical and Non-Medical staff remain below target. Non-medical appraisal rates reporting 62% and 73% respectively in March.

Actions: We are establishing a working group to look at how we can improve on our current appraisals rates. In parallel we looking at how we can bring on stream an electronic appraisal solution via TOTARA

Agency Use



- The Trust's annual agency spend target set by NHSI is £24.5m. There is an internal annual agency target of £22.0m.
- In 2017/18, the total agency cost is £19.98m. This is £2.02m lower than the Trust's internal agency target.
- The largest areas of underspend in 2017/18 is in Nursing (£2.78m lower than target) and HCA (£0.15m lower than target).
- The largest areas of overspend in 2017/18 is in Healthcare Scientist (£0.49m higher than target), AHP (£0.27m higher than target) and Non Clinical Support Staff (£0.19m higher than target).

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No.**	**4.2**
Report Title:	**Elective Care Recovery Programme Update**		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer Kim Barrow, Elective Care Recovery Programme Director		
Report Author:	Andy Irvine, Elective Care Recovery Programme Manager		
Presented for:	Assurance		
Executive Summary:	This report provides an update on the Elective Care Recovery Programme, including key highlights of the programme, an overview of the elective care pathways training plan, and a summary of overall programme risks.		
Recommendation	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Treat the patient, Treat the person Right Care, Right Place, Right Time		
CQC Theme:	Well-led, Safe, Caring, Responsive		
Single Oversight Framework Theme:	Quality of Care Operational Performance		
Implications			
Risk:	BAF Strategic Risk 2		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously considered by:	Quality and Safety Committee	**Date:**	19 April 2018

ELECTIVE CARE RECOVERY PROGRAMME

1. Key Highlights

Cancer	• Independent review at QMH commissioned and due to present their final report on 31st March 2018. The interim feedback has suggested that the systems and processes in place are safe but need to be refined. The draft report has been received by the Trust and it is undergoing the normal management review before signing off the recommendations and preparing the action plan. One of the key deliverables for 18-19. • Successful work continues to upgrade and improve the cancer IT system with our partners at Infoflex. • Six consecutive months of achieving the two week rule [14 day from referral to consultation] cancer target which represents real progress and stabilisation.
Diagnostics	• Achieved compliance and forecast to continue. • The substantive Divisional Director of Operations continues to strengthen the control and grip through a confirm and challenge approach. • The diagnostic PTL [Patient Tracking List] is in place with discussion continuing with our Partner Cymbio as to whether it should sit in the same place as all other PTLs. Patients going through diagnostics are being tracked and treated in a timely manner.
Treating Patients	• The new referral treatment [RTT] incomplete and planned patient tracking lists [PTL's] are in place and continue to be used and matured by the operational teams. Positive feedback from operational teams regarding the real improvements to the structure of these PTLs this month. • New and improved reports have developed by the business intelligence team to increase the type of tools available to clinical teams. Operational Managers will now help to refine and evolve them to ensure they work for them. • The number of patients waiting too long for their treatment continues to reduce.
Return to Reporting	• Data quality metrics have been agreed and built by our third part supplier. These will start to sit within the Trust's accountability framework to reduce errors and increase overall data quality. • Almost all patients from our phase one validation have now been contacted and appointed where necessary. Further assurance is to note that no further clinical harm has been identified during this reporting period.

Training	• Further communication across the organisation to highlight the importance of undertaking the foundation and basic modules of the RTT e-learning modules. Over 50% of the identified staff have now undertaken these modules which means the organisation is in a better place with its understanding of RTT. This training and learning opportunity has never been in place for St George's and is another step forward in our journey. • At the Trust Board in March a targeted training plan was presented. To give further assurance this has now commenced and through its accountability framework, the Trust will ensure progress is made against plan. Detailed later is a typical highlight report that will be used to track progress. • One of the Trust Board Non Executive Directors spent time this month with the wider training team to understand the issues, challenges and successes. This will help to further strengthen our assurance at Board level on what is considered to be a priority area throughout 18-19.
Next steps	• Further reductions in the number of patients waiting too long for treatment • Further implementation of maximum waiting cap for new outpatients – working to bring this cap down week on week • A real focus on training both on Cerner and RTT across the key staff groups • Sign off of specialty capacity and activity plans for 18/19 • Continue to appoint the appropriate patients from phase one validation and identify any potential harm • Further alignment with the outpatient transformation and theatre improvement programmes
Risk	1. Delivery of robust capacity plans that reflect demand 2. Sub specialty capacity pressures in Ear, Nose and Throat and General Surgery 3. Standard Operating Procedure [SOP] development to ensure front line staff are working to agreed rules 4. Training resource to train staff on the right way to process patients [SOP's] and RTT knowledge through e-learning packages. 5. Delayed Cerner implementation at QMH

Targeted Support Training

St George's University Hospitals NHS
NHS Foundation Trust

Summary:
Project kick off Monday 9th April 2018.
UNCS end-user report from iCLIP obtained.
Project sponsor provided with an updated approach to training – recommending all 355 staff identified as making potential iCLIP errors are addressed within Phase 1
11 staff interviewed to analyse potential DQ errors- combination of process, iCLIP system, training and behaviour issues identified. Engagement with Income Recovery Prog.
Project plan re baselining commenced
High level Training Needs Analysis completed.

RAG

Phase 1: Status Update - Training

G

Based on training the total 355 staff identified:

Area	Total	Visited for DQ Analysis	Trained
Outpatient staff	287	0	0
Inpatient	68	3 (+2 not on list)	0

Phase 1: Status Update – Project Milestones

G

Milestone	Timeline / Dates
Develop a detailed training plan	TBC
Develop and sign off training materials	TBC
Plan to implement KPI's / Dashboard	TBC
Training sessions planned	TBC
Training delivered	TBC

User Guides:

User Guide	Status
Understanding the Principles of managing the Elective Care Pathway using iCLIP	In progress
How Do I Guide for Registration of a new OP referral	Completed
How Do I Guide for C2C Patient Registration	Completed
How to schedule a Ward Discharge Appointment following an emergency inpatient admission via ED	Completed
How I do schedule a Ward Discharge Appointment following a planned inpatient admission	Completed
How do I add a IP & OP Tertiary referral in iCLIP	Not yet Started
How do I add a patient to the IP & DC waiting list	Not yet Started

Next Steps for this week: (week beginning 16.04.18)

- Re baselined plan completed and signed off
- Visit further staff booked in for DQ analysis
- Complete How do I guide on "Understanding the Principals of Managing the Elective Care Pathway data capture in iCLIP"
- Commence lesson plan development

Risks / Issues/ Concerns:

- Tertiary referral guide cannot be completed until a decision from the "Back to Reporting" members on how the organisation will manage Tertiary referrals has been made. This will require changes to iClip. Peter Ebioke is leading on this. David McCullock is currently testing a proof of concept to enable the decision that will define the To-Be workflows and inform what needs to be trained.

Overall Programme Risks

Key Risks			
Risk / Cause / Impact	**RAG Score**	**Executive Owner**	**Mitigating action/s**
High numbers of errors being added to the PTL **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. Large scale validation requirement needed to continually clean the errors being made.	20	Ellis Pullinger	**Controls in place**: Strong communications on the need and consequences. **Actions**: • 'How to guides' developed to address requirements in short term • Data Quality Dashboard in place to track errors on a daily basis • Have trained 839 staff including 353 clinicians on CDOF • E-Learning training in place and mapped to 3500 staff for roll-out • Keeping PTLs clean 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.
Insufficient outpatient and inpatient capacity to reduce RTT backlogs **Risk**: There is a risk that current capacity plans are not sufficient to reduce RTT backlogs on both SGH and QMH sites. **Cause**: Operational Planning **Impact**: An increase in the time for the Trust to return to National Reporting and the requirement of a significantly sized validation team. Excessive waiting times continue in some specialties.	20	Ellis Pullinger	**Controls in place**: Capacity planning process linked to contractual discussions **Actions**: • Development of backlog reduction plan – signed off by services • Outpatient clinic template clean-up: undefined slots • Increased outpatient new slots made available to CBS and ERS • Where necessary – outsourcing plans developed.
Adherence to Trust access policy: chronological booking and management of DNAs **Risk**: There is a risk that current capacity not being utilised effectively – particularly with regard booking patients in date order and removing patients who fail to attend. **Cause**: Booking from PTL / Process for managing DNAs **Impact**: Capacity wasteage / patients booked inappropriately.	16	Ellis Pullinger	**Controls in place**: Enhanced waiting list management, validation and review of all patients within current defined criteria **Actions**: • Launch of new Trust-wide PTL • PTL rollout to CBS and PPCs • Data Quality Dashboard tracking DNAs on a daily basis • Specialty level PTL management meetings in place
Time needed to rollout Cerner at QMH **Risk**: Trust cannot return to national reporting without an RTT compliant PAS system **Cause**: Non-RTT compliant PAS system at QMH **Impact**: The time needed to rollout Cerner at QMH will	16	Larry Murphy	**Controls in place**: **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
Consultant not completing the outcome functionality after training and implementation **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	**Controls in place**: Strong leadership from the Divisions and outcomes reported as part of the governance around access **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
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

Andy Irvine
Elective Care Recovery Programme Manager
April 2018

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No.**	**4.3**
Report Title:	**Emergency Care Performance and NHSI recommendations**		
Lead Director/ Manager:	Ellis Pullinger, Chief Operating Officer		
Report Author:	Fiona Ashworth, Divisional Director of Operations, Medicine and Cardiovascular Division & Gemma Phillips, General Manager for Emergency Department and Acute Medicine.		
Presented for:	Approval		
Executive Summary:	This paper presents an updated position on the Trusts emergency care performance, the 15 point plan encompassing the NHSI recommendations from the St Georges site visit in February 2018 and a revised performance trajectory for approval linked to the constitutional standard and national operating framework. Emergency care performance at St George's Hospitals NHS Trust has deteriorated in 1718 despite a number of interventions and delivering care within 4 hours to 85.7% of our patients against the 95% standard. A 15 point plan was drawn together in early February 2018, and the trust secured additional support through a service improvement director with the targeted aim of improvement and delivery of the 95% standard. Subsequently, In February NHSI visited the trust due to its fragile performance to undertake a diagnostic review and submitted a number of recommendations for implementation. This paper is being presented to confirm the trust wide actions and governance structure being taken to improve emergency care performance driven through the 15 point plan, and encompassing the observations and recommendations made by NHS Improvement and the focus of the Unplanned and Admitted Patient Care Transformation programme. This paper also submits a revised emergency care trajectory for discussion and approval, which complies with NHS operational Planning and Contracting Guidance 2017-2019 the trust is required as a minimum to meet 90% by September 2018 and 95% by March 2019.		
Recommendation:	• It is recommended that the Trust board note the key issues and actions to deliver improvement in emergency care performance. • Trust board is asked to consider and approve the emergency care performance trajectory of 92% 2018/19, and regulatory requirement of 90% performance by September 2018 and 95% in March 2019.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person. Right care, right place, right time. Build a better St George's.		
CQC Theme:	Safe, Effective, Responsive, Well-led		
Single Oversight Framework Theme:	Operational Performance, Leadership and Improvement, Quality of Care		

Implications			
Risk:	This risk is on the divisional risk register.		
Legal/Regulatory:	NHS Operating Standard.		
Resources:	N/A		
Previously Considered by:	Trust Executive Board Trust Board	**Date:**	18 April 201829 March 2018
Appendices:	3		

1.0 Purpose

1.1 This paper is being presented to confirm the trust wide actions and governance structure being taken to improve emergency care performance. The improvement structure is being delivered as part of the trust 15 point plan, which encompassing the observations and recommendations made by NHS Improvement following their site visit to St George's Hospital on 20th and 21st February 2018.

1.2 In line with NHS operational Planning and Contracting Guidance 2017-2019 the trust is required as a minimum to meet 90% by September 2018 and 95% by March 2019. In addition to the performance, quality and safety benefits of meeting the target, it should be noted that delivery of this plan remains linked to access of 30% of the Sustainability and Transformation Fund (STP), subject to the control total.

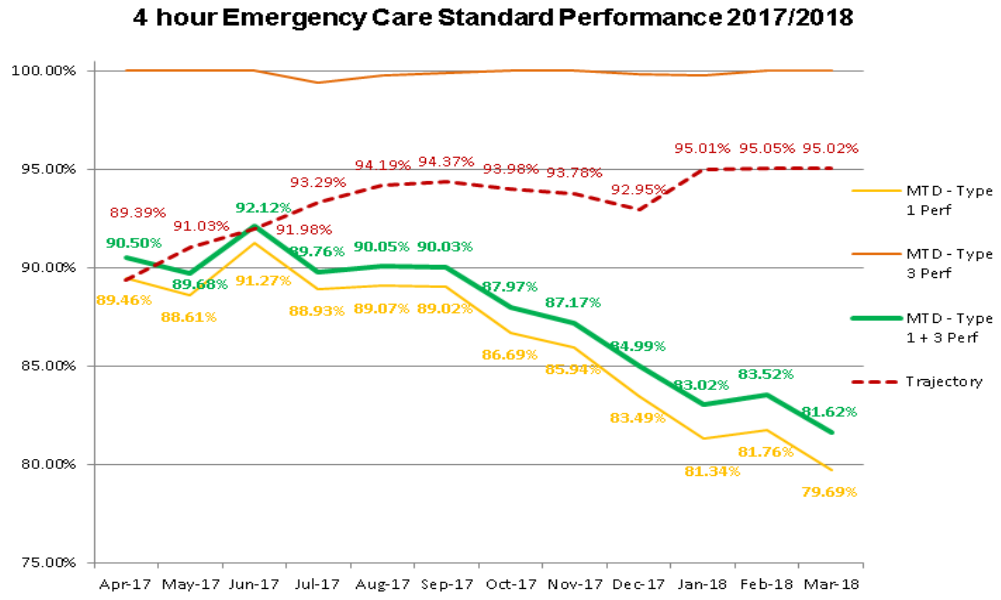
1.3 The NHSI recommendations have been aligned to the existing 15 point plan with a focus on the immediate to medium term changes required, whilst engaging with hospital staff to facilitate a change in an organisational cultural shift ensuring clear accountability and responsibility for the delivery of the 4 hour Emergency Care standard.

1.4 The paper outlines the expected impact of the actions being taken on performance and outlines the trajectory for improvement against the 4 hour Emergency Care standard in 2018/19.

1.5 The paper also highlights the importance of alignment between the 15 point plan and related improvement activities specifically in respect of the Unplanned and Admitted Patient Care programme.

2.0 Background

2.1 The Trust's performance against the 4 hour Emergency Care standard has become increasingly challenged since September 2017 and has been consistently below 2016/17 levels of performance. The Trust reported overall performance of 87.56% for 2017/18 with significant variability in daily performance. Monthly performance is detailed in the chart below:



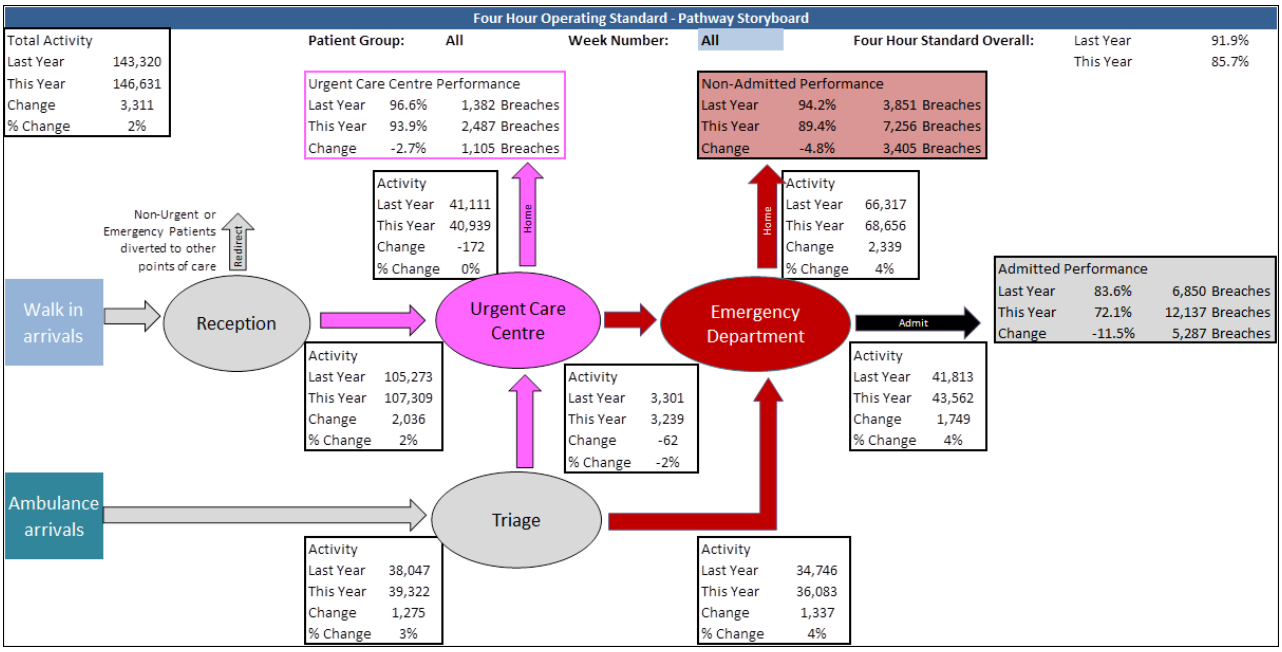
2.2 In February 2018, NHSI undertook a series of clinically led site visits to the most fragile systems for emergency care across London to review quality, patient flow and progress with a specific focus on emergency care improvement programmes, Emergency Departments (EDs), Acute Medical Units (AMUs), Ambulatory Emergency Care (AEC), inpatient wards, frailty intervention services, site management and discharge processes.

2.3 In early March 2018, the Trust received a copy of the report from NHS Improvement following their visit to St George's Hospital in February 2018 which outlines 24 observations with associated recommendations for implementation, including 16 that should be addressed in the short term (within one month).

2.4 These recommendations have been cross referenced with Trust's Quality Improvement Plan (QIP) and the Four Hour Emergency Care Standard 15 Point Plan.

2.5 The Trust also had Four, 12 hour trolley wait breaches in the last 6 months, 1 in November 2017, 2 in March 2018 and a further 1 in April 2018. 2 of these were associated with delays to securing an appropriate mental health bed and the other was due to internal process issues. An RCA has been completed for each with learning and improvements identified. The Trust is working closely with psychiatry liaison and partner organisations to improve the experience of patients attending the ED with primary mental health needs and to avoid breaches of the 4 hour standard for these patients.

2.6 Overall both admitted and non-admitted pathways performance has deteriorated significantly between 2016/17 and 2017/18 which is highlighted in the performance storyboard graphic below, and reflects the concern by NHSI regarding the Trust's 4 hour standard performance. The plan to recover our position targets both the admitted and non- admitted pathways in addition to system wide and transformation actions.



2.7 Currently the Trust is currently ranked nationally at 42/137 Trusts and regionally at 4/18 Trusts within the London region for Emergency Performance (all types) the week ending 15 April 2018. For Type 1 attendances only the Trust is ranked at 40/137 Trusts and regionally 4/18 Trusts as the charts below show. This is a significant improvement from the week of the 8th April, however consistency and variability on a day to day basis remains a challenge for the trust.

2.8 The Trust dashboard which is being developed with the Emergency Care Improvement Programme is on Page 13, and will be further developed to reflect the complete measurable metrics for the 15 point emergency care delivery plan.

3.0 Feedback from NHSI

3.1 The feedback from NHSI resonated with the 15 point plan already established in the trust, and suggested key timeline implementation segmented into short, medium and longer term; these have been embedded into the trust plan.

3.2 Overall, the NHSI review has highlighted and confirmed a number of opportunities to improve the structures, processes, behaviours and leadership which are contributing to organisational performance against the four hour Emergency Care standard being delivered well below the requisite 95%. (Full report appendix 3).

3.3 In the report, whilst NHSI recognised that there is a clear expectation set by the executive team that emergency care is an organisational priority, it was not apparent through observations and discussions that emergency care is everybody's responsibility and a key priority is to instil this as a change in the culture across the organisation. This is consistent with the observations of the trust Service Improvement Director that, whilst staff are committed to delivering a high level patient care there is duplication of effort and an observation of strong and conflicting series of silos within the organisation which are impeding best patient care through preventing effective patient flow.

3.4 In addition, there is a view at an organisational level that even when there is good flow within the organisation, ED rotas are sometimes misaligned to demand. The Emergency Care Improvement Programme (ECIP) Informatics lead is supporting the Trust in reviewing demand and capacity aligned to ED resources and rotas.

3.5 The close proximity of ED to CDU, AMU and the new Ambulatory Assessment Area (AAA) was widely acknowledged internally and noted by NHSI as an advantage, however transfers out of ED to AMU were observed to be slow, even when beds are empty and allocated to patients as was flow from AMU to inpatient wards. The need to review referral pathways into the new ambulatory care units and existing assessment areas including the Nye Bevan Unit (surgical assessment unit) presents a further opportunity for improvement to patient flow and performance and is a key priority.

3.6 The team observed several board rounds and spoke to nursing staff about ward processes where they found significant variation. Best practice in the implementation of the SAFER Patient Flow Bundle was not reflected on the wards that were visited and use of the discharge lounge for early discharges was variable.

3.6 Whilst NHSI did not meet with the Transformation Team, they recognised the existence of a dedicated improvement team and Programme Management Office (PMO) and recommended that the Trust considers how many of the team are dedicated to driving improvements in emergency care and patient flow.

3.7 The team stated that a shared commitment to common goals and objectives is sometimes missing, meaning that actions in support of an agreed escalation status can be misaligned and inconsistent, with staff sometimes interpreting agreements (and in some cases instructions) differently with a lack of consequence. There is a strong need for an improvement in the alignment of patient flow activities and accountability across the organisation including site team management.

3.8 NHSI verbally described an opportunity to improve the flow of patients via a frailty unit in place of CDU. Plans are already in progress to review the model of care for frail older patients across both St George's and Queen Mary's Hospitals, including a review of pathways, processes and length of stay in addition to the Older Person's Advice and Liaison (OPAL) team based across AMU and CDU.

4.0 Transformation Team

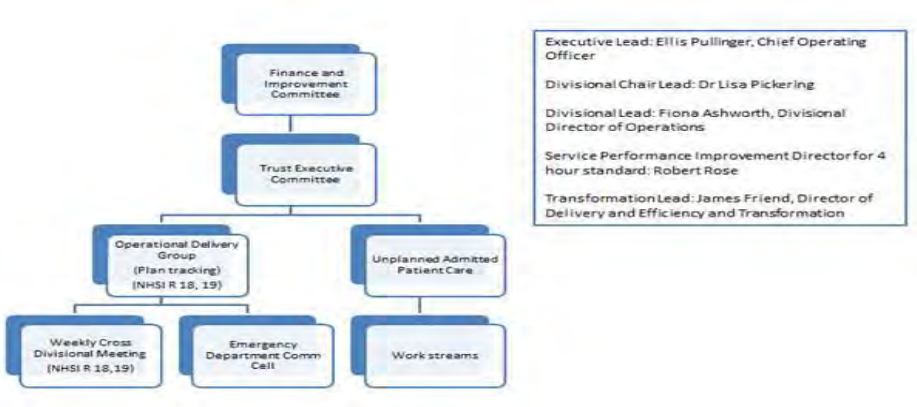
4.1 Transformation are providing support in delivery of the Unplanned and Admitted Patient Care programme which was established to help deliver local system delivery recommended improvements. Its core workstreams cover Streaming at the Front Door, Emergency Department Process Improvement, Ambulatory Care, Inpatient Process Improvement and Discharge Process Improvement. In collaboration with clinical and operational teams, the programme team have delivered a range of projects that are progressively improving patient flow reducing unnecessary admissions and building stronger working relationships with system partners - including Emergency Care Data Set, Acute Ambulatory Assessment, Children's Ambulatory Unit, electronic assessment and discharge notices).

4.2 Based upon learning during Q4 17/18 the transformation team has recommended a revised implementation approach for inpatient and discharge processes that balances process transformation and developing a high performing team culture to deliver emergency care performance. In partnership with the clinical and operational leadership teams, the programme will define daily / weekly minimum standards (tasks) that drive patient flow and support ward/site teams to better understand and enhance team collaboration, resilience and accountability, underpinned by PDSA (Plan Do Study Act) improvement cycles.

4.3 The initial implementation priorities will be on those wards where reductions numbers of long stay (stranded) patients will most immediately improve length of stay and bed availability for further patient admissions (currently expected to include 6-7 wards across medicine and surgery). Subsequent roll-out plans will follow a similar principle. The team will also support nurse and clinical leaders to help wards embed nationally recognised ways of working that help improve patient experience and flow including 'Red to Green', SAFER, 'PJ Paralysis' and 'Fit to Sit'.

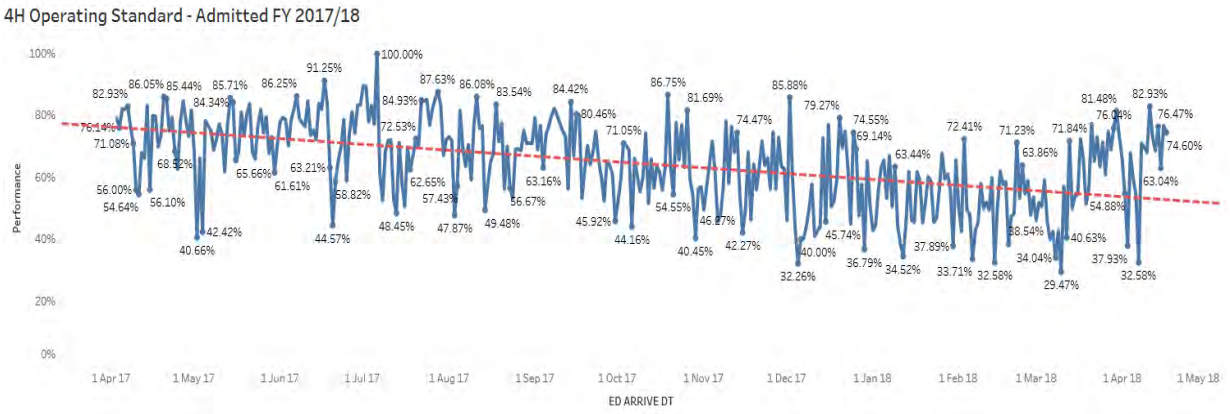
5.0 Governance Structure for Emergency Care Performance

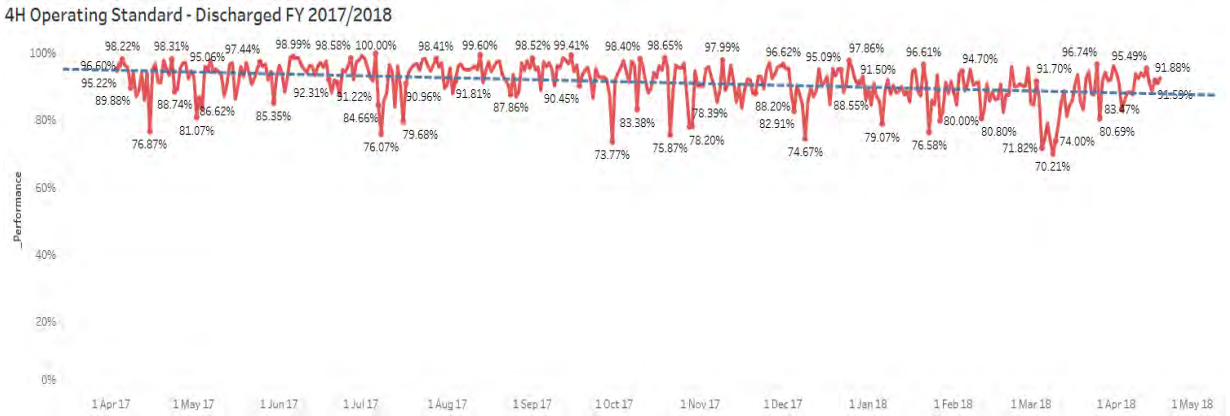
The diagram below outlines the governance structure of the oversight of Emergency Care Performance Improvement Group (ECPIG) which is chaired by the Chief Operating Officer.



6.0 Emergency Care Performance Improvement Trajectory 2018/19

6.1 In 2017/18 the Trust incurred an average of 58 breaches of the 4 hour standard every day, including 45 per day across Q1 and Q2 and 71 breaches per day across Q3 and Q4. The charts below summarise 4 hour performance for admitted and non-admitted cohorts from 1 April 2017 to date.





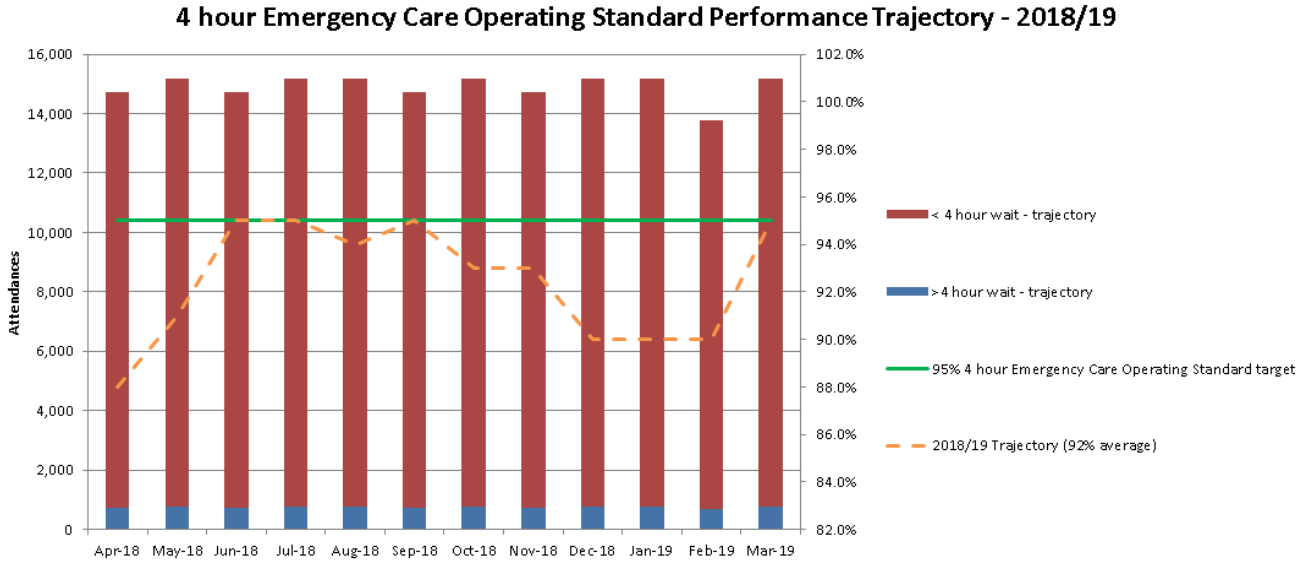
6.2 Based on the daily number of ED attendances (all types) as per the 2018/19 SLA plan the Trust has a maximum threshold of 25 breaches of the 4 hour standard per day in order to consistently deliver the 95% target (table1). In 2017/18, 78% of ED attendances were in the non-admitted category and 22% were admitted. Non-admitted breaches accounted for 43% of the total breaches; 57% of breaches were for admitted patients. Based on this, and in order to deliver 95% performance consistently, admitted performance would need to be 87% and non-admitted performance 97.2% on average.

Table 1

Daily attendances 2018/19 SLA (all types)	490							
4 hour standard performance (all types)	Daily breach threshold	No patients <4h	No. admitted breaches (57%)	No. admitted patients <4h	Admitted performance	No. non-admitted breaches (43%)	No. non-admitted patients <4h	Non-admitted performance
90%	49	441	28	80	74.1%	21	361	94.5%
91%	44	446	25	83	76.7%	19	363	95.0%
92%	39	451	22	85	79.3%	17	365	95.6%
93%	34	456	20	88	81.9%	15	367	96.1%
94%	29	461	17	91	84.5%	13	370	96.7%
95%	25	466	14	94	87.0%	11	372	97.2%

6.3 The plan is targeted to deliver sustainable improvements in Emergency Care performance that will as a minimum deliver the achievement of 95% performance against the 4 hour constitutional standard in March 2019.

6.4 The proposed revised trajectory reflects the actions being taken to improve performance across admitted and non-admitted pathways in line with the 15 point plan. Given the significant variability in performance and detailed actions the trajectory proposes a 92% overall performance, including 90% performance from September 2018 and 95% in March 2019.



NB. Activity based on 2018/19 SLA

6.5 The proposed trajectory requires a 50% reduction in non-admitted breaches (reduction of 13 breaches per day) compared to 2017/18 linked to the actions that are being taken to improve non-admitted performance. This includes sustainable “time to treatment” at 60 in ED;

The quarterly performance trajectory is outlined in table 2:

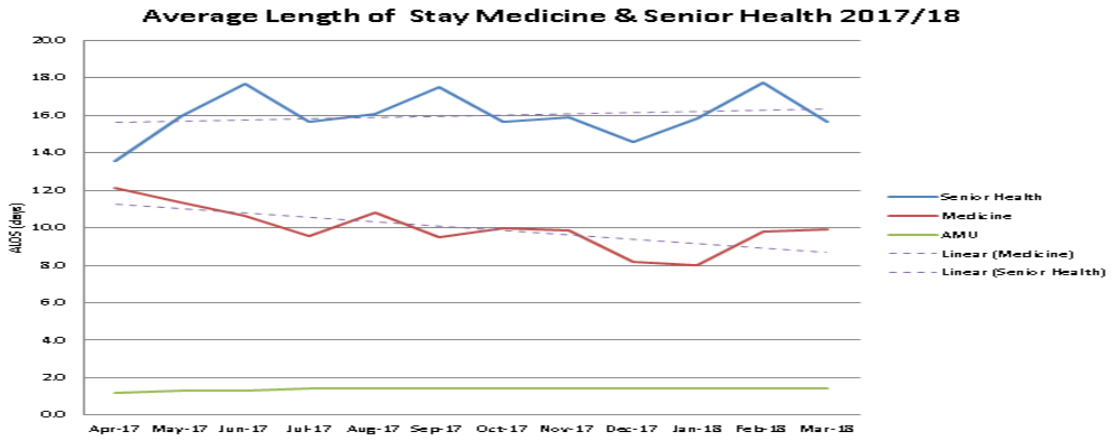
Table 2

2018/19 Period	2018/19 Trajectory
Q1	**91%**
Q2	**95%**
Q3	**92%**
Q4	**92%**
Total full year performance	**92%**

6.6 For admitted performance, the Emergency Care Improvement Programme (ECIP) have advised that to consistently delivery 95% performance overall, bed occupancy should be no higher than 92.5%. The same bed occupancy level (92.5%) is linked to the optimal delivery of safe patient care. It is statistically understood that when an organisation reaches 96% occupancy, it becomes extremely challenging to achieve 95% performance against the constitutional 4 hour standard.

6.7 It is expected that until some of the changes described in this paper are embedded, bed occupancy is likely to remain at around 95% on average over Q1 following the closure of the 'flu' ward in April 2018. Since December 2017, the Trust has been running at between 95-98% bed occupancy on average. Across Medicine and Senior Health there is a funded bed base of 219 beds. An additional 23 beds were opened at the end of December 2017 until mid-April 2018. During this period, the service also had an approximately 30 outliers, representing occupancy of 121% of funded bed base.

6.8 Length of stay across both medicine and senior health has increased since December 2018. The charts below show the average length of stay for both medicine and senior health across 2017/18:



6.9 Table 3 demonstrates the potential opportunity to reduce bed occupancy in medicine and senior health and therefore deliver flow and admitted performance. The reduction of 0.5 days LOS per patient across Medicine and Senior Health will be delivered through the embedding of SAFER and standardised ward process and enhanced focus on reducing stranded and super stranded patient numbers:

Table 3

Option	**Reduction in beds required**
Reduce Medicine and Senior Health LOS by 0.5 days per patient	-16
Reduce LOS as a result of frailty model Trust wide	-10
Full impact of ambulatory care	-4 (6 total, 2 already closed)
Total	**-30 beds**

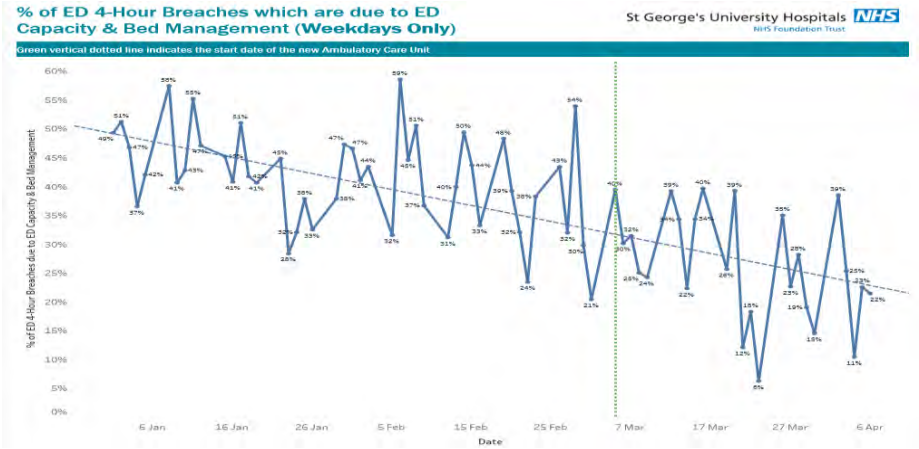
6.10 The above actions would contribute to reducing the number of medicine and senior health beds required by around 30 beds. These efficiencies will not result in the closure of beds, but will enable a reduction in bed occupancy to improve flow and performance. Based on the total Trust bed base of 825 beds (excluding maternity and critical care), this would result in a reduction in bed occupancy by 3.6% to 93%. To deliver Trust wide bed occupancy of 92.5%

efficiencies would need to be equivalent to 50 beds. A detailed refresh of the bed demand and capacity model is being undertaken across all Divisions supported by ECIP. This will be a key part of the winter plan for 2018/19 and will have input from system partners, with support from the CSU as will the delivery of the UAPC programme.

6.11 To deliver 95% performance for Emergency Care Operating Standard across 1819, all the actions and improvements in the admitted and non-admitted pathway need to be delivered consistently in line with the 15 point plan This includes bed occupancy and site management, ED and trust wide improvement approach to the emergency care standard.

6.12 A significant amount of work which is largely within the control of the trust, is required in order to ensure that the actions across admitted and non-admitted pathways are implemented concurrently, and enacted consistently in order to deliver the expected improvement. It is anticipated that further improvements could be made by continuing to strengthen working with system partners.

6.13 We are seeing the impact of our plan, for example the chart below highlights already the impact of to 4 hour breaches due to bed management and ED capacity both before and after the new AAA opened on 5 March 2018.



6.14 To further build on this success, a review of the standard operating procedures for all new and existing ambulatory and assessment areas by the end of May 2018, the transfer of the DVT pathway from the Urgent Care Centre within ED to the new Ambulatory Assessment Area (AAA) will take place in May 2018 in addition to a review of productivity and strengthening of the ambulatory care model to ensure direct access to ambulatory care units where clinically appropriate.

6.15 For admitted patients the demand and capacity model for 2017/18 highlighted a bed capacity gap across medicine and senior health of approximately 30 beds. The actual additional capacity in winter of 1718 was 53 beds due to increased length of stay, activity and flu. It is therefore anticipated that in order to deliver 95% in winter the service will require swing ward capacity in winter 2018/19 in line with the case already presented to the Investment and Disinvestment Group.

6.16 The Trust also needs to targeting ‘stranded’ (>7 day LOS) and ‘super stranded’ (>21 day LOS) patients in addition to DTOCs and NDTOCs and bed modelling at specialty level

supported by ECIP. This action is key to the LOS assumptions as is the model of care at for senior health trust wide.

7.0 Risks, Assumptions, Issues and Dependencies

7.1 The trajectory is based on the assumption that 2018/19 ED attendances deliver in line with the agreed SLA. The daily breach tolerance to deliver the proposed trajectory will vary depending upon overall Type 1 and Type 3 activity.

7.2 The trajectory also assumes that the new ambulatory care units, including AAA, CAU and the Haematology/ Oncology units are fully embedded by June 2018, including recruitment to the remaining vacancies required in order to extend the opening hours in line with the business case and deliver against the agreed KPIs.

7.3 It is critical to ensure alignment between the UAPC programme and 15 Point Plan Steering Groups, including use of common data sets/KPIs and consistency of approach to avoid unnecessary duplication/confusion, particularly for front line colleagues.

7.4 The key risks to delivery and actions to mitigate are outlined in the table 4:

Table 4

Risk	**Mitigation**
1. Lack of organisational compliance including the non-admitted pathway	Weekly cross divisional meeting introduced with effect from 9 April 2018. Clear executive steer that Emergency Care performance is an organisational priority. Clear governance structure established.
2. Increase in activity for admitted and non-admitted patients	Delivery of improvements in non-admitted pathway. Improvements length of stay, discharge processes and pathways through UAPC.
3. Increase in bed occupancy	UAPC programme, including implementation of SAFER as part of inpatient processes work stream and discharge work streams. Embedding of new ambulatory models of care.
4. Non-delivery of benefits aligned to Unplanned and Admitted Patient Care Programme	Programme and work stream reporting / escalation as part of trust governance processes.
5. Inability to recruit to vacancies to deliver required improvements, particularly AAA	Advanced Nurse Practitioner Vacancies re-advertised. If not successful, consider alternatives, including junior doctors, ACPs.

6. System wide support is not sustained in winter months due to capacity challenges	Established system partner meetings/working groups (e.g. Emergency Care Delivery Board, MADE events and Inclusion of key system partners within programme/project teams

10.0 Conclusion

10.1 The 4 hour Emergency Care Standard 15 Point Plan incorporating the actions are detailed within this paper in response to our local plans and the observations and recommendations from NHSI. Links to the Trust's QIP are highlighted, with clear leads and timeframes for delivery. Key to this is the need to address the culture which contributes to the variability and inconsistency in performance.

10.2 The delivery of the 15 Point Plan and wider improvements in emergency care performance are being supported by the Trust's Service Improvement Director (SID) with the delivery of the action underway. Progress and performance impact will be reported monthly at Trust Executive Committee measured on the defined dashboard.

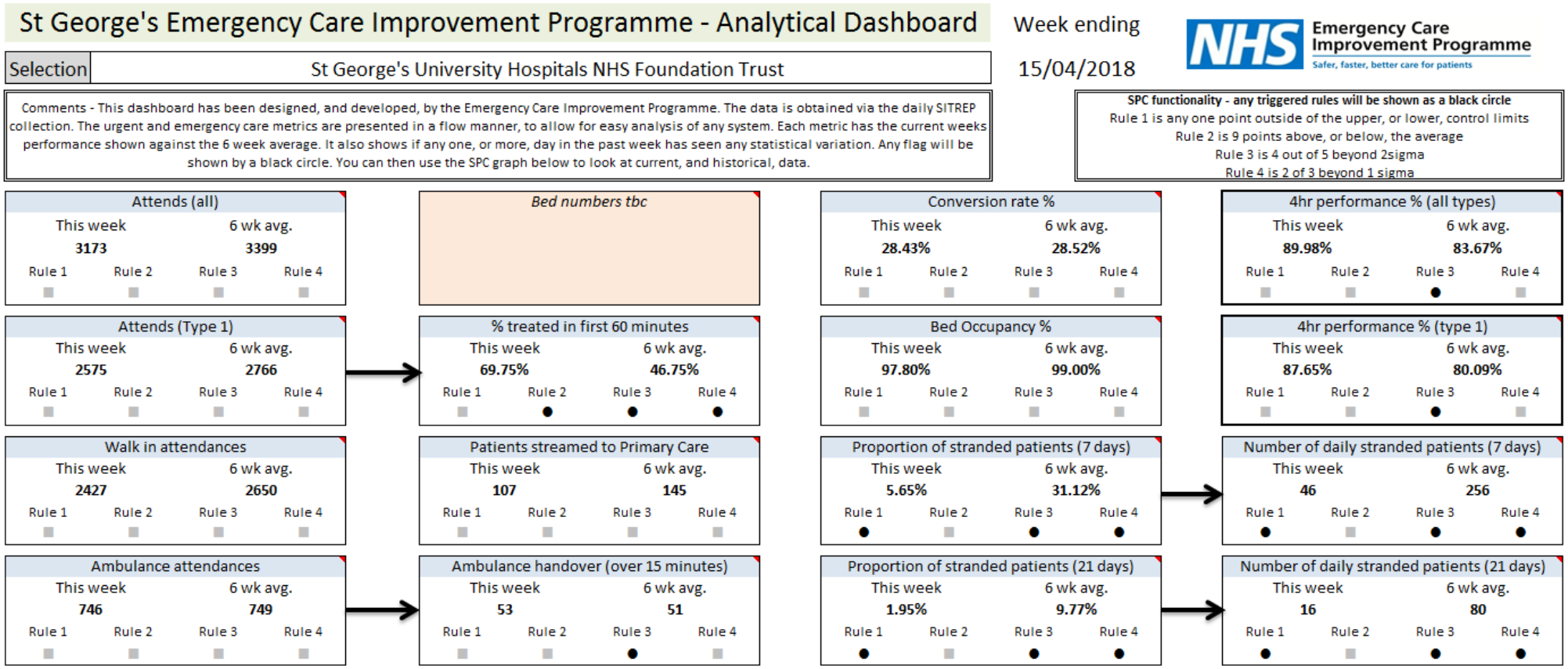
10.3 Point 24 of NHSI's report, relating to the limited Quality Improvement capability within the organisation is being taken forward by the Associate Medical Director for Quality Improvement and Clinical Transformation, in conjunction with the Transformation team and Clinical Directors. It is anticipated that this work will address the cultural shift that is required across the organisation in order to deliver sustainable improvement.

11.0 Recommendation

11.1 It is recommended that the Trust board note the key issues and actions to deliver improvement in emergency care performance.

11.2 Trust board is asked to consider and approve the emergency care performance trajectory of 92% 2018/19, and regulatory requirement of 90% performance by September 2018 and 95% in March 2019.

Appendix 1 - Draft 15 point plan analytical dashboard



Appendix 2- Four Hour Emergency Care Standard

15 Point Plan

	Objective	Link to NHSI recommendations	Link to QIP objectives	Actions and progress	Impact on performance	Lead/timeframe
ED operational performance improvement plan in support of response to NHSI (24) recommendations following site visit 20 and 21 February 2018						
1	Optimise flow within ED, proactively preventing breaches of the 4 hour standard	NHSI points 2 & 8.	1) Ensure flow of patients is optimised to deliver good patient care and performance 2) QIP 1,2,3,7	There is a now one GM working across ED and Acute Medicine. Together with the AGM they have a regular presence in ED. Tight oversight of patients above 3hrs and DTAs, alerting DDO and SID (in hours and tactical on call out of hours) when more than two four hour breaches occur per hour. Consultant in Charge to have oversight of non-admitted pathway and assessment times (time to treatment – TTT metric) to improve non-admitted performance. Three times daily clinical site management meetings review maximum length of time in ED, including potential 12 hour trolley breaches, but also those patients currently at 3 – 4 hours with no plan.	1. Improve non-admitted performance against 4 hour standard: Q1 – 95% Q2 – 95% Q3 – 95% Q4 – 95% 2. Improve Time to Treatment metric (treatment within 60 minutes): Q1 – 60% Q2 – 60% Q3 – 60% Q4 – 60%	Clinical Director for ED, GM for ED & Acute Medicine

				The DDO is alerted regularly as part of escalation and personally attends ED board rounds.		
2	Prevent the use of ED escalation areas without discussion of other preventative actions. Involvement of DDO or SID in hours and tactical on call out of hours, with one hour notice of impending need to open escalation (trigger >70 patients in department).	NHSI points 2 & 4 – SBAR approach to OOH conference call and ED presence on the call. Further improvement to ED board rounds. NHSI point 5 relating to 'fit to sit'. NHSI point 17, development of frailty unit.	1) To stop impact on non-admitted flow. 2) QIP 1-7	The ED escalation areas have been opened 7 times since the 15 point plan was launched on 25 February to 5th March 2018. On each occasion this has been approved in advance by the DDO (and on two occasions the SID) and has typically been for a maximum of 2 hours to manage patient surge, rather than stretch the use of existing clinical staff. The full capacity protocol is in place and has been used to support escalation to black (OPEL 3) on four occasions since 25th February 2018.	1. Impact on performance is linked to reduction in bed management and ED capacity breaches: Q1 – 10% reduction Q2 – 20% reduction Q3 – 20% reduction Q4 – 20% reduction	General Manager for ED & Acute Medicine supported by Transformation by 1st June 2018.
3	All patients to leave ED within 30 mins of bed being allocated, with discharge summaries completed within 30 mins or bed being allocated	NHSI point 4 relating to ED board rounds and management against 4 hour standard. NHSI Point 6 - transfer from ED to	1) Optimise patient flow 2) QIP1,2,3	Patients leaving ED within 30 mins of bed allocation is subject to review at the site operational meetings held at 8.30, 1300 and 1600 daily. This in turn provides a focus for improving operational performance.	1. Increase percentage of patients leaving ED within 30 minutes of a bed being made available (currently 30%, data requires validation): Q1 – 90%	CD and HoN for ED, supported by site team by 2nd April 2018

		AMU NHSI point 8 - response to operational pressure in line with OPEL and escalation policy.		Site team have established a transfer team to support outflow from ED. Operational pressures have inhibited clinical staff from consistently completing discharge summaries within 30 minutes. The focus being to avoid overcrowding the ED	Q2 – 95% Q3 – 95% Q4 – 95%	
4	Delivery of Emergency Department Inter-professional Standards (IPS) and adherence to Trust escalation policy linked to requirement for specialties to attend ED within 30 minutes of referral	NHSI point 8 – review triggers and actions align escalation policies.	1) Performance delivery 2) Adherence with escalation policy (inc. OOH). 3) QIP 1,2,7	ED to flag to divisional silver if internal operational standards not being met by medicine / surgery for example. On a day-to day basis specialty delays are raised at operational site meetings at times of exit block. Responsiveness is improving as the Trust is embracing ED operational performance as organisational care responsibility.	1. Decrease in breaches due to waiting for specialist opinion: Q1 – 5% decrease Q2 – 10% decrease Q3 – 10% decrease Q4 – 10% decrease	General Manager for ED & Acute Medicine and HoN for ED by 2nd April 2018 supported by site team.

5	AMU push for patients to go to base wards and pull from ED	NHSI point 6 relating to flow. NHSI point 9 relating to inpatient ward beds. NHSI point 7 relating to variation in ward processes.	1) Boarding in wards if there are more than 10 DTAs in ED & aim to have 10 beds by midday in AMU 2) QIP1,2,3,4,5,	Patient discharges from base wards to discharge lounge is improving. In addition, the bed manager for medicine personally details on the AMU white board the expected discharge times of patients on base wards. On 13th March; 11 patients passed through the discharge lounge by 11am and 44 by 5 pm. Typically, 5 patients pass through by 11am and 20 patients by 5pm.	Number of AMU beds available at midday: Q1 – 10 beds Q2 – 10 beds Q3 – 10 beds Q4 – 10 beds	Head of Operations and matron for AMU, by 2nd April 2018.
6	Fully embed best practice ambulatory care model and extend opening hours in line with business case	NHSI point 10- AAA and AAA SOP.	1) QIP 1,2,3	The new and expanded Ambulatory Assessment Area (AAA) facility opened on 5th March 2018 with extended hours (phased approach). The unit operates in line with the best practice 'process' as opposed to pathway specific model, with ambulatory care as the first line approach unless patients are clinically unstable, enabling rapid access to same day assessment, diagnostics and treatment.	1. Reduction in admissions to AMU compared to 2017/18: Q1- reduction of 3 admissions per day Q2 - reduction of 5 admissions per day Q3 - reduction of 5 admissions per day Q4 – reduction of 5 admissions per day 2. Reduction in number of	Clinical Director for Medicine, supported by Transformation team, 30th June 2018

				Review to be undertaken of all SOPs for ambulatory and assessment areas.	breaches due to bed management and ED capacity Q1 – 10% reduction Q2 – 20% reduction Q3 – 20% reduction Q4 – 20% reduction	30th May 2018
7	Breach validation takes place live as they occur	NHSI point 8 – revert to focus on 4 hour performance.	1) Accurate live information (clinically led) to agree appropriate actions to sustain flow, performance and optimised patient care (QIP1)	Breach validation is taking place live by a non-clinician. Currently there is inconsistent oversight by clinical staff. The emergency department are considering how best to introduce live clinical validation of breaches with the support of informatics colleagues.	No direct impact on performance due to live breach validation but will enable closer monitoring of ED position.	General Manager for ED and Acute Medicine by June 2018, with support from IT
8	Anonymised ED operational performance is displayed in the department (not visible to patients) and the MTC comparison graph is supplemented by a SWL graph	NHSI point 8 on mind set and delivery of constitutional standard.	1) Build on improving performance ensuring patient focus. 2) Develop a framework that will be used by ED for individual developments and delivery of	We are discussing with senior clinical colleagues where best to locate this information and what is displayed. The GM for ED and Acute Medicine is leading on this issue going this forward. Data to be presented through ED comm cell. The Medical Director and COO met with ED consultants on 2nd March to discuss the NHSI letter	No quantifiable impact on performance but awareness of performance against peers and higher performing Trusts is expected to contribute to cultural change.	General Manager for ED and Acute Medicine by 2nd April 2018

			both safe care and performance 3) QIP 1,2,3,4	following site visit on 20th and 21st February 2018. This was followed by a meeting with the AMU/AAA team on 9th March which was also attended by the Chief Nurse.		
9	Performance by shift and for the 24 hour period	NHSI point 3 – staffing and shift performance & point 8 on mind set and delivery of constitutional standard. NHSI point 18 – development of emergency care KPIs and cross-organisational visibility and action through COO.	1) Further develop a performance focussed environment 2) Live plan to resolve the previous issues 3) QIP 1,2,3,4,	We are discussing with senior clinical colleagues where best to locate this information and what is displayed. The GM for the Emergency floor is leading on this issue going this forward.	No quantifiable impact on performance but awareness of performance against peers and higher performing Trusts is expected to contribute to cultural change.	Informatics team, by 30th April 2018
10	Red hour v green hour and key issues (at every board meeting in ED)	NHSI point 8 on mind set and delivery of constitutional standard.	1) To understand the actions needed to provide optimise flow, and performance	The DDO for Medcard is supporting these meetings personally. Blocks to patient progress and exit from ED are identified and acted upon.	No direct impact on performance. Monitoring of red to green hours at board rounds in ED are an indicator of pressure in the department and will signal the need to take actions in	Clinical Director for ED by 2nd April 2018

			2) QIP 1,2,3		line with escalation policies.	
11	7.5% patients streamed to primary care (brief at the start of every day linked to board meeting)	NHSI point 21 – link to community services and GP OOH and point 18, development of KPIs for emergency care.	1) Deliver the standard agreed with CCG on optimising patient navigation 2) Patient to the right place and navigated from ED QIP 1,2,3,7	The DDO for Medcard is supporting these meetings personally.	1. Proportion of patients streamed to primary care: Q1 – 7.5% Q2 – 7.5% Q3 – 7.5% Q4 - 7.5% Impact on performance is linked to improvement in non-admitted performance (see point 1)	Clinical Director for ED and HoN for ED by 2nd April 2018
12	Increase streaming to AAA (including straight to AAA or other ambulatory service)	NHSI recommendation 10-AAA.	1) Deliver the 7.5% standard agreed with CCG on optimising patient navigation 2) Patient to the right place and navigated from ED 3) QIP 1,2,3,7	The new Ambulatory Assessment Area (AAA) was opened on 5th March 2018, 7 days a week. Hours will be extended in line with agreed business case as staff are recruited.	1. Reduction in number of breaches due to bed management and ED capacity Q1 – 10% reduction Q2 – 20% reduction Q3 – 20% reduction Q4 – 20% reduction	Clinical Directors for ED and Acute Medicine, by 30th June 2018 supported by Transformation and SID.

13	Reduce breaches due to waiting for specialist opinion. All specialties to deliver minimum of 60% performance. Specialties delivering >80% performance to sustain/improve position.	Point 8 NHSI recommendation, response to operational pressure and point 19 – lack of Divisional ownership.	1) System owned performance. 2) QIP 1,2,3,	Actively contact specialities who have not delivered 80% performance and require evaluation of breaches and a plan. Use of speciality linked SPAs to ensure that the response available for weekly performance review meetings.	1. Decrease in breaches due to waiting for specialist opinion: Q1 – 5% decrease Q2 – 10% decrease Q3 – 10% decrease Q4 – 10%decrease	General Manager for ED & Acute Medicine by 2nd April 2018, supported by DDOs across all Divisions.
14	Evaluate the role of flow co-ordinator, total retrain and delivery focus (and consider impact of role- end April 2018)	NHSI point 7 &11 – recommendation on discharge planning, SAFER and red to greens in wards	1) QIP 1,2,3,7,	The alignment of discharge co-ordinators, flow co-ordinators and patient flow which is also in response to the NHSI site visit on 20th and 21st February is considered in this paper.	This is an enabler to improve effectiveness of PFC role in proactively preventing breaches of the 4 hour standard.	AGMs for ED and Acute Medicine by 30th April 2018 with Transformation /SID support.
15	Optimise discharge planning through evaluation of discharge planning team roles and best practice models as part of improving flow	NHSI point 7 & 12 NHSI – recommendation on discharge planning, SAFER and red to greens in wards. Discharge co-ordinator review. NHSI point 13 regarding discharge lounge and 14 regarding inpatient therapy.	1) QIP 4,5 & 7	Matrix management as one team through a single accountable officer is being considered. Also being considered is whether the QMH, SGH or a hybrid model is the best one for discharge co-ordinators. Daily meetings with Wandsworth and Merton social services to review DTOCs are now in place. Daily review meetings for	1. Bed occupancy: Q1 – 95% Q2 – 92.5% Q3 – 92.5% Q4 – 95%	Head of operations supported by DDOs and Transformation team

		NHSI point 15, 16 & 22 on whiteboards and DTOCs. NHSI point 20 – demand and capacity in therapies.		patients with a LOS of >7 days (stranded) and >21 days (super stranded) now in place.		
	<u>Trust QIP Plan</u> 1. A&E 4 hour operating standard **95%** 2. Ambulance handover time 15min **100%** 3. % of patients assessed within 15 min of arrival at A&E **100%** 4. % of Daily discharges by 11am **40%** 5. Bed Occupancy **92.5%** 6. % of wards using SAFER **90% (staged)** 7. Patient Experience (FFT) **95%**					

Appendix 3 - NHSI Emergency Care Site Visit to St George's University Hospitals NHS Foundation Trust

Emergency Care Site Visit to St George's University Hospitals NHS Foundation Trust

Visit: 20 and 21 February 2018

Visitors:

- Angela Thompson, Director of Nursing and Deputy Regional Chief Nurse, NHS Improvement (London)
- Dr Cathy Cale, Deputy Regional Medical Director, NHS Improvement (London) – *20 only*
- Philippa Davies, Quality Improvement Director, NHS Improvement (South London)
- Gavin MacDonald, Head of Emergency Care Improvement, NHS Improvement (London)
- Elizabeth Comley, Senior Delivery and Improvement Lead, NHS Improvement (South London)

Context

In 2017 NHS Improvement undertook a series of site visits to the most fragile systems for emergency care in London to review quality, patient flows and progress with implementation of the nine nationally mandated 'must dos' with specific focus on emergency care improvement programmes, emergency departments (ED), acute admission units (AMU), ambulatory emergency care (AEC), inpatient wards, frailty intervention services, site management and discharge.

St George's performance against the four hour standard has become increasingly challenged since September 2017 and has been consistently below 2016/17 levels of performance since May 2017. It was therefore agreed with the trust that NHS Improvement would undertake a two day clinically led site visit of St George's (Tooting site).

The review was structured around a clinical walkthrough of the urgent and emergency care pathways at St George's Hospital and a series of observations both in hours and out of hours. Feedback is based on observations and information provided by the team at the hospital. If we have misinterpreted anything, please come back to NHS Improvement with issues of factual accuracy.

We would like to thank all those who helped to arrange the site visit, who led the walk through and who attended the meetings for giving up their valuable time. The engagement and openness of the teams was invaluable to the process.

Organisational Culture

There is a clear expectation set by the executive team that emergency care is an organisational priority. Through our observations and discussions, however, it was not apparent that emergency care is perceived as everybody's responsibility across the organisation. We emphasised the importance of instilling this.

There needs to be clear leadership and ownership of ED issues at a corporate and service level within divisions. We recommend that there should be a single executive lead for the ED pathway who supports the divisional and service level leads with implementation of improvement plans.

Emergency Department (ED)

The environment and facilities in the ED for patients and staff is impressive. The ED team were welcoming, open and clearly passionate about the service they provide. There was an acknowledgement by all members of the ED team that the previous months had been particularly challenging. Some members of the team identified staffing issues and flow through the organisation as limiting factors. Other members cited the pressure and challenges facing the whole of the NHS with St George's being in a similar position.

The Emergency Department was well laid-out with the configuration lending itself to options for redirection including to the Urgent Care Centre, GP out of hours, GP in hours via slots and the main department. We also noted the co-location of x-ray, CT scanning and blood testing via the hot lab. The close proximity of the CDU, AMU and new AEC is also advantageous.

Whilst the configuration described above is beneficial, we did observe and hear accounts of the CDU and UCC being used as part of 'escalation' capacity. Whilst the maximum length of stay on a CDU should be 24 hours, we noted many examples of two or three day lengths of stay in CDU. We highlighted this as an example of the ED 'consuming its own smoke' and recommended that the practice of using the CDU and UCC for these purposes is reviewed immediately and an alternative solution to additional capacity identified. It was also noted that the client group in the CDU were generally frail elderly and these were supported with an aid to early discharge by therapists and discharge co-ordinators. This would lend itself to a frail elderly pathway but not situated in the CDU.

The visiting teams observation of the way the department is managing flow is that they are focusing on preventing extended waits (+12 hours) rather than focusing on patients earlier in the pathway which would improve flow.

We observed and heard accounts of beds being kept overnight in some clinical areas in case a patient from that speciality requires admission. Whilst we agree that some beds need to be protected, for example, stroke and trauma, patients should be placed chronologically to avoid long waits in the ED which is not optimal for patient privacy, dignity or care. If there is a bed gap in a division, escalation plans should be identified in the afternoon prior to the 16.00 bed meeting with a risk assessed prioritisation for outlying and opening escalation agreed to ensure beds are available in the AMU and SAU for ED and to minimise clinical risk out of hours.

Acute Medical Unit (AMU)

The visiting team observed that the AMU is adequately sized and ideally co-located with the emergency department.

We observed that the transfers out of ED to the AMU appear slow, even when beds are empty and allocated to patients. For example, we observed a single hour period where seven empty beds on AMU were allocated to patients but only one patient arrived on to the AMU. We also observed delays in transferring patients from the AMU to wards, particularly early in the day. For example, we observed six patients allocated to empty beds on surgical wards at 7am but moved between 8.40am and 10.05am. This occurred while there were 17 patients with DTAs in the ED.

On the AMU and inpatient wards we visited on the evening of our visit, we found that there were no confirmed discharges for the following day and when queried, were told that this would only

be determined the following morning with patients unlikely to be discharged until late afternoon. On AMU, we would recommend the trust rapidly implements the golden patient principle and undertakes daily PDSA cycles with an aim to improve flow.

Inpatient Wards

We visited several wards as part of our review. This enabled us to observe board rounds and talk to nursing staff about ward processes.

The board rounds that we attended were run as consultant led multi-disciplinary board rounds before 10.00 which is good practice. Whilst the progress of every patient was discussed, there was little discussion regarding delays and how to address them. The visiting team did not observe the 'red to green' approach being used. We reviewed white boards across several wards, even where board rounds were not observed, and these were not consistent and did not appear to reflect recognised good practice in the implementation of the Safer Patient Flow Bundle. We noted one ward with an empty white board, with the exception of patient names. Upon querying this, we were told by the team that the ward was an escalation ward and they did not know how to complete it as it was different to the boards on other wards.

We recommend that the Trust must agree, implement and monitor a phased rapid roll out of Red2Green and SAFER with central resource identified and allocated from the transformation team to drive this.

We identified gaps in the knowledge and application of MCA and DOLs in both the ED and on two of the wards visited. Staff need to be very clear on the application of MCA and DOLs and the trust needs to consider how it is able to evidence that staff have the required knowledge and skills.

Departure Lounge

The departure lounge is open 8.30am to 9pm five days per week and as part of winter plans, opening has been extended to 10am – 7.30pm at weekends also. The team reported significant variability in the number of patients that go through the departure lounge daily and highlighted that the majority of these are late afternoon. For example, it was reported that three patients had been through on Sunday, 17 on Monday and 39 on Tuesday. On the day of the visit, the team reported that only four patients had been brought down by 10.30am. Several limiting factors were identified, as follows:

- The team did not receive a list of patients confirmed from the previous evenings Board rounds or site management information
- The departure lounge only has one phone meaning they cannot make calls to 'pull' patients and receive calls at the same time
- Whilst calls are made between 9.30am and 10.30am in the morning to 'pull' patients ready for discharge, the response is often that board rounds on the wards are on-going
- Not all wards seemed aware of the departure lounge opening hours and had patients waiting on wards ready for discharge
- The departure lounge team had a list of criteria for patient admission to the discharge lounge but these were three years old, although it was reported that a revised criteria had been drafted and were awaiting approval

- As the discharge lounge has only one toilet facility for male and female patients to use and as patients can go to the discharge lounge in nightwear the visiting team would suggest the mixed sex accommodation (MSA) compliance with this facility should be reviewed and that any SOP for admission to the lounge should refer specifically to the optimal management of MSA.

Workforce

It was reported that the head room for the nursing establishment was at 19%, this needs to be clarified and reviewed. It is unlikely that an ED establishment with the additional skills drills and training requirements would be able to manage within a 19% head room. However, there are a large number of senior post holders and thus any consideration of uplift should be in the context of a full establishment review taking into account all bands and mapping skills and staff numbers to activity.

It was reported that the medical team rotas may not be optimally mapped to activity and we therefore recommend that a review is undertaken of medical staff rosters against peak activity.

Role of the Transformation Team

The organisation has a dedicated Director of Transformation and an improvement team with a Programme Management Office (PMO). The visiting team did not meet with the team, however, the trust should consider whether an appropriate proportion of the team are dedicated to driving Emergency care and Patient Flow Improvement, and consider changing this to facilitate rapid improvement.

Observations and recommendations

	Observation	Recommendation
Short term: within one month		
1	There does not appear to be a clear plan for quality improvement in emergency care	Develop a written, clinically led, quality improvement plan for emergency care with potential work streams in ED, AMU, AEC, SAFER/Red2Green, Discharge and Frailty. The plan should include the key drivers of performance, quantifiable improvement, milestones, detailed steps and dates for delivery, responsible owner and executive lead. The plan should have a risk assessment with mitigation/ elimination for each project. Develop a governance structure for delivery of the plan with reporting through to both the A&E Delivery Board and Trust Board.
2	The evening conference call with the on-call executive and senior manager on-call is excellent practice but ED is not represented. The call was also moved from 10pm to 10.30pm by the site manager.	Have real discipline about the timing of this call. It should last no longer than 10 mins covering the situation, the risks and the mitigation, an SBAR approach could be used. The ED Consultant and nurse in charge of ED and AMU should be part of the call.
3	Out of hours, unfilled medical gaps on the rota are not being managed and/or escalated in hours to mitigate risk	The senior operational team should have a clear line of sight on any potential staffing gaps in ED with appropriate escalation and actions to manage the situation in hours to minimise out of hours risk.
4	ED board rounds occur but could be further improved	Develop a clear SOP for how the board round should function, including standing agenda, attendees and Chair responsibilities. Relocate the board round from the computer area in Majors to the large, wall mounted electronic screen and manage any patient confidentially issues. Include the on take teams and ensure that the focus is on the next steps to move the patient along the pathway, discussion of highest clinical risk patients should be included and emerging risks.
5	Apart from the ambulance area where there was evidence of ‘fit to sit’, all patients in ED are on trolleys	Where appropriate, sit patients out rather than place everyone on trolleys. This is important to allow patients and staff to have a ‘discharge first’ mind-set.

6	Transfers out of ED to AMU appear slow, even when beds are empty	Review pathway and consider implementation of a telephone handover of clinically risk assessed patients supported by an SOP with agreed criteria, consideration could also be given to a transfer team during times of peak demand but this needs to be mapped against activity.
7	Variation in process at ward level	Starting on AMU, there should be a clinically led, phased rapid roll out of Red2Green and SAFER with central resource identified and allocated from the transformation team to drive this, with an executive sponsor.
8	The organisations response to the operational pressure did not appear to be at the scale and pace required to recover the position. Teams were focused on 12 hours from DTA rather than 4 hours from arrival	Reset the 4-hours mind-set and factor into escalation plans that no patient should wait more than 12 hours from arrival. By doing this it will put the focus back on the pathway and reduce the risk or need for a 12 hour trolley wait for non-clinical reasons. Review triggers, actions and align both the bed escalation policy and status with the ED escalation policy and status. The Trust policies need to interface with that of the community providers, including social care and the CCGs. Be clear in the full capacity protocol which clinical areas are risk assessed and can be used and which cannot.
9	Empty beds are being kept overnight in some clinical areas in case a patient from that speciality requires admission, for example, we observed a scenario where seven surgical beds were kept empty overnight and there were 17 DTAs at 7am	It is acknowledged that certain specialty beds will need to be protected but general surgery wards should be part of the escalation policy and risk assessed for outlier use. Similarly if there are large numbers of empty beds in certain specialties then risk assessing a specific number which could be used for short length of stay patients could be considered. This ensures patient safety at both the front and back ends of the hospital rather than leaving the risk and poorer patient experience in the ED If there is a bed gap in a division, outlying should happen in the afternoon and evening to ensure beds are available for SAU, AMU and ED and to minimise clinical risk out of hours.
10	There was a lack of clarity and confidence of the ability to open the new AEC facility in March due to the work being completed on time, having a stable workforce to manage the areas and clarity around the operational functioning on the unit	Clear timeline for the opening of the unit. Executive approval of the staffing plan and activity which will be able to go through the unit. To have visibility of the SOP for the unit.

11	The discharge co-ordinators are a valuable resource but they appeared to focus on the complex patient discharges and not the 80% of simple ones. When the discharge co-ordinators are not on duty it is unclear how the ward staff pick up the actions to move the patient forward on the discharge pathway. The model appears to have put ownership of the patients discharge on the co-ordinator rather than it being everybody's business	Review roles and responsibilities and potentially reporting/ line management arrangements. Team working should be reviewed and consideration given to alignment with the site team.
12	There was a challenge identifying patients and matching to capacity in the community	There should be a waiting list held for all community capacity with a list of the next patient/s ready for discharge to each type of capacity.
13	Ward staff did not know the opening time and criteria for the discharge lounge	Relaunch and monitor utilisation at ward level and report at divisional performance reviews.
14	Long waits for inpatient therapy	Urgent prioritisation of the therapy workload to prioritise inpatients.
15	There is an issue with connectivity of the electronic white board on the wards which makes them unreliable on the ward round	Work with ICT to ensure the connectivity is reliable 24/7.
16	Understated DToC position	Run MADE events leading up to and post Easter to support discharge of some of the longer stay patients and identify internal delays to discharge. Review process for identification and management of DToC. Medically optimised, stranded and super-stranded patients. Undertake a multi-agency weekly executive and clinically led, stranded patient review. Divisions should come and present their patients.

Medium term: 2-3 months		
17	Progress the plan for developing/ expanding frailty intervention. This is a potential untapped opportunity for next winter	Understand the potential opportunity with regards to LOS savings. Develop a system-wide business case and resource the clinicians with management capacity to support development of the case.
18	It was difficult to get clarity on the information around all of the emergency care pathway This information should be in one place and visible to teams	Develop a set of KPIs for emergency care which gets measured daily and reported weekly. There should be an executive level meeting each week where the teams account for the performance and where issues can be escalated and rapidly addressed. It would be ideal if a non-executive director attended this meeting.
19	There is a lack of Divisional ownership of issues which contribute to flow. Each division externalised the problem	Each division should understand their contribution to emergency care and have identified KPI's which should be reviewed at their divisional performance review.
20	There is a waiting list for inpatient therapies	Demand and capacity work in therapies.
21	The GP OOH service was reported to be under-utilised on a daily basis	Review the activity and through the service and if required re-scope the service.
Long term: 3-6 months		
22	There is no electronic management of the beds	Scope and procure a live bed management system.
23	We did not test when the last demand and capacity on the bed base work was undertaken but we would recommend some work in this area	Undertake demand and capacity work and if necessary review or seasonally flex the bed base.
24	Limited QI capability	Set the right environment for QI.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No**	**5.1**
Report Title:	**Finance and Investment Committee report**		
Lead Director/ Manager:	Ann Beasley, Chairman of the Finance and Investment Committee		
Report Author:	Ann Beasley, Chairman of the Finance and Investment Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 19 April 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Finance and Investment Committee – April 2018

Matters for the Board's attention

The Committee continued its discussions on the estates risk, which had been allocated to it as part of the Board Assurance Framework, and took some assurance from the plans outlined by the Director of Estates and Facilities which would bring greater clarity over the next couple of months. It had a discussion on aspects of the water element of the estates risk but agreed that any patient safety issues would be raised at the Quality and Safety Committee. It reviewed both the finance and IT risks but accepted that there was as yet no change to the 'limited assurance'.

As previously agreed following the Deloitte Governance Review the Committee continued to consider performance insofar as it impacts on activity levels and therefore income and where it presents opportunities for productivity improvements. There was a further discussion on the performance in the Emergency Department, and it was agreed that in future some of the interim targets, such as the Time to Treatment, would be added to the Integrated Quality and Performance Report to allow a better understanding of where improvements need to be made. The Committee noted that there would be an update on the 15 point Action Plan at the Trust Board.

The Committee was concerned that the Trust is not meeting all its Cancer targets but the executive gave some assurance that the results would improve for March and April.

The Committee congratulated the team on delivering its forecast outturn of £(53)m. Whilst this did not achieve the NHSI target of £(45)m, the fact that the forecast had remained stable for a number of months, was a really important milestone on the road to financial recovery. The Committee noted that within this, some Divisions had delivered their forecasts whilst others had not, which needed to be further investigated to help drive improvements in the culture of financial accountability.

The Trust had received late notification that it would receive additional capital funding that needed to be spent in the 2017/18 financial year. The Committee was pleased to note that most of it had been spent albeit within the time available it had not been possible to spend it on more structural projects that would have de-risked the capital programme for 2018/19.

On business and financial planning for 2018/19, the Committee noted that there had been a Board workshop earlier in the week which had highlighted the need for further progress in developing Green Cost Improvement Programmes, particularly on pay, and further clarity about the proposed treatment of RTT issues.

The Committee welcomed the sustained improvement in the cash position.

The Committee took some assurance from a report from the Head of Procurement on improvements both within the Trust and within the South West London Collaboration. It also approved a policy on access by supplier representatives.

It became clear in its discussions on other draft policies that the Trust as a whole needed a better governance process for all policies and that discussion on the financial aspects, which were within the remit of this Committee, should await that being developed. It did however approve a policy on financial transactions.

The Committee noted the initial results from its Effectiveness Review. Most respondents had replied positively, recognising the improvements in the work of the Committee over the year,

but there were clearly still some areas for improvement which would be brought together in an action plan.

Recommendation

The Board is recommended to receive the report from the Finance and Investment Committee on 19 April 2018 for information and assurance.

Ann Beasley
Finance and Investment Chair, NED
April 2018

St George's University Hospitals NHS
NHS Foundation Trust

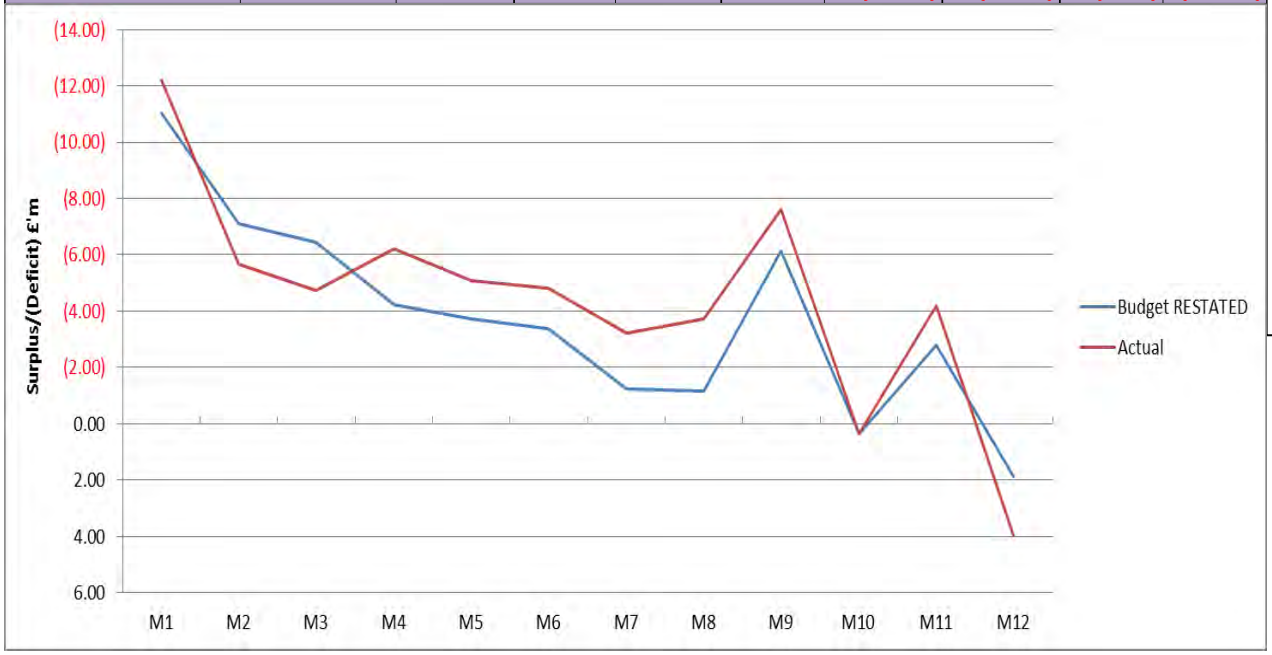
Meeting Title:	**Trust Board**		
Date:	**26 April 2018**	**Agenda No.**	**5.2**
Report Title:	**2017/18 Outturn Finance Report**		
Lead Director/ Manager:	Andrew Grimshaw		
Report Author:	Michael Armour & Tom Shearer		
Presented for:	Update		
Executive Summary:	Overall the Trust is reporting a deficit of £53.1m at the end of the financial year 2017/18, an adverse variance to plan of £8.1m. The Trust delivered £43.6m of CIPs which is £0.1m better than plan. Capital expenditure against the CDEL of £51.8m has been incurred year to date. This is £0.8m below the NHS Improvement CDEL budget. This is an abridged pack as the draft accounts have not been submitted to NHS Improvement as yet.		
Recommendation:	The Trust Board notes the Trust's reported financial outturn in 2017/18.		
Supports			
Trust Strategic Objective:	Deliver our Transformation Plan enabling the Trust to meet its operational and financial targets.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	Finance and Use of Resources		
Implications			
Risk:	**BAF Risk 6**: Failing to Deliver the Financial Plan		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Finance and Investment Committee	**Date:**	19 April 2018
Appendices:	N/A		

Financial Report 2017/18 Outturn

Chief Finance Officer 26 April 2018

1. 2017/18 Outturn Financial Performance

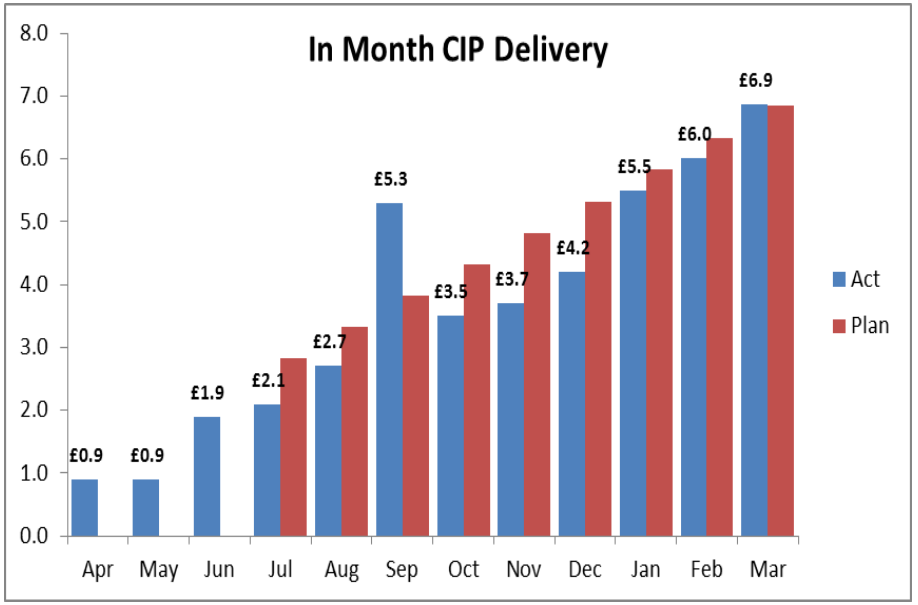
Category	Sub Categor	M12 Budget (£m)	M12 Actual (£m)	M12 Variance (£m)	M12 Variance %	Full Year Budget (£m)	Full Year Actual (£m)	Full Year Variance (£m)	Full Year Variance %
Income	SLA Income	58.88	57.99	(0.89)	(1.5%)	674.91	659.97	(14.94)	(2.2%)
	Other Income	10.09	12.24	2.15	21.3%	116.88	117.83	0.95	0.8%
Income Total		68.97	70.23	1.26	1.8%	791.79	777.81	(13.98)	(1.8%)
Expenditure	Pay	(39.17)	(37.79)	1.38	3.5%	(487.80)	(480.62)	7.18	1.5%
	Non Pay	(25.09)	(28.01)	(2.92)	(11.6%)	(314.98)	(320.54)	(5.56)	(1.8%)
Expenditure Total		(64.26)	(65.80)	(1.54)	(2.4%)	(802.77)	(801.16)	1.62	0.2%
Post Ebitda		(2.83)	(0.46)	2.37	83.7%	(34.02)	(29.76)	4.26	12.5%
Grand Total		1.88	3.97	2.10	111.8%	(45.00)	(53.11)	(8.11)	(18.0%)

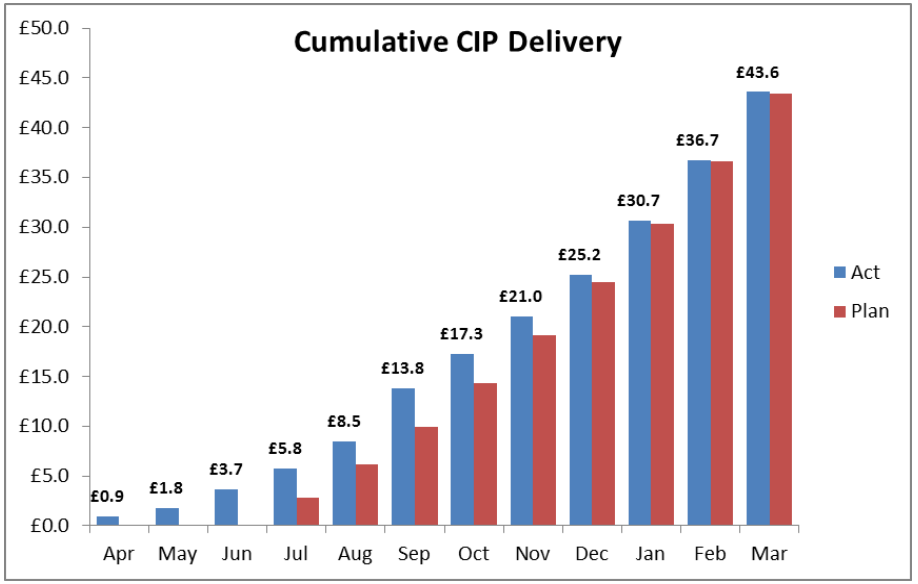


Trust Overview

- Overall the Trust is reporting a deficit of £53.1m in 2017/18, an adverse variance to plan by £8.1m.
- **Income** is £14m adverse to plan. Due to:
- **SLA Income** is £15m under plan, owing to shortfalls of on pass-through, in Elective, higher challenges, offset by Daycase over performance and Outpatients.
- **Other income** is above plan by £1m; the key driver is higher than planned VAT reclaims and RTA income.
- **Pay** is £7.2m favourable, with all major staff groups underspending with the exception of medical pay. The in month position has moved adversely to budget as a result of an increasing level of CIPs being phased into the position
- **Non-pay** is £5.6m overspent, due to expenditure on the ECRP project, offset by reduced clinical consumable expenditure.
- **CIP delivery** of £43.6m is £0.1m better than plan. The Trust has over-delivered on Income CIPs by £8.4m and under-delivered on expenditure CIPs by £8.3m.

2. 2017/18 CIP Performance





CIP Overview

- At the end of Month 12, the Trust is reporting a cumulative delivery of £43.6m of savings . This includes a number of central initiatives which are non-recurrent in nature and have been classified as 'CIPs'
- £6.9m of savings/benefits were reported in March (these included the achievement of a Trust wide CQUIN, Additional Winter Funding and Revenue to Capital movements).

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 three 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 use of non-recurrent items, to achieve the 2017/18 forecast outturn, has put pressure on the exit run rate of the Trust. Reducing the run rate through a series of recurrent CIP initiatives is a key priority for 2018/19. This will require continued focus on pay costs and WTE reduction.

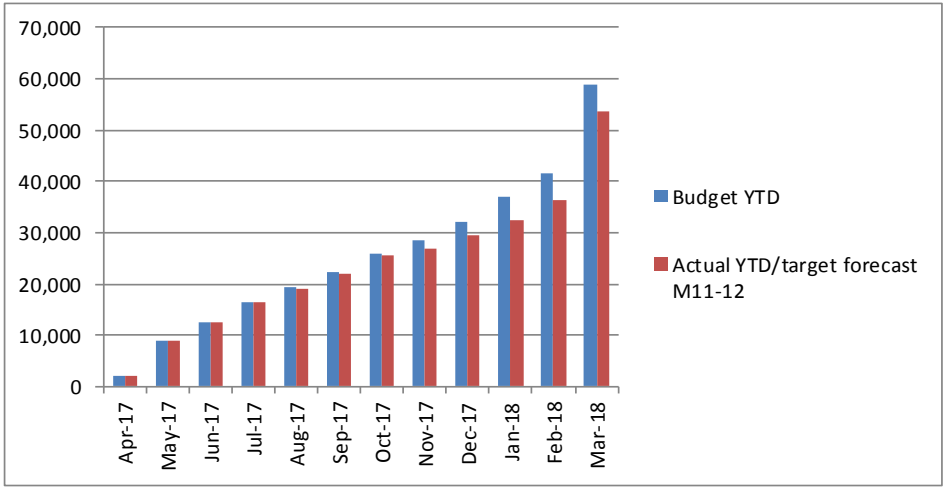
- Maximising CIP delivery in 2018/19 will necessitate the identification of material opportunities through appropriate cost benchmarking. These opportunities need to be translated into divisionally owned plans with the required KPIs agreed to monitor progress. Performance against these KPIs then needs to be regularly monitored and mitigating actions agreed where achievement is forecast to deviate from plans.

3. 2017/18 Full Year Capital Programme

Capital expenditure summary M12 2017/18

Spend category	2017/18 Original Budget £000	Base Budget £000	Budget re: loan & PDC Mar 18 £000	Total budget £000	M12 YTD actual £000	YTD Variance vs Revised budget
Energy Perform Contract	**5,555**	5,555		**5,555**	**5,688**	*-133*
Infra Renewal	**10,492**	6,825	1,837	**8,662**	**6,225**	*2,437*
Med Eqpt	**3,194**	4,457	5,496	**9,953**	**9,612**	*341*
Major Projs	**22,210**	14,434		**14,434**	**14,115**	*319*
IMT	**2,567**	12,602	4,446	**17,048**	**14,471**	*2,577*
Other	**601**	1,634	50	**1,684**	**2,850**	*-1,166*
SWL PATH	**684**	684		**684**	**639**	*45*
Contingency/Headroom	**1,096**	776	20	**796**		*796*
Total	**46,400**	46,967	11,849	**58,816**	**53,600**	***5,216***
Less: capital value of new fin leases				-6,000	-1,743	
Less: capex funded by donated capital				-430	-286	
Add: PFI revers interest				192	182	
NHSI CDEL / outturn vs CDEL				**52,578**	**51,753**	
Variance vs CDEL					825	
Variance as % of CDEL					1.6%	

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



- As reported last month, the Trust received notifications on Friday 2nd March of a DH PDC capital allocation of £1.849m for cyber security and DH Capital loan for £10m towards the PAU bid made earlier in the year. DH stipulated the Trust must spend these capital monies by the year end and therefore the Trust activated plans to spend the PDC allocation and loan in accordance with DH instruction.
- As a result capital expenditure in March was £17.3m - an historically very high monthly spend total incorporating the investments funded by the additional PDC and loan (£11.849m).
- For the purposes of measuring capital expenditure against the NHSI Capital Department Expenditure Limit (CDEL) the finance leases are excluded as well as adjustments for donated capital grants and after taking into account all these adjustments the Trust's CDEL outturn for 2017/18 was £51.75m vs the CDEL target of £52.6m, a variance of £0.8m (1.6%).

4. Finance and Use of Resources Risk Rating

Use of resource risk rating summary	Plan (M12 YTD)	Actual (M12 YTD)
Capital service cover rating	4	4
Liquidity rating	4	4
I&E margin rating	4	4
Distance from financial plan	n/a	2
Agency rating	1	1

Basis of the scoring mechanism

Area	Weighting	Metric	Definition	Score			
				1	2	3	4
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.
- In 2017/18, 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 is worked out as the actual % I&E deficit (6.48%) minus planned % I&E deficit (5.68%). This value is -0.80% which generates a score of 2. This is an improvement from last month's score of 3. The reason for this is mainly the recategorisation of 'Recharges Out' (c£40m, mainly GP Leo) from Pay to Income. This is as per accounting guidance . In this pack 'Recharges Out' are shown as an offset to Pay Expenditure.

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No**	**5.3**
Report Title:	**NHSI Narrative Annual Plan**		
Lead Director	Suzanne Marsello, Director of Strategy		
Report Author:	Tom Ellis, Head of Business Planning		
Presented for:	Approval		
Executive Summary:	The Trust is required to submit its Annual Operating Plan to NHS Improvement on 30 April 2018. This includes a full set of financial, activity, workforce and triangulation spreadsheets, alongside an update to the narrative annual plan submitted in April 2017 (which was a submission required to cover a two year period 2017-19). This paper specifically relates to the narrative Plan, a refresh of which is required as part of the annual plan submission. Trust Board is asked to approve the narrative Plan for submission. If any final amendments to the narrative Annual Plan are requested by directors, the Trust Board is requested to delegate authority to the Chairman and CEO to approve any updated version for submission to NHSI.		
Recommendation:	Trust Board is asked to: 1. Note the process of development the narrative annual plan has been through 2. Approve the narrative plan submission, subject to any final amendments required by Board prior to submission and work on-going, noted in section 2. 3. Agree delegated authority to the Chairman and CEO to approve any final revisions prior to submission.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person Right care, right place, right time Balance the books, invest in our future Build a better St. George's Champion Team St. George's Develop tomorrow's treatments today		
CQC Theme:	Safe, Effective, Responsive, Caring, Well Led		
Single Oversight	Quality of Care (safe, effective, caring, responsive)		

Framework Theme:	Finance and Use of Resources, Operational Performance, Strategic Change, Leadership and Improvement Capability (well-led)		
Implications			
Risk:	N/A, if the Trust submits the plan to agreed timetable.		
Legal/Regulatory:	The Trust is required to submit a finalised annual plan on 30 April 2018.		
Previously Considered by:	Trust Executive Committee Finance and Investment Committee	**Date:**	18 April 2018 19 April 2018
Appendices:	Appendix 1 - 2018/19 Annual Operating Plan Narrative Appendix 2 - NHSI formal feedback on 8 March submission		

NHSI Annual Operating Plan

1.0 Purpose

1.1 The Trust is required to submit its Annual Operating Plan to NHSI on 30 April 2018. This includes a full set of financial, activity, workforce and triangulation spreadsheets, alongside an update to the narrative plan submitted in April 2017 (which was a submission required to cover a two year period 2017-19). This paper specifically relates to the narrative plan, a refresh of which is requested as an element of the annual planning submission.

1.2 The Trust submitted a first cut narrative Plan, alongside detailed activity, financial and workforce information, on the 8 March 2018. NHSI, in its formal feedback regarding the Plan, raised 19 questions (attached as Appendix 2) that needed to be addressed for the final submission. These will all have been addressed in the final narrative.

1.4 Consultation, review and approval of iterations of the Plan, and the information and assumptions the content is based on, have been reviewed twice by the Council of Governors, at Board seminars, and through TEC (four times) and FIC. The document has been updated in line with comments received and the evolving activity and financial picture.

1.5 The Trust re-submitted the full suite of planning documents to NHSI on 6 April, in line with NHSI requirements. Providers could have been required to resubmit again on the 20 April, to address specific questions raised by NHSI, but the Trust received no such request.

1.6 This paper needs to be read in conjunction with finalised 2018/19 Financial Plan Budget Setting paper being presented by the CFO as a separate item. It was agreed when the narrative Plan was considered by FIC on 19 April 2018 that the financial narrative would be presented to Trust Board under the separate financial plan item, and therefore the finance section in the narrative Plan document for Trust Board is intentionally left blank. The final narrative will be inserted prior to submission and based on the financial paper discussion.

2.0 Areas of on-going work

2.1 The iteration of the narrative Plan is accurate as at 20 April, when papers for the April Trust Board are circulated. Work is on-going to refine and finalise the content, although it is not anticipated that the Quality and Workforce sections will change in any noteworthy way.

On 18 April, Ian Dalton, CEO of NHSI, wrote to all provider CEOs asking for greater clarity on four key points:

a) The number of beds open/available during the year
b) The activity the Trust will deliver
c) The financial position that will be sustained
d) The performance levels the Trust will "*genuinely expect to deliver*", highlighting any gaps.

Activity and finance is covered in detail in the full suite of planning submissions. The narrative Plan includes a section on performance, agreed with the COO. A section detailing proposed bed stock and overall capacity will be added to narrative Plan, to ensure point a) above is addressed in the final version submitted.

Further to the paragraph above, the Trust Board is asked to note that work remains on-going to finalise the following two key areas:

- The financial position: dealt with in the separate Financial Planning paper to Board
- 95% ED standard: Trust Board is due to approve a 4 hour Emergency Department trajectory at the April Board. As agreed at FIC on 19 April, the narrative Plan will then be updated to reflect the outcome of the Board discussion and decision. The draft figures, reflective of those the Board is being asked to approve, are included in this version of the narrative plan for completeness sake.

Overall, it is not anticipated that this work will significantly change the content of the attached narrative plan, but it is important for the Board to understand that work on the final plan remains on-going.

3.0 Summary & Recommendation

3.1 The Trust Board is asked to:

1. Note the process of development the narrative annual plan has been through
2. Approve the narrative plan submission, subject to any final amendments required by Board prior to submission and work on-going, noted in section 2 above.
3. Agree delegated authority to the Chairman and CEO to approve any final revisions prior to submission.

Tom Ellis
Head of Business Planning
April 2018

Appendix 1 – Narrative Annual Plan 2018/19

St George's University Hospitals NHS
NHS Foundation Trust

2018/19 Annual Plan – V3.2

Contents **Page**

1. 2018/19 Overview and context

1.0 2018/19 Overview

St. George's University Hospitals NHS Foundation Trust ('St. George's' or 'the Trust') has experienced a number of years of significant financial, operational, quality and leadership challenges. The Trust remains in Financial and Quality Special Measures (FSM and QSM), and is forecast to deliver a £53m deficit in 2017/18. Though the challenges remain substantial there is a new confidence within the Trust that it can overcome them, driven by a new substantive leadership team setting a new direction for the Trust. This mid-term update to the two year 2017 – 2019 Annual Plan outlines the Trust's 2018/19 quality, financial, workforce and operational plans.

The 2015/16 Annual Plan stated that *"The turnaround and transformation process that is now required will require a sustained 3 to 5 year programme coupled with sustained external support and cash resource to achieve."* This remains the case, and the challenge for the Trust is to exit FSM and QSM as quickly, and sustainably, as possible, whilst at the same time taking our workforce with us on a journey of change over the coming years.

1.1 St. George's Vision: Outstanding Care, Every Time

The Trust Board agreed and launched the new organisational strategic objectives in late 2017. These will provide a clear framework for the Trust to work to during 2018/19. St. George's Vision: Outstanding Care, Every Time is designed to focus on improving care for patients, and the working lives of staff. These new objectives, outlined overleaf in Figure 1, give staff, patients, and external stakeholders greater clarity about areas of focus for the next 18 months and highlight where we intend to improve.

These objectives will form the basis of the annual corporate objectives for 2018/19 against which progress will be reported to Trust Board on a quarterly basis.

With the focus on the fundamentals of care and operational delivery, the Trust believes these are a balanced set of objectives, the delivery of which is essential to the organisation's long term future.

The Trust Board has agreed a process and timescales for the development of a new Clinical Strategy, which will be developed with full engagement from our staff and external stakeholders. Defining what St. George's 'is' and 'does' will bring clarity to all Trust staff about the organisation's longer term direction of travel, and will facilitate the Trust's decision making, for example in where to focus scarce investment resources.

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 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 Emergency Department 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

2.0 2018/19 South West London sector developments

2.1 The South West London Health and Care Partnership (SWL HCP)

The SWL HCP produced a One Year On discussion document in November 2017, a key element of which was to commit to producing borough level Local Health and Care Plans by December 2018. For St. George's this means close involvement for the HCP being developed for Wandsworth and Merton.

There continues to be a focus on a number of the priority areas identified in 2016, although the emphasis of some for the SWL HCP, and / or for St. George's as an organisation, are now different as outlined below.

2.2 Locality Teams

During 2017/18 the contract for Community Adult Health Services for Wandsworth, previously held by St. George's, was awarded to a new provider. This means that St. George's is no longer required to play such a central role in this area of work. However, St. George's continues to work with the community providers to ensure that patient pathways from acute to community, and between mental and physical health, work as effectively as possible.

In Merton there has been a particular focus on diabetes, where the outcomes for the population are poor and therefore this is one of the top public health priorities, with one of the St. George's consultants playing a key role in working differently with primary care to manage people with diabetes in the community. For 2018-19 the Health Innovation Network has agreed to provide project management support to take this further by looking at working differently with people who have a diagnosis of both diabetes and severe mental illness, who have poor health outcomes. This would be a joint piece of work across primary care, community, acute St. George's and mental health.

2.3 Acute Provider Collaborative

The position of the SWL HCP is that there will not be any decisions made involving reconfiguration of the existing acute hospital providers that would involve closing any acute hospital sites, but that the focus should be on the providers working collaboratively to ensure best use of the collective capacity (estates, bed and workforce) to deliver high quality clinical services to the population of south west London.

Key areas of focus for 2018-19 are in relation to the sustainability of out of hours radiology provision; a strategic plan for increased utilisation of Queen Mary's Hospital as a significant asset to south west London; and exploring opportunities to expand the existing south west London-wide elective surgery model for orthopaedics to other surgical specialties, and how the overall bed stock can best be used in the interests of patients.

In addition a number of areas of collaboration are underway relating to corporate/ back office functions, including procurement and digital.

A Workforce Action Board is in place and there has been progress in plans to develop a south west London-wide staff bank, which has now gone live in a limited number of wards in each Trust to begin with.

2.4 Specialist Commissioning

In line with the two-year plan, St. George's is fully involved in the NHSE Specialised Commissioning review across South London which is currently focussing on cardiology, neurosciences, renal and paediatrics.

3.0 2018/19 Quality Plan

3.1 Approach to Quality Improvement

In October 2017 the Trust launched Outstanding Care, Every Time – Our Quality Improvement Plan. The Quality Improvement Plan (QIP) sets out the Trust's plans to improve over an 18 month period and the framework for St. George's quality improvement work in the future. The delivery of the plan is supported by joint working with the Institute for Healthcare Improvement (IHI) which will equip Trust staff with an improvement methodology and the skills and tools to continually improve patient safety and quality, provided by the Quality Improvement Academy (QIA). The launch of the QIA in November 2017 will enable St. George's to harness the quality improvement opportunities identified by staff in the front line of delivering care and support them with effecting change in their areas.

The QIP includes the work undertaken to address the areas for improvement identified in the full Care Quality Commission (CQC) inspection in June 2016 and goes beyond this to set out St. George's plans to achieve a rating of 'Good' and on to 'Outstanding'.

Quality improvement is led at executive level by the Chief Nurse and the Medical Director. The governance framework for our Quality Improvement Programme is aligned to the Trust's Quality and Financial Recovery Programme. This has oversight and external scrutiny at a Trust level by NHSI. Each workstream of the QIP has terms of reference and is held accountable through the weekly Quality Delivery Meeting and the Trust Recovery and Improvement Group for Finance and Quality Meeting (chaired by the Chief Nurse), with reporting to the Quality and Safety Committee.

Progress with the delivery of milestones in the work streams is monitored by the Quality Delivery Meeting alongside the performance indicators in the Quality Improvement Dashboard. The indicators in the dashboard have improvement trajectories where appropriate and enable the Quality Delivery Meeting to ensure that improvement projects are having the expected impact on performance; this is also used to provide assurance to the Quality and Safety Committee.

Alongside the programmes of the QIP the Trust has also developed systems to provide further assurance from ward through to the Board on the quality of our services. These include systems established to provide oversight and assurance of clinical services and to ensure we are able to monitor improvement and identify areas where further improvement is needed.

The following are in place:

- Ward and department level quality information available in real time, published and displayed in the ward or department.
- An internal multi-professional monthly quality inspection programme.

- Quality review inspections with majority of external reviewers including NHSI, commissioners, Healthwatch and leads from other Trusts.
- A ward accreditation programme.
- Clinical audit programme
- Executive walkabouts
- Full Board visits to wards and departments including support functions

The outputs from these systems are used throughout the Trust to keep staff and patients informed about quality performance from ward level and to monitor services through the governance framework. The information is reported through Divisional Governance Boards (DGB) to the Patient Safety and Quality Meeting and through to the Quality and Safety Board Sub- Committee. The Board gives direct feedback at the beginning of every Board meeting on the observations from their walkabout and what they have heard from patients and staff.

The Trust gathers feedback from individual patients through the Friend and Family Test and localised patient surveys to identify areas for improvement, and in 2018/19 St. George's will be implementing its Patient Partnership Strategy to ensure that its users are fully involved in the Trusts quality improvement work.

3.2 Summary of the Quality Improvement Plan

Our QIP sits alongside our Financial Recovery Programme and the Elective Care Recovery Programme. These three programmes have been developed to work together and ensure we address our quality, financial and performance challenges in a joined up way. The QIP will be delivered through three change programmes and two enabling programmes of work.

Safe and Effective Care Programme

This programme is made up of work streams that aim to consistently deliver the fundamentals of patient care and ensure that improvements we make are sustained in the long term. The work steams are:

- Fundamentals of care
- End of life care
- Dementia, Mental Capacity Act and Deprivation of Liberty Safeguards
- The deteriorating patient
- Medicines optimisation

The projects within the Safe and Effective Care work streams are designed to ensure that we get the basics right for all of our patients and we further develop our patient care to be outstanding, every time.

Flow and Clinical Transformation Programme

This programme is made up of work streams that address process and operational improvement to improve the flow of patients along their care pathway, from arrival through to discharge. This programme is addressing how effectively a patient moves along their care pathway from arrival to discharge. Through the programme we aim to reduce waiting times, cancellations and delays to patients. We will ensure they receive the right information, are booked efficiently in advance, have safe and effective care and are discharged safely. The work streams are:

- Unplanned and admitted care

- Theatres
- Outpatients

Quality and Risk Programme

This programme consists of work streams that look at improving our risk management systems to ensure they are effective. A significant part of this workstream is designed to improve how we learn as an organisation, in particular from the information we get from incidents, complaints and patient feedback and from the outcomes of our internal audit programme including national audits. The work streams are:

- Floor to Board governance
- Complaints management
- Learning from incidents
- Healthcare record management

These programmes are supported by enabling programmes designed to improve staff engagement; to develop leadership skills at all levels of the organisation; to improve our IT systems and to improve our built environment.

3.3 Summary of St. George's Quality Impact Assessment process

All service developments and cost improvement schemes are managed within a governance framework. This is illustrated in graphic 1 below. The QIA process is completed at Gateway 2 and service developments or Cost Improvement Programmes (CIPs) that meet the QIA criteria cannot proceed beyond this gateway until approval is given.

The criteria for the QIA process is any scheme valued at over £100k; any scheme where the staffing will be reduced; or any scheme where any clinical risk has been identified. Schemes that meet one of these criteria are reviewed by the Medical Director and/or the Chief Nurse (depending on scheme value, identified risks, and focus of risk – clinical, nursing, both etc), and if rejected are returned to the division. Once a scheme is approved the Medical Director and Chief Nurse seek assurance through the monitoring of the schemes that the scheme has not had any unforeseen impact on quality so that interventions are made if necessary during the implementation (gateway 3) phase.

Cumulative impacts of CIPs on overall patient care, outcomes or experience will be identified through Trust wide performance monitoring. Route cause analysis will be undertaken to identify issues which should identify if CIPs are contributory factor.

Figure 1 – The CIP Life Cycle

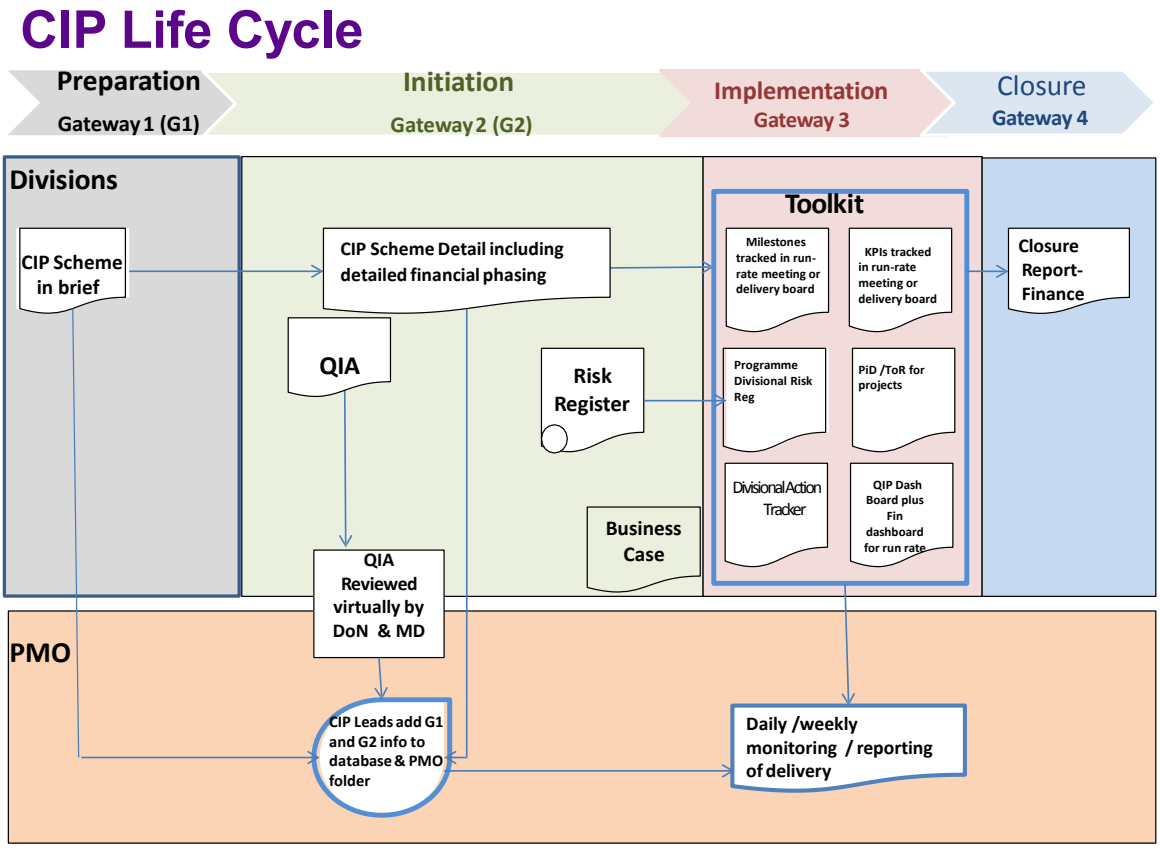
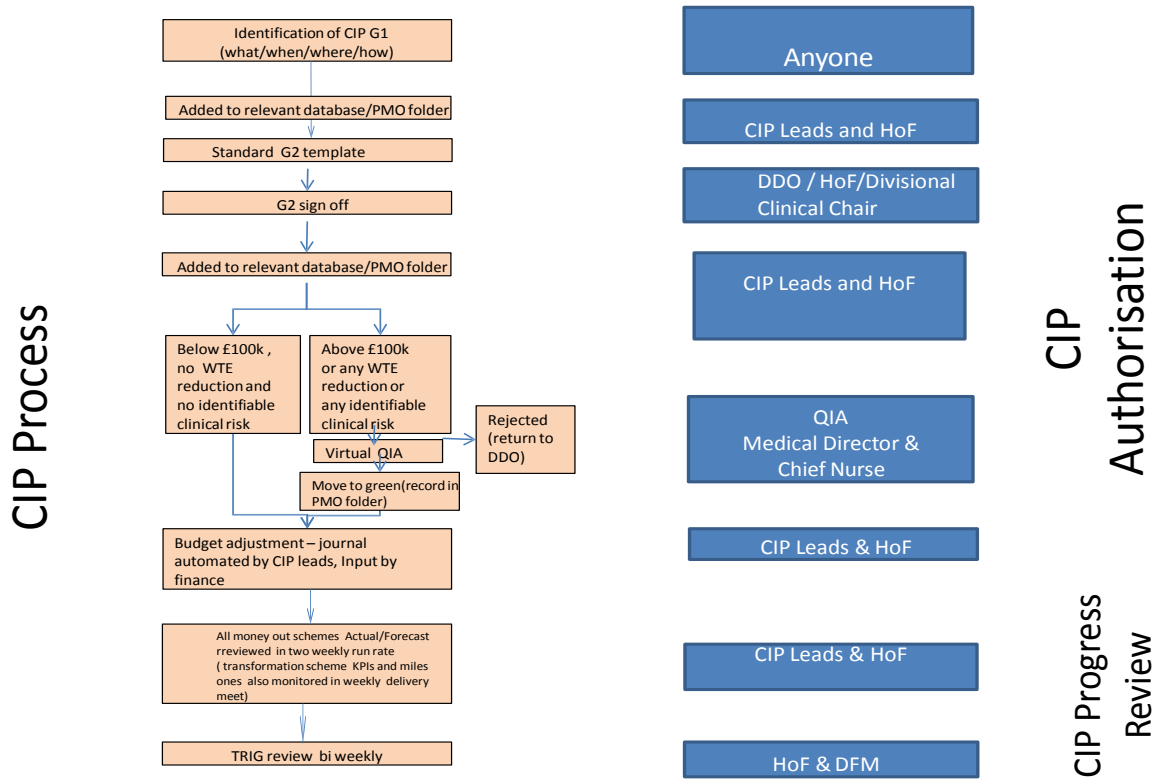


Figure 2 – The CIP Process



3.4 Summary of triangulation of quality with workforce and finance

Triangulation of quality with workforce and finance is carried out throughout the organisation. Divisional governance meetings review indicators and their interdependencies in relation to performance, finance, quality, workforce, and risk and key items for escalation are addressed.

At the executive led divisional performance reviews areas of underperformance are reviewed in terms of delivery against national/internal standards, financial implications, impact on quality and patient care and experience, and workforce implications associated with it. In addition to this the impact of potential workforce issues are discussed and their impact on respective areas, both short and long term with remedial actions.

The Trust Recovery and Improvement Group for Finance and Quality brings together all the work
streams and ensures that the Trust has an integrated approach to its improvement work. The Finance and Investment Committee, Quality and Safety Committee, Workforce and Education Committee bring all elements at monthly Trust Board and key indicators from all domains are reported in the monthly Trust Board Performance and Quality Report. The Board scrutinise performance indicators and request further details or recovery action plans where required. Also, in relation to particular areas the board may request specific thematic analysis and forecast for future performance and any associate implications. The board will then use this data to identify key priority and development areas for the Trust for both the immediate term and strategic long term.

3.5 Specific Quality Improvements

3.5.1 Reducing Gram Negative infections

The Trust had a total of 67 hospital acquired infections, as well as 169 identified as community acquired. A full action plan to reduce Gram Negative (GN) bacteraemias is in development, to address this challenge, and will be monitored at the Infection Control Committee. The Trust has agreed with Wandsworth CCG an initial 10% reduction of hospital-acquired episodes in 2018/19 compared to 2017/18 i.e. nor more than 60 episodes.

Actions already underway include completion of an analysis of previous GN bacteraemias. Using data from 2017/18 the Trust will review details of all the bacteraemias with patient categories and risk factors for infection – from this the Trust will identify which of the above infections might have been preventable. Analysis of 47 episodes of hospital-onset E coli bacteraemia for the first 8 months of 2017/18 showed that potentially 18 of these episodes were preventable.

The Trust will then identify a range of interventions to reduce these infections, monitoring the response during 18/19. Interventions are likely to include: improved vascular line and catheter care, agreed treatment protocols to prevent relapse of infection, prevention of surgical infections including review of surgical prophylaxis, prevention of diabetic foot infections, antibiotic prophylaxis for neutropenic patients, and review of prophylaxis for endoscopy procedures (related to biliary sepsis). Many of these interventions are already in place as a result of work related to reduction of all hospital-acquired infections including MRSA and C difficile, but the Trust will need to review these to see that current practices are also directed at prevention of GN infections.

Wandsworth Clinical Commissioning Group (CCG) is also in the process of developing a plan to reduce the community-acquired component of these infections – which is the majority. This will require some co-ordination around care of patients with urinary catheters in the community.

3.5.2 Mortality Review Processes

The Trust has a positive record on hospital mortality indicators. The Summary Hospital-level Mortality Indicator (SHMI) for October 2016 to September 2017 shows the Trusts mortality is *'lower than expected'* at 0.83. St. George's is one of 16 Trusts nationwide in this category. In addition, with regard to Hospital Standardised Mortality Ratio, the Trust scores are categorised as *'Significantly better than expected'*.

The Trust has a dedicated independent team reviewing deaths in a timely way. During 2017/18, the team reviewed 1,008 deaths and provided clinical and risk teams' information for learning and improvement. All patients where a care issue may have contributed to death are escalated to the risk team the same day and included in SIDM discussions.

Work in the bereavement office supports families with better processes, clarification of information for families, and the Trust has also set up an email account to help support families if requested

The Trusts Mortality Monitoring Committee review team was one of only three Trusts invited to present to the national event *'Learning from Deaths – one year on'* on 14 December 2017. The Trust will review the Learning from Deaths Policy in line with publication of national guidance on engagement with families and carers. The national guidance is still evolving and the Trust will ensure it incorporates the outputs into its local systems and processes, which may require revisions to the Trust policy.

5.0 2018/19 Workforce Plan

The Trust's ability to manage, develop, inspire, and lead its current and future workforce is central to being able to meet its service and financial objectives.

Currently staff costs account for 62% of St George's overall operating expenditure. The Trust is part way through a process of alignment with both financial and service activity plans to ensure the proposed workforce levels are affordable and sufficient to deliver safe, efficient and effective care to patients.

To support the Cost Improvement Programme (CIP) a key workforce aim for the Trust is to ensure that the organisation is able to meet its activity and service requirements from within available resources and to reduce funded establishment. Pay savings will be generated by both actual establishment reductions, alongside the reduction in usage of bank and agency. St. George's met the 2017/18 target of reducing its agency spend from £43m to £24m. Ambitious targets/ceilings for 2018/19 have been set for £17m, which means that we will have a monthly agency ceiling of £1.42m for all months in 18/19.

Establishment reductions will be delivered through natural staff turnover generating the flexibility to restructure, including role redesign, skill mix reviews, and up-skilling, alongside the removal of unfilled vacancies and improved recruitment & retention strategies. These changes will be underpinned by the QIA process outlined in section 3.3. Specific schemes already identified to drive this reduction in staff costs include:

- For 2018/19 job planning round to ensure the Trust is maximising direct clinical care PAs to increase productivity. Done successfully, this will lead to a reduction of PAs
- Introduction of new roles and extended responsibilities of Nursing Associates, Medical Associate professions to include Physicians Assistants, Surgical Nurse Advance Practitioners, Advanced Critical Care Practitioners
- Nursing staff review of safer staffing levels, which will reduce the total nursing costs for this portion of the Trusts nursing workforce
- Workforce Review for new model of care in ED, to attract consultants with a 7/3 Job Planning Programmed Activities, utilisation of Advanced Nurse Practitioners to replacing more expensive junior doctor roles, utilisation of Health Care Assistants and Associate Nurse Practitioners to support the nursing establishments
- Skill-mix review in Outpatients, where currently 50:50 qualified to unqualified, with ideal ratio of 20:80 with qualified nursing staff (band 5 -8) and unqualified health care assistant roles (band 2 – 4).
- Generally, whether there is the current requirement of higher banded workforce in comparison to non-qualified/lower banded staff appropriately proportioned
- Roles and responsibilities – qualified/clinical staff undertaking functions that could ideally be undertaken by non-clinical (known as upskilling and downskilling).

Figure 3 – 2018/19 Staff Plan - WTE

Staff Categories	WTE as at 31/03/19
Total Substantive Non Medical -Clinical Staff – all scientific, therapeutic and technical staff, support staff, nurses (Registered Nursing, Midwifery and Health visiting staff = 2,557.9 WTE – a subset of the WTE shown)	5,005.7
Total Substantive Medical and Dental Staff – career/staff grades, trainee grades and Consultants	1,255.0
Total Substantive Non Medical- Non-Clinical Staff – admin and clerical, infrastructure support	1,677.8
Substantive WTE	**7,938.4**
Bank	692.1
Agency staff (including, Agency, Contract and Locum)	321.1
Total WTE	**8,951.7**

The Trust expects to reduce its establishment by circa **500 WTE** for 2018/19 as part of the CIP programme. The Trust is aiming for the full impact of CIPs reductions to be in place by 1 July 2018. The following table outlines the proposed phasing of establishment reductions. All CIP plans require a QIA to be undertaken (see section 3.3), and any planned reductions in staffing will go through this process to ensure safety and quality are protected.

Figure 4 – Phasing of WTE CIP programme

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay Baseline	9,387	9,391	9,392	9,391	9,400	9,400	9,400	9,400	9,400	9,399	9,399	9,399
Service Developments	13	13	13	47	47	47	47	47	47	47	47	47
Marginal Cost	29	29	29	29	29	29	29	29	29	29	29	29
CIP	- 76	- 214	- 351	- 524	- 524	- 524	- 524	- 524	- 524	- 524	- 524	- 524
Draft WTE	**9,353**	**9,220**	**9,083**	**8,943**	**8,952**	**8,952**	**8,953**	**8,953**	**8,953**	**8,952**	**8,952**	**8,952**

The Trust will need to re-engineer its processes to be able to reduce pay costs, and it will need to ensure that clinical quality, patient safety and activity are not adversely impacted by this reduction.

5.1 High Level Assumptions

The Trust recognises that whilst there will need to be reductions in the number of WTEs employed, the achievement of challenging financial targets will not come from a wholesale reduction in posts alone.

Working assumptions against a range of workforce productivity and efficiency targets are being developed which will quantify each of the following areas contributions to producing the required reductions in WTE (or equivalent productivity improvements):

- Reduction in the workforce
- Reduction in agency costs
- Reduced vacancy rate
- Technology to support increased productivity
- New roles and extended responsibilities

- Increased workforce attendance
- Job planning

The reduction in the workforce would need to take account of the minimum staffing levels to provide day-to-day safe services. It is expected that the reduction would have a greater impact on corporate back office posts. The Trust will use a methodology for making ensuring that wherever possible turnover, temporary staffing spend and vacancies are used to remove costs.

5.2 Workforce Key Performance Indicators (KPIs)

The following are KPI's (data as at January 2018) monitored and reported to NHSI via monthly in year monitoring return. The Trust is determined to raise performance against each of these KPI's, and will be developing plans for 2018/19 to deliver this improvement.

Figure 5 – Performance against workforce KPI's

	Mandatory Training	Vacancy	Sickness Absence	Non-Medical Appraisals	Medical Appraisals Job Plans	Gross Turnover
Actual	85.56%	15.69%	3.61%	74.25%	80.55%	18.8%

5.3 Workforce Supply

The Trust is not alone in experiencing increased demands for its services, but new staff can only come from new graduates, returning practitioners or recruitment from elsewhere. The Trust has sought to access all these markets, starting with increased student numbers for both its nursing staff and junior doctors as well as actively recruiting overseas within Europe, India and the Philippines.

A previous trip to India in November 2017 resulted in 73 posts being offered to nurses, which are going through the International Recruitment process. The recent trip in April 2018 resulted in 108 offers being made with 75 posts offered in India and 32 posts offered in Dubai. Additional recruitment is planned for nurses for 2018/19 from the Middle East and Europe which has previously been extremely successful.

St. George's has also used a range of strategies to address these challenges from upskilling our existing staff, identifying the skills mix through labour market and improving our recruitment and retention strategies. For example, the Trust successfully upskilled Surgical Nurse Advance Practitioners (SNAPs) and Advanced Care Practitioners (ACPs) as senior decision makers, to support Surgery and Theatres, particularly covering the night shifts where there are a reduced pool of medical staff.

The Trust has improved the recruitment process with a significant reduction in the time between vacancies arising and conditional job offers. This is helping ensure staff offered posts start work at the Trust.

5.4 New Roles

The Trust has been successful in its bid to introduce the new Nursing Associate role and the pilot commenced in January 2018. It will provide highly skilled support to registered nurses

in Neurosciences and Medicine and is actively supporting 8 trainees who qualify in 2018/19. In reviewing our workforce model and supporting new roles in nursing we have recruited another 24 trainees who have started on this university programme to qualify as Nursing Associates.

The Trust's Associate Practitioner band 4 role in Peri-operative care and Neonatal care supports workforce transformation, with the second cohort of nurse associate practitioner roles underway.

In recognising the challenges in the medical workforce and needing to provide 7 day services we continue to support advanced roles such as nurse endoscopist, nurse practitioners and surgical nurse advanced practitioners in the medical and surgical pathways. The Emergency Department have appointed a Nurse Consultant to lead this for the ED to supplement the ED workforce. The training for these nurses will follow the national syllabus that has been launched and the Royal College of Emergency Medicine competencies. This will start in September 2018/19.

The Trust continues to be the leading user of the Physician Associate roles, with currently 25 on our payroll, and will continue to roll out deployment and expand on further training and development for this cohort.

5.5 Apprenticeship levy

The cost of the apprenticeship levy to St. George's is 0.5% of payroll i.e. in the region of £2.5 million. This is significantly more than the Trust has ever spent on Continued Professional and Personal Development (excluding doctors in Training). Maximum benefit for utilisation has been viewed in 2 ways:

- providing apprenticeship employment opportunities (with real apprenticeships) and/or
- upskilling existing workforce - replacing CPPD spend

Uptake for traditional apprentices falls short of the public sector target of 2.3% of the workforce (circa 200 apprentices per annum for St. George's). A major barrier is the requirement to release apprentices for off-the-job training for 20% of the time. Many of the apprenticeships in Business Administration, Healthcare Support worker, etc. only utilise £2-£3,000 for each place, so make very little impact on the Trust use of the apprenticeship levy.

Up -skilling the workforce uses higher value apprenticeships. For example, the second cohort of Trainee Nursing Associates have their training funded from the apprenticeship levy at £15k per person. The Trust was a pilot site for Nursing Associate roles in 2017, with eight on the first intake in January 2017, and 24 on the 2nd intake in January 2018. Whilst the initial eight are not apprentices, they will be joining the nursing workforce in January 2019 in Band 4 roles. The second cohort will complete the apprenticeship in January 2020, and will also join the nursing workforce in band 4 roles. Nursing workforce reviews will re-structure the establishments to take account of this enhanced nursing support role, which will complement the current workforce.

6.0 Key Performance Indicator Performance

6.1 Referral to Treatment (RTT) Performance

The Trust has been non-reporting for 18 week RTT since June 2016. The Trust continues to take significant steps to improve its 18 week performance, and anticipates returning to full 18 week RTT reporting for the St. George's site only during 2018/19. The Trust is proposing to improve its RTT position by 10% during 2018/19.

6.2 Emergency Department (ED) 4 Hour Performance

The Trust did not hit the 95% target at any point during 2017/18. The challenges faced in meeting this target relate to flow out of the department into ward beds, and out of the Trust back into the community, to create those ward beds. The Trust cannot commit at this point in time to meeting the 95% target, and the following graph and table outline the Trust proposed position, about which it is currently in discussion with NHSI. It should be noted that the ED trajectory shown below has still to be formally approved by the Trust Board – this is due April 2018 – nor NHSI or Commissioners. For ED the quarterly trajectory based is as follows, getting the Trust to an average of 92% over the year:

Figure 6 - ED Performance

18/19 Quarter 2018/19	ED Performance trajectory
1	91%
2	95%
3	92%
4	92%
Total full year performance	**92%**

6.3 Cancer Waits

There are eight cancer targets. The Trust has had challenges in meeting them over the recent past, but in January 2018 met seven of the eight targets and is confident that it can sustainably maintain this level of performance for these seven over the course of 2018/19. The target that the Trust has consistently not met during is 85% of patients beginning their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. Figure below shows the trajectory that has been agreed with NHSI for 2018/19 for this target, will see this target consistently delivered during 2018/19.

Figure 7 – Cancer Performance

	April '18	May '18	Jun '18	Jul '18	Aug '18	Sept '18	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	Mar '19
Patients beginning treatment	63.0	63.0	61.5	68.5	66.5	64.5	62.5	49.5	54.0	54.0	49.5	56.0
Patients seen within target	55.0	56.0	54.0	59.0	57.0	57.0	53.5	43.0	48.0	47.0	43.0	48.0
Performance %	**87.3%**	**88.9%**	**87.8%**	**86.1%**	**85.7%**	**88.4%**	**85.6%**	**86.9%**	**88.9%**	**87.0%**	**86.9%**	**85.7%**

6.4 Discharge Planning

St George's is committed to improving the current model of discharge planning within the hospital, acknowledging that doing what is right for patients is also right for the whole flow within the hospital and the overall local health economy. The key priority is to prevent admission wherever possible and to enable patients to leave the hospital at the earliest possible opportunity, in the knowledge that the deterioration associated with a long hospital stay is avoidable with early planning of discharge (it is estimated that 10 days of inactivity linked to deconditioning in a hospital bed for an older person can result in the personal cost of 10 years of normal muscle ageing and the subsequent loss of function).

The eight high impact changes (HIC) and the underlying key principles developed by national strategic system partners, including the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), NHS England, Department of Health (DOH) and the Emergency Care Improvement Programme (ECIP), form the foundations of the change opportunities at St. George's.

Figure 8 – St. George's 8/19 plan for high impact changes

Workstream	Activity / initiative	2018/19			
		Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar
Hospital Discharge	High Impact Change 1: Implement early hospital discharge planning	PIP	PIP	PIP	E
	High Impact Change 2: Implement system to monitor patient flow	E	M	M	M
	High Impact Change 3: Implement multidisciplinary discharge teams	E	E	E	M
	High Impact Change 4: Home First/Discharge to Assess scheme in place	PIP	PIP	E	E
	High Impact Change 5: Seven-day service in place	PIP	PIP	PIP	E
	High Impact Change 6: Trusted Assessor models in place	PIP	PIP	PIP	E
	High Impact Change 7: Promoting choice and self-care for patients	PIP	PIP	E	E
	High Impact Change 8: Enhanced health and care services in care homes	E	E	E	M

Key:
PIP=plans in place, E= Established, M= Mature

Workstream outcomes from 2017/18 have enabled the organisation to enter this financial year with established changes in place for HIC 2, 3and 8. The priority focus for early 2018/19 is to put in place solid plans for HIC 1 (implement early hospital discharge planning), 3 (implement multi-disciplinary discharge), and 7 (promoting choice and self-care for patients), and pick up HIC 5 (seven day services and HIC 6 (Trusted assessor models in place), in the latter part of the year alongside the progression of last year's workstreams. By the end of 2018/19 the Trust aims to have achieved mature status in three areas and established status in five areas.

Getting it right at the beginning of the hospital experience is pivotal for discharge planning: communicating clearly to patients and family and staff so that all are clear about the expectations of care in the hospital and transfer of care beyond the hospital setting.

The key vision is for a whole system of health and social care partners to embrace ways of working together wherever possible to enable patients, who need support of some kind on leaving hospital, to return home as soon as possible so that they are assessed in the right place at the right time by the right people. By developing good relationships within the system and building processes and pathways to support effective working (such as data sharing with community partners so that they can proactively respond to patients early in their admission), the intention is to prevent some of the 1-3 day Length of Stay (LOS) cohort being admitted, reduce hospital LOS wherever possible particularly for the “stranded” (more than 7 day LOS) and “super stranded” (patients in more than 21 days) cohorts, speed up hospital discharge with assurance that this is done working within the parameters of the choice protocol to facilitate improved patient outcomes long term.

The Trust will measure impact by:

- Continuing to measure and track patient flow using ED data set within 24 hours as part of the SAFER and Red2Green roll out
- Performance indicators for impact of AAA – aim to reduce 1-3 day LOS cohort
- Monitoring and tracking of the percentage of stranded and super stranded patients with Divisional agreed targets.
- Improve processes for DTOC coding and capture the impact of daily whole system meetings with key partners and weekly escalation meetings.
- Monthly Performance monitoring of repatriations and impact on whole system flow
- Day of Care Audits Quarterly and MADE events to support deep dive monitoring and capturing the system changes e.g. measuring the impact of therapies reconfiguration on patient flow and quarterly audits
- Monitoring of readmissions monthly to ensure that there are no unintended consequences to improved flow out of the hospital

Appendix 2 – NHSI Feedback on 8 March narrative annual plan submission

Feedback	
Activity	
1	**17/18 FoT:** Broadly in line with the NHS Improvement's expectations with the exception of 1st OPA suggesting a currency/methodology issue with the draft activity plan. Please can the Trust review and verify the accuracy of these numbers?
2	**Growth:** Plan shows a marked reduction in 'other referrals' suggesting a service change. Please can the Trust review and verify the accuracy of these numbers and if accurate, detail any service change planned
3	**Growth:** Planned growth is not in line with observed growth, with the exception of A&E, suggesting QIPP impact. a. Please can the Trust review and verify the accuracy of these numbers? b. Please can the Trust provide growth bridges to show change and deliverability?
4	**Phasing:** The Trust's phasing of activity does not look in line with historical seasonality (based on 2017/18 actuals) Please can the Trust review and verify the accuracy of these numbers?
5	**Delivery:** We note that a marginal improvement to length of stay is required to deliver forecast elective and non-elective activity within the current bed base.
6	**Delivery:** Conversion rates for referrals / first OPA is out of line with 2017/18
Finance	
7	**Control total:** The Trust has not accepted the CT and is planning to deliver a £(29)m deficit in 2018/19. As discussed at the Provider Oversight Meeting on 15th March, this plan is not acceptable to NHS Improvement. Please can the Trust review whether it can improve on its planned deficit by delivering its CIP contingency of £5m, maximising the impact of pay CIPs and considering other non-recurrent opportunities.
8	**Run rate:** The Trust has reported a forecast monthly exit run rate of c. £(5.5)m. The lack of improvement in your monthly run rate continues to be our key concern and we continue to expect the Trust to return to run rate breakeven as quickly as possible.
9	**CIPs:** The Trust's plan includes CIP achievement of £50m (5.9% of baseline expenditure) which represents a significant challenge for the Trust given the current maturity of CIP plans (c.£26.5m).
Workforce	
10	As discussed at the Provider Oversight Meeting on 15th March 2017 and subsequent meeting with the FSM team, further work is required to understand and develop the Trust's workforce plan.
Quality	
11	**Planned workforce reduction:** Can the Trust please confirm that any changes to the nursing, midwifery and AHP workforce have been reviewed and signed off by the Chief Nurse and in addition, any changes to the medial workforce have been reviewed and signed off by the Medical Director.
12	**Non-clinical workforce changes:** Can the Trust provide detail with regard to assessment of risk and impact of these proposed changes.
13	**IPC:** Can the Trust detail plans in place in 2018/19 to further reduce gram negative infections.
14	**QIA process:** Can the Trust confirm that all CIPs that could have a clinical impact, including corporate services, are signed off by Medical Director and Chief Nurse.
15	**QIA process:** Can the Trust confirm that the QIA process includes monitoring of the cumulative effect of schemes that may impact on patient care, outcomes or experience.

16	**Activity plans:** Can the Trust confirm Medical Director and Chief Nurse involvement in the development of activity plans. Can confirmation also be provided that the Board has signed off activity plans.
17	**Activity plans:** Where there are large activity plan changes, can the Trust confirm that these are reflected in the QIA/CIP process.
18	**Discharge planning:** Can the Trust detail initiatives to improve effective discharge planning in 18/19 and how outcomes will be measured and monitored?
19	**Mortality review processes consistent with the national "Learning from Deaths" policy**: Can the Trust provide detail on how and what processes are in place to ensure all deaths are reviewed and learning from deaths shared as per the NQB "Learning from deaths" guidance.

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No.**	**6.1**
Report Title:	**Workforce and Education Committee report**		
Lead Director/ Manager:	Stephen Collier, Chair of Workforce and Education Committee		
Report Author:	Stephen Collier, Chair of Workforce and Education Committee		
Presented for:	Information		
Executive Summary:	This paper sets out the key issues reviewed and agreed by the Committee at its meeting on 12 April 2018, including commenting on levels of assurance to the Board on the key risks allocated to the Committee.		
Recommendation:	Note this report		
Supports			
Trust Strategic Objective:	Valuing our staff		
CQC Theme:	Well-led		
Single Oversight Framework Theme:	Quality of care, Finance and use of resources, Leadership and Improvement capability		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Equality Impact Assessment:	N/A		
Appendices:	N/A		

1. Committee Chair's Overview

This paper reports on the Workforce and Education Committee held on 12 April. We had good attendance and a strong contribution from all attendees. It was also good that two of our (now) three Divisions were represented, although the empty chair reserved for the Surgical Division was a continuing reminder of their absence. I have written to the Divisional Chair but, at the date of writing this report, have not had a reply. The Trust's Chief Executive and interim CMO were able to be present for much of the meeting and their input was extremely helpful and allowed us to move things along well (see below).

There has been a small number of areas (Safe Working, Mandatory Training performance, and to a lesser extent Workforce Planning) where issues have been identified at previous meetings of the Committee but resolution has not been forthcoming. It was therefore encouraging that at its meeting the Committee was able to crystallise the beginnings of a process to address each of these. We will hope for reports of progress on these at future meetings.

In my previous report to the Board I noted the pressure on Committee time. We therefore agreed to move from four full meetings per year, to six. Dates for these will be agreed so as to fit sensibly within the current cycle of Board and related meetings.

Finally within this introduction, the usual observation: that a number of items discussed at the Committee and reported on below have implications for more than one of our four[1] strategic theme priorities. The reporting of these under any specific theme should not be taken to imply that these wider implications are not also considered. Please also note that a number of areas discussed, notably around HR service delivery, are not reported on here given that they are now business as usual for the Trust.

2. Key points:

Board Assurance - The Committee ended its meeting by reviewing the four **Trust-level risks** that have been assigned to the Committee to monitor, and provide assurance on mitigation. On one of these, (Strategic Risk 1: role design, skill mix, recruitment and retention) we concluded, after a very full discussion led by Elizabeth Palmer, that we could not give a reasonable assurance rating. Rather, we had only limited assurance. Although there are clear plans in place and some excellent preparatory work has been undertaken, this has not yet started to bite on the risk itself. The Board should therefore take some comfort from the context in which we are setting our assurance rating - that we have a real belief that the actions currently planned will allow us to gain a reasonable assurance here. In the absence of delivery, however, we have only a limited assurance. On the other three[2] risks, we are able to provide reasonable assurance.

We agreed that the **Committee Terms of Reference**, agreed at the previous meeting, would be treated as final – with the addition of a change of meeting frequency from four to six meetings annually. We also agreed that we would meet once or twice a year at the QMH site.

[1] Being (1) engagement; (2) leadership and development; (3) workforce planning; and (4) compliance.
[2] Being: SR8, culture; SR10, training; and SR11, leadership and development.

Theme 1 – Engagement

Alison Benincasa provided us with a very helpful and thorough update on the good and rapid progress being made with the Trust's Staff Engagement Plan, within which was a strong equality and diversity theme. We had a discussion on whether the Behaviours Charter proposed to be developed should focus on bullying and harassment, or go wider and set expectations across all behaviours and ways of staff working together. In our deliberations we firmly favoured the latter, and Alison will revert to the steering group on this basis. We were also encouraged by the way values based recruitment had been introduced and, in a different context, we had a useful discussion on the ways that training in recruitment practice and a change in panel practice might help address unconscious bias and predisposition. The HR team will progress these.

Harbhajan Brar reported on the steady progress on staff opinion shown in the latest **staff survey** and whilst he made clear that these were early days (the survey having been undertaken in October 2017) the results were encouraging. A greater test would be whether the results of the 2018 survey would show further and stronger improvement. The staff survey had reinforced that the areas of focus for the Trust with its staff over the next twelve months should (and would) be: structured personal development; organisational development to provide clearer career pathways; and more transparent bases for promotion and accessing training opportunities.

The updated **Staff Wellbeing Strategy** was approved, and Dr Rhia Gohel thanked for her work. Robert Mouat gave us a timely reminder on ensuring that the Trust was focussed on early identification of those experiencing domestic violence, and providing timely support.

We had a lively and good-natured discussion on the **gender pay gap report** (GPGR), and Sion Pennant-Williams was thanked for the excellent data analysis and presentation that he had undertaken in a compressed timescale to ensure the Report was available within the mandatory timescale. The proposed follow-on actions set out in section 6 of the Trust's GPGR were endorsed by the Committee and it was noted that the next report would be based on pay data at 31 March 2018, so we have already passed that measuring point. The HR team is clearly sighted on a number of the issues identified and will work closely with Prof Rhodes (who had made a really helpful contribution to setting out the remedial actions in the GPGR), and we will check progress at the half year on the steps we have taken by then on the actions identified.

The performance of the Trust against the **Workforce Race Equality Standard** (WRES) was disappointing, whether measured against all other Trusts and FTs or just Pan-London Trusts and FTs. We agreed that the Trust could and would improve its performance, and set out a set of challenges for Celia Oke the Trust's new Diversity and Inclusion Lead who would start shortly. In a lively discussion we also agreed that there was a need for a twin-track approach – the primary focus would be on engaging with our staff and asking them for a lead on what would be most useful to them, and specifically to the various cohorts within the wider staff, and this would be supported by a secondary track of adjusting the way recruitment and promotion processes worked to ensure that they were objectively fair and inclusive, and not held back by unconscious assumptions or bias. There is much to do here, and we acknowledged that this would require sustained effort and confidence-building which would need to be progressed over time. It was really encouraging that our CEO agreed to take a leadership role on Track 1, supported by Harbhajan and his team, (and the latter would lead on Track 2).

Theme 2 – Leadership and Progression

We had a short update from Sarah James on progress with the **development centre** which was being undertaken for the Trust by The King's Fund. Although going well generally and with good feedback from participants, there had been a recent blip in one of the programmes, with a number of non-attendances due to work pressures within the St George's site. Sarah was taking steps to ensure this did not recur. Divisional representatives present agreed to do what they could to support this.

Theme 3 - Workforce Planning

Sion Pennant-Williams reported to us on **Workforce KPIs**. Sion noted that our current Establishment comprised some 9,350 FTEs ('*posts*'), although there were some 8,950 FTEs ('*people*') actually employed or engaged - including bank and agency (with bank utilisation trending up and agency trending down). There was therefore a gap of c 400, representing vacancies that the Trust had not been able to cover. The Committee was particularly pleased to see the continuing positive performance on agency spend. Jacqueline McCullough reported that the bank staff booking App was now up and running again, which will help maintain the downwards trend on agency use. We were concerned about the continuing steady deterioration in the levels of **mandatory training**. In discussion we agreed that when new training was added to the list we would not include that training in the aggregate MAST statistics until six months after its introduction. We would however monitor the take-up of new training on a stand-alone basis within that period.

Ranjit Soor updated us briefly on the **Workforce Strategy** which she had begun to draw together, but which had been paused pending completion of workforce planning for the 2018-19 financial year. Harbhajan updated us on the **Workforce Plan, 2018-19** and setting a right-sized establishment for the current year. In broad terms, agreement had been reached (and a budget prepared) on a re-set Establishment. This contemplated a reduction in Establishment posts of c540. The exact allocation of these across the Establishment was work in progress. The belief was that this would not affect people currently in post, but the final analysis had yet to be completed between the HR team and finance, who continued to work closely together on this. We asked for an update as this work was completed.

Theme 4 – Compliance

We received a report from Sunil Dasan, our **Guardian of Safe Working**. In a very comprehensive report, he highlighted continuing problems in general surgery, and to a lesser extent ENT. Given that this was the third meeting in a row where this was being identified, we had a discussion about what would be required to resolve what looked to be on the way to becoming an intractable problem for the Trust. It was clear that whilst a part of the cause was the external labour market, we understood from Sunil that better internal planning and a longer range planning horizon within Divisions would be a major contributor to a resolution.

Prof Rhodes offered a number of helpful suggestions to address this and agreed to lead an informal Project Group to work with Divisions, the Director of Medical Education, and the University to improve forward planning of rotas, and thereby reduce the levels of exception reporting. There was clearly interest in and commitment to a fix from the Divisions present. We will hopefully receive an update (and better news) at our next meeting.

Stephen J Collier
Workforce and Education Committee Chair, NED
April 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No**	**7.1**
Report Title:	**Audit Committee report**		
Lead Director/ Manager:	Sarah Wilton, Chair of the Audit Committee		
Report Author:	Sarah Wilton, Chair of the Audit Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meeting on the 12 April 2018.		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	N/A		

Audit Committee – April 2018

Matters for the Board's attention

1.0 The Committee was updated on the Final Internal Audit reports. Overall, it was assured that progress was being made and the Trust was moving towards an improved position. However, there was limited assurance on the review of Business Continuity Arrangements. The report highlighted that the business continuity plan was out of date and was under review and that the central resource allocated may be insufficient. The Committee heard that a number of the recommendations had been accepted, which included the re-instatement of the Business Continuity Steering Group which would in future be chaired by the Chief Operating Officer. Additional resources would be made available for the Emergency Planning Team to improve their ability to discharge training delivery, oversight and embedding of processes within the Trust.

2.0 The Committee received a progress update on the 2017/18 Internal Audit plan. All reports had been completed, with the exception of audit of facilities and estates management which had been postponed until Q1 2018/19 to enable the new Director of Estates and Facilitates to undertake a review of risks across his portfolio. Draft reports on the Board Assurance Framework and Learning from Incidents and Complaints had been issued on 9 April 2018. The Committee also received the interim Head of Internal Audit Opinion Report, which had concluded that reasonable assurance could be given that there was a generally sound system of internal control and that controls were being applied consistently. While further progress needed to be made, this was an improvement on the previous year in which the Opinion was one of limited assurance only.

3.0 The Trust's External Auditor provided an update on progress against the External Audit Plan for 2017/18 and, as with the Internal Audit, concluded that the Trust was in a better place compared to the same point the previous year. The External Auditors also provided a benchmarking report for the Trust's 2016/17 Annual Report. This showed how the previous annual report compared with those of other Foundation Trusts. In a number of areas, the Trust was either ahead of its peers or among the pack, though the report also highlighted a number of areas for improvement. The Committee heard that the benchmarking report was being used as a reference as the Trust developed its annual report for 2017/18.

4.0 The Committee considered drafts of the 2017/18 Annual Report and Quality Report, noting that these were a work in progress and that significant development of both was required before final submission to NHS Improvement (NHSI) in May. The annual accounts were still being finalised and a draft of these would be provided to NHSI on 24 April. The Committee agreed that ahead of it agreeing the final documents on 21 May, the Committee – and the Board as a whole – should see and be able to comment on a near-final draft. It was agreed this would be circulated on 9 May. One area that needed to be finalised was the selection for the Quality Report of an indicator by the Council of Governors for use by the external auditors. While further work was necessary over the

coming weeks, the Committee noted that, overall, the preparation of the annual report was in a significantly better place this year compared with the previous year.

5.0 The Head of Procurement reported to the Committee that volumes of Breaches and Waivers had increased since January but there was now more rigorous challenge. Procurement training would be rolled out to staff over the next three-to six-months so staff were clear on the process and also to identify spending patterns within the divisions.

6.0 The Interim Head of Financial Controls provided a report on debt write-offs and bad debt provision for 2017/18. As Chair of the Audit Committee, I approved the write-off of approximately £153,000 of non-recoverable debt which were made up of invoices exceeding the £10,000 limit for Chief Financial Officer approval. In order to meet the year end timetable, I approved this request. The Chief Financial Officer had approved the write-off of a large number of low value invoices, which were all under £500, totalling £346,000, under his delegated authority.

7.0 The Committee approved changes to the Trust's Standing Orders (SOs), Scheme of Delegation and Standing Financial Instructions (SFIs), following an initial review by the Director of Corporate Affairs. The changes gave effect to the updated financial limits in the Schedule of Delegation which had been agreed by the Committee in January. Further changes were made to ensure the Standing Orders, in particular, were consistent with the Trust's Constitution and the governance framework required of an NHS Foundation Trust; the SOs and SFIs had last been updated in September 2015 but no comprehensive review had been undertaken since the Trust became a Foundation Trust in February 2015. The immediate changes were agreed and the Committee noted that a comprehensive review of these core governance documents would be undertaken in Quarter 2 2018/19. The Committee was assured by the Director of Corporate Affairs and Chief Finance Officer that the updated documents were fit for purpose pending this further review.

8.0 Finally, the Committee agreed to undertake an annual review of its effectiveness ahead of its next full meeting on 12 July 2018, noting that the next Audit Committee meeting would take place on 21 May 2018 for review of the Annual Report and Accounts for recommending to the Board for approval.

2.0 Recommendation

2.1 To receive the update from the Audit Committee meeting on 12 April 2018 for information and assurance.

Sarah Wilton
Audit Committee Chair, NED
April 2018

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No**	7.2
Report Title:	**Board Assurance Framework (BAF)**		
Lead Director/ Manager:	Avey Bhatia, Chief Nurse and Director of Infection Prevention and Control		
Report Author:	Elizabeth Palmer, Director of Quality Governance		
Presented for:	Decision / Assurance / Discussion		
Executive Summary:	This paper brings to the Board the summary page of the Board Assurance Framework. The summary sheet of the BAF gives an overview of the risk profile of the Trust and will assist with setting the Board agenda to ensure it is directed to improving control of these strategic risks. The BAF has been updated with the quarter 4 assurance rating and statements from the committees of the Board. The Workforce and Education Committee reviewed the strategic risks assigned to them at its April meeting. The assurance rating for SR1 concerning the development of new and innovative roles and ways of working to address staffing needs has been changed to 'limited' assurance. While the Committee recognised the controls in place they agreed that they had insufficient assurance on the impact and effectiveness of the controls at the present time to give more than a 'limited' assurance rating. For all other risks the assurance rating is unchanged from quarter 3. There has been no change to the risk rating of the strategic risks. The BAF is designed to be reviewed by the Board after the close of each quarter, however while assurances are limited the assuring committees have been providing a monthly update on the delivery of actions designed to improve controls and thus strengthen assurances.		
Recommendation:	The Board is asked: 1. For strategic risks reserved to itself (SR 9,16,17) to: • Confirm the risk rating • Agree the assurance rating • Agree the assurance statement 2. For the 14 risks assigned to its assuring committees to: • Note the risk score, assurance rating and statement from the relevant assuring committee.		

	3. To agree that monthly updates continue to be provided to the Board until the assurance position improves.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care, Leadership and Improvement Capability		
Implications			
Risk:	The strategic risk profile		
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:	N/A		
Previously Considered by:	Workforce and Education Committee Finance and Investment Committee Quality and Safety Committee	**Date**	12 April 2018 19 April 2018 19 April 2018
Equality Impact Assessment:	N/A		
Appendices:	Summary Board Assurance Framework (BAF)		

Appendix 1

Board Assurance Framework
April 2018

BOARD ASSURANCE FRAMEWORK OVERVIEW									QUARTER 4
Strategic Objective	Risk appetite	Strategic Risk		Quarterly Assurance Rating Q1	Q2	Q3	Q4	Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score
Treat the patient, treat the person	*Moderate*	*SR1*	We are unable to develop new roles, changes in skill mix and innovative ways of working that address the long term staffing (supply) requirements of the Trust as well as address the immediate recruitment and retention issues, which could result in care which is below the minimum standard.				Limited	The Committee recognises that there has been improvement in the vacancy rate and in time taken to recruit, however the risk has not significantly reduced and the Committee have only limited assurance that the controls are effective for this risk.	Director of HR and OD	Workforce and Education Committee	16
	Low	*SR2*	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.				Limited	The Committee recognises the improvement in the management of our waiting lists and the impact of the Elective Care Recovery Programme. The Committee is assured that the Unplanned Admitted Care Programme will improve control of this risk but continues to have limited assurance from key performance indicators that controls are operating effectively at present.	Chief Operating Officer	Quality Committee	16
	Low	*SR3*	We do not have effective, accessible and widely utilised learning and improvement methodologies, resulting in care which is below local and national standards and best practice.				Partial	The Committee is assured that the Quality Improvement Plan (QIP) workstream for learning is being delivered and that the Quality Improvement Academy has been launched. However, assurance remains partial as a number of key indicators in the QIP Dashboard are yet to be met.	Chief Nurse	Quality Committee	12
Right care, right place, right time	*Low*	*SR4*	Our pathways are not well integrated with, or supported by the key external organisations that make up the local health economy to enable us to manage demand or patient flow effectively, resulting in poor or delayed care for our patients.				Limited	Work continues to develop relationships and pathways and the Committee received assurance that the Unplanned Admitted Care Programme will improve control of elements of the pathway risk. However, key performance indicators do not provide assurance that controls are operating effectively at present. This risk links with SR17.	Medical Director	Quality Committee	8
Balance the books, invest in our future	*Low*	*SR5*	Financial efficiency, forecasting and accountability is not seen as a priority for service managers or our wider workforce, resulting in overspending, poor budgetary management which could lead to poor service delivery and regulatory action.				Partial	The Committee received assurance that the training to support staff with managing finanicial matters is being delivered. The Committee is assured that the cost improvement programmes (CIPs) are closely monitored. The Committee is reasonably assured that controls are generally adequate but because of the number of CIPs rated as 'red' is of the view that greater focus is needed on developing robust CIP plans and moving them to a green assured position as quickly as possible.	Chief Finance Officer	Finance and Investment Committee	16
	Low	*SR6*	We do not understand our business sufficiently to identify and implement efficiency and improvement opportunities				Limited	Although we are starting to develop a greater understanding of our business there are still significant gaps. Divisions still lack capacity and capability to fully understand efficiency opportunities in their business.	Director of Efficiency and Transformation	Finance and Investment Committee	20
	Low	*SR7*	We do not have a clear and effective business planning cycle to enable clear, timely and realistic plans and trajectories. This results in the Trust having incomplete plans and management action becoming reactive.				Limited	The Committee is assured that the financial and operational plan for 2018-19 is in the final stages of development but assurance that this risk is controlled remains limited until reporting against the plan across the first quarter of 2018/19 demonstrates its delivery.	Chief Finance Officer	Finance and Investment Committee	15
Champion team St George's	*Low*	*SR8*	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.				Partial	Staff survey results have moved in a positive direction and the Committee is assured that the staff engagement programme is being delivered. The Committee has reasonable assurance that controls are generally adequate and effective but there are areas where further improvement is needed.	Director of HR and OD	Workforce and Education Committee	10
	Moderate	*SR9*	Due to a failure to develop and implement an effective communications strategy our staff feel disengaged, uninformed and unvalued.				Partial	The Annual Communications Survey has been carried out and is being analysed, this is a source of assurance on the control of this risk and will be available in the first quarter of 2018-19. Assurances available for SR8 are also relevant to this risk. The Board is assured that the controls are in place assurance on effectiveness is partial at present.	(CEO) Director of Corporate Affairs	Board	12
	Low	*SR10*	We do not provide accessible training in the right place at the right time for our staff, in order to ensure that they are able to do their jobs effectively, resulting in staff dissatisfaction and poor care for patients.				Partial	Key performance indicators for mandatory and statutory training and appraisal give partial assurance but improvement is needed for the Committee to be confident that the controls are effective.	Director of HR and OD	Workforce and Education Committee	9
	Moderate	*SR11*	We fail to develop our future leaders and we fail to provide clarity to them about their roles and accountabilities, which leads to low job satisfaction, high turn-over and on-going instability amongst our senior leaders.				Partial	The operational restructure designed to clarify roles, responsibilties and accountabilities is being implemented and the Kings Fund leadership development programme is underway. The Committee continues to be assured that the controls are generally adequate. However, assurance on the effectiveness of the controls is not available at present.	Director of HR and OD	Workforce and Education Committee	9
Build a better St George's	*Low*	*SR12*	Our IT systems are unreliable, unstable and do not support us to provide excellent care or provide us with the information and analysis required to manage the Trust effectively.				Limited	The Committee heard that a prioritised work plan will be presented to the Board in May. The continuing level of risk is much higher than the Committee is content to accept and assurance remains limited on the control of this risk.	Chief Information Officer (CIO)	Finance and Investment Committee	20
	Low	*SR13*	Our estate is poorly maintained and underdeveloped, resulting in buildings which are not fit for purpose and may be closed by the regulator, impacting delivery and risking patient safety.				Limited	The Committee heard that the Premises Assurance Model (PAM), a key source of assurance, is currently being populated. The Board is to recieve an update paper in April and a Board seminar is planned for May. Assurance reports are being collated from the Authorised Engineers (external assurance). A full PAM review is being undertaken in July. Currently there is limited assurance due to lack of a centrally maintained information repository.	Director of Estates and Facilities	Finance and Investment Committee	15
	Low	*SR14*	We are unable to secure the investment required to address our IT and estates challenges and as a result are unable to transform our services and achieve future sustainability.				Limited	A bid for additional funding will be submitted to NHSI in May. The Trust is also investigating other sources of funding to help support capital funding; for example leasing and managed service contracts.	Chief Finance Officer	Finance and Investment Committee	16
Develop tomorrow's treatments today	*High*	*SR15*	We fail to see an improvement in our research activity and profile with consequence impacting on the reputation of the Trust.				Partial	The Committee is assured that the control of this risk is generally adequate while recognising that strengthening the links between the University and the Trust through the Joint Research Committee will improve their effectiveness.	Medical Director	Quality Committee	12
Build a better St George's	*Moderate*	*SR16*	We do not have a clearly articulated and deliverable strategy underpinned by widely communicated and owned supporting delivery plans, resulting in an inability to take strategic decisions as an organisation, leading to difficulty in identifying clincial service priorities and consequently a lack of engagement in the future success of the Trust amongst our workforce.				Limited	The Board agreed the strategy process and timescales in the March meeting. Two non-executive directors have been identified to act as links to the strategy development. The Board receives assurance from the monthly clinical strategy development highlight report which outlinines progress. Gaps in control remain regarding capacity to deliver, the recruitment to the two strategy posts is delayed as it is linked to the operational restructure of the Clinical Divisions; the Director of Financial Planning is not in post until the end of May.	(CEO) Director of Strategy	Board	12
	Moderate	*SR17*	A lack of strong, productive relationships with our key external stakeholders may result in a lack of alignment of the plans across the local health economy with our priorities and an inability to provide a source of collaborative leadership for the STP.				Limited	The Board receives assurance through the partnership highlight report for this risk. The Director of Strategy has built relationships with key stakeholders both within and outside SWL; for key stakeholders regular meetings are in place; in addition the DoS regularly attends the relevant SWL Health and Care Partnership meetings. The CEO continues to provide a lead role within the Acute Provider Collaborative and at the SWL HCP system-wide Programme Board.	Chief Executive	Board	12

sMeeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No.**	**7.3**
Report Title:	**Interim Report on NHS Premises Assurance Model (PAM)**		
Lead Director/ Manager:	Kevin Howell, Director of Estates & Facilities		
Report Author:	Kevin Howell, Director of Estates & Facilities		
Presented for:	Assurance		
Executive Summary:	To inform the Trust Board with the detail of what the PAM (Premise Assurance Model) is, how the Estates and Facilities division is utilising it, to assure compliance with policy and regulation and the responsibilities that are inherent within it, of the Trust Board. **Key messages** The PAM was developed with the NHS to create a common framework to assure all NHS Trusts against safety in a consistent manner This underpins the NHS constitution that: "You have the right to be cared for in a clean, safe, secure and suitable environment." The PAM framework is used to assure and demonstrate NHS Trusts' compliance across the multiple dimensions in good control and management of our Estates and Facilities. This paper will provide a high level description of what the PAM is and how it can be used by the Board to understand assurance and track what activity has been undertaken to date to assure the safety of our Estate. It will also provide an overview of a review which was commissioned with a third party, NIFES, to report on our compliance in limited areas between 2016 and 2018.		
Recommendation:	To review all the materials and acknowledge that this provides a much improved understanding of the PAM, the responsibilities inherent within it and it's use within St. George's University Hospital (SGUH), for current and future compliance of safety across our Estate.		
Supports			
Trust Strategic Objective:	Building a better St George's		
CQC Theme:	Safety and Well Led.		
Single Oversight Framework Theme:	Quality of care, Operational performance		
Implications			
Risk:	Failure to suitably assure SGUH's position across the NHS' constitution right; if the PAM framework is not followed as the standard in assuring our Estate		

	against the safety criteria held within the PAM. Being non-compliant with regulation and policy.		
Legal/Regulatory:	Statutory Compliance		
Resources:	Internal management within structure. External assessment and assurance to be part of the capital/revenue bid.		
Previously Considered by:	N/A	**Date:**	N/A
Equality Impact Assessment:	N/A		
Appendices:	Appendix 1 – Premises Assurance Model Appendix 2 – WHHT PAM Dashboard Appendix 3 – Premises Assurance Model - Must do actions 2016/17		

NHS Premises Assurance Model (NHS PAM)

1.0 Introduction – What is PAM?

The NHS have developed, with the support of the Department of Health, the NHS Premises Assurance Model (NHS PAM) to support the NHS nationally in meeting its commitments under the NHS Constitution 'to provide services from a clean and safe environment, that is fit for purpose based on national best practice' and the regulatory requirements, to ensure 'service users are protected against risks associated with unsafe and unsuitable premises.'

The NHS PAM consists of two parts:-

- Self-Assessment Questions (SAQs) relating to estates and facilities which are completed by the Trust and then loaded into the model (Appendix 1– example)

- Metrics use available data, to produce indicators which show the estates and facilities of any Trust relative to its peers. This uses the information collected through the Estates Return Information Centre (ERIC) process, already in place within the Trust (Appendix 2 – example)

2.0 Scope – How does it work?

2.1 The NHS PAM is a management tool, designed to provide assurance and a nationally consistent approach to evaluating NHS premises performance against a set of common indicators. It delivers a basis for:

- Assurance on the premises in which NHS Healthcare is delivered.

- Driving premises-related performance improvements throughout the system.

- Providing greater understanding of the vital role that NHS premises play in the delivery of improved clinical and social outcomes.

2.2 Locally, it supports clinical leaders and Directors of Finance and Estates who, in using the NHS PAM, will have the right information to make more informed decisions on the management and development of their estates and facilities assets. It also provides important information to Commissioners for use during the commissioning process and Regulators for assurance and in identifying risks. The NHS PAM is also a key enabler to allow the NHS to deliver its commitment to cross government initiatives.

2.3 The NHS PAM Assessment will cover all the Trust's owned and operated properties, including the Private Finance Initiative (PFI) sites and those under Service Level Agreement (SLA), Lease or other form of tenure.

The way in which the self-assessment is undertaken and subsequently adopted locally will greatly influence the level of assurance that can be drawn from the use of the NHS PAM.

Following the self-assessment assurance can be increased by:

- Embedding the NHS PAM compliance framework within job descriptions, training and roles and responsibility.
- Agreement and review of the NHS PAM assessment by the Board.
- Scrutiny and dialogue with commissioners on the NHS PAM assessment.
- The level and role of audit within the NHS PAM process.
- If the NHS PAM has formed the basis for a CQC inspection.
- If the self-assessment or parts of it has been independently verified or peer reviewed.
- The level which the self-assessment is consistent with patient feedback.

3.0 St George's statement – What St George's has done

3.1. It is the policy of St Georges NHS Foundation Trust (the Trust/STG) to provide, maintain and develop a high quality environment in a professional, efficient, cost effective and customer focused manner to enable the Trust to meet its aims today and in the future all for the benefit of clients, staff and visitors.

In order to achieve this, the Trust shall put in place an operational structure with the necessary resources to comply with legislative requirements and current best practice.

3.2. The Trust will utilise the NHS PAM as a tool to achieve the following:

- Allow the Trust to demonstrate to their patients, commissioners and regulators that robust systems are in place to assure that our premises and associated services are safe.
- Provide a consistent basis to measure compliance against legislation and guidance.
- Allow the Trust to compare how efficiently they are using their premises.
- Help to prioritise investment decisions to raise standards in the most advantageous way.

- Assure the Board of our compliance.

A third party company (NIFES), have carried out a survey of our estates and facilities performance against the Self-Assessment Questions (SAQs) within the NHS PAM. The initial review was carried out in 2016.This review was not completed in totality and remained in draft until 2018. The final interviews to complete the 2016 survey were undertaken in March 2018.

Estates and Facilities have reviewed the output and assessed what evidence is in place as well as identified actions required to be undertaken to improve our compliance position. These actions are held in the Estates & Facilities action plan and evidence to support the assurance has started to be collected to allow evidence to be logged within our Evidence Library.

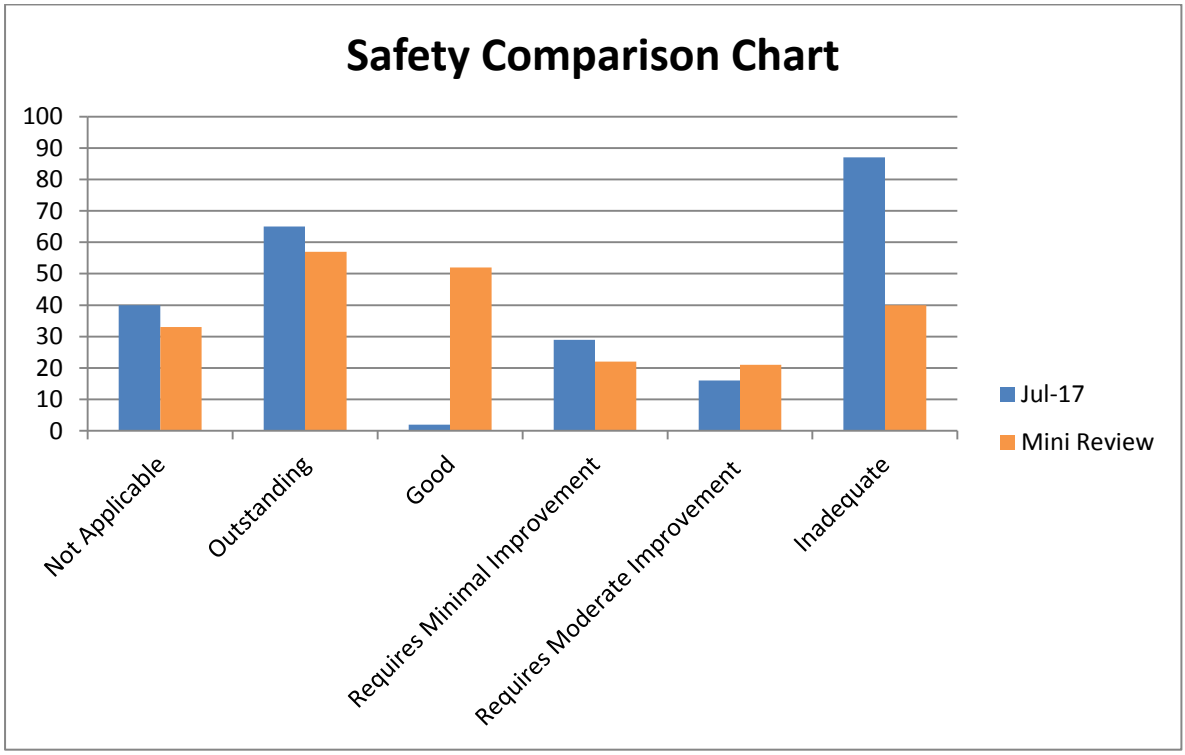
On receipt of the report from NICE in February/March 2018, it became evident that there were a number of outstanding issues. If the report had been issued it would have identified various areas which had fallen into the inadequate, requires moderate and requires minimal improvement categories. The overarching plan was for another review to be undertaken on an annual basis. This meant the next review was set for in October/November 2018.

With the lapse of time between the surveys being undertaken and the issuing of the report, the Director of Estates & Facilities had serious concerns about the level of assurance that could be given to the committees and Board on our progress and trajectory. The initial thought was that the review had not picked up all areas of information which since January, had been progressed.

Giving the substantial numbers of inadequate, the Director of Estates & Facilities asked for a “quick and dirty review” to be undertaken on one particular area, the safety domain. The review was specifically aimed at Estates and did not pick up any review of soft Facilitates. Substantial records had originally been received from our FM services which had already gained assurance and therefore we needed to understand the worst performing aspect which was our hard FM Estates.

The resultant detailed analysis shows that there was a substantial improvement in the Safety domain as shown in the safety comparison chart. This also indicated to the Director of Estates & Facilities that some of the work that had been undertaken for the gathering of information in the first three months of the calendar year, had started to prove fruitful. It was believed that a more detailed review may also realign the overall scoring and whilst there would not give complete assurance, it would give limited or better assurance to the Board if the planned full review was brought forward to July 2018, rather than in September/October of 2018.

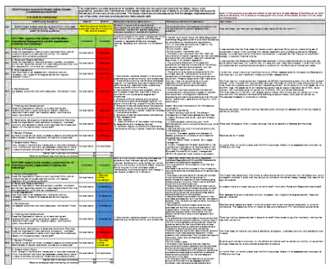
The information database had not been maintained to an adequate standard. Whilst there is evidence of good practice in general applications of the principles, this only gave limited assurance as physical/recorded evidence were not available in a singular repository



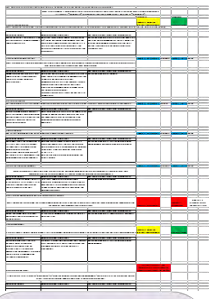
4.0 Structure of PAM

4.1 The assessment is based on the following five Domains which require a response to a questions set which is summarised as follows:

- Efficiency
- Safety
- Effectiveness
- Patient Experience
- Organisational Governance

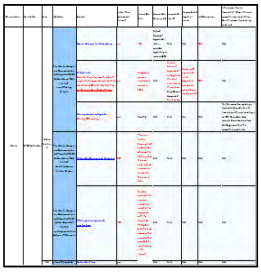


The NIFE PAM assessment
NIFE have carried out a review of our compliance against the set of Self Assessment Questions in 2016.



EF PAM review
E&F then reviewed the results to understand what the gaps are to build an action plan and a library of our evidence.

THE E&F Action Plan
Actions have been identified, owners allocated and milestones planned out.



Evidence Library
To provide a view of where our evidence is stored and what is available we have created a log of all evidence by area and hyperlinked back to the available documents or highlighted the gap.

Domain	Domain statement
Safety	The organisation provides assurance for Estates, Facilities and its support services that the design, layout, build, engineering, operation and maintenance of the estate meet appropriate levels of safety to provide premises that supports the delivery of improved clinical and social outcomes.
Patient experience	The organisation ensures that patient experience is an integral part of service provision and is reflected in the way in which services are delivered. The organisation will involve patients and members of the public in the development of services and the monitoring of performance.
Efficiency	The organisation provides assurance that space, activity, income and operational costs of the estates and facilities provide value for money, are economically sustainable and meet clinical and organisational requirements.
Effectiveness	The organisation provides assurance that it's premises and facilities are functionally suitable, sustainable and effective in supporting the delivery of improved health outcomes.
Organisation governance	How the organisations board of directors deliver strategic leadership and effective scrutiny of the organisations estates and facilities operations. How the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the NHS Boards and embedded in internal governance and assurance processes to ensure actions are taken where required.

Dependent on the answers to the different activity against each Domain, an indication of performance in dashboard format can be provided. From the questions asked and replies received where there is less than full assurance, must do actions plans can be produced with timescales set against each, with responsible persons identified (an example is attached from West Hertfordshire NHS Trust as Appendix A, B & C).

4.2 The first four domains listed above, cover the main areas where Estates and Facilities impact on safety and efficiency. The Organisational Governance Domain acts as an overview of how the other four Domains are managed as part of the internal governance of the NHS organisation. Its objective is to ensure that the outcomes of the Domains are reported to the Board and embedded in internal governance processes to ensure actions are acted upon and resolved where required.

Below each domain, is a list of activity including CQC standards - these are grouped to give assurance against each domain. Pass/fail is based on the responses to the SAQ's set against these activities.

5.0 Responsibilities

5.1 Trust Board

5.1.1 The Trust Board has overall accountability for all the activities of the organisation, which includes the management and maintenance of the Trust's Estate and ensuring the NHS PAM is appropriately utilised as an assurance tool.

5.2 Chief Executive

5.2.1 The Chief Executive has overall statutory and operational responsibility for the management and maintenance of the estate and will ensure that the NHS PAM is completed in accordance with DoH Guidelines.

5.2.2 The Chief Executive delegates the operational day to day responsibility and authority to the Director of Estate and Facilities, who will ensure the NHS PAM is completed, reviewed and findings reported.

5.3 Director of Estate and Facilities

5.3.1 The Director of Estates and Facilities will ensure the NHS PAM is completed, maintained and reported on, in accordance with the latest NHS PAM advisory documents issued.

6.0 Training

6.1 All managers will be given training on how PAM works, how to gather and record information and how to report/action. The Executive Directors and Board will be given a presentation on the working of PAM and its purpose within a board development day.

7.0 Next Stage

7.1 Review assurance documents and work plans from Authorised Engineers (AE) to populate the library – 2 months.

7.2 Gather together information packages into an electronic or physical library – 2 months.

7.3 Instigate annual review of overall PAM by external assessor in advance of annual review date – July 2018.

7.4 Board development session allocated to understanding PAM – May 2018

7.5 Complete appointment to senior Head of Estates position to identify professional substantive level – May 2018.

7.6 Carry out restructure of Estates & Facilities division to re-align statutory compliance portfolio by creating a central business section which oversees the contract and reporting responsibilities and a subsection of the estates division to hold the professional managers to account. We will divide operational and business management – 12 months.

7.7 Create investment portfolio and business care from emergency action plan and create substantive programme with milestones identified to give regular updates to the Board for assurance – 12 months.

Kevin Howell
Director of Estates & Facilities
April 2018

Appendix 1 **PREMISES ASSURANCE MODEL (PAM) – Groupings & Activity Area**

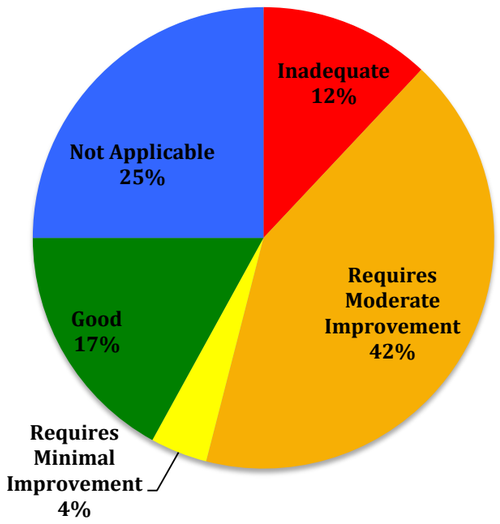
St George's University Hospitals NHS
NHS Foundation Trust

Effectiveness	Efficiency	Patient Experience	Safety		Governance
Policies	Procurement	Patient Commissioner Engagement	Asset Management & Maintenance	Fire Safety	Shared Vision
Strategy	Estate Operating Costs (vfm)	PLACE	Design & Layout	Waste Management	Governance
Acquisition & Sales	Space Utilisation	Cleanliness	Health & Safety	Cleanliness / Infection Control	Accountability
Land & Property Management	Capital Investment	Catering Services	Catering Services	Laundry & Linen	Risk Management
Transport & Access		Car Parking	Asbestos	Medical Devices	
Sustainable Development		Portering	Medical Gas	Security Management	
CQC Fundamental Standards & KLOE		Switchboard	Water	Emergency Planning & Resilience	
Nutrition & Hydration Needs (Standard 14)			Electrical Systems	Transport Services	
Premises & Equipment (Standard 15)			Mechanical Systems	Pest Control	
Good Governance (Standard 17)			Ventilation	Reporting Systems	
Staffing (Standard 18)			Lifts	Contractor Management	
			Pressure Systems	Capital Projects	
			Decontamination		

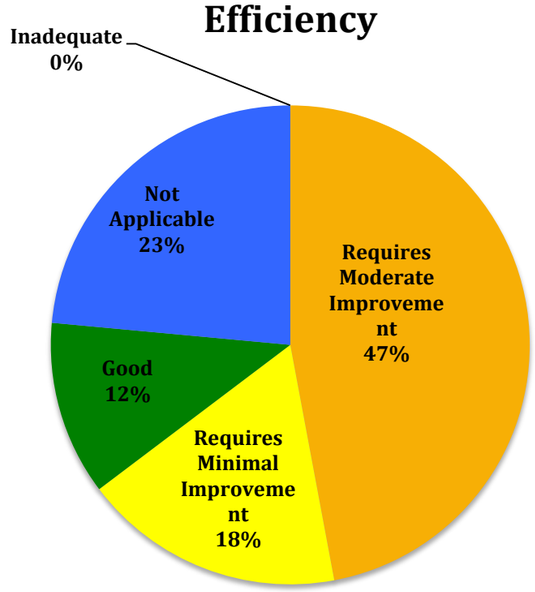
Appendix 2

WHHT PAM DASHBOARD (2015/16) - BY DOMAINS

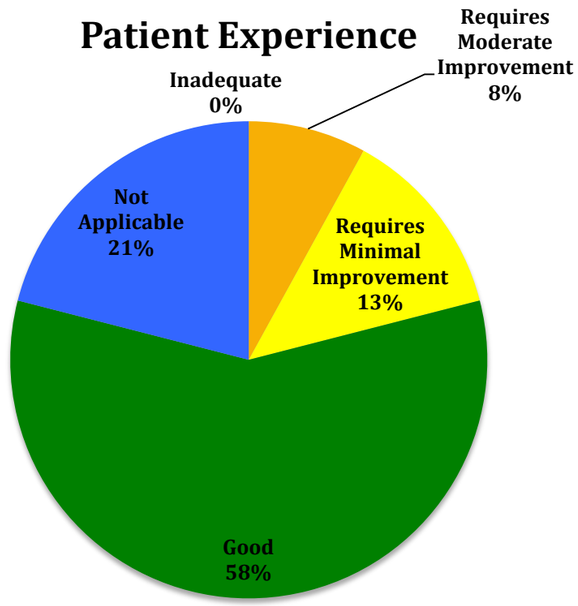
Effectiveness



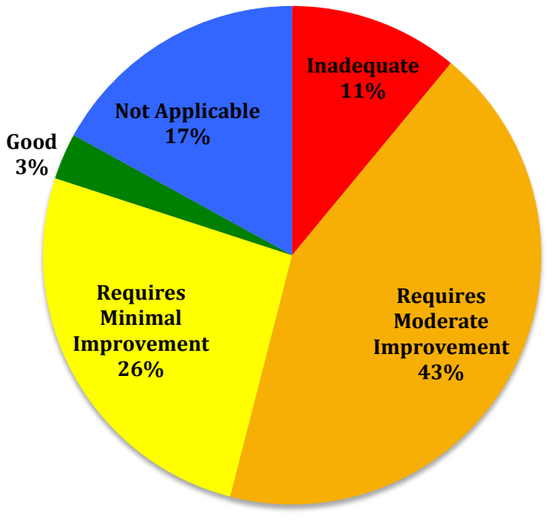
Efficiency



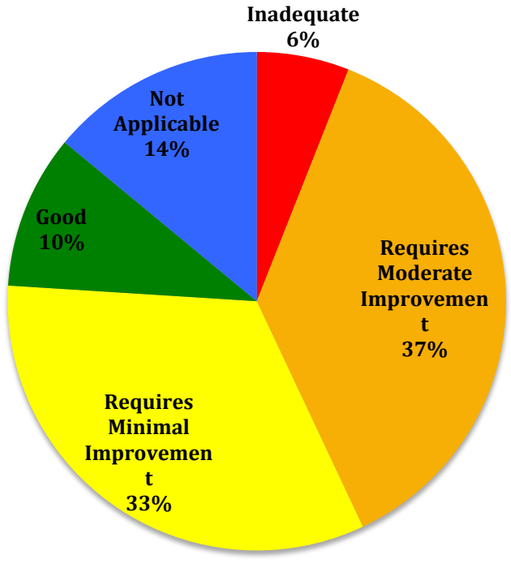
Patient Experience



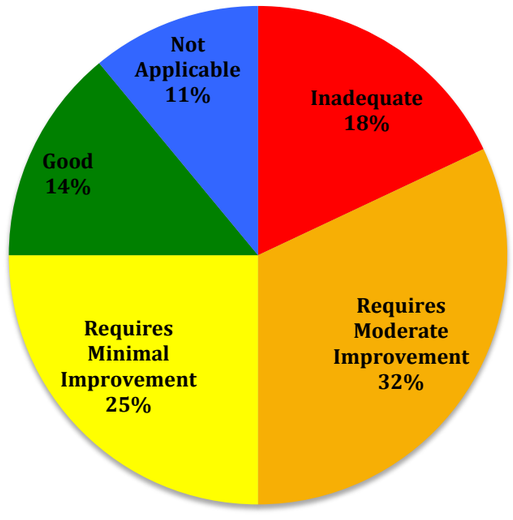
Safety (Hard Services)



Safety (Soft Services)



Organisational Governance



St George's University Hospitals NHS
NHS Foundation Trust

Appendix 3

Premises Assurance Model (PAM) - Must Do Actions for 2016/17 (Version 1)

Serial	Domain	Element	Requirement	Actions Required	Target Date	RAG (Delivery)
1	**Effectiveness**	E3: A well-managed robust approach to management of land and property	Disposal of Freehold and Leasehold land and property	Process, roles and responsibilities to be defined. Property manager to be appointed.	31 Aug 2016	
2		E4: A well-managed annually updated Board approved sustainable development management plan	Sustainable development management plan (SDMP) in accordance with Sustainable development Unit (SDU) guidance	Define sustainable development roles and responsibilities within Trust. Nominate lead Exec. Produce SDMP for Board approval	30 Jun 2016	
	Efficiency	Nil				
	Patient Experience	Nil				
3	**Safety (Hard Services)**	SH1: Estates and facilities operational management	Estates and facilities operational policy with underpinning procedures that comply with relevant legislation and published guidance	Develop an Estates & Facilities operational policy providing clear direction for service and with evidenced links to relevant legislation and published guidance	30 Jun 2016	
4			Does organisation have appropriately qualified, competent and formally appointed people with clear roles and responsibilities, supported by accurate and understood current job descriptions.	Roles and responsibilities to be defined in operational policy and strategy documents. Job descriptions to be signed by incumbents. Annual competency review of staff through appraisal process.	31 Jul 2016	
5			Are assets, equipment and plant adequately maintained	Develop infrastructure asset register for plant and equipment. Update 6 Facet condition survey. Develop ppm programme based on SFG20. Develop life cycle replacement programme.	1 Nov 2016	
6			Does organisation have an up to date training and development plan	Develop a costed training matrix for Division based on essential, mandated and professional development requirements for all staff / positions	30 Jun16	
7		SH2: Design, layout and use of premises	Does the Organisation have a policy for the management of small and capital works that complies with relevant legislation and published guidance	Develop a policy with supporting procedure documents for the management of small and capital works.	31 Jul 16	

St George's University Hospitals NHS
NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	26 April 2018	**Agenda No**	**7.4**
Report Title:	**St. George's Hospital Charity Quarterly Report**		
Lead Director/ Manager:	Suzanne Marsello, Director of Strategy		
Report Author:	Suzanne Marsello, Director of Strategy		
Presented for:	Update		
Executive Summary:	As part of the revised link between St. George's and St George's Hospital Charity, it has been agreed that a quarterly report should be provided to Trust Board to provide an update regarding the activities of the Charity, and an overview of the grants awarded by the Charity. This report is the first such report to Trust Board and has been developed in collaboration with the Interim CEO of the Charity. The Chair and Interim CEO of the Charity have been invited to attend the May Trust Board meeting to provide an overview of the activities of the Charity and their priorities.		
Recommendation:	Trust Board is asked to note the report, and the investment that has been agreed by the Charity in support of Trust projects.		
Supports			
Trust Strategic Objective:	Treat the patient, treat the person. Right care, right place, right time. Balance the books, invest in our future. Build a better St. George's. Champion Team St. George's. Develop tomorrow's treatments today.		
CQC Theme:	Safe, Effective, Well-Led.		
Single Oversight Framework Theme:	Strategic Change.		
Implications			
Risk:	As outlined in paper.		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	Trust Executive Committee	**Date:**	18 April 2018
Appendices:	None		

St. George's Hospital Charity Quarterly Report

1.0 Purpose

1.1 The report is provided to give Trust Board an update regarding the activities of the Charity, and an overview of the grants awarded by the Charity in its Trustee's meeting on 23 March.

1.2 A regular quarterly report will be provided going forward that details grants awarded and other key activity related to the Charity.

2.0 Update

2.1 Martyn Willis retired from the position of Chief Executive at the end of March 2018. The Charity is advertising for a new Chief Executive through recruitment consultants Saxton Bampfylde.

2.2 Paul Sarfaty (one of the Charity's Trustees) has been appointed as Interim Chief Executive from 1 April 2018.

2.3 The Charity organised and hosted the first SGUH Staff Appreciation Awards evening at Wandsworth Town Hall on 15 March 2018, which was very successful.

2.4 A review of Special Purpose Funds (SPFs) is under way to better understand value and performance. Some consolidation of the c. 270 separate funds is a likely recommendation outcome to enhance efficiency and sustainability.

3.0 Overview of Grant Awards

3.1 A total of £322,810 was awarded in support of projects on 23 March, as detailed below:

Grants Awarded and Approved on the 23 March 2018 (Trustee's meeting)		
	Purposes	
Ad-Hoc Grants		
Imaging & Proteomic assessment of aortic aneurysm	For assessment of Aortic aneurysm in patients with bicuspid and tricuspid aortic valve	**£57,000**
Young Onset Dementia	This is a very successful ongoing project for which we continue to raise funds and from which, if approved, this grant will be made	**£25,000**
Surewash 'Go' portable machine	A grant was made for one of these machines three years ago in the Infection Control Division and has proved to be very effective in training staff on proper hand washing.	**£9,900**
Neuro ICU Relatives room	To give patient families a better experience	**£21,250**
	Sub-Total	***£113,150***

ANNUAL GRANTS		
Arts budget	This is a request to increase the Arts budget by £11,000 on previous years.	**£78,660**
Art Director's salary	This will be the third year of four that has been previously approved by Trustees to support the grant from the Big Lottery Fund of £144,000 over four years.	**£52,000**
Christmas Grant		**£22,500**
Medical Research	There is no official application for this as it is a commitment made to the trust and the University as part of our research initiative	**£50,000**
Gardens	To pay for the 40,000 bulbs planted each year. Full application with agenda pack	**£5,000**
Volunteers Outing	Report and application with agenda pack	**£1,500**
	Sub-Total	***£209,660***
	Grand Total	***£322,810***

3.0 Recommendation

3.1 Trust Board is asked to note the report, and the investment that has been agreed by the Charity in support of Trust projects.

3.2 The Chair and CEO of the Charity have been invited to attend the May Trust Board meeting to provide an overview of the Charity and key priorities to the Board.

Suzanne Marsello
Director of Strategy
April 2018